

Submission to the Preventative Health Taskforce on 'Australia: The Healthiest Country by 2020'

It would be very sad to survive HIV and die of something else that was preventable.¹

Epidemiologist Dr. John T. Brooks referring to obesity,
Centers for Disease Control and Prevention

The Australian Federation of AIDS Organisations (AFAO) congratulates the Preventative Health Taskforce on the delivery of an excellent discussion paper and accompanying technical papers. The standard of information, means of presenting that information and the genuine efforts to set tangible targets is to be applauded.

AFAO is the peak body for Australia's community sector response to the HIV/AIDS epidemic. AFAO is charged with representing the views of its members: AIDS Councils in each state and territory, the National Association of People Living with HIV/AIDS, the Australian Illicit and Injecting Drug Users League, and Scarlet Alliance - the national organisation representing sex workers. The implications of effectively representing our membership in this submission are twofold. Firstly, while AFAO broadly supports the propositions put forward in *Australia: The Healthiest Country by 2020* ('the preventative health discussion paper'), and is in general agreement with that proposed by the Taskforce, many of the areas are outside the agency's expertise. Consequently, this submission will limit comment in the first instance to the three key preventative health areas and their application to our primary are of focus: HIV. Secondly, the mechanism for delivering state-based HIV services has changed considerably during the last decade, with many services broadening their focus to include lesbian, gay, bisexual and transgender (LGBT) health. This is partly a response to the majority of people diagnosed with HIV infection in Australia being men with a history of homosexual contact², that gay men and men who have sex with men continue to be a priority for HIV prevention education, and an understanding that an HIV message is likely to be most effective if understood as part of a broader, holistic approach to health. To represent the interests of many of our member organisations, this submission will also make reference to areas of LGBT health.

1. HIV infection and AIDS in 2008

The Human Immunodeficiency Virus (HIV) attacks the human immune system, leaving infected people vulnerable to chronic progressive illness, opportunistic

¹ In Alicia Chang, "Obesity a Problem in HIV Population", Associated Press, 4 October 2007.

² National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2007*. National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, 2007, p.18.

infections and cancers. By the end of 2007 there had been 27 331 diagnoses of HIV infection, 10 230 diagnoses of AIDS, and 6767 deaths from AIDS related illnesses in Australia (67 deaths in 2007). Currently, some 16 690 people are estimated to be living with HIV. Some 90% of those infected are men.³

The clinical manifestations of chronic HIV infection have changed dramatically since the mid-1990s as a result of combination antiretroviral therapy. Many people living with HIV (PLHIV) now expect to live long lives, although an HIV diagnosis continues to have a profound effect on those diagnosed. While treatments have significantly impacted disease progression, these same treatments frequently result in episodic illnesses and co-morbidities with greater immediate impact than the actual HIV infection. Treatments are complex and many include toxicities which trigger severe side effects. PLHIV's needs have become longer term and increasingly complex, sometimes the result of the cumulative affect of living for years with fluctuating health. Many struggle with HIV's unpredictability.

2. Lessons from Australia's response to HIV/AIDS

In basic terms, the Australian approach to HIV has been extraordinarily successful and has enjoyed long-term recognition as an example of international best practice. Its effectiveness is identified numerous times in the preventative health discussion paper, including its 'quite spectacular long-term returns on investment and cost savings'⁴.

Australia's official response to HIV is encapsulated in the *National HIV/AIDS Strategy (2005-2008)*. It stipulates the two goals of eliminating HIV transmission and minimising the personal and social impacts of HIV/AIDS through six guiding principles:

- leadership: strong and visible leadership by the National Government (including bipartisan support), and by all other relative parties
- the HIV/AIDS partnership: recognising the importance of a multi-sectoral response from government, community, PLHIV, researchers and the fields of science and medicine
- the centrality of PLHIV: ensuring policies and programs are informed by the experiences of PLHIV, are responsive to need, and take adequate account of the full range of personal and community effects of policy directions
 - an enabling environment: delivering a supportive social, legal and policy environment that encourages PLHIV and affected communities to support and promote education and prevention, respond to education, access voluntary

³ Ibid.

⁴ p.xi, based on the findings in Abelson and Applied Economics, 'Returns on Investment in Public Health', Canberra, Department of Health and Ageing, 2003.

testing and treatment services, and participate effectively in all levels of the response.

- non-partisan response: ensuring the response does not become inappropriately 'politicised'
- health promotion and harm minimisation: including addressing disease prevention, education, social mobilisation and advocacy, with an emphasis on a complete state of wellbeing: recognising vulnerabilities can be influenced only by a holistic approach addressing the total experience, not just individual behaviours

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

- the provision of appropriate levels of funding in most instances (via transparent and accountable mechanisms), and the clear delineation of prevention monies from monies for direct service provision, and
- the funding and delivery of expert research and surveillance data (developed with communities and service providers), ensuring the HIV response has been evidence based.

From a community perspective, it must be stated that at times the partnership approach has been a struggle but in broad terms, lines of communication have usually remained open. In addition to significant budgetary savings, the partnership approach has saved many thousands of lives. It is an important preventative health model and future Australian preventative health strategies would benefit from close reference to its structure and lessons learned through its implementation.

3. The importance of targeting

Social factors influence broader patterns of health and illness within any given population. While the preventative health discussion paper refers to social determinants and targeting, it does so in a very limited number of instances. People living with HIV, and gay, lesbian, bisexual and transgender people are absent.

Mainstream health promotion campaigns are appropriate at times, however, the impact of targeting health promotion cannot be overestimated. The HIV sector has weighty experience of effectively targeted preventative health campaigns. Unfortunately GLBT community based agencies have received less targeted funding, and strong research and targeted preventative health campaigns for these communities are only beginning to emerge.

PLHIV have both specific primary health care needs and also particular experiences of living and participating in the broad Australian community which impact their health. There is also a significant body of anecdotal and research evidence that suggests GLBT people experience different patterns of illness from the rest of the population and have significant unmet health needs.⁵ Obesity, tobacco and alcohol can be understood as impacting these (and other) communities in different, tangible ways. Following is an outline of current research to which AFAO has referred on the three priority areas. AFAO strongly argues for Australia's preventative health framework to specifically acknowledge the necessity of targeted health promotion and commit to the delivery of adequate funds to research, devise and deliver effective preventative health measures to these population groups.

3.1 Issue 1: Obesity

HIV - Until recently, HIV has been associated with undesired weight loss⁶ as it commonly affects both the immune system and causes metabolic disruption and body fat changes. Before the availability of anti-retroviral treatments, many patients experienced 'wasting syndrome', the uncontrollable loss of greater than 10 percent body weight. Currently, many people experience lipodystrophy - the diminishing of fat from legs, arms, buttocks, or face (sunken cheeks), and/or a significant increase in the amount of visceral fat (fat deep within the body) around their gut, and sometimes also their neck and shoulders. Some of these changes are likely the result of antiretroviral therapy while others result from HIV itself. The complex relationships between the virus, immune and metabolic changes, and antiretroviral therapy remain poorly understood⁷. Issues surrounding lipodystrophy, its cause and its inter-relationship with treatments and other side effects are inordinately complex and require highly specialised medical/scientific investigation. As an isolated 'consequence' of HIV infection, lipodystrophy largely remains outside the reach of a direct preventative health approach, although good health practices remain important.

A somewhat unexpected development is the growing concern about the intersection of HIV and obesity. 'HIV has become a chronic disease. Long-term complications related to diet, overweight, and obesity have gained a new importance.'⁸ The implications are significant as the resulting predispositions to

⁵ Marian Pitts, Anthony Smith, Anne Mitchell, Sunil Patel, *Private Lives - A report on the health and wellbeing of GLBTI Australians*, March 2006

⁶ Including 'Wasting Syndrome': the progressive and uncontrolled loss of more than 10 percent of your body weight, accompanied by symptoms of diarrhea, fever or weakness that persist for over a month.

⁷ Liz Highleyman, Inflammatory Changes May Help Explain Elevated Cardiovascular and Diabetes Risk in HIV Patients on Antiretroviral Therapy on HIVandHepatitis.com.

⁸ Kristy M. Hendricks, Karen Willis, Robert Houser, and Clara Y. Jones, 'Obesity in HIV-Infection: Dietary Correlates', *Journal of the American College of Nutrition*, Vol. 25, No. 4, 321-331 (2006).

diabetes and cardiovascular disease are complications associated with HIV and/or its treatment.

Most data is US based. In 2001, Hodgson found a high prevalence of obesity among HIV patients: 34% overweight and 9% being obese.⁹ A 2005 study by Amorosa et al¹⁰ found obesity had become more common than wasting amongst HIV-positive people in Philadelphia. Research found some 58% of HIV-positive women and 42% of men were either obese or overweight: 31% of women and 30% of men being obese.¹¹ The figures did not significantly differ from those of the urban Philadelphia general population. The report suggested the possibility that:

given the association of AIDS with progressive and dramatic wasting, despite potential morbidities, some HIV-infected patients may favor [stet] maintaining elevated weight to serve as a protective cushion against future wasting or may believe that being overtly overweight masks their disease from friends or acquaintances.¹²

There is no available data on whether and how broadly this possibility may apply in Australia.

The 2006 US study by Hendricks et al reported 13% of males and 29% females were obese.¹³ That study found that since 1998, the prevalence of overweight among Nutrition for Healthy Living study subjects had risen from 27% to 34% percent in women, and from 33% to 40% percent in men. The prevalence of obesity had risen from 6% to 13% percent in men, and from 21% to 29% in women.¹⁴

A 2007 Californian study by Dr Crum-Cianflone reviewed 663 HIV patients' medical records at two Navy hospitals and found 63% of patients were overweight or obese. Strikingly, some 30% of people with AIDS were overweight or obese. These numbers were considered particularly notable given study participants were drawn from the military and where considered likely to be in better physical shape than the general population.¹⁵ Analysts surmise the medical

⁹ Hodgson, Ghattas, Pritchitt, Schwenk, Payne, Macallan, 'Wasting and obesity in HIV outpatients', *AIDS*, 15, 2001, pp.2341 –2342.

¹⁰ Valerianna Amorosa, Marie Synnestvedt, Robert Gross, Harvey Friedman, Rob Roy MacGregor, Debie Gudonis, Ian Frank, Pablo Tebas, 'A Tale of 2 Epidemics: The Intersection Between Obesity and HIV Infection in Philadelphia', *Journal of Acquired Immune Deficiency Syndromes*, 15 August 2005, 39(5), pp.557-561.

¹¹ Ibid.

¹² Ibid. Note, similar assertions have been made in relation to African and Indian populations.

¹³ Kristy M. Hendricks et al, at 8 above.

¹⁴ Shevitz and Knox, 'Nutrition in the era of highly active antiretroviral therapy', *Clinical Infectious Diseases*, 32(12), 2001, pp.1769 –1775, in Kristy M. Hendricks et al, at 8 above.

¹⁵ Alicia Chang, at 1. above.

advances that have resulted in more HIV patients living longer, now mean many are prone to the same bad habits as many HIV negative Americans: poor eating choices and lack of exercise.

There are no available data on the incidence of overweight and obesity among HIV positive Australians: an issue in itself. The 'HIV Futures' series by the Australian Research Centre in Sex, Health and Society is the most authoritative source of longitudinal data on the experience of Australian PLHIV. *HIV Futures 5: Life as we know it* (HIV Futures 5) reports that when asked about health management strategies, almost all participants agreed that exercise, healthy eating and an optimistic outlook were important or very important strategies. Notably, those who indicated they exercised and ate well were more likely to agree with the respective statements than those who did not: ¹⁶

Looking after my physical fitness is an important part of managing my HIV infection	
• strongly agree	47.0
• agree	47.8
• disagree	4.8
• strongly disagree	0.4
Healthy eating is an important part of managing my HIV infection	
• strongly agree	43.3
• agree	52.1
• disagree	3.7
• strongly disagree	0.8

As weight loss is a documented predictor of decreased survival of PLHIV, the role of intentional weight loss in overweight and obese HIV infected people also requires thorough scientific study.¹⁷

GLBT – Gay men appear to enjoy some statistical privilege in relation to overweight and obesity. The 2004 Australian study 'Private Lives'¹⁸ found that gay men were less likely to be overweight or obese than the Australian average male (43% to 54%). One consequence of that understanding is there is little Australian data on overweight and obesity among gay men, and limited effort to develop means to reach those gay men who are overweight.

¹⁶ J Grierson, R Thorpe and M Pitts, *HIV Futures 5: Life as we know it*, monograph series number 60, The Australian Research Centre in Sex, Health and Society, Latrobe University, Melbourne, 2006.

¹⁷ Tang, Forrester, Spiegelman, Knox, Tchetgen, Gorbach, 'Weight loss and survival in HIV-positive patients in the era of highly active antiretroviral therapy' in *Journal of Acquired Immune Deficiency Syndromes*, 31 :pp.230 –236 in Kristy M. Hendricks et al, at 8 above.

¹⁸ Marian Pitts et al, at 5 above.

'Private Lives' also identified that lesbian women were more likely to be overweight or obese than the Australian average female (49% to 38%). A 2007 report on the health and wellbeing of lesbian and bisexual women in Western Australia¹⁹ found that some 23% of lesbian and bisexual women were overweight (compared to 26.5% of women in the general population), and 22% of lesbian and bisexual women were obese (compared to 18% of women in the general population).

The study found that:

- the median number of serves of vegetables eaten per day was 2, and only 12% of participants consumed the recommended five serves/day, compared with 17% of women in the general population.
- lesbian and bisexual women consumed fast food more frequently than women in the general population, with 53% of participants reporting that they ate fast food once or twice/week, compared to 28% of women in the general population.
- just over half of participants (53%) reported they ate fast food once or twice/week, compared with 27.5% of women in the general population. Some 7% of participants reported they ate fast food three or four times/ week, compared with 2% of women in the general population, and 5% of lesbian and bisexual women ate fast food five or more times per week, compared with 0.2% of the general population.
- two out of five women (41%) did not engage in moderate physical activity in the previous week, and one in five (20%) did not engage in vigorous physical activity, suggesting that a significant proportion of lesbian and bisexual women are insufficiently active for health benefit. Of note, the women that did engage in physical activity did so for a longer period of time than women in the general population.

Further research needs to be done, and appropriate targeted preventative health measures taken.

3.2 Issue 2: Tobacco

Data from the HIV Futures 5 study shows that almost half of PLHIV smoke (47.6%), more than twice the rate of the general Australian population (23%). This figure is particularly concerning as many of the conditions associated with smoking are much more likely to occur in those who are HIV positive. Smoking weakens overall immune response, making PLHIV who smoke more vulnerable to infections and AIDS-defining illnesses including serious and debilitating lung bacterial infections such as *Pneumocystis carinii* pneumonia (PCP). HIV positive

¹⁹ Zoë Hyde, Jude Comfort, Graham Brown, Alexandra McManus, Peter Howat, *The Health and Well-Being of Lesbian and Bisexual Women in Western Australia*, 2007.

smokers are also likely to develop cancers such as throat, lung, anal, and colon cancer at higher rates than the HIV-negative Australian population.

Diabetes diagnosis is becoming more common among PLHIV as a side effect of some HIV antiretroviral treatments: a problem that smoking compounds as smoking directly affects insulin sensitivity and therefore negatively affects blood sugar metabolism. Smoking significantly increases the risk of cardiovascular disease, again exacerbating the effect of HIV infection and treatments, and emphysema is likely to occur earlier in HIV positive smokers than in HIV negative smokers. HIV positive smokers are more likely to develop difficult to treat oral health conditions, including Oral Hairy Leukoplakia (Epstein Barr Virus), Oral Candidiasis (Thrush), Mouth Ulcers, and Oral Cancers. Smoking may also compound the negative impact of HIV infection and treatment on bone mineral density, triggering osteoporosis (declining bone porosity) and osteopenia (bone thinning).

Importantly, a US study recently found that smoking cessation in symptomatic HIV positive people can significantly improve symptom burden for HIV positive people from as early as three months of cessation.²⁰ The HIV community sector has basic strategies in place to impact this issue. The Australian Federation of AIDS Organisations/National Association of People Living with HIV Education Team has an education campaign underway on the specific harms of smoking to PLHIV and advice on quitting. Many of the State and Territory AIDS Councils and positive organisations have QUIT Smoking Programs, including Queensland Positive People who are developing a 'give up smoking' support program that welcomes PLHIV people to contact the agency to seek existing supports or to be involved in the program's development.

GLBT - Numerous studies have documented higher rates of smoking among GLBT people, particularly among lesbians. Murnane et al's 2000 report on alcohol and other drug use among GLBT Victorians found female respondents expressed concern about the level of tobacco use within the lesbian community.²¹ According to the survey, the level of women's tobacco use was higher than that of men in that sample, and both men and women in the Australian National Household Survey. The 2005 study by Hillier et al²² based on national longitudinal study data of young 9260 Australian women aged 22 to 27 years found that non-heterosexual women were more likely to be current smokers. The 2006 study by

²⁰ Virrine, Arduino, Gritz, 'The effects of smoking abstinence on symptom burden and quality of life among persons living with HIV/AIDS', *AIDS Patient Care and Studies*, 21(9), 2007, pp.659-66.

²¹ Alison Murnane, Anthony Smith, Louise Crompton, Pamela Snow and Geoffrey Munro, 'Beyond Perceptions: A review of alcohol and other drug use among gay lesbian, bisexual and queer populations in Victoria', The ALSO Foundation, Centre for Youth Drug Studies and Vic Health, June 2000.

²² Lynne Hillier, Richard de Visser, Anne Kavanagh, Ruth McNair, 'The association between drug use and sexual orientation in young women', Australia, 2005.

Pitts et al²³ found more than a third of respondents reported using tobacco more than five times in the previous month (37%) compared to approximately 24% of respondents in the Australian Bureau of Statistics' National Health Survey. The 2007 study by Hyde et al²⁴ found lesbian and bisexual women smoked at a rate nearly double that of the general female population surveyed in the *WA Health and Well-Being Surveillance System* sample (28.1% to 14.8%).

The evidence of higher rates of smoking among PLHIV and lesbians has broad implications for targeted QUIT initiatives. The potential is great:

decisions to quit smoking are not made solely by isolated persons, but rather they reflect choices made by groups of people connected to each other both directly and indirectly at up to three degrees of separation. People appeared to act under collective pressures within niches in [a] network. ... Network phenomena might be exploited to spread positive health behaviors. Indeed, cessation programs for smoking and for alcohol use that provide peer support — that is, that modify the person's social network — are more successful than those that do not.²⁵

3.3 Issue 3 - Alcohol

Alcohol consumption impacts HIV in terms of risk practices, access to treatments and disease progression.

- **Risk Behaviours**

Some studies have sought to establish an association between alcohol, drug use and unsafe sex, however, whether or not there is a causal link remains disputed.²⁶ Newman et al's research²⁷ into barriers and incentives to HIV treatment uptake among Aboriginal people in Western Australia found that alcohol 'featured in the accounts of many participants, as a key element of the

²³ Marian Pitts, at 5 above.

²⁴ Hyde et al, at 19 above.

²⁵ Nicholas A. Christakis and James H. Fowler, 'The Collective Dynamics of Smoking in a Large Social Network', *The New England Journal of Medicine*, 21:358, 22 May 2008, pp.2249-2258. Also see, Malchodi, Oncken, Dornelas, Caramanica, Gregonis, 'The effects of peer counseling on smoking cessation and reduction'. *Obstetric and Gynecology*, 101, 2003, pp.504-510, and McKnight and McPherson, 'Evaluation of peer intervention training for high school alcohol safety education' *Accident, Analysis and Prevention*, 18, 1986 pp. 339-347.

²⁶ Minichello et al. 2003, Træen et al. 2003, de Graaf et al. 1995, Weatherburn et al. 1993 cited in Henrike Korner, Olympia Hendry, and Susan Kippax, 'It's not just condoms: Social contexts of unsafe sex in gay men's narratives of post-exposure prophylaxis for HIV', *Health, Risk & Society*, March 2005; 7(1): pp.47 – 62.

²⁷ Christy Newman, Maria Bonar, Heath Greville, Sandra Thompson, Dawn Bessarab, Susan Kippax, 'Barriers and incentives to HIV treatment uptake among Aboriginal people in Western Australia, in *AIDS*, 21, January 2007, p.S13-S17.

risk context in which they acquired HIV'. Alcohol consumption was also identified as a factor associated with inconsistent condom use among multi-partnered HIV-negative men, among the 7000 Sydney Sexual Health Centre patients surveyed.²⁸

An important paper by Korner, Hendry and Kippax²⁹ explores in-depth details of exposures and participants' understanding of 'risk'. It documents the physical, social and emotional contexts in which unsafe sex occurs. Their findings are important. Firstly, they argue these contexts interact in various ways, and alcohol is just one factor at play. Secondly, their research has serious implications for the targeting of safe sex messages involving alcohol (and safe alcohol consumption involving sexual risk practices). Their research is principally among men who have a solid understanding of, and commitment to, safe sex messages. While participants reported a broad range of drug and alcohol consumption in connection with the unsafe sex episode concerned, a major theme was 'being in control despite being seriously affected by alcohol. Some participants emphasised that using condoms was a matter of routine, irrespective of drugs and alcohol with the exception of this particular episode'³⁰.

Where unprotected sex occurred in conjunction with drugs and alcohol, drugs and alcohol were not seen as an excuse. Rather, some participants emphasised their own role in allowing unsafe sex to happen and insisted that they should have been in control. Where a causal relationship between alcohol and unprotected sex was acknowledged, participants did not negate their own responsibility.³¹

- **Access and Adherence to HIV Treatments**

Studies by Haubrich et al and Chander et al are just two of numerous studies considering alcohol and its impact on access to HIV treatments and treatment adherence³². Australian research by Newman et al³³ found that despite the availability of treatments in both urban and rural areas, only 11 of the 20 Aboriginal participants were on antiretroviral treatment at the time of interview.

²⁸ Tawk, Simpson, Mindel, 'Condom use in multi-partnered males: importance of HIV and hepatitis B status', *AIDS Care*, 2004, 16(7), pp. 890-900.

²⁹ Henrike Korner et al, at 26 above.

³⁰ *Ibid.*

³¹ *Ibid.*, p.54.

³² See for example, Haubrich, Little, Dube, Forthal, Beall, Kemper, Hwang, McCutchan, 'Self reported treatment adherence and drug/alcohol use are associated with virologic outcomes in CCTG 570: a clinical strategy trial of HIV RNA antiretroviral (ARV) monitoring, *International Conference on AIDS*, 12: 597, 1998, and Geetanjali Chander, Bryan Lau, Richard D. Moore, 'Hazardous Alcohol Use: A Risk Factor for Non-Adherence and Lack of Suppression in HIV Infection' in *MedScape Today*, 2007.

³³ Christy Newman et al, at 27 above.

Four of the women had been prescribed treatment during pregnancy only. Heavy alcohol consumption was one of the main barriers to treatment.³⁴

Alcohol featured ... as a perceived factor in the progression of infection. Some had stopped drinking, but those who continued reported difficulties in maintaining treatment regimens. One participant, a mother in her early thirties living in rural Western Australia, stopped taking medication while drinking, and then took extra doses to 'catch up': If you've had a hard night out it stops you. But you know, you make it up until ... You don't double your dose but you take your one dose again ... until you start catching up.

Although participants expressed a willingness to comply with treatment regimens, the requirements for adherence are such that they were almost inevitably compromised by heavy regular alcohol consumption.

- **Disease progression**

HIV - Acute and chronic alcohol abuse impairs various functions of the immune system and has been implicated as a cofactor in HIV disease progression. A 1996 study by Lake-Bakaar and Grimson³⁵ found alcohol consumption was associated with an increased probability of AIDS. Their cross-sectional study of HIV disease in intravenous drug users put the relative risk of AIDS at 3.8 times higher in heavier drinkers than moderate drinkers. The higher rate of alcohol abuse in the group with AIDS suggested a possible link between alcohol and HIV disease progression although a causal association was not proven.

The 2006 study by Samet et al³⁶ examined alcohol use among PLHIV and found heavy drinkers³⁷ on anti-retroviral therapy were more likely to have higher HIV viral load (after adjustment for medication adherence). In those not on anti-retroviral therapies, heavy drinking was associated with lower CD4 cell counts.

The HIV Futures 5 study found that 77% of respondents had consumed alcohol during the previous 12 months,³⁸ suggesting a lower percentage of Australian PLHIV consume alcohol than in the general population (some 83%)³⁹, however, alcohol consumption remains an issue for some PLHIV. HIV Futures 5 states approximately one in five (19%) of respondents felt that they drank more alcohol

³⁴ together with fear of disclosure and discrimination, and poverty.

³⁵ G Lake-Bakaar and R Grimson, Alcohol abuse and stage of HIV disease in intravenous drug abusers, *Journal of the Royal Society of Medicine*, 89(7), July 1996, pp.389–392.

³⁶ Jeffrey Samet, Debbie Cheng, Howard Libman, David Nunes, Julie Alperen, Vincent Faber, Richard Saitz, 'The Impact of Alcohol Consumption on HIV Disease Progression', 2006.

³⁷ 4 drinks on any day or >14 drinks/week in men; >3 and >7 respectively in women

³⁸ p. 51.

³⁹ 2007 National Drug Strategy Household Survey, Australian Institute of Health and Welfare.

than they would like.⁴⁰ Such findings have prompted researchers and agencies to consider specific interventions for PLHIV. For example, the HIV Futures 5 report states some 4.5% of clients of HIV/AIDS organisations accessed their internal drug and alcohol treatment services and 14 percent accessed external drug and alcohol treatment services. Some two thirds of those clients lived below the poverty line.⁴¹

GLBT - While Australian research on alcohol and drug use by gay men and (particularly) by lesbians is limited, that which exists suggests patterns and rates of use are different - with rates of use higher than those of the heterosexual population.⁴² Numerous studies have suggested that to some extent at least, drug and alcohol use common to GLBT Australians is the result of their experiences of stigma, discrimination and abuse, internalised homophobia, and also particular mechanisms for socialising (a reliance on 'bar cultures').

Murnane et al's study of gay, lesbian, and queer communities in Victoria found that alcohol and drug use was two to four times higher than in the Victorian population as a whole.⁴³ Gay men and lesbians were less likely to abstain from drug and alcohol use, were less likely to stop using both illicit drugs and alcohol as they grow older, and there appeared to be less distinction in patterns of use between lesbians and gay men than between heterosexual men and women. The 2007 study by Hyde et al⁴⁴ states health care providers working with gay men and lesbians reported the prevalence of substance abuse in those communities to be two to three times higher than observed in the heterosexual population. That study also found that nearly a third of lesbian and bisexual women (31%) exceeded National Alcohol Guidelines⁴⁵ but that only 7% of women described themselves as being a 'heavy drinker', suggesting they were unaware 'their consumption patterns were potentially harmful, and that heavy drinking may be a normalised behaviour amongst lesbian and bisexual women'.⁴⁶

There is evidence that young GLBT people's experiences of homophobia and transphobia lead to higher rates of drug and alcohol use, compared to exclusively heterosexual youth.⁴⁷ Hillier et al's 2005 data on young Australian women aged 22 to 27 years found that they consumed alcohol at high risk levels (7%

⁴⁰ p.52.

⁴¹ p. 67.

⁴² Alison Murnane et al, at 21 above.

⁴³ Ibid.

⁴⁴ Hyde et al, at 19 above.

⁴⁵ That women should consume an average of no more than 2 standard drinks per day and no more than 14 standard drinks over a week; consume no more than 4 standard drinks in any one day; and have one or two alcohol free days per week.

⁴⁶ Hyde et al, at 19 above.

⁴⁷ Pereira, D. (1999) "HIV/AIDS and its 'willing executioners': The impact of discrimination". Murdoch University *Electronic Journal of Law* 6 (online only).

compared to 4% of the general population).⁴⁸ This may, in part, be a consequence of 'a serious lack' of drug and alcohol-free forums in which to interact.

3.4 Summary

Available data on the impact of obesity, alcohol and tobacco on PLHIV and GLBT people is patchy (making the point once again that further research is required to facilitate an evidence-based approach) but that which exists clearly indicates that PLHIV and GLBT experience of obesity, tobacco and alcohol differ from that suggested by broad population data. Some areas of possible leverage have already been identified. Others will follow. While general preventative health strategies must be inclusive of PLHIV and GLBT, targeted health prevention strategies are also crucial.

AFAO welcomes the work of the Preventative Health Taskforce and looks forward to the development and implementation of well developed, evidence based strategies to improve the health of all Australians, including PLHIV and GLBT populations.

⁴⁸ Lynne Hillier et al, at 22 above.