



STRATEGIC PLAN 2014 – 2017

BOARD OF DUBLIN AIDS ALLIANCE

APRIL 2014

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1. INTRODUCTION

1.1. BACKGROUND

Dublin AIDS Alliance (DAA) is a voluntary non-governmental organisation which provides a range of services and supports to people living with HIV¹ and which advocates on behalf of people with HIV. Formed in 1987, DAA has also developed programmes and initiatives around sexual health education and preventative strategies to reduce the contraction and transmission of HIV. Since its establishment DAA has consistently engaged in policy development and in lobbying and campaigning on issues around HIV, sexual health and the promotion of human rights and equality for people living with HIV. DAA has also been involved in programmes and strategies aimed at increasing public awareness and understanding about HIV – its causes, its consequences, and the stigma associated with HIV and AIDS.

Since its formation in 1987, DAA has recognised the importance of collaborative work with other agencies and organisations within the statutory sector and within the community and voluntary sector. There is a clear role for statutory agencies (especially in relation to clinical and medical issues) and for voluntary organisations (in relation to advocacy, social supports, policy development) both in relation to supporting people living with HIV and in the broader areas of HIV prevention, education and sexual health promotion. The struggle to combat HIV, to provide services/supports for people living with HIV and to reduce HIV prevalence rates in Ireland is a shared challenge amongst many statutory sector and voluntary organisations in Ireland. DAA believes that it has played an important role in complementing the work of other agencies/organisations and in contributing to the lives of people affected by HIV (and ‘at risk’ of HIV).

1.2. STRATEGIC PLAN

DAA is clearly aware of the need to constantly renew and regenerate its priorities and key focuses. HIV is an ever evolving issue – there have been many lows and some highs within the last 30 year period. Lows in relation to the numbers of people dying through HIV when it progresses into AIDS and other life threatening conditions, and highs in relation to medical advances and the positive impact which highly active antiretroviral therapy (HAART) can have upon the life expectancy and quality of life for people living with HIV. Over the last number of years there has been a sharp global reduction in the number of people dying due to

¹ HIV is an acronym for Human Immunodeficiency Virus

HIV and AIDS, in the number of people contracting HIV and changes in the proportions of people contracting HIV through different modes of transmission. These types of developments need to be reflected in the work of HIV support organisations such as DAA and in the future priorities and focuses of HIV support groups. For example in Ireland there has been a significant increase over the last 6 years in the number of HIV cases among men having sex with men whilst at the same time there has been a substantial reduction in HIV cases transmitted by intravenous drug use.

Relevant trends and patterns need to be reflected in Strategic Plans produced by organisations within the community and voluntary sector. It is helpful that very precise and specific figures concerning HIV are produced on an annual basis by the HSE Health Protection Surveillance Centre. The production of these figures gives a clear sense of emerging trends and patterns and enables organisations such as DAA to be clear and to be sure that they are responding to real needs rather than imagined needs – in other words, there is an evidence base for DAA deciding upon its future focuses and priorities. In a scenario where there seems to be significant change happening with HIV every few years (e.g. changes in transmission trends within Ireland, changes in medication and vaccines) it is entirely appropriate that DAA would carry out a regular analysis of needs and circumstances within the field of HIV and then use this analysis to construct new Strategic Plans on a regular, three year basis.

1.3. METHODOLOGY FOR CONSTRUCTING 2014 – 2017 STRATEGIC PLAN

This Strategic Plan for DAA was produced between October 2013 and February 2014. The following strategic review and planning activities took place within this five month period:

- Analysis of figures and statistics concerning the prevalence of HIV at both the global and national levels
- Analysis of trends and patterns relating to the modes of transmission for HIV in Ireland
- Consideration of documents and reports concerning clinical and medical improvements in the treatment of HIV
- Interviews with key, relevant personnel from the HSE
- Interviews with medical social workers from the main hospitals in Dublin who are working with people diagnosed with HIV
- Interviews with representatives of other HIV support organisations in Ireland

- Consultations with managers and staff within DAA
- Consultations with the Board of DAA

The process of producing the 2014-2017 Strategic Plan involved consultations with 34 people and the analysis of over 30 documents and reports.

1.4. STRUCTURE OF STRATEGIC PLAN

This introductory section of the Strategic Plan will be followed by an analysis of current patterns and trends in relation to HIV in Ireland (Section 2). Section 3 will consider the main issues and challenges for DAA and for other organisations and agencies dealing with HIV within Ireland. Section 4 of the Strategic Plan will set out the main priorities and focuses for DAA in the period from 2014 to 2017. Section 5 of the report will outline the specific Strategic Objectives and associated outcomes/actions which will inform the work of DAA over the next three years.

2. ANALYSIS AND OVERVIEW OF HIV IN IRELAND

2.1. INTRODUCTION

The analysis of the current situation in relation to HIV in Ireland is considered an important aspect of DAA's Strategic Plan for the period from 2014 to 2017. It is essential that the priorities and focuses set out in the Strategic Plan correspond with outstanding and recognised needs and that the Strategic Plan is informed by an analysis and by evidence which would suggest that DAA's proposed actions over the next few years will make a difference and will have an impact (especially in relation to people from 'high risk' population groups). It is also considered that the analysis of HIV in Ireland will be of interest to organisations and individuals who have an interest in HIV and broader issues relating to sexual health, equality and human rights. In this context, the analysis section of the DAA Strategic Plan will be performing a public information and public awareness role, a role which has always been an important aspect of DAA's work.

The analysis and overview of HIV in Ireland will be structured under the following headings:

- **Definitions and understanding of HIV and AIDS**
- **HIV in Ireland – facts and figures**
- **HIV in Ireland – modes of transmission**
- **HIV in Ireland – testing and late presenters**
- **Recent developments in relation to HIV**
- **Outstanding needs in relation to HIV**

2.2. DEFINITIONS AND UNDERSTANDING OF HIV AND AIDS

(i) History and Evolution

HIV (human immunodeficiency virus) is the virus that causes AIDS. This virus may be passed from one person to another when infected blood, semen, vaginal secretions or rectal secretions come in contact with an uninfected person's broken skin or mucous membranes². In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Some of these people will develop AIDS as a result of their HIV infection.

² A mucous membrane is wet, thin tissue found in certain openings to the human body. These can include the mouth, eyes, nose, vagina, rectum, and opening of the penis.

The earliest known case of HIV-1 in a human was from a blood sample collected in 1959 from a man in Kinshasa, Democratic Republic of Congo (how he became infected is not known). Genetic analysis of this blood sample suggested that HIV-1 may have stemmed from a single virus in the late 1940s or early 1950s.

We know that the virus has existed in the United States since at least the mid- to late 1970s. From 1979 to 1981 rare types of pneumonia, cancer, and other illnesses were being reported by doctors in Los Angeles and New York among a number of male patients who had sex with other men. These were conditions not usually found in people with healthy immune systems. In 1982 public health officials began to use the term "acquired immunodeficiency syndrome," or AIDS, to describe the occurrences of opportunistic infections, Kaposi's sarcoma (a kind of cancer) and Pneumocystis Carinii Pneumonia, in previously healthy people. Formal tracking surveillance of AIDS cases began that year in the United States.

In 1983, scientists discovered the virus that causes AIDS. The virus was at first named HTLV-III/LAV (human T-cell lymphotropic virus-type III/lymphadenopathy- associated virus) by an international scientific committee. This name was later changed to HIV (human immunodeficiency virus). For many years scientists theorized as to the origins of HIV and how it appeared in the human population, most believing that HIV originated in other primates. Then in 1999 an international team of researchers reported that they had discovered the origins of HIV-1, the predominant strain of HIV in the developed world. A subspecies of chimpanzees native to west equatorial Africa had been identified as the original source of the virus. The researchers believe that HIV-1 was introduced into the human population when hunters became exposed to infected blood.

(ii) HIV Infections

Since 1981, when doctors first recognized HIV as a new illness, scientists have learned much about how a person becomes infected with HIV. The virus is spread through contact with an infected person's body fluids - through blood, semen, breast milk, rectal secretions and vaginal fluids. HIV can be transmitted through sex (anal, vaginal and oral), contaminated blood (by sharing or by being accidentally stuck with a contaminated needle, or through transfusions before blood products started being screened in Ireland for HIV in 1985) or through mother to child infection (during pregnancy, birth or breast feeding).

Once inside the body, HIV particles invade CD4 cells³ and use the cells' own building machinery and materials to produce billions of new HIV particles. These new particles cause the infected CD4 cells to burst (lyse). The new particles can then enter the bloodstream and infect other cells. Once someone is infected with HIV, the number of their CD4 cells continues to decrease. HIV is actively copying itself and killing CD4 cells from the time the infection starts. Eventually, the number of CD4 cells drops below the threshold level needed to defend the body against infections, and the person develops AIDS.

An estimated 34 million people in the world are living with HIV and AIDS. More than 90% of these people live in developing countries. About 2.6 million people are newly infected per year. Although survival has improved dramatically in developed countries, that is not the case in many under developed countries. In some parts of Africa, more than half of adult deaths are AIDS-related, leaving millions of children orphaned after their parents died of AIDS.

(iii) Symptoms

In its early stages, HIV infection may have no symptoms or may cause a flu-like illness with some of the following symptoms: fever, sore throat, rash, nausea and vomiting, diarrhoea, fatigue, swollen lymph nodes, muscle aches, headaches, and joint pain. Although most people experience symptoms within the first few weeks of being infected with HIV, many people and their doctors dismiss the illness as a routine cold or flu. In a small number of cases, this early stage of infection may progress to meningitis (inflammation of membranes covering the brain) or severe flu-like symptoms that require hospitalisation.

As the number of CD4 cells drops below normal (normal cell counts are 500 to 2,000 cells per cubic millimetre of blood), the person may begin to develop swollen lymph nodes and skin problems such as varicella-zoster (shingles), seborrheic dermatitis (dandruff), new or worsening psoriasis, and minor infections. Ulcers can develop around the mouth and herpes outbreaks (oral or genital) may become more frequent. Over the next few years, as CD4 cells continue to die, skin problems and mouth ulcers develop more often. Many people develop diarrhoea, fever, unexplained weight loss, joint and muscle pain, and fatigue. Old tuberculosis infections may reactivate even before AIDS develops (tuberculosis is one of the most common AIDS-related infections in the developing world)

³ CD4+ T cells are white blood cells that are an essential part of the human immune system. If CD4 cells become depleted, for example in untreated HIV infection or following immune suppression prior to a transplant, the body is left vulnerable to a wide range of infections that it would otherwise have been able to fight.

Finally, with further decreases in the levels of CD4 cells, the person develops AIDS. According to the European Centre for Disease Prevention and Control, for an HIV-infected person, some signs that AIDS has developed (known as AIDS-defining conditions) are:

- The CD4 cell count has decreased to fewer than 200 cells per cubic millilitre of blood.
- An opportunistic infection has developed, indicating that the immune system is severely weakened. These types of infections include specific causes of pneumonia, diarrhoea, eye infections and meningitis. Some of the causes of these opportunistic infections include Cryptococcus, reactivation of cytomegalovirus, reactivation of toxoplasma in the brain, wide-spread infection with Mycobacterium avium complex and Pneumocystis jirovecii (formerly called Pneumocystis Carinii) in the lungs.
- A type of cancer has developed that shows that the immune system is severely weakened. For those who are infected with HIV, these cancers can include advanced cervical cancer, Kaposi's sarcoma (a cancer causing round, reddish spots in the skin and mouth), certain types of non-Hodgkin's lymphoma and brain lymphoma.
- An AIDS-related brain illness has developed, including HIV encephalopathy (AIDS dementia) or progressive multifocal leukoencephalopathy (PML).
- There is severe body wasting (HIV wasting syndrome).
- There is an AIDS-related lung illness, such as pulmonary lymphoid hyperplasia or lymphoid interstitial pneumonia (usually seen only in children).

(iv) Diagnosis

In seeking medical assistance, doctors may ask about possible HIV risk factors, such as previous sexual partners, intravenous drug use, blood transfusion and occupational exposure to blood, such as accidentally being stuck by needles. Doctors might ask about a variety of symptoms, such as fever, weight loss, muscle and joint aches, fatigue and headache, and about medical problems in the past like sexually transmitted infections or hepatitis. This typically is followed by a complete physical examination. During the exam, doctors will look for a thick, white coating on the tongue called thrush (infection with Candida), any skin abnormalities and swollen lymph nodes. To make the diagnosis of HIV infection, however, laboratory tests are needed.

HIV testing can be done with a blood test done in a healthcare setting (e.g. GP's surgery, STI or GUM clinic) or in a non-clinical setting – DAA provides a regular HIV/STI testing service. In some places, the test can be done with an oral swab and uses saliva instead of blood. The initial screening test is called an enzyme immunoassay (EIA or sometimes an enzyme linked immunosorbent assay - ELISA). The EIA detects disease-fighting proteins that are made by the immune system called antibodies. The EIA test for HIV infection looks for antibodies made by the immune system specifically against the virus. If the EIA is positive, a Western blot test, which also measures the body's antibody response to HIV but is more accurate than the EIA, is done to confirm the diagnosis. There are several causes of false positive EIAs, but a false positive Western blot is very rare.

Neither the EIA nor the Western blot is accurate immediately after a person is infected with the HIV virus. The period between infection with HIV and the development of positive test for antibodies is called "the window period." This term refers to the window of time between getting the HIV infection and the ability to detect the body's response to infection (the development of antibodies). Although it is possible to measure the virus directly in the blood (viral load test), this test is used for diagnosis only in special circumstances.

If a person has been diagnosed with HIV, the doctor will determine if the virus has weakened the immune system by ordering a blood test to check on CD4 cell count. If a person has fewer than 200 cells per cubic millilitre of blood, this means that the person will have AIDS. It may also be necessary to have further tests to diagnose AIDS-related conditions, including opportunistic infections or cancers, depending on individual symptoms. HIV infection is a lifelong illness. There is no known cure for HIV. However, advances in treatment have changed the thinking about HIV as an acute disease. Doctors now consider HIV a long-term chronic condition that can be controlled with medications and healthy life style choices.

(v) Prevention

HIV infection can be passed from person to person in any of the following ways:

- Unprotected sexual intercourse (heterosexual or homosexual; anal, vaginal or oral sex) with an infected person
- A contaminated transfusion (extremely rare in developed countries since blood products started being tested for HIV)
- Needle sharing (if one intravenous drug user is infected)
- Occupational exposure (needle stick with infected blood)

- Organ transplant taken from an HIV-infected donor
- Babies can become infected through their mothers before or during birth or through breastfeeding.
- There is no evidence that HIV can be spread through the following: kissing; sharing food utensils, towels or bedding; swimming in pools; using toilet seats; using telephones; or having mosquito or other insect bites. Casual contact in the home, workplace or public spaces poses no risk of HIV transmission.
- Although several HIV vaccines are being tested, none has been approved.

HIV transmission is preventable, and prevention and awareness programmes and initiatives focus primarily on:

- Safer sex and the consistent use of condoms and lubricant (lube) for all types of sexual activity.
- Early and regular testing.
- Access to and the promotion of needle exchanges.
- Access to and the promotion of Post-Exposure Prophylaxis (PEP)⁴
- Education and making informed choices.

(vi) Treatment

The World Health Organisation recommends that patients start taking antiviral medications (antiretrovirals) before the CD4 count falls below 350 cells per cubic millilitre of blood. Many experts suggest using 500 as the benchmark. Most recently, some doctors are recommending starting treatment immediately after the diagnosis is confirmed. The exact timing will depend on many factors, risks and benefits that should be discussed by the patient and the doctor. If the decision is made to start treatment, the doctor will choose a combination of drugs called antiretrovirals to fight the HIV infection. To control the reproduction of HIV in the body, medication called HAART (Highly Active Anti-Retroviral Therapy) is prescribed. These medications attack HIV at multiple points in its growth cycle and are more effective in suppressing the virus. Combining drugs also limits the risk that HIV will become

⁴ Post-Exposure Prophylaxis (PEP) involves taking anti-HIV drugs within 72 hours of having been exposed to the HIV virus and before the virus has time to replicate in one's body. PEP consists of 2-3 antiretroviral medications taken for 28 days.

resistant to drugs, which would mean the drugs are powerless against this resistant strain of HIV.

People with high levels of the HIV virus in the blood (the viral load) will progress more rapidly to developing AIDS-related illnesses. Though it is not possible to clear the virus from the body completely, the goal of treatment is to keep the virus from reproducing. This can be achieved when the viral load test cannot detect the HIV virus in the bloodstream (the virus never goes away, it just goes to very low levels). When the virus is not reproducing quickly, it is less likely to kill CD4 cells. As the CD4 cell count increases, the immune system regains strength.

There are many available antiretroviral medications. Many of these can be prescribed in combination form making the total number of different "pills" available closer to 30. Many medications have two or three names and may be referred to by the generic name, trade name or a three letter abbreviation (for example, AZT is also known by its generic name, zidovudine, and by its trade name, Retrovir). Numerous combinations can be made depending on patient and doctor preference. Because many of these drugs have side effects, such as nausea and diarrhoea, the exact medications prescribed for a particular person may depend on side effects. It is very important for a person to tell his/her doctor about ALL other medications which they take (including herbals and non-prescription medications) because there can be serious drug-drug interactions with commonly used medications. Also, no one should take an antiretroviral medication that was not specifically prescribed for them by a health care provider.

(vii) Prognosis

The average time for HIV infection to progress to AIDS is 10 to 11 years for people who do not take antiretrovirals. In people with a very high HIV viral load, AIDS may develop sooner (within 5 years after infection). Once HIV infection has progressed to AIDS, there is an increased risk of death that varies dramatically from person to person. For example, some people with AIDS have died shortly after they were diagnosed, whereas others have lived 12 years or more.

Because very potent medication against HIV has only been available since 1996, we do not yet know how long people will live with HIV infection if they are tested early and treated appropriately. The outlook, however, is very good, especially for those who begin

antiretrovirals at an early stage of the disease. Life expectancy for people living with HIV is the same as the general population if there is an early diagnosis and appropriate treatment and medication provided. If infected with HIV, it is best to find out as soon as possible so that treatment can be started before the immune system is weakened. Since potent antiretrovirals became available, the number of AIDS-related deaths and hospitalisations has decreased dramatically. The AIDS-related death rate in some parts of the developing world, however, remains staggeringly high due to lack of access to life-saving antiretrovirals.

2.3. HIV IN IRELAND – FACTS AND FIGURES

Comprehensive and detailed information about HIV in Ireland is collected on an annual basis through the HSE Health Protection Surveillance Centre. The HPSC produces an annual report on HIV in Ireland which provides very useful information, data and analysis about issues such as the prevalence of HIV in Ireland, modes of transmission for HIV cases in Ireland, country of origin and ethnicity of people who are tested HIV positive, the stages of infection for people with HIV and the number of deaths caused by HIV and AIDS.

The information collected and analysed by the HPSC has become even more comprehensive in recent years with the designation of HIV as a notifiable disease in Ireland. In September 2011, with HIV becoming a notifiable disease, the voluntary surveillance system was changed to a mandatory system. This means that when a person is given a positive HIV diagnosis, a confidential form has to be completed by the relevant healthcare worker and this form is then sent to the Director of Public Health for that area. This has resulted in a situation where all HIV cases diagnosed in Ireland are recorded and used to build upon a more complete picture of HIV in Ireland. In addition, from January 2012 all HIV notifications were entered into the Computerised Infectious Disease Reporting (CIDR) system. This is of enormous benefit to organisations such as DAA since it helps to ensure that our work is evidence-based and that we are responding to the analyses and data clearly set out in the annual HIV in Ireland reports produced by the HPSC.

Since the early 1980s until the end of 2012, a total of 6,629 people were newly diagnosed with HIV in Ireland. It is estimated that there are approximately 3,200 people in treatment. The figure of people living with HIV in Ireland is unknown. There are two key issues concerning the difficulties in arriving at a definitive figure about the number of people living with HIV in Ireland. The first difficulty is the difference between the figure of 6,629 newly

diagnosed between the early 1980s and 2012 and the figure of 3,200 people in treatment – a difference of 3,429 people. Some of these people will have died, some will have left Ireland, some will have been diagnosed with HIV but are not in treatment. The second difficulty about getting an accurate figure for people in Ireland living with HIV is that many people with HIV have not been tested or diagnosed. International figures would suggest that this figure represents around 20%-30% of the people with the HIV virus.

In 2012, there were 341 newly diagnosed cases of HIV in Ireland. As in previous years HIV cases were most prevalent across three particular subgroups of the population: men having sex with men, heterosexual people from a country with a generalised HIV epidemic⁵ and intravenous drug users. The figure of 341 for 2012 represents an increase in the HIV figures for Ireland after a period of 3 years during which the newly diagnosed cases decreased each year:

New HIV diagnoses by probable route of transmission, 2003 to 2012⁶											
Prob Route Transmission	MSM		IDU		Hetero		MCT		Other/Unk		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	
2003	76	19.0	50	12.5	222	55.4	11	2.7	42	10.5	401
2004	63	17.6	74	20.7	179	50.0	3	0.8	39	10.9	358
2005	60	18.4	67	20.6	171	52.5	3	0.9	25	7.7	326
2006	89	25.2	59	16.7	181	51.3	2	0.6	22	6.2	353
2007	91	23.3	55	14.1	165	42.2	6	1.5	74	18.9	391
2008	105	26.0	40	9.9	190	47.0	7	1.7	62	15.3	404
2009	138	34.9	30	7.6	162	41.0	5	1.3	60	15.2	395
2010	134	40.6	22	6.7	124	37.6	9	2.7	41	12.4	330
2011	140	43.9	16	5.0	116	36.4	3	0.9	44	13.8	319
2012	166	48.7	13	3.8	130	38.1	5	1.5	27	7.9	341

The figure of 341 newly diagnosed HIV cases in Ireland in 2012 represents a notification rate of 7.4 per 100,000 population. This rate of 7.4 compares to a European Union average figure of 5.7 per 100,000 population (with the rates within individual countries ranging from 0.9 to 27.3). The ages of people diagnosed with HIV in 2012 ranged from 3 years to 73 years with the median age being 33. The largest number of new diagnoses occurred among men aged

⁵ A generalised HIV epidemic is where more than 1% of the general population is HIV positive.

⁶ MSM = men having sex with men; IDU = intravenous drug users; Hetero = heterosexual sex; MCT = mother to child transmission

30-34 years (52 cases) followed by men aged 25-29 years (48 cases). The highest number of new diagnoses in women was in those aged 30-34 years (25 cases). Young people aged 15-24 accounted for 11.1% of new diagnoses and persons aged 50 or over accounted for 9%. A total of 244 diagnosed people were male (71.6%) and 97 were female (28.4%). This gives a rate of HIV infection of 10.7 per 100,000 among men and 4.2 per 100,000 among women.

In relation to area of residence within Ireland a total of 244 (71.5%) of the new diagnoses for HIV in 2012 were within the HSE East region which covers Dublin and the general Leinster area. This figure of 71.5% for the HSE East region is considerably higher than the proportion of the population of the country which lives in the HSE East region. The figure can be explained by a combination of factors. Firstly many people who originally have come from other parts of Ireland are now living in the Greater Dublin area. Secondly, for those people diagnosed with HIV who did not give their area of residence the alternative location was where the HIV infection was diagnosed. Thirdly, people living in the Dublin area have better access to testing services. A large proportion of new cases are diagnosed in the Dublin area (perhaps for reasons relating to convenience and/or anonymity). The outcomes from the 2012 HIV in Ireland report would suggest that there is a clear need for HIV services and supports which are based in the Dublin region.

2.4. HIV IN IRELAND – MODES OF TRANSMISSION

There are only five fluids in which HIV can survive in high enough viral loads for it to be passed from person to person. These are blood, breast milk, semen, vaginal fluid and rectal secretions. There are three main ways in which HIV is generally transmitted: sex (through unprotected sexual contact with an infected person); blood (through infected blood products like transfusions or sharing needles); and pregnancy (from mother to child in the womb, during labour or after birth from breast milk). In analysing the 341 newly diagnosed HIV cases in Ireland in 2012 nearly half of the transmissions (48.7%) are among men having sex with men (MSM), nearly two in five are through heterosexual sexual contact (38.1%), 3.8% are through intravenous drug use and 1.5% are through mother to child transmission. For the remaining 7.9% (i.e. 27 cases) transmissions, the mode of transmission is unknown. In considering these figures in more detail the following trends and patterns emerge:

- There has been a very significant increase in the number of HIV cases among MSM. These numbers have increased from 60 in 2005 to 166 in 2012. In percentage terms

this represents a dramatic rise in the proportion of new HIV transmissions amongst MSM from 18.4% in 2005 to 48.7% in 2012. Whilst much work has been done within the MSM community, further engagement is required in trying to reverse this pattern which has seen a 176% increase over seven years in the number of MSM contracting HIV. This type of increase compares sharply and unfavourably to the improved trends which are apparent within other HIV ‘at risk’ groups (for example, transmissions through intravenous drug use have dropped from 67 in 2005 to 13 in 2012). It is clear that DAA, together with other relevant voluntary organisations and statutory agencies, need to develop new strategies to tackle the high level of HIV diagnosis within the gay community. In relation to places of origin for MSM who contracted HIV 56% were born in Ireland, 13% in South America, 10% in Western Europe and 5% in Central and Eastern Europe.

- The number of people who contracted HIV in 2012 through heterosexual contact reduced from 55.4% in 2003 to 38.1% in 2012 – in real terms there was a reduction from 222 in 2003 to 130 in 2012 through this mode of transmission. Among the heterosexual cases, 63% were among individuals originating from countries with generalised epidemics, 8% had a high risk partner or a partner known to be HIV positive and 6% had a partner originating from a country with a generalised epidemic. The number of heterosexual cases originating in a country with a generalised HIV epidemic had been decreasing since 2008 but increased slightly in 2012. In relation to the 130 heterosexual HIV cases diagnosed in 2012, 84 were women and 46 were men. Where the CD4 count was available (i.e. indicating the extent or severity of HIV), 59% of heterosexual HIV cases in 2012 were diagnosed late including 42% who were severely immune-compromised. This demonstrates the importance of early testing and early diagnosis since the HIV infection can be much more serious (and perhaps life threatening) if it is only diagnosed at a late stage in the HIV cycle.
- There has been a welcome and noticeable reduction in the number of intravenous drug users (IDU) diagnosed with HIV over the last eight years with the numbers reducing from 67 in 2005 to 13 in 2012. This net reduction is also reflected in the proportion of IDUs within people newly diagnosed with HIV – this has seen a substantial reduction from 20.6% of newly diagnosed HIV people in 2005 to 3.8% of newly diagnosed people in 2012. It is evident that a range of positive public health measures have made a significant difference in relation to the decrease in HIV cases amongst IDUs. These

include the wide availability of kits and paraphernalia which include items such as clean needles, syringes, swabs and condoms. The improvements that have taken place in recent years in relation to IDUs and HIV are a clear demonstration of the tangible benefits of effective and targeted public health measures and strategies. However it is important not to become complacent, IDUs remain a key population group at risk of HIV and the promotion of early testing and access to needle exchanges must continue.

- Mother to child transmission (MCT) of HIV has remained fairly steady over the last 10 year period⁸. Whilst there were 11 newly diagnosed cases of HIV through MCT in 2003, the numbers from 2004 to 2012 have varied between 2 and 9 new cases each year. In 2012, there were 5 new cases of HIV through MCT and this represents 1.5% of the total number of newly diagnosed HIV cases in 2012. The probable countries of infection for the 5 children diagnosed with HIV in 2012 were in sub-Saharan Africa. No MCT cases were identified in children born in Ireland in 2012. The Rainbow Clinic in Our Lady's Children's Hospital in Crumlin reported that there were 97 babies born to HIV infected mothers in Ireland during 2012. Of this number, 88 infants were not infected and 9 were of indeterminate status (i.e. do not meet the criteria for HIV infection and are under 18 months at the time of test).

In relation to country of origin and ethnicity for new HIV diagnoses in 2012, 162 (48%) were born abroad with 123 (36%) born in Ireland. There is no/limited information about country of origin for the other people diagnosed with HIV in 2012. Of the 162 not born in Ireland 52% were born in sub-Saharan Africa, 15% were born in South America and Latin America, 13% were born in Central and Eastern Europe and 12% were born in Western Europe. The majority of MSM HIV cases were born in Ireland whilst the majority of heterosexual cases were from sub-Saharan Africa. In relation to the people who did disclose their country of origin (i.e. 285) a total of 57% were born outside Ireland. This outcome clearly indicates the importance of organisations such as DAA continuing to work closely with migrant, non-Irish communities and groups which are living in the Dublin area – this need to work with these communities is reflected in the fact that the number of new diagnoses amongst those born in sub-Saharan Africa increased from 63 in 2011 to 84 in 2012.

⁸ it should be noted that there is a voluntary ante-natal HIV testing programme available to expectant mothers within all maternity hospitals in Ireland.

2.5. HIV IN IRELAND – TESTING AND LATE PRESENTERS

Earlier references have been made in this Strategic Plan to the fact that testing, and especially early testing, is of critical importance in getting people with HIV onto an appropriate treatment programme which is going to positively impact upon the quality of their future life. In addition, the earlier that HIV is diagnosed and treated the less likely it is that HIV will be transmitted to other people because it is less likely that the person testing HIV positive will engage in unsafe sexual practices. Therefore, there are clear, identifiable and indisputable advantages associated with early testing for HIV, early diagnosis and an earlier treatment programme. Conversely the later that people are tested for HIV (i.e. following infection) the worse the prognosis since HIV has been building up and mutating within the body for too long a period of time. It is clear that two key challenges in relation to testing and diagnosis are firstly that people do not go for HIV tests (circa 20%-30% of people with HIV have not been tested and do not know if they have the virus) and secondly that people go for tests as early as possible if they think that they might have been infected with the virus.

The annual HIV in Ireland report produced by the HPSC contains useful information about the stages at which people in Ireland are diagnosed with HIV. The 2012 report noted that 48% of people diagnosed with HIV in 2012 were late presenters and as the report concludes '*late presentation is associated with poorer outcomes and a greater chance of onward transmission*'. In relation to late presentation this is defined as when there is a CD4 count of less than 350 cells/mm. The figure of 48% late presenters in Ireland compares to a European Union figure of 49%. The proportion of those diagnosed late varied by risk group and was highest amongst heterosexual males (64%) and intravenous drug users (63%). In 2012, 24% of people were severely immune-compromised at diagnosis (with CD4 cell count of less than 200 cells/mm) – this compares to a 2011 figure of 33%. The 2012 HIV in Ireland report notes that '*the reduction seen in late diagnosis in 2012 is encouraging but the proportion needs to continue to drop further*'. Of the 341 new diagnoses in 2012, 34 people were diagnosed with AIDS defining illnesses – 19 heterosexual, 13 MSM and 2 intravenous drug users. In 2012, the most commonly reported AIDS related illnesses were PCP (Pneumocystis pneumonia) – 32%, Kaposi's sarcoma – 24%, TB – 24% and Candidiasis – 12%.

In relation to testing for HIV the number of tests conducted between 2010 and 2012 are as follows: 180,055 in 2010, 184,521 in 2011 and 175,488 in 2012. In 2012 a total of 55,257 males and 118,455 females were tested for HIV in Ireland (with the gender of the remaining 1,766 defined as unknown). This discrepancy between testing for males and females is

explained by the HIV voluntary antenatal programme which is available in all maternity units in Ireland. The testing rate in Ireland in 2012 was 38.2 per 1,000 population whilst in other European countries the testing rates ranged from 8.3 per 1,000 population in Poland to 98.3 per 1,000 population in Austria.

2.6. RECENT DEVELOPMENTS IN RELATION TO HIV

It is recognised that the period of time since the emergence of HIV and AIDS in the late 1970s and early 1980s has been a time of tragedy and huge loss as millions of people have died through AIDS and AIDS-related illnesses. Whilst the HIV and AIDS epidemic has not affected Ireland to the same extent as some other countries (especially in sub-Saharan Africa) there has still been a significant impact upon the 6,629 people diagnosed with HIV over the last 30 years, an impact upon their families, an impact in relation to the estimated 790 who have died through AIDS and AIDS-related illnesses in Ireland. However, there are also grounds for some hope and optimism. After years of rising numbers with HIV, the global pattern is beginning to demonstrate a decrease in the number of HIV diagnoses and in the number of people dying through HIV and AIDS. There were 2.3 million new HIV infections globally in 2012 which is a reduction of 33% over 5 years and the number of HIV infections among children has dropped over 52% in the same period to 260,000. In 2012 AIDS-related deaths have dropped by 30% since peaking at 2.3 million deaths worldwide in 2005.

Improvements in treatment, in medication and in testing have been key elements in the improvements which have taken place in the area of HIV and AIDS over the last number of years. The development of highly active antiretroviral therapies has revolutionised HIV treatment in the last 15 years. At present there is no effective vaccine against HIV but there is growing evidence that antiretroviral treatment strategies can prevent HIV transmission and acquisition. In 2012, antiretroviral treatment was provided for 115 of the newly diagnosed HIV cases in Ireland. Since no information on whether antiretroviral treatment was provided or not for 134 people, the total of 115 who were referred for antiretroviral treatment represents 55.5% of the newly diagnosed people for whom full treatment information was provided. This is an encouraging and positive development.

It is also encouraging that there is an end in sight and the prospect of the first AIDS-free generation since the late 1970s and early 1980s with Dr. Luiz Loures, deputy Executive Director of UNAIDS, stating that the ending of the epidemic in 16 years' time (i.e. in 2030) is

a realistic goal. *'I think that 2030 is a viable target to say that we have reached the end of the epidemic'* Dr. Loures said *'HIV will continue existing as a case here or there but not at the epidemic level we have today. We can get to the end of the epidemic because we have treatments and ways to control infection'*

'Over the years the gloom and disappointment chronicled in the early editions of the UNAIDS global report on the AIDS epidemic have given way to more promising tidings'

Michel Sidibé,

Executive Director of UNAIDS in his 2013 annual report

3. KEY ISSUES AND CHALLENGES IN RELATION TO HIV

3.1. INTRODUCTION

The previous section of this Strategic Plan has set out important developments which have taken place over the last 30-35 years. These include the identification of the virus in the late 1970s and early 1980s in the United States; the spread of the virus to other parts of the world; the naming of the virus as HIV in 1983; the death and suffering caused by HIV and AIDS over the last few decades (with millions of people dying each year through AIDS and AIDS related illnesses); medical improvements that have taken place over the last 10 year period with the antiretroviral therapies making significant improvements to the quality of life and longevity of people with HIV; the grounds for hope and optimism that a vaccine could be produced within the next few years (which would vaccinate people against HIV in the same way that people are vaccinated against illness/diseases such as meningitis, malaria, polio and measles); and the prospects for the first AIDS-free generation in over three decades.

It is evident that with antiretroviral therapies having a real and positive impact on people with HIV and also with scientists and clinicians hopeful of developing a vaccine for HIV, this is a defining period in the history of HIV and AIDS. However there are still enormous issues and challenges in relation to HIV and AIDS – around matters such as stigma, discrimination, equality, disclosure and criminalisation. This section of the Strategic Plan will consider these key issues and challenges, issues and challenges which also have to have a significant impact on the work of HIV support organisations such as DAA. In a real sense, consideration of key issues and challenges has to inform the future work and priorities of DAA. This section of the Strategic Plan will address the following issues and challenges:

- **Prevention**
 - **HIV prevention and health promotion**
 - **Development of testing and screening services**
 - **Men having sex with men**
 - **Prevalence of STIs in Ireland**
- **Stigma, disclosure and normalisation**
 - **Stigma and discrimination**
 - **Disclosure and criminalisation**
 - **Normalisation of HIV and danger of complacency**

3.2. PREVENTION

3.2.1. HIV PREVENTION AND HEALTH PROMOTION

Prevention and education are major issues for organisations working in the area of HIV. There are only five fluids in which HIV can survive long enough to be passed from person to person (i.e. blood, breast milk, semen, vaginal fluid, rectal secretions) and there are generally only three ways of transmitting the virus (i.e. sex, blood, pregnancy). Unlike other medical conditions and illnesses it is not something which happens to a person within their lifetime for no particular cause (e.g. multiple sclerosis, muscular dystrophy). There is always a human reason for HIV and this reason is capable of being controlled and addressed. Therefore, unlike other conditions which are not caused solely by person-to-person transmission, it should be possible through prevention and health promotion work to radically reduce the negative impact of HIV at the global level and within Ireland. Earlier references have been made in this Strategic Plan to the positive patterns which have emerged in recent years in relation both to the reduced number of people dying through AIDS and to the decreasing number of people each year being diagnosed with HIV.

Prevention strategies which have had an impact in Ireland include the greater availability of kits for drug users (containing clean needles, syringes, swabs etc.). This has resulted in the number of HIV cases amongst IDUs reducing from 74 in 2004 to 13 in 2013. Other important prevention and education measures include sex education and relationships modules in schools, free availability of condoms, higher levels of testing (so as to prevent onward transmission) and early diagnosis (through effective antiretroviral therapies the risk of transmission to an uninfected person can be reduced by up to 96%). There is also a need for effective nationwide information and education campaigns which would help to debunk some of the myths and misinformation about HIV and AIDS, would encourage good/safe practice in relation to sex and drugtaking, would promote HIV testing and would really emphasise the point that human beings have it within our own capacity (together with vaccines and antiretroviral therapies) to significantly reduce and ultimately eradicate HIV and AIDS.

‘HIV is a preventable disease and testing is one of the best forms of preventing the spread of HIV – knowing your status so that others do not become infected. In other words, if everyone knows their HIV status and those with HIV continue to prevent the spread of the virus, HIV can be eliminated altogether. With the right commitment and the right approach to sexual health we can live in a HIV free world’

- Pam McHugh, Chair of Dóchas HIV and AIDS Working Group

3.2.2. DEVELOPMENT OF TESTING AND SCREENING SERVICES

There is a widespread recognition and acceptance of the clear need for more HIV testing to take place so as to ensure that HIV can be diagnosed at the earliest possible opportunity. This has the primary benefit of ensuring that people with HIV can enter into treatment more quickly – all the available evidence demonstrates that if people begin receiving treatment when the CD4 levels are relatively high there are much better outcomes than when the CD4 levels begin to drop below 350 cells/mm. A further discernible benefit is that there is less likelihood of onward transmission – if a person is diagnosed HIV positive it is more likely that they will not engage in unsafe practices. In addition when a person with HIV is on effective antiretroviral therapy the risk of their sexual partner(s) acquiring HIV through unprotected sexual intercourse is significantly reduced⁹ and ¹⁰. The benefits of early testing and early treatment is recognised in the National Sexual Health Strategy, *‘the early treatment of known HIV cases may represent a significant prevention strategy to reduce ongoing HIV transmission’*.

It is estimated by the European Centre for Disease Control (ECDC) that over 30% of the 2.3 million people living with HIV in Europe are unaware of this infection, and are at risk of severe complications and possibly death as they cannot benefit from treatment¹¹. In 2010 in Ireland a total of 24% of newly diagnosed HIV cases were diagnosed at a very advanced stage of HIV (compared to 33% in 2011) when antiretroviral therapies can only have a limited impact. In order to decrease the number of late presenters and to ensure early diagnosis and access to treatment and counselling the ECDC and many other bodies recommend the promotion of HIV testing and counselling. Furthermore they recommend equal access to HIV testing and treatment for all population groups (and not just ‘high risk’ groups such as MSM, IDUs, people in prison, sex workers, migrants especially from high prevalence countries and other mobile populations). In 2013, an influential panel of doctors and scientists in the United States (the US Preventative Services Task Force) called for HIV

⁹ Studies by the Centre for Disease Control in the United States have indicated that effective HIV treatment can reduce the risk of transmission of the virus to an uninfected partner by as much as 96%.

¹⁰ The World Health Organisation stated in a June 2013 report that ‘since 2010 there has been increasing evidence on both individual clinical benefits and population benefits of earlier antiretroviral therapies. People who initiate these therapies between CD cell count of 350-500 cells/mm and maintain a suppressed viral load, should have improved survival and a reduction in HIV related illnesses. Earlier treatment is also associated with a reduction of HIV transmission to others and this can benefit the community and public health in general’.

¹¹ In England, Public Health England estimated that in 2012 22% of people living with HIV were unaware of their status (a decrease from 25% in 2011)

testing for all Americans aged 15 to 65, regardless of whether they are considered to be at high risk. They believe that this would help lift some of the stigma of testing.

'Late diagnosis and delayed access to treatment are the most important factors associated with HIV related illness and death, and also affects onward transmission'

- Message from 2013 European HIV Testing Week

'34 million people in the developing world are living with HIV – 80% of those are undiagnosed'

- Pam McHugh, Chair of Dóchas HIV and AIDS Working Group

3.2.3. MSM

In considering the statistics set out in the 2012 'HIV in Ireland' report produced by the Health Protection Surveillance Centre, one of the most significant outcomes relates to the ongoing increase in the number of HIV transmissions among men having sex with men (MSM). The number of HIV transmissions among MSM has increased from 60 in 2005 to 166 in 2012. This represents a percentage increase from 18.4% of all newly diagnosed HIV cases in 2005 to 48.7% of all newly diagnosed HIV cases in 2012. This is a particularly worrying trend at a time when there have been decreases in the numbers contracting HIV amongst other 'at risk' categories. It is considered very important to try and identify the reasons why the rates of HIV have increased significantly amongst MSM in Ireland especially when testing rates are fairly high amongst MSM¹². It is also important to recognise that the pattern in Ireland mirrors what is happening in other European countries with MSM now the predominant mode of transmission in the EU area (39.9% in 2011). A report from the European Centre for Disease Control recommended that interventions to control HIV among MSM should be the cornerstone of HIV prevention strategies in countries in Western Europe.

It is evident that a primary challenge for DAA, for other HIV support organisations and for LGBT groups is to halt and to reverse the increase in HIV cases amongst MSM. It should be noted that DAA has been to the forefront in Gay Health Network (GHN) activities for many years and has played a key role in securing funding for GHN for the joint HSE Man2Man programmes in 2011, 2012, 2013 and 2014. Although some people are of the view that

¹² In 2012, a total of 2,896 men tested for HIV with the Gay Mens Health Service (an increase of 39% over 2011). In 2012, a higher proportion of MSM tested at an early stage of HIV diagnosis (i.e. CD4 count of more than 350 cells/mm) than people from other higher risk groups – 61.2% of MSM diagnosed with HIV tested at an early stage compared with figures of 37.5% for IDUs and 36.1% for heterosexual males. This demonstrates a responsible approach to HIV testing amongst MSM.

prevalence of HIV amongst MSM is a problem or an issue for the LGBT community to address and to sort out, there is another view that it is a society-wide matter and that it only serves to further marginalise and stigmatise if HIV among MSM is only considered to be a key issue for the LGBT community. The significant and worrying rise in MSM transmissions also requires organisations such as DAA to play an active, leadership role. Since DAA's main area of interest and concern is HIV and since nearly 50% of all newly diagnosed HIV transmissions in 2012 were among MSM, it is considered that DAA has to play a strong role in developing preventative, education and community support strategies focused on MSM and, together with other relevant organisations and agencies, in reducing the number of HIV cases transmitted among MSM. This will build upon the work which DAA has been carrying out with the LGBT/MSM communities over the last number of years.

3.2.4. PREVALENCE OF SEXUALLY TRANSMITTED ILLNESSES IN IRELAND

There is a clear connection between HIV and other sexually transmitted illnesses (STIs). On the basis of the figures produced by the HPSC in relation to HIV in Ireland in 2012 it is evident that over 90% of HIV transmissions have resulted from sexual practices and activities, whether among MSM or through heterosexual sex. This relationship between HIV and sex is further emphasised by the fact that having another STI is more likely to increase the chances of acquiring or transmitting HIV infection than would be the case if a person did not have another STI. Therefore it is a cause of some concern that of the 341 new diagnoses of HIV in Ireland in 2012, 16% were co-infected with more than one STI (Chlamydia, Gonorrhoea or Syphilis), 7% were co-infected with Hepatitis C and 5% were co-infected with Hepatitis B. Co-infection rates varied by modes of transmission. One in four MSM (27%) with newly diagnosed HIV infection were co-infected with an STI compared to one in 20 heterosexuals (5%). A total of 69% of IDUs with newly diagnosed HIV infection were co-infected with Hepatitis C.

These figures and outcomes serve to emphasise the importance of DAA and other HIV support organisations placing a strong focus on safer sexual practices which will lessen the possibilities of people acquiring HIV and other STIs (32.9% increase in gonorrhoea cases between 2011 and 2012). Whilst never wishing to diminish the pleasures and satisfaction of sexual activity it is also necessary to take certain precautions and measures which will prevent the transmission of STIs including HIV. In this context, and as part of their prevention and health promotion work, organisations such as the HSE and HIV support

organisations need to place their work within a sexual health and well-being framework. In more particular terms relevant organisations need to support and endorse the National Sexual Health Strategy and to play leadership roles in leading and implementing certain actions and measures within this strategy. In considering the strong and indisputable link between HIV and sexual activity, it is important that organisations promote the safer sex message and that they work together to influence key target groups and especially those target groups most at risk of acquiring HIV and other STIs.

The success of the DAA social media STI prevention campaign called Just Carry One which targeted young people has demonstrated the clear need for this type of social media sexual health promotion. During 2013, the campaign saw an increase of 523% in followers, 88% of whom are aged 24 and younger. The recent report from the joint HSE Gonorrhoea Information Campaign recommends that social media campaigns such as this one should be resourced to build on its success and develop a sustained national STI prevention campaign. Just Carry One is one of only two social media campaigns with the primary aim of promoting condom use to prevent STIs. The second is the ‘Johnny’s Got You Covered’ campaign led by the HSE Crisis Pregnancy Programme. Whilst using different approaches/models of promotion, both programmes experienced high engagement rates during the Gonorrhoea Information Campaign.

3.3. STIGMA, DISCLOSURE AND NORMALISATION

3.3.1. STIGMA AND DISCRIMINATION

Whilst there has been some welcome normalisation of HIV in recent years with less hysteria and hyperbole about HIV and AIDS and with those infected by HIV able to live longer and healthier lives (if diagnosed early enough and put on an appropriate treatment programme at this early stage in the HIV infection), there is still considerable stigma and discrimination for people living with HIV. This is clearly reflected in the ways in which people who do disclose their HIV status are very often treated differently (in social circles, within the workforce, within local communities) than people with other long-term chronic illnesses such as arthritis, multiple sclerosis or Parkinson’s Disease. There is concern that because many people feel that HIV is self-inflicted and that people bring it upon themselves (e.g. through intravenous drug use, through unsafe sexual practices) there is less empathy and sympathy for people with HIV. There is also a high level of ignorance about HIV and about how HIV is transmitted (e.g. people believing that it can be transmitted through sharing cups, hugging,

sleeping in the same bed, kissing, using the same toilet seat). This ignorance only serves to compound the stigma and discrimination experienced by many people living with HIV.

A 2008 report entitled “HIV Related Stigma and Discrimination in Ireland Today”, the first national report on HIV related stigma, reveals that ignorance and stigma surrounding HIV and AIDS remains strong in Ireland. The report was launched as part of the ‘Stamp Out Stigma’ campaign, a collaboration between the Department of Health, Irish Aid, non-governmental organisations focused on HIV and sexual health and people living with HIV. While the report found that the Irish public has a “notable level of sympathy and understanding towards those with HIV and AIDS”, some of the statistics it uncovered are shocking. The report found:

- 23% of people would be worried about eating a meal prepared by someone with HIV
- 15% of those surveyed believe that those with HIV only have themselves to blame for their condition
- 49% of people living with HIV claim to have been discriminated against by their own friends and 28% by their own families.
- 43% have been discriminated against by their local community, 25% by social welfare and 18% by school or college.
- The report highlights “a considerable level of discrimination’ among the medical profession”, with 37% of people with HIV claiming to have been discriminated against by a doctor and 34% by a dentist.
- 84% of people with HIV feel that people with the virus are viewed negatively by society. However just 54% of the general public agree with this.

People are wary, and at times fearful, of disclosing their HIV status – they might lose friends and family members, or not be successful in job applications. There is a clear need to tackle the stigma which is still evidently associated with HIV and AIDS and to communicate to people the message that HIV is a manageable, long-term chronic illness, that major medical advances have been made in recent years in relation to HIV, that people with HIV do not pose a danger or a threat and that regular ongoing testing for HIV should become part of normal health check procedures – people should be getting checked for HIV as they would get checked/tested for other viruses and medical conditions. Whilst there have been some public awareness programmes in recent years (e.g. Stamp Out Stigma) it is considered that they should be more sustained and that they should reach a wider audience – through social media and through radio and television advertising. There is also a need to develop more

targeted strategies aimed at tackling stigma and discrimination towards people living with HIV – these targeted strategies could be directed at groups such as employers, healthcare workers and teachers/educators.

Many incidences of discrimination occur with professionals, particularly health professionals¹³. DAA clients have experienced discrimination as a result of disclosing (or having their status disclosed) to non-HIV consultants, GPs, dentists, chiropodists, nurses, ambulance staff, Accident and Emergency staff, general hospital staff and holistic therapy practitioners. They have also experienced discrimination from fire staff, the Gardaí, staff in Social Protection and Dublin City Council offices (this is not an exhaustive list).

In some cases people have been refused treatment or care outright; in other cases health professionals pass the buck believing that there are 'special places' to treat non HIV related medical needs. Professionals often act on incorrect beliefs that certain policies exist around HIV. Some overall examples:

- GPs believing that they need to inform their patient's employer when their patient tests HIV positive.
- A worker in the Department of Social Welfare (now Social Protection) believing the AIDS Fund Housing Project housed *all* people with HIV (this was in 2010).
- A disability related agency refusing a support service to a client due to HIV status.
- Dentists referring clients to the Dental Hospital for routine work and/or giving clients the end appointment each day in order to reduce risk of cross infection to other patients.
- A chiropodist refusing to treat a client due to the client's HIV status.
- Gardaí/prison officers informing 'cell mates' of another person's HIV status for 'safety' reasons.
- Nurses and doctors double gloving when dealing with people living with HIV.
- Jobs being offered to clients and then withdrawn after clients disclose their status.
- A youth agency wondering what special forms had to be filled out when hiring a person living with HIV (belief that they had to formally declare they had hired a person living with HIV).

¹³ This assertion is based on research carried out in Ireland and in England, and on DAA's own experience of working with clients.

- Parents whose children are attending a crèche being told that a child living with HIV was also attending the crèche.

3.3.2. DISCLOSURE AND CRIMINALISATION

On the 13th of February 2012 a group of 20 organisations and individuals convened in Oslo to sign a declaration against the unjust prosecution and criminalisation of people living with HIV. The meeting took place on the eve of the High Level Policy Consultation on the Criminalisation of HIV Non-Disclosure Exposure and Transmission, where UNAIDS Executive Director, Michel Sidibé, made a speech advocating that *‘laws must support dignity, not discrimination’* for people living with HIV. Globally, there is a mounting number of cases of people being persecuted for HIV non-disclosure, potential exposure and non-intentional transmission. The declaration states that this is a negative public health strategy and seriously impacts upon human rights. The declaration *“provides a roadmap for policymakers and criminal justice system actors to ensure a linked, cohesive, evidence-informed approach to produce a restrained, proportionate and appropriate use of the criminal law, if any”*, regarding cases of ‘criminal’ HIV transmission. The criminalisation of those living with HIV has negative implications, potential stigmatisation of HIV, and misapplication of the law, resulting in a disincentive to HIV testing. Criminalisation of people living with HIV for reckless or accidental transmission may therefore be counterproductive.

In relation to Ireland, there has been a certain level of interest concerning the issue of criminal proceedings for people who have infected other people with the HIV infection. However, there is still much more work to be done around matters such as accidental or intentional transmission of HIV, the disclosure of one’s HIV status to sexual partners and the legal position within Ireland concerning criminal proceedings being brought for potential offences relating to injury/illness or death brought about by HIV transmission. It is considered that DAA and other relevant HIV support organisations and legal advice organisations (e.g. FLAC) could play a useful role in clarifying the current situation in Ireland around criminalisation for HIV transmission and in developing legal measures which strike the balance between a person intentionally infecting another person with HIV (without disclosing HIV status and the person who has been infected subsequently feeling no need to go for HIV testing/diagnosis) and other HIV transmission cases which are not intentional and where the infected person is clearly informed of the need to link into HIV testing/treatment as

soon as possible.¹⁴ Over the last number of years DAA has been working with the National AIDs Trust and the Terrence Higgins Trust in order to enhance our knowledge and effectiveness in responding to issues concerning disclosure and criminalisation.

3.3.3. NORMALISATION OF HIV AND DANGER OF COMPLACENCY

A number of interviewees consulted during the strategic planning process said that it is very good that significant advances have been made in relation to antiretroviral therapies for HIV and that this has resulted in a situation where HIV has been normalised to the extent that it falls into the category of a manageable, long-term chronic illness. As one interviewee said *'it is no longer the death sentence which it was 25 years ago'*. Whilst this normalisation of HIV is welcomed it is also clear that it is different to other chronic long-term illnesses for reasons set out earlier in this report – reasons to do with stigma, with discrimination, with the fact that it can be transmitted from person to person and with the reality that 20%-30% of people with the HIV infection have not been treated/diagnosed and may transmit the virus to other people without even knowing that they themselves are a carrier of the virus. These facts combine to set HIV apart from other chronic illnesses.

However, it is also recognised that it can be difficult to strike the right balance between the normalisation of HIV on the one hand (it is undoubtedly positive that more people with HIV are living more normal lives and living for longer periods of time) and the distinctive characteristics of HIV on the other hand (such as the ones set out in the previous paragraph). There is a particular concern about the seemingly increasing normalisation of HIV leading to more complacency about the main risk factors associated with the transmission of HIV. Some interviewees said that the improvements in medical science (especially with the antiretroviral therapies) had led people to believe that HIV is not as bad as it used to be, that there are remedies for HIV and that it is less dangerous to engage in activities which might lead to HIV

¹⁴ DAA concurs with the UNAIDS position that, in all instances other than intentional transmission, the application of criminal law should be rejected by legislators, prosecutors and judges. In particular, criminal law should not be applied to cases where there is no significant risk of transmission or where the person:

- Did not know that s/he was HIV positive;
- Did not understand how HIV is transmitted;
- Disclosed his or her HIV positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means);
- Did not disclose his or her HIV positive status because of fear of violence or other serious negative consequences;
- Took reasonable measures to reduce risk of transmission, such as practising safer sex through using a condom or other precautions to avoid higher risk acts;
- Previously agreed on a level of mutually acceptable risk with the other person.

(since it is ‘just another long-term illness’). There is a clear concern about this thought process both from the perspective of the person who believes this and the person(s) whom he/she might potentially infect with HIV. Ongoing work needs to take place to guard against complacency and to alert people to the fact that deaths through HIV and AIDS still continue to take place in Ireland (10 people died through AIDS in 2012).

Outcomes from workshop amongst DAA staff about particular characteristics and distinctiveness of HIV:

- **HIV is a communicable infection.**
- **There is no cure for HIV.**
- **While there have been many advances in HIV medication, HIV is still a 'young' illness. Research is only commencing on the health implications for those on longterm medication.**
- **Stigma – People living with HIV or those perceived to be HIV positive are irrationally stigmatised.**
- **Discrimination, including refusal of service, travel restrictions, life assurance.**
- **Inequalities.**
- **Limited supports available (particularly in rural communities).**
- **HIV mainly affects marginalised groups.**
- **Criminalisation: HIV transmission is criminalised.**
- **HIV is not a mainstream health issue, or seen as affecting the general population.**
- **Mental Health issues - particularly around the challenges in reducing the spread of HIV.**
- **HIV infection is preventable.**
- **Sexual and reproductive health restrictions and other issues.**
- **Expectations around disclosure, and lack of understanding among professionals.**
- **Many HIV-related issues are driven by moral judgements and blame.**

4. FUTURE DEVELOPMENT OF DAA – KEY ISSUES TO BE CONSIDERED

4.1. INTRODUCTION

The future work of DAA has to be informed by a range of issues including the need for the services and supports being proposed in this Strategic Plan; the ways in which DAA can ‘add value’ and bring a new approach or dimension to various supports and services; and the gaps in provision which could usefully be filled by DAA. It is also important that the work of DAA corresponds to public health priorities set out in documents such as Future Health, Healthy Ireland, the National Sexual Health Strategy (pending), the National Drugs Strategy and the National Hepatitis Strategy. This will ensure that DAA is helping to achieve some national/governmental objectives, especially around areas where non-governmental organisations such as DAA can have more impact and have more connections and inroads than Government Departments and statutory agencies. The future work of DAA also has to take into account ways in which DAA might operate in collaboration with other organisations so as to maximise the resources which we have at our disposal and to work together towards better collective outcomes.

This section of the Strategic Plan will consider a number of key issues which are important in the construction of Strategic Objectives and work programmes for DAA over the next three years. These key issues which will inform our ongoing work are as follows:

- **Consistency with national policies and frameworks**
- **Compliance with criteria and expectations of funders and supporters**
- **Collaboration and co-ordination**
- **A focus on HIV and related sexual health issues**
- **Tackling stigma and discrimination**
- **Testing and screening for HIV**
- **Prevention and education strategies**
- **Policy development in relation to HIV and AIDS**
- **Client support and one-to-one work**
- **Unique characteristics and roles of DAA**

4.2. CONSISTENCY WITH NATIONAL POLICIES AND FRAMEWORKS

Whilst DAA is an independent autonomous organisation it is also evident that DAA shares many of the public health concerns and priorities of the Irish government and of statutory agencies (such as the HSE) and of statutory programmes (such as the Crisis Pregnancy Programme). These public health priorities and concerns include the need for safer sexual practices, the desire that everyone in Ireland experiences positive sexual health and wellbeing, the need to reduce sexually transmitted infections, the need to decrease the prevalence of HIV, the need to ensure that more people are tested for HIV (especially within the most ‘high risk’ groups), the need for safer and healthier practices amongst intravenous drug users and among MSM. Through its work in these areas of concern and need (e.g. through client support, through prevention and health education), DAA is assisting the government to achieve its public health priorities and in some instances it is able to do things more effectively than statutory agencies on account of its flexibility, its independence from government, its base within the local community in the Inner City of Dublin, and the contacts and networks which it has built up over many years.

To an extent, DAA is partnering with the State to assist the State in achieving a number of public health priorities. The specific areas of work are set out in the Service Level Agreement between the HSE and DAA within which the HSE commits to providing a certain sum of money each year for an identified and agreed set of tasks, actions and outputs. Therefore the HSE is not providing money to DAA as an act of charity – rather it is on account of the fact that DAA is well positioned and well-connected so as to enable it to achieve important outcomes and results for the State (and which would have been much more difficult for statutory agencies to achieve). DAA is clearly working towards policy objectives contained in a number of key governmental documents relating to public health – namely Future Health, Healthy Ireland, the National Drugs Strategy, the National Hepatitis Strategy and the National Sexual Health Strategy. Within the National Sexual Health Strategy there are a number of references to the key roles to be performed by non-governmental organisations such as DAA – around issues such as prevention, education, training, screening and testing.

4.3. COMPLIANCE WITH CRITERIA AND EXPECTATIONS OF FUNDERS AND SUPPORTERS

In the course of designing and implementing its Strategic Plan for the period from 2014 to 2017, DAA will endeavour to ensure that it operates at the highest standards of governance

and accountability and of openness and transparency. DAA has always been a transparent organisation and this is reflected in the ways in which the financial accounts of DAA are openly available and in the comprehensive annual reports which are widely distributed to funders, supporters and other interested groups. DAA is also keenly aware of the need to continually review and evaluate its work so as to ensure that it is making its most effective contributions within the resources which it has at its disposal¹⁶. The wide-ranging nature of the consultations that have taken place in relation to the production of the 2014-2017 Strategic Plan is a clear demonstration of the desire of DAA to make sure that it will be responding to real needs and circumstances as they exist in contemporary Ireland and that as far as possible there is an evidence base for the priority work areas which are identified (e.g. the fact that 20%-30% of people with HIV have not been tested or diagnosed, the fact that 48% of transmissions in 2012 were among men having sex with men, the fact that 47.5% of people infected with HIV in Ireland in 2012 were born outside of Ireland).

In addition to ensuring that DAA applies good practice in relation to having a strong evidence base and rationale for its activities and interventions DAA will also aim to ensure that it places an important emphasis on outcomes and impact. Whilst there is a significant body of information which suggests that DAA has been very busy in recent years (e.g. in 2012, 1638 interventions provided to 342 people living with HIV), there needs to be a greater focus on the outcomes which have emerged from all of the activity in which DAA has been involved. In other words, how have the lives of people living with HIV improved as a result of DAA's work? how has DAA contributed to lessening the prevalence of HIV and STIs in Ireland? how many of the people newly diagnosed with HIV in Ireland link into the services and supports provided by DAA? what specific supports and services provided by DAA could not be delivered as well by other agencies? what are the 'value added' contributions of DAA? It is considered that responses to these questions and issues will go a long way in determining the impact of DAA's work and the ways in which DAA is contributing to preventing further transmissions of HIV and to providing supports and services to people living with HIV.

¹⁶ DAA is committed to implementing quality improvement tools for HIV prevention projects and programmes and to this end is participating in Quality Action training, a HSE supported project for improving HIV prevention in Europe.

4.4. COLLABORATION AND CO-ORDINATION

In addition to working with statutory agencies around priorities such as testing for HIV (DAA is currently providing a HIV testing service with the GUIDE Clinic from St. James Hospital and DAA is also playing a lead role in the Gonorrhoea Information Campaign with the HSE Health Promotion and Improvement Department and other key partners), DAA is also committed to working in co-operation and collaboration with other organisations within the community and voluntary sector in Ireland. This would build upon work which has already been taking place in recent years. For example the training and education sections of DAA and the Irish Family Planning Association have developed a Memorandum of Understanding which aims to maximise the training and education resources and staff which are available within the two organisations. Over the years DAA has also collaborated with other HIV support organisations in Dublin and in other parts of Ireland – for example the Stamp Out Stigma and Do You Choose It campaigns. In more recent times DAA has also collaborated with the Gay Health Network and the HSE in the Man2Man.ie programme which is the first national HIV Prevention and Sexual Health Programme targeted at men who have sex with men.

DAA intends to both deepen and broaden collaboration with other relevant organisations and agencies over the period of the 2014-2017 Strategic Plan. In recognition of the fact that tackling HIV and AIDS is a shared challenge DAA has identified the need to improve contacts and relationships with relevant statutory bodies (so that there is a greater flow of referrals between DAA and hospitals in the Dublin area), with HIV support organisations (so that more co-ordinated projects and campaigns can be developed) and with other organisations and groups within the community and voluntary sector in Ireland (so that more concentrated and co-operative work can take place around ‘high risk’ groups such as gay men and immigrants from sub-Saharan Africa). Over the years DAA has developed partnerships and joint initiatives with organisations and programmes such as Ana Liffey, Uisce, Chrysalis Drug Project, Gay Health Network, Gay Switchboard Dublin, LGBT Helpline, Crisis Pregnancy Programme, the Irish Sexual Health and HIV Network, SpunOut.ie, the Union of Students in Ireland, the HSE Public Health Department East and the HSE Health Promotion and Improvement Department.

4.5. FOCUS ON HIV AND RELATED SEXUAL HEALTH ISSUES

In analysing the National Sexual Health Strategy (NSHS) it is evident that HIV has been integrated into the broader sexual health context in Ireland. It has been clustered with other unintended consequences of sexual activity such as STIs and unplanned/crisis pregnancies. DAA welcomes the fact that within the NSHS, HIV is being integrated with other unintended consequences of sexual activity and that it is not being stigmatised or demonised or seen '*as a thing that it is completely different from anything else*' (quote from person consulted during the strategic planning process). This will certainly help in the process of taking the stigma away from HIV and AIDS, a process which will also be assisted by the fact that people with HIV can now lead relatively normal lives with antiretroviral therapies (especially if they are diagnosed and treated shortly after being infected) and by the hope that a vaccine will shortly be produced to prevent the transmission of HIV. It is very positive that there have been significant global outcomes in the struggle to overcome HIV and AIDS e.g. 700,000 fewer new HIV infections across the world in 2012 compared to 2001, reduction of 24% in AIDS related deaths globally between 2006 and 2012, a vision of an AIDS-free generation.¹⁷

This then raises the issue of whether there is a need for HIV specific support organisations when HIV is being increasingly normalised (as a chronic long-term illness) and when it is being integrated into the broader spectrum of sexual health policies and programmes. There is, however, a strong counter-argument to this view which is based on the fact that approximately 9,000 people in Ireland have been infected with HIV over the last 20 years (combination of people who have been tested/diagnosed for HIV and people not tested for HIV); there are over 3,000 people in treatment for HIV; there were 341 people tested HIV positive in 2012; over 10 people each year die of AIDS and AIDS related illness; there is still tremendous ignorance and stigma about HIV and AIDS in Ireland; and people are very reluctant to disclose their HIV status (even to their closest friends and family members). Thus, there are still substantial challenges in relation to HIV and AIDS in Ireland and it is considered important that there are HIV specific organisations such as DAA which are addressing the types of issues and concerns set out in this Strategic Plan. For these reasons it is appropriate for DAA to maintain its clear and explicit focus on HIV and AIDS whilst also recognising the fact that DAA needs to embrace broader strategies which also have a HIV

¹⁷ The 2012 theme of the UNAIDS was 'Getting to Zero – Zero new HIV infections, Zero discrimination, Zero AIDS-related deaths'

dimension – strategies such as the NSHS and the National Drugs Strategy and the National Hepatitis C Strategy.

4.6. TACKLING STIGMA AND DISCRIMINATION

DAA will maintain a strong commitment to tackling stigma and discrimination for people living with HIV and in relation to the broader public awareness and understanding of HIV and AIDS. Whilst there have been welcome improvements in the medical treatments for HIV, there are still major problems around the social aspects of HIV and AIDS. This is one of the clearest outcomes from the wide-ranging consultations which have taken place around the 2014-2017 Strategic Plan for DAA. The advances in medical science in treatments for HIV and AIDS have not been mirrored by a more benign and empathetic understanding of what it is like to live with HIV and this results in people living with HIV being shunned, isolated and afraid to disclose their HIV status. As one interviewee said *‘whilst medically HIV is being normalised and is another chronic long-term illness, it has not been normalised at a societal level. People still treat you differently if you say you have HIV rather than something like arthritis or diabetes’*. The situation for people living with HIV is further exacerbated by the discrimination they often experience on account of their HIV status (when they try to access services such as certain healthcare services).

Awareness of methods of transmission

Although four-fifths of the British public are aware of the main method of transmitting HIV – sex without a condom between two men and/or a man and woman - there is still a fifth who do not mention each of these. In addition, almost a fifth mention at least one incorrect method of transmission (such as spitting, sharing a glass, or coughing/sneezing). Furthermore, there have been increases since 2007 in the proportion of people selecting some of the incorrect methods of transmission of HIV such as spitting (by five percentage points) and through kissing someone (by five percentage points). There is therefore still a need to improve awareness among the public about transmission, both in order to try to prevent the spread of the disease, and also to prevent misconceptions which fuel HIV stigma and discrimination.

Attitudes towards people with HIV

There have been some noticeable changes in attitudes towards HIV and people living with HIV since previous waves of this research. There is a ‘mixed picture’ - with, for example, an

increase in belief that people with HIV deserve the same level of support and respect as those with cancer (from 70% in 2007 to 74% in 2010) and in belief that most people with HIV can work these days like anyone else (from 71% in 2007 to 73% in 2010); but a decline in the proportion of those would feel comfortable working with a colleague who was HIV positive (from 70% in 2007 to 67% in 2010) or who believe relationships with a family member or neighbour would not be damaged if they had HIV (for a family member from 74% in 2007 to 69% in 2010; for a neighbour from 67% in 2007 to 63% in 2010).

Reaction to attitudinal statements added to the survey this year reveals that around one in ten people agree that they do not have much sympathy for people with HIV. This agreement increases to three in ten if a person was infected through unprotected sex, and approaching half (46%) if they were infected through injecting drugs. This illustrates that the public are less sympathetic if an individual is deemed to have been infected due to their own actions, particularly less common social behaviour (such as sharing needles). This lack of sympathy is particularly concerning as by far the most common forms of transmission among people diagnosed with HIV in 2009 was unprotected sex (95%), followed by sharing needles when injecting drugs (2%). It therefore seems there is still work to be done to increase public sympathy and understanding towards people with HIV.

Although the majority (69%) agree it is right that there are laws to protect people with HIV from discrimination, approaching two-fifths (38%) of the public believe that their employer should tell them if a colleague is HIV positive. This view is much more common among people who admit they do not have much sympathy for people with HIV (52% vs. 35% of those who disagree). For some this may stem from concerns related to misconceptions about how HIV can be transmitted: for example, those who think their employer should tell them about a colleague with HIV are more likely than average to believe HIV can be transmitted through sharing a glass (4% vs. 1%) and spitting (13% vs. 8%).

General knowledge of HIV

It is important that the public are well informed about HIV, not only to prevent transmission but also to try to challenge common myths and reduce the stigma that is associated with the condition. This research has found that people with better knowledge about HIV (who correctly identify at least four out of nine statements about HIV as true or false) are more sympathetic towards people with HIV (e.g. 76% who have average/fairly good knowledge of HIV vs. 67% overall disagree that they don't have much sympathy for people with HIV).

However, when presented with a selection of true and false statements about HIV there seems to be much confusion, often with broadly equal proportions thinking statements posed to them are true, false or not knowing. This was the case for six of the nine statements. For example, roughly similar proportions believe it is true (32%), false (39%) or don't know (29%) that people with HIV have a lot more time off work due to illness than those without the condition. As well as demonstrating the public's confusion about some of the realities around HIV today, the sizeable proportion who respond 'don't know' to these statements indicates that some of the public are quite aware that their knowledge about HIV is limited. More encouragingly, seven in ten think it is false that people in the UK infected with HIV will probably die within three years, as people with HIV who receive treatment can in fact go on to have a near normal life span. In addition, there is relatively high awareness that many people with HIV in the UK do not know they have it - just over half think estimates that put this figure at more than 20,000 are true, which is clearly an important message both for encouraging people to protect themselves from HIV transmission and to get tested.

Despite the general lack of understanding and confusion about HIV, or perhaps because of it, the public feel education about HIV is important. The vast majority (85%) agree that young people should be educated about HIV at secondary school and just over two-fifths would themselves wish to hear more about the reality of HIV in the UK today.

Young people themselves (16 to 24-year-olds) are significantly more likely than older people to believe that they do not know enough about how to prevent HIV transmission during sex (18% compared with the average of 12%) and 52% of this age group are interested in hearing more about the reality of HIV in the UK.

- Ipsos MORI research on 'HIV – Public Knowledge and Attitudes' (2010)

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Key reasons for the stigma associated with HIV is that it is transmitted from person to person (with people often having misguided notions that it can be transmitted by actions such as hugging and shaking hands) and that in many cases it is self-inflicted through unprotected/unsafe sex and intravenous drug use (thus making the victims less deserving of our sympathy or support according to some people). DAA will aim to tackle misinformation and ignorance about HIV and AIDS and will strive to increase people's awareness and understanding about HIV and AIDS – its causes, its consequences, its treatments, its impact on people living with HIV and on their friends and families. DAA will use some of the

analyses and insights set out earlier in this Strategic Plan to enhance public perceptions about HIV and AIDS.

DAA will also collaborate with other relevant voluntary organisations and statutory agencies to launch vigorous and ongoing public awareness campaigns and programmes. These will need to be sustained over a long period of time and should not just be one-off initiatives such as Stamp Out Stigma. It is considered that sustained campaigns will require a certain level of funding. DAA can play its role in encouraging statutory public health authorities and private companies to provide funding towards sustained HIV public awareness campaigns within the print media, electronic media and social media.

4.7. TESTING AND SCREENING FOR HIV

Earlier references have been made in this Strategic Plan to the critical importance of testing as a mechanism for getting people with HIV into treatment as soon as possible (thereby improving the prognosis for reasonable health outcomes) and as a way of reducing onward transmission of HIV (people diagnosed with HIV will generally not engage in activities which will put other people in danger of contracting HIV). DAA will place an even stronger emphasis on HIV testing and screening during the period of the 2014-2017 Strategic Plan with the intention of reaching more of the 20%-30% of people currently living with HIV who have not been treated/diagnosed for HIV, who are therefore not in treatment for HIV and who are generally unaware of their HIV status. In conjunction with the GUIDE Clinic in St. James Hospital DAA has successfully established a HIV testing initiative at our premises in Parnell Square in Dublin over the last couple of years and this service has attracted up to 30 people for HIV testing on each of the afternoons when it has operated (and, on occasions, there has been a need to turn people away and/or run a second parallel testing service to cope with the demand). This clearly demonstrates the value of an anonymous, community based service in a non-clinical setting and DAA intends to develop its testing work further over the next number of years.

At the national level, DAA will also campaign for HIV testing and screening to be routinely offered within hospitals, health centres and other public health settings within Ireland. This type of routine testing and screening is already in place for women within maternity units in Ireland (so as to screen for the onward transmission of HIV from mothers to their babies in the womb). There are national and international statistics available for rates of HIV testing

per 100,000 population across the European Union, and Ireland (through the work of DAA and other agencies/organisations) should aim to significantly increase the number of people tested for HIV per 100,000 population. In more particular terms DAA will campaign with others for universal HIV screening of all people aged 15 to 65 (along the lines of what is being proposed in the United States by the influential US Preventive Services Task Force). DAA will also carry out more targeted work around HIV testing/screening with groups which are considered ‘high risk’ in relation to HIV. These groups include MSM and people originating from a country with a HIV and AIDS epidemic (generally countries in sub-Saharan Africa). DAA will work with relevant representative/support organisations for these ‘high risk’ groups with a view to increasing the levels of HIV testing/screening.

Today at least one in three of the 2.3 million people living with HIV in Europe are unaware that they are HIV positive. Half of those living with HIV are diagnosed late – which delays access to treatment. This means that many people are not being tested prior to symptoms emerging. This could be because there are barriers to requesting an HIV test, barriers to offering HIV tests, or barriers to the implementation of European HIV testing guidelines. This is despite the benefits of early HIV diagnosis being well-documented. These statistics suggest that we need to be doing more to encourage individuals who are unknowingly living with HIV to take an HIV test and to better target HIV testing at people who could have been at risk.

- From 2013 European HIV Testing Week

‘HIV testing should be offered in a wider range of settings rather than is currently the case, including both healthcare and community based settings as well as outreach programmes’

- From 2013 European HIV Testing Week

4.8. HIV PREVENTION AND EDUCATION STRATEGIES

DAA will continue to prioritise its work around the issues of HIV prevention and HIV education and sexual health promotion. The spike in figures for HIV cases in Ireland in 2012 (i.e. a figure of 341 new diagnoses which reverses a downward trend in the previous three years) serves to reinforce the need to remain vigilant in relation to HIV and not to become complacent because there are now better treatments for HIV. It is important to recognise that

AIDS is still a fatal illness and that even with improvements in medication over 10 people each year in Ireland are dying due to HIV and AIDS.

For these reasons DAA will maintain a strong focus on prevention and health promotion through strategies such as HIV testing (which will help to prevent onward transmission of HIV), the distribution of condoms (so as to reduce the incidences of unsafe/unprotected sex), public awareness campaigns, participation in events such as Sexual Health Awareness Week and the training of healthcare professionals, trainers, teachers and others who are working with groups identified as being at 'high risk' of contracting HIV (e.g. MSM, sex workers, people in prison, intravenous drug users). HIV is a preventable condition since it is transmitted from person to person and DAA will continue to do all that it can to prevent onward transmissions from people infected with HIV to people who are not infected with HIV. DAA will also continue to support people living with HIV in issues around disclosure and safer sex practices.

Whilst the main focus of DAA's education and training work is on the general population of young people, DAA has clearly identified the need to give particular attention to two main target groups: MSM and people who come from countries where there is already a high prevalence or epidemic of HIV (i.e. sub-Saharan Africa). In relation to these two particular groups, the outcomes from the 2012 HIV in Ireland report state that 48.7% of new HIV cases in 2012 were transmitted among MSM whilst 48% of the people diagnosed with HIV in 2012 were born outside of Ireland. Thus, there is a strong evidence base for DAA focusing its preventative and training work on the gay male community and on immigrant communities in addition to its ongoing work with the general population (with a particularly strong focus on young people under the age of 25).

These two target groups are also priority target groups (i.e. LGBT/MSM communities; migrant communities) for the Social Inclusion section of the HSE and it is interesting to note that responsibility for organisations such as DAA has now been transferred from the Addiction Services section within the HSE to the Social Inclusion section of the HSE. It is considered that a greater focus by DAA on prevention and education work with MSM groups and with immigrant/migrant groups will be of particular interest to the Social Inclusion units within the HSE. It is anticipated that much of this work could be extended beyond the Dublin area into other parts of Ireland. DAA already has a presence outside of Dublin through social media platforms (e.g. Facebook, Twitter), through attendance at its training events and through the delivery of condoms to colleges across Ireland.

Awareness of HIV status and antiretroviral therapy (both for people living with HIV and as post exposure prophylaxis for potentially exposed individuals) are essential factors in the prevention of morbidity and mortality associated with HIV and in the prevention of new HIV infections. People at risk of HIV will be made aware of the benefits of knowing their HIV status, encouraged to test for HIV and avail of antiretroviral therapy as appropriate. Positive prevention (defined by UNAIDS as positive health, dignity and prevention), the promotion of condom use and testing, targeted education and outreach initiatives which have been a cornerstone of HIV prevention will be maximised in the context of reducing negative sexual health outcomes. MSM are most at risk for HIV transmission. Campaigns will take into account that many MSM do not self-identify as gay or bisexual and may not perceive themselves to be at risk of HIV or other STIs.

- Extract from National Sexual Health Strategy (2013)

4.9. POLICY DEVELOPMENT IN RELATION TO HIV AND AIDS

There are a number of issues around which policies need to be developed in Ireland concerning the circumstances and needs of people with HIV and people at risk of contracting HIV. These issues include the universal testing and screening of people for HIV, the greater availability of free condoms to low income, at risk groups (e.g. immigrants in ‘direct provision’ settings, people in prisons); the extent to which people should be expected to disclose their HIV status (to healthcare workers, to employers, to immigration authorities/controls); and the ways in which people transmitting HIV to other people should or should not be considered liable for a criminal offence. In relation to these policy matters, DAA needs to consider the best strategies for the successful progression of its policy positions concerning these matters. In particular DAA needs to decide whether it is better pursuing policy objectives and policy goals by itself or whether it is better to collaborate with other HIV support organisations and perhaps other organisations in the community and voluntary sector in Ireland (including public interest law organisations and associations).

There is a growing body of international good practice and international case law in relation to policy issues concerning HIV and AIDS. Over the course of the next three years DAA will develop contacts in other countries in order to link into international experiences which are relevant to, and transferrable to, the Irish context. On account of the fact that HIV and AIDS

is clearly a global issue it makes sense for DAA to learn from the experiences of other countries where lobbying and campaigning on matters concerning HIV and AIDS is more advanced than it is in Ireland. It is considered that much more needs to be done in relation to lobbying around matters such as universal testing/screening, disclosure and criminalisation and that DAA should play a more prominent role in this aspect of its work over the next period of time. More rigorous lobbying around key issues will have the dual advantages of firstly helping to ensure that HIV and AIDS is kept on the agenda (there is a sense that it has been side-lined and marginalised in recent years) and secondly helping to raise the profile of DAA as an effective lobbying organisation for people living with HIV.

4.10. CLIENT SUPPORT AND ONE-TO-ONE WORK

Over the course of the last number of years DAA has developed a strong and positive reputation for its client work and its community based outreach services and supports. A number of the interviewees consulted during the strategic planning process commented upon the links and contacts which DAA have established within some of the hardest to reach target groups who would be considered to be at ‘high risk’ in relation to HIV. These target groups have included MSM, immigrants from sub-Saharan African countries, immigrants from Eastern European countries and intravenous drug users. DAA has placed a particular emphasis on making its services and supports as accessible as possible to people from these ‘high risk’ target groups. This is achieved through being open and non-judgemental, through taking people where they are at during a particular stage in their lives, through going to where people from target groups are most comfortable and relaxed, through respecting cultural traditions and norms, and through going to the effort of translating information notes and good practice guides into different languages (on our website, information is translated into 33 languages). It is considered important that DAA builds on its reputation and street-cred (particularly in the North Inner City of Dublin) and, if feasible, to extend its community based outreach services beyond the North Inner City.

DAA also needs to be clearer about the objectives and the impact of its outreach work and should aim to develop measurements or key performance indicators (KPIs) against which progress and achievements can be determined. Whilst it is positive that DAA are out-and-about within local communities it is also important that this work is strategic and that it is making a difference. This criteria or measurement of ‘making a difference’ (and perhaps doing things that other organisations cannot or will not do) can also be applied to the one-to-

one work carried out by DAA with people who are living with HIV. Whilst it is evident that the community based setting for DAA's work appeals to some clients it is also necessary to be clear about what distinguishes DAA's work from, for example, the work of medical social workers in hospitals and the work of external counsellors. Feedback from people consulted during the strategic planning process would indicate that DAA is particularly well regarded in relation to the advocacy work which they carry out for clients around issues such as health provision, social welfare benefits, housing and employment. There were also positive comments about new initiatives that have taken place in recent years in relation to DAA supporting people living with HIV to advocate for themselves.

4.11. UNIQUE CHARACTERISTICS AND ROLES OF DAA

Interviewees consulted during the strategic planning process were all of the opinion that there is a definite ongoing role for DAA into the future. There are thousands of people living with HIV in Ireland, hundreds are being diagnosed HIV positive each year in Ireland, there is still a huge stigma around HIV and AIDS and there is an ongoing major job of work to be done around HIV prevention, sexual health education and public awareness concerning HIV and AIDS. In responding to these challenges, interviewees felt that there was a strong, unique and influential role to be performed by DAA (for reasons set out earlier in this document). Indeed some of the interviewees said that DAA should be more public and more vocal about its work and that it should engage in more lobbying and campaigning around key issues which would attract more political and public attention. These people said that DAA was relatively low-key and low-profile compared to some other organisations within the community and voluntary sector in Ireland and that it would be in the best interests of DAA to have a stronger presence within the media (which it could then use to campaign for the issues which are of most concern to people living with HIV and to other HIV activists).

In considering the ongoing development of DAA it was suggested that the organisation gives some thought to its name and to its geographical reach. In relation to its name Dublin AIDS Alliance has a strong brand name and a strong reputation for doing good and effective work. However, it is also important to balance an affinity and an affection with a name to the suitability of the name in achieving organisational objectives. For example if an organisational objective is to encourage people to link up with the services and supports being provided by DAA, is the words 'AIDS' in our title going to deter people from contacting us? In relation to the word 'Alliance' it was pointed out that when DAA was first

established in the late 1980s, it was an alliance of different organisations based in Dublin. However it ceased to be an alliance of organisations from the 1990s onwards.

In relation to geographical reach and coverage it is evident that DAA has had an impact outside of Dublin during the 25 years of its existence. Many of those seeking support, who turn up for testing and counselling and who attend DAA training programmes live outside Dublin and many people availing of information on the DAA website are not from Dublin. It is also important to note that DAA's STI prevention social media campaign 'Just Carry One' is a national campaign as is the joint GHN and HSE Man2Man.ie programme. It was suggested during the consultations that DAA should further broaden its geographical focus beyond Dublin since there are no HIV support organisations in the other counties of Leinster (e.g. in large towns like Mullingar, Kilkenny, Dundalk, Drogheda, Navan). In this context DAA should consider how it might further extend its work beyond the Dublin area to other counties in the Eastern region of Ireland (initially perhaps through having information about DAA in local hospitals, health centres and various community settings).

5. STRATEGIC PRIORITIES AND STRATEGIC OBJECTIVES FOR DAA, 2014-2017

5.1. INTRODUCTION

The previous sections of this strategic planning document have set out the background to, and context for, the work of DAA in relation to HIV and other related issues. These sections of the document have explored the main challenges and needs concerning HIV and AIDS and have examined the most appropriate roles of non-governmental organisations such as DAA in responding to these needs and challenges. These challenges/needs include reducing the prevalence of HIV (especially amongst ‘high risk’ groups such as MSM and people originating from countries where there is a HIV and AIDS epidemic); increasing testing for HIV as a mechanism both to decrease onward transmission of HIV and to get people into treatment as soon as possible; tackling issues concerning the stigma and discrimination associated with HIV and AIDS; and creating greater public awareness about the causes and consequences of HIV.

This section of the Strategic Plan will set out the ways in which DAA will respond to these challenges and needs in the period from 2014 to 2017. It is recognised that DAA, on account of its relatively limited resources, can only do a certain amount in relation to ‘big ticket’ issues such as reducing the overall prevalence of HIV in Ireland and in tackling issues concerning stigma, discrimination, disclosure and criminalisation. However DAA also believes that through building relationships and strategic partnerships with other organisations and agencies (in the public, private and community/voluntary sectors) it can make a real and meaningful difference in relation to key issues such as more people getting screened/tested for HIV and people with HIV receiving adequate and appropriate supports and services. Whilst other agencies such as the HSE have a multifaceted range of activity areas (e.g. hospitals, community care, mental health and addiction) the major outstanding focus for DAA is HIV. In this context DAA (as a specialist HIV organisation) is well positioned to play a lead role in mobilising the resources available within the public and private sectors in Ireland, in the development of strategies to prevent the transmission of HIV and to provide appropriate services and supports to people living with HIV.

In setting out the main strategic priorities and strategic objectives for DAA in the period from 2014 to 2017, this section of the document will be structured around the following headings:

- **Guiding principles which will inform and guide the work of DAA**

- **Vision Statement and Mission Statement**
- **Strategic Objective No. 1 – To work towards reducing the prevalence of HIV in Ireland through effective prevention strategies**
- **Strategic Objective No. 2 – To increase public awareness and understanding around HIV and AIDS and to reduce the stigma and discrimination connected with HIV and AIDS**
- **Strategic Objective No. 3 – To improve the quality of life for people living with HIV through quality evidence-based support and advocacy services**
- **Strategic Objective No. 4 – To enhance the promotion of broader sexual health objectives through education and training and through health promotion projects/campaigns in line with national policy**
- **Strategic Objective No. 5 – To inform and to influence policy around issues concerning HIV prevention and sexual health and relating to the lives of people living with HIV**
- **Strategic Objective No. 6 – To enhance the organisational effectiveness and efficiencies of DAA**

5.2. VALUES, BELIEFS AND GUIDING PRINCIPLES WHICH WILL INFORM AND GUIDE THE WORK OF DAA

DAA is acutely aware of the cultural and economic barriers that can affect life choices, rendering both men and women more vulnerable to HIV. Our support, prevention, education and training programmes are therefore rooted in capacity building and experiential learning techniques, which enable the negotiation of safer sex and/or injecting practices. While supporting service users around the choices available, DAA's approach broadly reflects a harm minimisation model, which emphasises practical rather than idealised goals.

DAA's individual and group interventions are, at all times, age appropriate and sensitive to the psychosocial needs, learning abilities and life experiences of our clients. We operate under an ethos of equality and are committed to making a positive contribution towards a humane and just society. DAA strives to ensure an environment that promotes equal opportunity and prohibits discrimination, while further enabling our staff, volunteers and service users to experience dignity and respect at all times.

The work of DAA between 2014 and 2017 will be informed and guided by the following principles and beliefs:

- **DAA will be non-judgemental in its work and in the ways in which it interacts and relates to people linking into its services and supports.**
- **DAA is an inclusive organisation and will endeavour to work with any individual or group who seeks advice, supports and/or services from DAA.**
- **DAA believes in the rights and expectations of people living with HIV to be treated with equality, dignity and respect and to be consulted about issues and services concerning them.**
- **DAA will aim to ensure that people living with HIV are provided with opportunities to link into services and supports which are appropriate to their needs and circumstances.**
- **DAA believes that medical advances in relation to HIV (with people leading more normalised lives through anti-retroviral therapies) now need to be matched by social advances in relation to HIV (with significant reductions in the levels of stigma, discrimination and isolation experienced by people who disclose or reveal their HIV status)**
- **DAA is of the view that a very significant public health priority is to reduce the estimated 20%-30% of people living with HIV who have not been tested or diagnosed for the HIV virus.**
- **DAA believes that people living with HIV and people at risk of contracting HIV can play a vital role in reducing HIV transmission.**

5.3. VISION STATEMENT AND MISSION STATEMENT

5.3.1. VISION STATEMENT

To contribute towards a significant reduction in the incidence and prevalence of HIV in Ireland and towards the realisation of an AIDS-free generation¹⁸

5.3.2. MISSION STATEMENT

Advocating for individuals living with HIV, preventing new HIV infections and combating HIV-related stigma and discrimination

5.4. STRATEGIC OBJECTIVE NO.1 – TO WORK TOWARDS REDUCING THE PREVALENCE OF HIV IN IRELAND THROUGH EFFECTIVE PREVENTION STRATEGIES

5.4.1. RATIONALE AND EVIDENCE BASE

DAA will work with other relevant statutory agencies and non-governmental organisations to reduce the prevalence of HIV in Ireland. In the period from 2008 to 2011 there was a significant reduction of 21% in the numbers testing HIV positive (from 404 in 2008 to 319 in 2011). However in 2012 there was a regrettable reverse in this positive trend with the numbers increasing from 319 in 2011 to 341 in 2012 – an increase of 6.9%. It is important that the figures re-commence their downward pattern in much the same way as road traffic fatalities in Ireland have decreased from 396 deaths in 2005 to 162 deaths in 2012. In considering the ways in which DAA might play its most effective role it is important to note that all HIV transmissions are caused by human-to-human contact (and are therefore preventable) and that the most significant modes of transmission are MSM (48.7% of new diagnoses in 2012). It is also notable, in relation to targeting services and supports, that 162 of the new HIV diagnoses in 2012 (i.e. 48%) were in people born outside of Ireland.

It is very helpful that the statistics produced by the HPSC in the Annual ‘HIV in Ireland’ reports contain such detailed breakdowns in relation to issues such as modes of transmission,

¹⁸ An AIDS-free generation means that

- Virtually no children are born infected with HIV
- As these children become teenagers and adults they are at a far lower risk of becoming infected than they would today, on account of a wide range of HIV prevention tools.
- If they do acquire the HIV virus they will have access to treatment that helps them from developing AIDS and transmitting the virus to others.

ethnicity and countries of origin, region within Ireland where HIV was diagnosed and stages of infection at which HIV was diagnosed. In assisting DAA and other organisations to achieve reductions in the prevalence of HIV in Ireland this annual analysis by the HPSC clearly points to the areas of work where most effort and resources need to be expended e.g. in relation to MSM; in encouraging people who believe they may be HIV positive to present for testing at the earliest possible opportunity; strong focus within the eastern region of Ireland. Positive movement in reducing prevalence levels amongst MSM, in early testing so as to prevent onward infection and in lower levels of HIV in the eastern region (and especially within Dublin) would lead to significant overall reductions in the prevalence of HIV in Ireland. DAA also believes it is most important that people living with HIV are actively involved in the development of new and creative HIV prevention strategies.

5.4.2. STRATEGIC GOALS AND ACTIONS

5.4.2.1. TO DEVELOP AND TO EXPAND COMMUNITY-BASED HIV TESTING SERVICES TARGETING POPULATION GROUPS AT RISK OF HIV

Actions

- Expansion of current DAA community-based HIV testing service to meet growing need
- Development of outreach HIV testing services in two other locations in the Greater Dublin area in partnership with relevant community-based projects
- Work in partnership with the Gay Health Network to secure funding and to roll out a pilot community-based HIV testing programme within the gay community

5.4.2.2. TO LOBBY FOR UNIVERSAL HIV TESTING AND SCREENING TO BE PROVIDED FOR PEOPLE OVER THE AGE OF 15

Actions

- Lobby and campaign for HIV testing and screening to be provided in much the same way as testing/screening for other medical conditions.

Recent estimates by HIV clinical services and the HPSC suggests that the prevalence of HIV in adults in the greater Dublin area has reached a threshold at which it may be cost effective to offer routine, opt-out, HIV testing to individuals attending any

health care setting. Research is currently underway to assess the feasibility and effectiveness of routine, opt-out HIV testing in various clinical settings. This work will be continued and used to make recommendations around HIV testing with appropriate implementation plans. Advances in HIV testing also provide increased opportunities for testing in non-clinical settings.

- National Sexual Health Strategy (2013)

5.4.2.3. WORK WITH THE MSM COMMUNITY TO DECREASE THE PREVALENCE OF HIV WITHIN THIS COMMUNITY

Actions

- Build on the existing partnership with the HSE through our active role in the Gay Health Network and lobby the HSE to resource a sustained national HIV prevention programme for MSM
- Build on the joint national Man2Man.ie programme and develop a range of new HIV prevention strategies in partnership with the Gay Health Network, HSE and relevant MSM groups and organisations

5.4.2.4. TO WORK WITH IMMIGRANT COMMUNITIES LIVING IN IRELAND TO REDUCE THE PREVALENCE OF HIV INFECTIONS AMONG THIS POPULATION GROUP

Action

- Identify areas for expansion of targeted outreach work with migrant groups and communities in Dublin and deliver relevant services and supports within these areas and existing outreach areas
- Ensure, where relevant and affordable, that educational materials are available and accessible in different languages

5.4.2.5. TO DEVELOP AND DELIVER TARGETED HIV PREVENTION, EDUCATION AND TRAINING PROGRAMMES¹⁹

Actions

- Identify and strategically target relevant organisations who work with population groups at risk of HIV and poorer sexual health outcomes, to encourage these groups to participate in HIV prevention, education and training programmes
- Further development of the existing DAA ‘free condoms’ service (both on-site and outreach services) and to secure resources and partnerships to build a sustainable service
- Ongoing and creative development of digital media strategy for DAA for usage in prevention, education and training programmes and strategies

5.5. STRATEGIC OBJECTIVE NO.2 – TO INCREASE PUBLIC AWARENESS AND UNDERSTANDING AROUND HIV AND AIDS AND TO REDUCE THE STIGMA AND DISCRIMINATION CONNECTED WITH HIV AND AIDS

5.5.1. RATIONALE AND EVIDENCE BASE

There is still a great deal of ignorance and misinformation in Ireland about HIV and AIDS. It is both surprising and frustrating that 30 years after the HIV and AIDS issue first came to national prominence in the western world that there is still such a lack of general awareness and understanding about HIV. The experiences of DAA would indicate that many people think HIV and AIDS to be the same thing; that the general public do not know that HIV can only be transmitted through semen, blood, breast milk, vaginal fluids and rectal secretions; that people are generally not aware that people with HIV can lead relatively normal lives (when on the appropriate antiretroviral treatments); and that there are still many misconceptions about modes of transmission with people believing that HIV can be transmitted, for example, through activities such as kissing, hugging, sharing cups and cutlery.

This misinformation and these misconceptions feed into all sorts of negative attitudes and stigmas about people living with HIV and often results in those people being shunned, excluded and marginalised. There is a clear job of work to be carried out in increasing public

¹⁹ Research, such as the UNAIDS Policy Position Papers, is continuing to demonstrate that sustained prevention and education programmes are a key variable in the reduction of incidences of HIV and sexually transmitted infections. For example, Stover (2002) estimates that prevention initiatives could reduce up to 63% of new HIV infections.

understanding around HIV and AIDS in Ireland and in debunking the myths and erroneous information which has built up around HIV and AIDS over the last 30 years. As one of the leading HIV support organisations in Ireland, DAA has a clear role to play in creating more awareness about HIV both amongst the general public and amongst people working with high-risk groups. It also has an important function to perform in identifying and highlighting incidences of discrimination against people who are HIV positive. This especially applies to incidences of discrimination from key service providers within the State.

5.5.2. STRATEGIC GOALS AND ACTIONS

5.5.2.1. TO DEVELOP, IN CONJUNCTION WITH OTHER RELEVANT ORGANISATIONS AND AGENCIES, A SUSTAINED AND CONCENTRATED PUBLIC AWARENESS CAMPAIGN IN RELATION TO HIV AND AIDS

Actions

- Secure funding, and identify key partnerships, to develop and implement a national HIV awareness campaign
- Develop and implement targeted HIV awareness campaigns using new social media techniques
- Enhance our relationship with the media and to increase national coverage of key issues relating to HIV
- The commissioning of a survey to gauge the level of public awareness about HIV and AIDS and about attitudes to people living with HIV²⁰

²⁰ This would be similar in style to one recently commissioned on depression which found that 20% of people would not employ somebody they knew had been depressed, 21% said that if they had depression they would not tell anyone, 30% would not vote for a politician if they had a history of depression and 19% said that depression is a sign of personal weakness.

5.5.2.2. TO DEVELOP GREATER UNDERSTANDING AND AWARENESS OF HIV AND AIDS AMONGST RELEVANT PROFESSIONAL GROUPS WHO ARE IN REGULAR CONTACT WITH POPULATION GROUPS AT RISK OF HIV

Actions

- Increase participation and inputs at conferences and seminars organised by relevant professional associations
- Identify HIV-related issues for topical discussion/debates, and organise seminars for relevant professional associations and networks (perhaps around Irish AIDS Day, World AIDS Day and Zero Discrimination Day)
- Develop professional education workshops and deliver to strategically identified professional networks and associations
- Identify gaps in relevant HIV policy areas, linked particularly with client-based issues, and assist in the progressive development and progression of these policy areas/issues

Good quality training for professionals who are working specifically in the area of sexual health or who may incorporate sexual health into their existing work is a crucial element to promoting sexual health and wellbeing and reducing negative sexual health outcomes. Sexual health training will aim to improve knowledge and skills level of participants while enabling them to explore attitudes and values which facilitate the delivery of supportive sexual health services.

Sexual Health and Other Professionals	Action	Partners
	Those working with vulnerable and at-risk groups will be trained in recognising and responding to the sexual health needs of their clients. Sexual health will also be incorporated into training courses for professionals who directly implement sexual health education and prevention activities.	HSE, Clinics, NGOs, other health and non-health professionals HSE, Colleges, professional bodies, NGOs.

- Extract from National Sexual Health Strategy (2013)

5.6. STRATEGIC OBJECTIVE NO.3 – TO IMPROVE THE QUALITY OF LIFE FOR PEOPLE LIVING WITH HIV THROUGH QUALITY EVIDENCE-BASED SUPPORT AND ADVOCACY SERVICES

5.6.1. RATIONALE AND EVIDENCE BASE

The total number of people in Ireland who have contracted HIV between the early 1980s and 2012 is estimated to be around 9,500. Within this number 6,629 people have been tested positive for HIV and a further approximate figure of 2,800 – 2,900 have contracted the HIV infection but have not been tested or diagnosed. In considering the circumstances of people diagnosed with HIV national and international evidence would indicate that coming to terms with this diagnosis can be a very difficult and traumatic experience for many people. There are the healthcare consequences of the HIV diagnosis and decisions to be made about the best types of treatment; there are the issues around stigma associated with HIV and about how to disclose or reveal one's HIV status; there are the social consequences, isolation and alienation experienced by many people living with HIV; there are often workplace and accommodation difficulties when people reveal their HIV status.

In enabling people to overcome these difficulties and challenges, it is evident that DAA has an important role to play in supporting people diagnosed with HIV. This can be achieved both by direct 1-to-1 advocacy and support and through the development of peer support networks such as the All-Ireland Network of People Living with HIV which DAA has helped to support and develop. On the basis of the strategic planning consultations it is evident that an important issue for the next three years is to improve the lines of communications and referrals between DAA and the main hospitals in the Dublin area so as to ensure that people who have tested positive are directed to and/or are made aware of the services and supports being provided by DAA. It is also recognised that many people tested HIV positive will not wish to link into supports being provided by DAA or by any other non-governmental organisations.

5.6.2. STRATEGIC GOALS AND ACTIONS

5.6.2.1. PROVIDE HIGH-QUALITY, EVIDENCE-BASED SUPPORT AND ADVOCACY SERVICES TO PEOPLE LIVING WITH HIV

Actions

- Enhance relationships and partnerships with relevant organisations to ensure efficient referral pathways and information flow to and from DAA
- Advocacy on behalf of people living with HIV in relation to issues such as discrimination, rights and legal issues around HIV
- Provision of counselling and support services in relation to disclosure, secondary prevention, leading a healthier life and other decisions that living with HIV may impact upon
- Effective and creative usages of the digital media to provide advocacy, information and support through websites, interactive forums etc.

5.6.2.2. TO FACILITATE AND SUPPORT THE DEVELOPMENT OF SELF-ADVOCACY AND PEER SUPPORT AMONGST PEOPLE LIVING WITH HIV

Actions

- Develop the capacity-building programme further to establish an All-Ireland Network of People Living with HIV
- Support the All-Ireland Network of People Living with HIV to provide peer support, including the use of new technology and social media
- Publish, in consultation with people living with HIV, relevant information and education materials including contributions to print media
- Set up a peer support group for those people who have recently been diagnosed with the HIV infection

5.7. STRATEGIC OBJECTIVE NO.4 – TO ENHANCE THE PROMOTION OF BROADER SEXUAL HEALTH OBJECTIVES THROUGH EDUCATION

AND TRAINING AND THROUGH HEALTH PROMOTION PROJECTS/CAMPAIGNS IN LINE WITH NATIONAL POLICY

5.7.1. RATIONALE AND EVIDENCE BASE

There is a clear linkage between HIV and sexual practices with the large majority of HIV infections resulting from sexual activity between a person infected with HIV and a person not infected with HIV. There is also a connection between HIV and other sexually transmitted illnesses (STIs) since people with other STIs are more likely to acquire or transmit HIV. In Ireland in 2012, 16% of people newly diagnosed with HIV were also co-infected with one or more STI (primarily Chlamydia, Gonorrhoea or Syphilis) with 27% of newly diagnosed MSM being co-infected with a STI. There is a clear need to promote the message and practice of safe sex and to educate and discourage people from engaging in sexual activity which will put them at risk of being infected with HIV or other STIs. It is recognised that a significant amount of work is already taking place at the national policy level (e.g. within the HSE, the National Sexual Health Strategy), at the community level (e.g. within schools and youth organisations) and within voluntary organisations (e.g. IFPA, Well Woman Centre) in relation to safer and more responsible sexual health. In this context, DAA aims to complement the sexual health education and training work which is already being carried out by many statutory and community based providers.

DAA has a long track record in supporting initiatives concerning sexual health (e.g. the Just Carry One and Man2Man campaigns) and in delivering training programmes and educational courses on sexual health and well-being. In 2012, for example, DAA delivered 50 training and education programmes to 54 different organisations and these involved a total of 835 participants. These programmes were provided to key population groups at risk of HIV and Hepatitis C as well as to staff, parents, carers and other professional groups and organisations working with groups at risk of poorer sexual health outcomes. At the policy level, DAA has played an active role in the development and promotion of strategies such as the National Sexual Health Strategy, the Hepatitis C strategy and the National Drugs Strategy, all of which have a sexual health context. In the period from 2014 to 2017 DAA will further enhance its work around sexual health education and the development of sexual health policies with a view to lessening risky/unsafe sexual practices which may lead to people acquiring HIV or other STIs.

5.7.2. STRATEGIC GOALS AND ACTIONS

5.7.2.1. TO DEVELOP AND DELIVER TARGETED HIV AND SEXUAL HEALTH EDUCATION AND TRAINING PROGRAMMES

Actions

- Enhance the delivery of training for trainers programmes within sectors and organisations working with population groups at risk of poorer sexual health outcomes
- Identify opportunities for the development of strategic partnerships in the delivery of training for trainers programmes
- Support the delivery of training and education in relevant sectors through the provision of up-to-date training and educational resources
- Develop and deliver further training programmes based on need and in line with national policy

5.7.2.2. TO DEVELOP PARTNERSHIPS AND PARTICIPATE IN RELEVANT COMMITTEES AND NETWORKS INVOLVED IN SEXUAL HEALTH PROMOTION AND EDUCATION

Actions

- Participate in the development of the National Sexual Health Strategy implementation plan and deliver relevant actions within this Strategy
- Participate in the implementation of relevant objectives of the national Hepatitis C Strategy
- Deliver on relevant North Inner City Drugs Task Force strategic goals, in line with the National Drugs Strategy
- Co-operate with other voluntary and community organisations involved in sexual health education and promotion so as to ensure optimum utilisation of available resources and, where necessary or appropriate, greater coherence in relation to sexual health education and promotion

5.7.2.3. TO PLAY A LEAD ROLE IN THE DEVELOPMENT OF EXISTING SEXUAL HEALTH PROVISION INITIATIVES AND THE ESTABLISHMENT OF NEW INITIATIVES

Actions

- Seek financial support/resources to enhance and further develop the DAA social media campaign (Just Carry One prevention campaign) including the resources to enable youth organisations to provide free condoms to young people
- Lobby the HSE to implement the recommendations of the Gonorrhoea Information Campaign report and work in partnership with the HSE and existing Working Group partners to develop a national STI Prevention Campaign targeting young people
- Ensure the inclusion of broader sexual health promotion and education in the joint Gay Health Network and HSE Man2Man programme, including the provision of free condoms to the MSM population

5.8. STRATEGIC OBJECTIVE NO. 5 – TO INFORM AND INFLUENCE POLICY AROUND ISSUES CONCERNING HIV PREVENTION AND SEXUAL HEALTH AND AROUND THE LIVES OF PEOPLE LIVING WITH HIV

5.8.1. RATIONALE AND EVIDENCE BASE

There are a number of policy areas around which it is necessary to effect positive changes, changes which have the potential to reduce the prevalence of HIV in Ireland and to improve the conditions of people living with HIV. These policy areas include the move towards universal screening for HIV (in much the same way as universal HIV screening currently takes place for ante-natal women in maternity hospitals); the need for clarity in relation to the criminalisation (or otherwise) of people who transmit the HIV virus onto other people; policies concerning the ways in which professional workers interact and deal with people who are HIV positive; and policies and procedures in relation to the delivery of sex education within schools. It is evident that some policy issues will require legislative change within the Houses of the Oireachtas, some will require changes within Government Departments, others may require changes within professional bodies and associations (e.g. doctors, dentists).

DAA intends to play a stronger and more assertive role in relation to policy issues and policy developments over the next three years. It will place a stronger emphasis on research and in gathering together information and analyses which will enable it to present strong policy arguments to policy makers and key influencers within Irish society. DAA will link into the experiences and the research already carried out by sister HIV organisations in other parts of the world who have also been working on bringing about positive policy changes in relation to HIV within their own countries. Therefore collaborations and partnerships will be developed both at the international level and at the national level within Ireland where DAA will work closely with key statutory organisations, HIV support organisations and other relevant groups in bringing about positive policy changes. It is anticipated that the net results of these policy changes will be a reduction in the prevalence of HIV and a stronger focus on tackling the stigma and discrimination experienced by many people living with HIV.

5.8.2. STRATEGIC GOALS AND ACTIONS

5.8.2.1. TO INFLUENCE AND TO EFFECT POSITIVE POLICY CHANGES IN RELATION TO KEY POLICY ISSUES

Actions

- Publication of National Sexual Health Strategy and subsequent implementation of the recommended strategies and actions within the National Sexual Health Strategy
- Assistance in the development of legislation and/or other policy instruments in relation to issues which impact upon the quality of life for people living with HIV and/or upon other HIV related matters
- Promote, and campaign for, the greater availability of condoms to people who cannot afford or cannot access condoms

5.8.2.2. TO INFORM AND EDUCATE LEGISLATORS AND SENIOR PUBLIC SERVANTS ABOUT CURRENT ISSUES IN RELATION TO HIV AND SEXUAL HEALTH

Actions

- Regular twice yearly briefings and discussions on HIV and sexual health with relevant Government minister and with opposition spokespeople on health

- Briefings and discussions with key officials within the Department of Health and the HSE on current trends and needs in relation to HIV, AIDS and sexual health

5.8.2.3. TO ACTIVELY PARTICIPATE IN INTER-AGENCY GROUPS AND FORA WHICH ARE PROGRESSING ISSUES THAT CORRESPOND TO STRATEGIC OBJECTIVES AND PRIORITIES OF DAA

Actions

- Continue to participate in the work and activities of the Irish Sexual Health and HIV Network (previously called HIV Services Network)
- Continue to participate in the structures of the National Drugs Strategy
- Identify other relevant committees and networks within which DAA should be involved and actively participate in these committees/networks
- Continually review the involvement of DAA in various committees and networks so as to ensure that this involvement is an effective use of staff resources

5.8.2.4. TO DEVELOP LINKAGES AND PRACTICAL WORKING RELATIONSHIPS WITH OTHER HIV SUPPORT ORGANISATIONS IN IRELAND AND IN OTHER COUNTRIES

Actions

- In conjunction with other HIV support organisations, DAA will bring together HIV support organisations on a twice yearly basis to discuss and work through issues relating to HIV in Ireland (rather than a broader sexual health agenda). These meetings may also involve other people with an interest in topics being discussed e.g. counsellors, medical social workers
- DAA will seek to identify opportunities for deeper collaboration with other HIV support organisations in Ireland (on occasions, these will be underpinned by Memorandums of Understanding and strategic partnership agreements)
- DAA will participate in the work and activities of European-wide HIV bodies such as AIDS Action Europe, HIV Europe and the HIV/AIDS Civil Society Forum

5.8.2.5. TO MAINTAIN AND UPDATE RESOURCE MATERIALS AND OTHER INFORMATION RELATING TO HIV, AIDS AND SEXUAL HEALTH

Actions

- Collection and dissemination of documents, reports and articles covering HIV which will aim to ensure that DAA is kept abreast of key developments which are taking place in relation to the issues of HIV and AIDS
- Seek funding and staff resources to organise and maintain archival HIV and sexual health-related materials for availability to the public
- Development and expansion of online weekly news bulletin concerning HIV and sexual health related issues
- Develop and implement a Digital and Social Media Strategy to enhance the dissemination of information about HIV-related issues and DAA services
- Review and re-develop the DAA website to make it more effective and user-friendly, taking into account statistical data on traffic and visitors

5.9. STRATEGIC OBJECTIVE NO.6 – TO ENHANCE THE ORGANISATIONAL EFFECTIVENESS AND EFFICIENCIES OF DAA

5.9.1. RATIONALE AND EVIDENCE BASE

In order for DAA to achieve the ambitious objectives and goals which it has set for itself between 2014 and 2017 (as laid out in this Strategic Plan), it is important that DAA has the appropriate structures and resources which will be required to successfully progress and implement the 2014-2017 Strategic Plan. At the structural level the board of DAA is clearly aware of the more onerous responsibilities that now pertain to the Directors of charities and other non-governmental organisations in Ireland. The board is also keenly aware of the extensive negative publicity which visited the charities sector in Ireland during the final months of 2013 and the DAA board will do all that it can to ensure the highest levels of corporate governance and probity within the affairs and activities of DAA.

This will involve developments such as adopting the Governance Code, producing a Board Governance Handbook and ensuring that the financial records and accounts of DAA are

presented in as open and transparent a manner as possible (in accordance with the Statement of Recommended Practice guidelines which are an exemplar for the charities sector). DAA will also put structures and strategies in place for regular and ongoing reviews of the implementation of the 2014-2017 Strategic Plan and will continually seek to identify opportunities where collaboration with other organisations might bring about cost savings and/or lead to more significant collective outcomes and impact in relation to HIV and AIDS. The DAA board will also strive to diversify the funding base for DAA in order to lessen its dependence on HSE funding through securing more significant financial assistance from the business sector.

5.9.2. STRATEGIC GOALS AND ACTIONS

5.9.2.1. TO IMPROVE CORPORATE GOVERNANCE SYSTEMS AND STRUCTURES WITHIN DAA

Actions

- Adopt and sign up to the Governance Code which is a code of good corporate practice for organisations within the community and voluntary sector in Ireland
- Recruit 4-5 new Directors onto the board of DAA
- Production of a Board Governance Handbook for existing and future Directors of DAA
- Update DAA staff handbook so as to reflect best practice in relation to policies and procedures for staff members
- Implementation of the SORP (Statement of Recommended Practice) which is a recognised and reputable standard for reporting and accounting for charitable and voluntary organisations

5.9.2.2. TO STRENGTHEN MECHANISMS AND SYSTEMS FOR ASSESSING IMPACT AND OUTCOMES FROM THE WORK OF DAA

Actions

- Production of annual work programmes which will contain targets, goals and key performance indicators against which progress can be measured and assessed
- Annual review and planning meetings to review implementation of Strategic Plan over the previous year and to plan ahead for the following year
- Continuation of production of Annual Reports and dissemination of these reports to funders, supporters and other interested organisations/bodies
- Pilot the application of Quality Action/Quality Improvement tools to evaluate the impact of HIV prevention programmes and projects
- Research, identify and invest in a robust mechanism for recording qualitative and quantitative data to enable the evaluation of service delivery outcomes

- Ensure that DAA has the information technology systems in place to carry out its work in an efficient and effective manner

5.9.2.3. TO RENAME AND REBRAND DAA AS THE LEADING HIV ORGANISATION IN IRELAND AND IN ORDER TO REFLECT THE VISION, MISSION AND OBJECTIVES OF THE ORGANISATION

Actions

- Change the name of DAA to another name which has more of a national emphasis (e.g. Ireland rather than Dublin) and which focuses on HIV (rather than AIDS which may be a deterrent to people newly diagnosed with HIV).
- Rebrand and launch the ‘new’ organisation complete with new 2014-2017 Strategic Plan, new website and new promotional materials.
- Continue to develop relationships and explain new and expanded role with other organisations in Ireland which are working around the issues of HIV and sexual health.

5.9.2.4. TO DIVERSIFY AND BROADEN FUNDING BASE FOR DAA

Actions

- Secure significant levels of multiannual funding (i.e. for 3-5 year periods) from 2-3 businesses/corporations.
- Secure funding from the European Commission for a pan-European programme which will involve a minimum of 4-5 HIV support organisations across Europe and which will focus on an issue of common interest and concern e.g. universal screening for HIV, reducing the high proportion of people with HIV who have not been tested or diagnosed for HIV.
- Lobby the HSE to return DAA to previous levels of funding and to commit the HSE towards funding this 3 year Strategic/Business Plan which is largely focused on assisting the government to achieve national policy objectives around sexual health and HIV/STIs

- Encourage government to resource the implementation of the National Sexual Health Strategy and to put together collaborative partnerships to implement actions within this strategy

5.9.2.5. TO WORK TOWARDS THE APPROPRIATE STAFFING COMPLEMENT FOR DAA, A COMPLEMENT WHICH WILL ENABLE IT TO ACHIEVE ALL OF THE STRATEGIC OBJECTIVES AND STRATEGIC GOALS SET OUT IN THIS STRATEGIC PLAN

Actions

- On the basis of additional funding being secured, employ specialist workers in areas such as policy development, training, campaigning and research so as to enable DAA to progress and successfully complete all of the actions contained in this Strategic Plan.
- Provide opportunities for DAA staff to engage in training and continuous professional development so as to enhance their skills and the quality of the contributions which they will continue to make to the work of DAA

6. SUMMARY

DAA has achieved a significant amount since its establishment in 1987. It has provided a range of supports and services to many hundreds of people diagnosed with HIV; it has advocated on a number of issues of concern and interest to people living with HIV; it has played a leading role in a number of public health awareness initiatives aimed at reducing the prevalence of HIV and other sexually transmitted illnesses in Ireland; and it has run training programmes and education courses for thousands of healthcare workers and other people who work regularly with those at 'high risk' of contracting HIV. It is clear that DAA has played a very important and significant role in the fight against HIV and AIDS and has played its role, together with other statutory agencies and voluntary organisations, in reducing the diagnosed cases of HIV in Ireland by 15.6% between 2008 and 2012.

Whilst recognising the work and achievements of DAA and other organisations involved in issues relating to HIV and sexual health, it is also of critical importance to be continually vigilant in preventing people from acquiring the HIV infection. The need for this vigilance is clearly demonstrated in the 6.9% increase in the cases of new HIV diagnoses between 2011 and 2012. Hopefully this year-on-year spike in the number of HIV cases will be reversed in future years and the prevalence of new HIV diagnoses will follow the downward patterns which took place between 2008 and 2011. In addition to reducing the prevalence and incidences of HIV in Ireland, DAA is also committed to tackling the stigma and discrimination associated with HIV and AIDS. Although there is not the same type of hysteria connected with HIV and AIDS as in the 1980s and the 1990s, the experiences of DAA in recent years would suggest that there is still a lot of misinformation and misunderstandings about HIV and that people living with HIV have to endure stigmatisation and discrimination and social exclusion which people with other long-term chronic illnesses do not have to endure.

DAA aims to build upon its work and achievements of the last 27 years and we believe that we can make significant contributions to reducing the prevalence of HIV in Ireland and supporting people living with HIV. We feel that as one of the leading non-governmental organisations in Ireland which has a particular and specific focus on HIV, we have an important role in helping to ensure that HIV remains on the public health agenda and that the appropriate resources and services are invested in preventing HIV, in promoting safe sex and in supporting people living with HIV. The DAA Strategic Plan for 2014-2017 aims to encapsulate the main issues and challenges in relation to HIV in Ireland and we believe that

the proposed responses to these issues and challenges (as set out in the previous sections of this document) will make a real and meaningful difference in the fight against HIV in Ireland. Through the collective efforts of all relevant organisations and agencies working together in a co-ordinated manner, DAA believes that we in Ireland can make our own contributions towards the creation of an ‘AIDS-free’ generation.