厚生労働科学研究費補助金エイズ対策研究事業
男性同性愛間の HIV 感染対策とその評価に関する研究

MSM に対するエイズ政策の国際比較研究
－オーストラリアの MSM へのエイズ政策と実行－

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研究要旨

この研究は、日本の MSM における HIV 感染対策としての地域レベルでの取り組みや国家的な政策を考える上で有用となる情報を提示することを目的としており、HIV 対策とその実践に成功した国から関連する情報を収集し、分析を加え、その実際について概説する。本研究は、オーストラリアの HIV／AIDS 政策やその実践に焦点をあてた評価研究である。オーストラリアでは 1984 年に HIV 感染のピークを迎え急速に広まった後、1980 年代を通して徐々に減少した。しかし 2000 年から HIV 感染率は再び増加してきている。オーストラリアの HIV 感染は、全感染の 70%がゲイの間で起きているというのが特徴である。オーストラリアにおいて HIV 感染者を急速に減少させることができた要因として、特に、感染には必須の早期対応を行った活発なゲイ組織の存在や、教育や支援を確実に行うためにゲイ組織に予算を割り当てるという、パートナーシップアプローチをとった政府の強固なリーダーシップが挙げられる。このオーストラリアでの経験は、教育とフィードバックにより、ゲイ自身が教育や研究の結果を通じて自ら責任をもって評価し、政府が資金を提供して予防に支援的な環境を創生することが、HIV 感染の減少という優れた結果をもたらすことを示している。

A. 研究目的

The aim of this research is to describe and analyze a number of counties worldwide which have implemented successful and less successful HIV policy and practice in relation to HIV prevention among MSM.

The purpose of examining international HIV policy regarding HIV prevention and support among MSM is to investigate what is shown to be effective in order to inform community level and national HIV policy for MSM in Japan.
Over the next 2 years, 5 countries will be compared, including the USA, Germany, Thailand and another industrialized Asian country such as South Korea, Hong Kong, Singapore, or Taiwan. This paper will present the findings regarding Australia’s response to HIV. In

particular it will focus on the factors behind Australia's rapid response to HIV infections among MSM from the early 1980s to the current day and the actions of the government and gay communities.

B. 研究方法

The method employed is a policy evaluation of policy and practice in response to HIV among homosexual men in Australia. First, a literature search of academic publications and government and AIDS related reports were conducted in relation to the following:

- History of the epidemic
- Epidemiology
- Structure of HIV/AIDS treatment, prevention and support policy and programs
- Budgets
- Legal, social and political responses to homosexuality and discrimination
- Policy and program evaluation

This revealed 35 policy documents which were evaluated in relation to their relevance to the Japanese situation.

C. 研究結果

Background

Australia has a population of 20 million people and the land area is similar to that of the continental United States. The population is ethnically diverse, with 25 % of the population coming from non-English speaking backgrounds, and 2% being Aboriginals, who experience lower life expectancy and high health burden. Since the 1970s, there has been a strong feminist, health consumer and gay liberation movement and in 1975 the first National Conference of Lesbians and Homosexuals was organized. The Sydney Gay and Lesbian Mardi Gras was first held in 1979 as a political demonstration for gay rights, but it has now become a large cultural gay, lesbian, bisexual, trans-gender and trans-sexual event with about half a million people attending. Up until the 1980s, homosexuality and prostitution were illegal in all states of Australia.

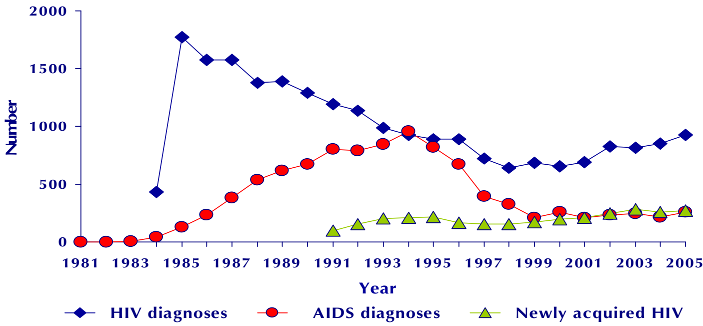
Epidemiology

Consistent with a number of industrialized countries, including the United States and OECD European countries, epidemiological data indicates that AIDS emerged in 1983. Australia experienced a peak in HIV infections in 1984 followed by a rapid then gradual decline in

annual reported HIV infections through the late 1980s and 1990s[1]. Since 2000, HIV infections rates have begun to gradually increase again, see Figure 1.

Figure 1

Diagnosis of HIV Infection[1] and AIDS in Australia



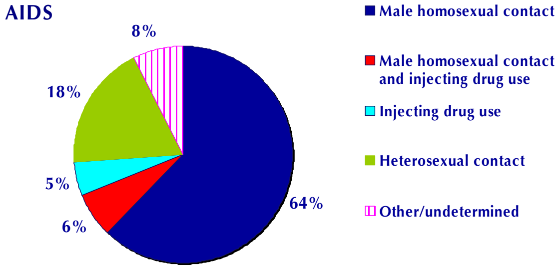
[1]HIV diagnoses adjusted for multiple reporting. AIDS diagnosis adjusted for reporting delays

Source: State and Territory health authorities

In the early stages of Australia' s epidemic, 95% of HIV infections were among MSM. Since 2000, MSM make up 70% of HIV infections (See Figure 2), due to increasing HIV infections amongst immigrants from countries of high HIV prevalence.

Figure 2

AIDS, 2001 - 2005, by HIV exposure



Source: State and Territory health authorities

Similar to Japan, HIV infections are reported through the whole country, with the highest concentrations in the 2 most populous states, NSW (capital city: Sydney) reports an infection incidence rate of 6 per 100 000 people and Victoria (capital city: Melbourne) reports an incidence rate 4.2 per 100 000 people[1].

History

Before AIDS patients had been diagnosed in Australia, gay communities had already begun mobilizing in response to the disease which had been affecting gay men in New York and San

Francisco. In Sydney, articles relating to 'gay cancer' had appeared in the gay press and community meetings had been held as early as 1989. It is of note, that despite knowledge on the transmission of AIDS, gay men had discussed and promoted condoms for use in anal sex, as early as 1989 [2]. After the first AIDS patients were diagnosed in 1983, due to the cooperation of the Minister of Health at the time, strong pressure from the gay communities, and a government who chose to treat AIDS as a public health issue, health funding was provided to establish AIDS councils in gay communities in the largest cities, Sydney and Melbourne. Initial response to HIV included the provision of funds to import testing kits from the United States, establish links between health services and AIDS councils in anticipation of the rise in HIV patients, and provide education about the AIDS despite there being little information available on how HIV was transmitted.

AIDS Panic

In 1984, media hysteria followed the deaths of 3 babies who had received infected blood from a gay donor with AIDS. Conservatives blamed gays and the labor government for promoting homosexuality. The day after the media panic, the Health Minister organized a meeting with all state health ministers, and provided a budget for HIV testing, to create a network of AIDS councils, and organize a National AIDS Task Force within the government and a National Advisory Committee on AIDS with representatives from government, the medical profession, and community organizations [3].

In the early days, strong leadership by the government combined with gay communities experience in community organizing gained from lobbying for law reform allowed for success in affecting a community response to HIV. The establishment of AIDS action committees within gay communities, funded as AIDS councils, was done in recognition that knowledge of gay culture and practices was essential for realistic and effective programs. It was also assumed that people would not seek HIV testing if there was not a relationship of support between government and communities' initiatives. A public health approach with partnership between government and community has been at the cornerstone of Australia's approach, but it must be recognized that without the pressure from the gay community, and the involvement of hundreds of gay and lesbian volunteers in education and support at AIDS councils this approach would not have been possible. Furthermore, early government action was symbolic in showing that the government cared about the survival of affected communities [4].

AIDS policy and program structure

Due to the federal nature of Australian government, HIV/AIDS policy is developed and funded at the national level, with responsibility for implementation lying at the state level.

A brief outline of the HIV/AIDS education program is as follows:

- AIDS Councils located in each state to provide HIV education, support and outreach for gay and other HIV affected communities.
- State and national HIV positive group providing education and support for people with HIV (NAPWA : National Organisation of People Living with AIDS).
- HIV prevention and support programs for people with hemophilia, Aboriginals, injecting drug users, migrants.
- Advertising campaign for general population.
- HIV education provided in schools.
- Epidemiological, social and behavioral research conducted through 3 national research centers.
- Peak body to coordinate the program and provide national policy input (AFAO: Australian Federation of AIDS Organisations).
- Regular evaluation of AIDS policy and practice.
- National AIDS Committee made up of politicians, medical experts, AIDS NGOs and general community members.
- Removal of legal and structural barriers to prevention including decriminalization of homosexual sex, removing barriers to condom accessibility, removing criminal sanctions on carrying drug injecting equipment, laws to guarantee confidentiality of HIV test results, anti-discrimination legislation and public education campaigns.

HIV/AIDS prevention and education funding

Current total yearly funding for HIV/AIDS prevention education is around 40 million Australian dollars [5]. While MSM account for around 80% of HIV infections, about one quarter of funding is targeted to programs for MSM (See Figure 3). The reason for this has been the subject of much discussion within gay communities, with criticisms that gay community members are working voluntary without payment. A more positive view sees gay community organizations as highly efficient. AIDS councils, have been vocal in demanding that current funding levels are inadequate to implement necessary prevention and support activities.

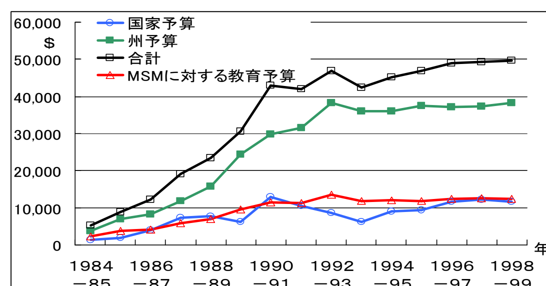


Figure 3 Funding allocations according to HIV exposure categories

Prevention education and support at the local level: the Victorian AIDS Council

The population of Victoria is half that of Aichi ken, with the population of the State’s capital city Melbourne is approximately the same as Nagoya. HIV prevention education and support for HIV positive gay men in the state of Victoria is conducted through the Victorian AIDS Council, Gay Men’s Health Centre and Positive Living Center in Melbourne, as well as operating offices and outreach with community health centers in country areas.

Funding is provided to conduct:

- HIV prevention education for MSM
- Counseling and support
- Needle Exchange Program and education for drug users
- Support for People with HIV including housing, and at home care
- Needle Exchange Program for People with HIV.

In 1983, VAC had 3 staff, and 21 years later in 2004, this had grown to 102 people including part and full time workers, and 300 volunteers. Funding is provided through federal and state health budgets, and in 2006 amounted to 2.7 million Australian dollars - See Figure 4[6].

Figure 4. VAC Funding in 2006

総額	**＄2,693,562**	**2億4千万円**
注射針の交換プログラム／教育	＄396,822	3千6百万円
HIV感染予防行動変容プログラム	＄1,357,215	１億２千万円
スタッフへのHIV予防トレーニング	＄651,345	5千9百万円
HIV陽性者への住宅環境への支援／自宅介護	＄288,180	2千6百万円
HIV陽性者への注射針の交換プログラム／教育	＄20,000	180万円
HIV陽性者グループへの支援	＄230,000	2千万円
	＊＄=AUD	

Research relating to MSM

Epidemiological, behavioural and social research relating to MSM are collected through national HIV research centers. An outline of the population, testing behaviours, and HIV risk behaviours of Australian MSM follows.

Population

According to the 2000 Sex in Australia random survey of 10,000 adult respondents, 5.9% of men reported some homosexual sexual experience in their lives, and 2.6 % identified as gay or bisexual[7]. In comparison, according to Kihara Masahiro' s random survey with 5,000 Japanese adults in 1999, 1.2% of men expressed an attraction to the same sex[8].

Testing Behavior

HIV testing behaviour among Australian MSM, in comparison with other industrialized countries, is relatively high. In 1998, between 85 and 90% of MSM in Australian state capital cities had ever been tested for HIV, in comparison with 82% in the United States, 53% in Canada, and 66% in London[9]. In comparison with Japan, in 1998, 36% of MSM had ever been tested for HIV[10]. Australian periodic survey data indicates that HIV testing behavior has remained consistent since the beginning of the epidemic. See Figure 5.

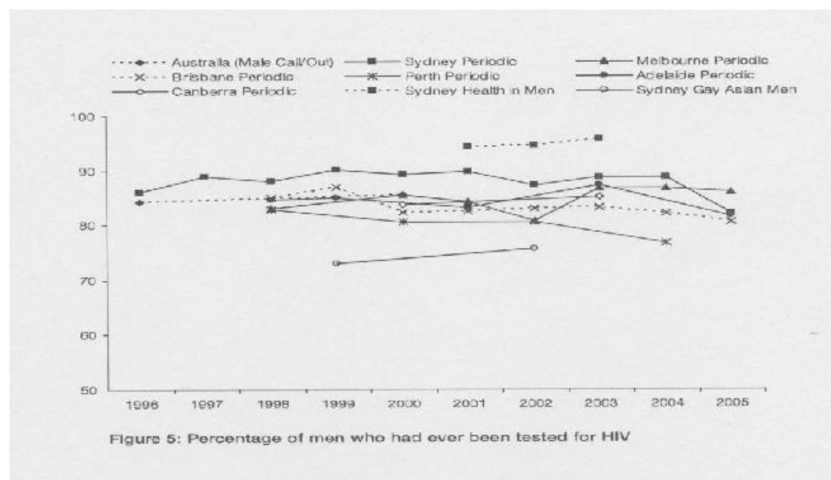


Figure 5: Percentage of men who had ever been tested for HIV

Australian research indicates that MSM who undertake HIV risky sexual behavior and those who have strong connection to gay communities are more likely to undertake HIV testing [11,12].

MSM and community attachment

Research in the late 1980s found significant differences in the behaviour of gay community attached and non gay community attached men, in relation to demographics, sexual behavior and experience of HIV [11]. Gay community attachment is measured by the level of physical and social attachment with gay venues including bars, dance parties, gyms, cruising spots, friends, media and organizations.

Gay community attached men were:

- More likely to be younger, have a higher education and be less likely to engage in blue collar work.
- More likely to undertake regular HIV testing and make safe sex agreements with regular sex partners.
- More likely to have a regular male partner, more casual male partners, and more frequent male to male sex.
- Undertook a wider range of sexual practices, including anal and oral tactile, and engage in esoteric practices.
- Used a wider variety of places to see casual male partners. Most commonly making contact through parties and friends, then gay bars.
- More likely to know some one with HIV, know someone who had died from AIDS, or cared for someone with HIV or AIDS.

Non gay community attached men were:

- More likely to avoid unsafe sex with casual partners.
- Less likely to have a regular male partner.
- More likely to have mainly casual male partners.
- More like to dress in women's clothing.
- More likely to engage in group sex.
- More likely to use cruising venues and advertisements in gay media to find sexual partners.

Risk behaviour

Since behavioral surveys began in the 1996, unprotected anal sex with casual partners has experienced a slight rise through the 1990s, which has leveled out since 2000. Since 2000, the Health in Men study has collected quantitative data on the numbers of protected and unprotected episodes of insertive and receptive anal sex with and with out ejaculation amongst HIV negative and positive men [13].

The results of this research indicate that:

- For the most part, HIV positive MSM and HIV negative MSM report very similar patterns of sexual and drug use behaviours.
- The number of episodes of unprotected anal sex among casual partners is quite low. For the most part, most MSM's use condoms with receptive anal sex with casual sex partners.

- HIV positive men are more like to have engaged in unprotected anal sex with casual partners.
- Even removing unprotected anal sex with casual partners among HIV positive MSM with HIV positive partners, unprotected anal sex among casual partners is high, although this has decreased between 2000 and 2005.
- The majority (90%) of unprotected anal sex acts with casual partners are carried by 10% of the MSM in the sample.

Investigation of the predictors of frequent risk takers, which is defined as more than 5 events of unprotected anal sex with a casual partner in the previous 6 months, has revealed the following relational factors [13]. Frequent risk takers were less likely to have a regular partner, dislike condoms, hold greater optimist about HIV treatments, were more likely to discuss HIV status with casual partners, and were more likely to engage in adventurous or esoteric sex practices. Since the late 1990s, research indicates that engaging in esoteric/ adventurous sexual practices is a predictor is unprotected anal sex with a casual partner. Esoteric and adventurous sex, whose behaviors include fisting, rimming, water sports, using sex toys and cock rings, engaging in bondage and discipline, sadomasochism, and dressing up in fantasy costume.

Research since the 1980s indicates that homosexually active men no longer have strong physical or social connections to gay community and no longer have primarily gay social networks. This is probably due to the introduction of homophobia education and schools and strategies to deal with physical and verbal violence towards gays and lesbians[14]. 'Post AIDS' has been used to describe the changing relationship that gay men have with HIV, in that young gay men have become sexually active in a time when AIDS is no longer a 'crisis' because HAART therapies have prolonged the lives of people with HIV[15].

Why the increase in new HIV infections?

The increase in HIV infections since 2000 has been subject of much discussion and debate among researchers, policy analysts and gay communities. Research indicates that increasing infections are a result of increasing transmission, and not changes in testing rates[16]. Changes in the epidemiological picture are one part of the cause, in that new infections are mainly among heterosexuals who were born overseas in countries with HIV infection rates. However, sharply increasing infections among gay men in Melbourne and Sydney has been blamed on 'policy drift and faltering of leadership' by Don Baxter from the Australian Federation of AIDS Organisations[17], and this has been acknowledged in the 2002 evaluation of AIDS policy conducted by the Department of Health and Aging[18]. Analysis of gay behavioral and social research [14] has concluded that public

health and health promotions' focus on 'risk behavior' has limited effectiveness in that problematizing gay men's sexual behavior leads to less engagement by affected individuals, and suggests a greater focus on community development approaches.

Evaluation of current policy has concluded the following recommendations:

- Switching funding within the budget to have a stronger focus on gay men.
- Implementation of a new strategy which:
    1. Increases awareness about sexual health testing.
    2. Reinforces condom use.
    3. Supports gay community activities and establish discourse around sex and the increase of new infections.
    4. Involves HIV positive gay men and MSM in prevention efforts, and seeing this involvement to be crucial.
    5. Acknowledging that more understanding is needed about the role of alcohol and drug use in gay men's sexual activity.

Responding to increasing infection rates will, given the fact that MSM have experienced consistent exposure to HIV prevention education programs for the last 20 years, is seen to be a complicated problem requiring a number of strategies. Widening the approach to one that involves sexual health, mental health, and sex education programs, is seen as necessary.

D. 考察

HIV prevention policy and practice needs to be based on strong links between affected communities, prevention specialists (ie AIDS educators in NGOs, and theoretically and methodologically strong epidemiological, behavioral and social research. The Australian experience shows that enabling gay men to be responsible for evaluating risk, through education and research feed back, with government funding and legally and socially supportive environments, has produced good outcomes in reducing HIV infections.

E. 結語

Evaluation of Australian policy and practice reveals that strong government leadership combined with funding provided for gay community to develop relevant education programs has effectiveness in reducing HIV infections among MSM. The results of this evaluation have the following implications for Japanese HIV policy and programs:

・The current approach with prevention groups and activities centered within gay communities and areas with concentrations of gay commercial venues has international precedence and has research evidence supporting its success (Feacham 1996).
・Japanese gay NGOs are receiving very low levels of funding in comparison to the Australian response.
・High level government commitment and cooperation, coupled with prevention efforts focused within gay communities are effective in promoting HIV protective sexual behaviors among gay men.

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