REVIEW OF:

Prevention and Public Health Strategies to inform the Primary Prevention of Family Violence and Violence Against Women

March 2017
Abbreviations

ABS     Australian Bureau of Statistics
AIDS    Acquired immune deficiency syndrome
AIHW    Australian Institute of Health and Welfare
ANPHA   Australian National Preventive Health Agency
COAG    Council of Australian Governments
FCTC    Framework Convention on Tobacco Control
HIV     Human Immunodeficiency Virus
IUD     Intravenous drug user
LGA     Local Government Area
MACASHH Ministerial Advisory Council on AIDS, Sexual Health and Hepatitis
MSM     Men who have Sex with Men
NACAIDS National Advisory Council on AIDS
NGO     Non-Government Organisation
NHPA    National Health Priority Areas
NTS     (Australia's) National Tobacco Strategy
NSP     Needle and Syringe Program
MAB     Motor Accident Board
PVAW    Prevention of Violence Against Women
TAC     Traffic Accident Commission
WHO     World Health Organization
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The problem of family violence presents a significant challenge for government and community in Victoria. Its impacts on health, the economy and society are well understood, however coordinated efforts to reduce and ultimately eliminate family violence have only just begun.

Following the Royal Commission into Family Violence, Victoria is now poised to achieve a world-first reduction in levels of family violence, which in the main is perpetrated by men against women who are partners or ex-partners but which also includes elder abuse, adolescent violence towards parents and violence in same-sex relationships.

In coming years the response to family violence in Victoria will include a significant focus on primary prevention – that is, stopping violence before it starts by addressing its underlying drivers and causes. This is an unprecedented opportunity to create actions that both involve and target the whole community – not just victims and perpetrators – and that generate genuine change in attitudes, behaviours and social norms across the whole population.

Prevention in this field will build on and draw from strategies and learnings in other areas where there have been significant reductions in a health or social problem over time. For example in the areas of road trauma and tobacco control, and others, there have been significant and sustained efforts to reform policy, build research, deliver programs and monitor outcomes.

This rapid review summarises evidence from some key public health areas where the history of actions, strategies and lessons learned can be used to inform prevention policy in the area of family violence and violence against women.

National and international literature has been sourced for the review to provide a knowledge synthesis about significant issues causing deaths, injury and long-term morbidity.

Four issues were selected for investigation and a case study is presented in each, reflecting the current status and key issues involved:

1. Road safety and accident prevention
2. Tobacco control and prevention of harms from exposure to tobacco smoke
3. Obesity prevention
4. HIV/AIDS prevention in Australia.

These issues were selected because they represent investments in large-scale, longer term public health programs over 30-50 years that utilise a breadth of strategies and methods to achieve reductions in harm. In each area there have been improved population health outcomes from a significant, and often socially entrenched, problem – or point to what is needed to improve health outcomes.

The common thread in all the case studies is that the problem is preventable but complex and requires sophisticated responses. Each case study investigates the combination of legislative, institutional, policy and programs responses that have aimed to ‘change the story’ behind the problem, with the following insights.

Insights 1

Obesity Prevention

The gap in singular and sustained institutional mechanisms to lead and coordinate efforts is likely contributing to the weaker achievements in health outcomes. The response to obesity seems more dispersed compared to other health issues, and while there are numerous research and advocacy groups in the field, there is little by way of formal mechanisms to provide visibility and coherence for prevention efforts. This has weakened the evidence-building
and population monitoring activities across the field, potentially leading to mixed messages for consumers and also policy-makers.

By way of contrast, in the area of smoking reduction the early establishment of centralised coordinating mechanisms is understood to have strengthened ability to achieve policy and legislative change over time thus leading to improved health outcomes.

Insights 2
HIV/AIDS Prevention

The rapid and coordinated mobilisation of governments and community has enabled significant activity in the area of effective community education and awareness-building – and to some extent, behaviour change – both in the most at-risk groups and in the general community. The response to HIV/AIDS has developed and has achieved progress towards its targets in a shorter timeframe compared to other health issues. It has done so despite raising controversial social questions about sexuality and human rights that had not previously been openly discussed, and despite requiring difficult conversations at the individual and also policy level. Government and civil society organisations worked closely together to ensure efforts to change attitudes and behaviours were well-targeted and involved mobilisation of opinion and action within key groups. This enabled introduction of policies and regulations that may otherwise have become points of resistance.

While the achievements in this health area are remarkable, there is now risk in becoming complacent and winding back strategies rather than embedding them.

Insights 3
Road Safety and Accident Prevention

The role of legislation, infrastructure design and policy reform has been vital to address the physical environment and circumstances in which people make choices around driving and safety. Despite funding for roads and infrastructure being a highly politicised issue among jurisdictions in Australia, the available funding has been utilised for coordinated and evidence-based effort owing to the clear legislative and policy framework that informs road safety. This is complemented by national strategies that provide clear roles and responsibilities across levels of government within agreed national goals, objectives and priorities. However, the acceptance of legislation has been dependent on concerted public education programs and also enforcement.

Importantly, following on from changes in the legislation and physical environment, this is the only public health issue where a zero-deaths target has been established within public-facing campaigns, with bodies in the field holding themselves accountable to a zero-deaths target and inviting community to do the same.

Insights 4
Tobacco Control

There has been continued resistance from industry and others to undermine and oppose health promotion efforts at every level. The resistance is well-funded and coordinated and also well-documented, targeting governments, industry and community and involving its own funding sources and research initiatives. As the sophistication of tobacco reduction efforts has increased over time, so too have the resistance efforts and this parallel trend will likely continue into the future. This review did not investigate the extent or nature of government and non-government responses directly to resistance, however it is clear that the sustained and multi-faceted efforts have helped to ensure that resistance does not lead to a reduction in central investment and coordinated effort to improve health outcomes.

This rapid review has highlighted several learnings and strategies that are translatable and relevant for the prevention of family violence and violence against women. A combination of strategies across legislation, bi-partisan policy, direct participation, social marketing, research and organisational change will be essential, as well as the institutional arrangements and coordinating mechanisms to ensure prevention is a visible and sustained approach.

However, there are important differences in the area of violence compared to other health issues, and there are specific complexities that will require new and more sophisticated approaches to the prevention of violence. The drivers of family violence are deeply entrenched in our societies and relationships and prevention will require difficult conversations about power, control and also gender among individuals and policy-makers. The resistance and opposition to prevention of family violence will reflect vested interests at several levels and so is likely to feature as a prominent and necessary stage of community engagement with the topic – but also one that can be planned for and overcome.

In summary, the prevention of family violence and violence against women provide an opportunity to draw from and build on the strategies used in other health and social change areas, but is also an opportunity to move beyond what’s been tried before and apply genuinely new thinking and new innovations in order to eliminate family violence.
Family violence includes single and continued experiences of harm, fear, control and threat in the family context, both physical and non-physical. The most common form of family violence in Victoria is intimate partner violence by men against women, however other forms include adolescent violence against parents and elder abuse.

Violence against women, as a separate but strongly linked area of study, also includes child sexual abuse, harmful traditional practices, non-partner rape, sexual assault, and harassment (Arango et al. 2014).

Following the conclusion of the Victorian Royal Commission into Family Violence, the Victorian Government is undertaking significant planning and reform activity to implement the 227 Commission recommendations.

The Victorian Government has released a ten-year statewide Family Violence Action Plan, and a dedicated Primary Prevention Strategy.

The Primary Prevention Strategy for family violence/violence against women offers an unprecedented opportunity to intensify and advance prevention investment in Victoria. The ten-year vision of the Primary Prevention Strategy is a Victoria where all women, men and children can live safe and free from violence. To achieve this, the key behavioural changes that are likely to be required are:

- Increased government, non-government and community effort to address the gendered drivers of violence.
- Increased capacity of community members (especially men and boys) to engage in more equal and respectful relationships, within families/households, organisations and communities.
PURPOSE OF THIS REPORT

This report extracts and summarises evidence from key public health and policy areas where the history of actions, strategies and lessons learned, can be used to inform prevention policy in the area of family violence and violence against women.

A scenario-based case study approach is taken with a focus on the following questions:

• What are the key drivers and factors creating this scenario?
• What are the key strategies and approaches that have been undertaken to prevent this scenario?
• What combination of strategies and interventions have been effective, and why?
• What are the most significant milestones/policy changes achieved over time?
• What are the institutional arrangements that have enabled coordinated and sustained efforts over time?
• What is considered an acceptable threshold of change over time, and how is this counted/measured?

Each of the case studies demonstrates how a combination of legislative, institutional, policy and program responses has 'changed the story' behind the problem over a significant period of time and with sustained joint efforts by government, community and experts across sectors.

Change The Story – a framework for prevention

The Victorian Government’s Primary Prevention Strategy is strongly informed by the evidence and guiding actions in the national evidence base and framework for prevention of violence against women, known as Change the Story, which was released in November 2015.

The concepts and elements for action outlined in Change the Story contribute to the basis for investigation in this evidence review.

Change the Story is a nationally agreed framework for a shared understanding about the need for the collaborative action necessary for the prevention of violence against women and their children. The framework is intended to inform and support the development of policy and legislation, prevention strategies, programming and advocacy that seeks to reduce the drivers of violence against women.

Element 1: An explanatory model of violence clarifies what constitutes violence against women and explores the gendered nature of this violence. It identifies the drivers of violence, together with a number of reinforcing factors.

Element 2: Key actions to prevent violence outlines the range of actions needed through legislative, institutional and policy responses; implemented in settings such as workplaces, schools, community organisations, sports clubs, media and popular culture; and tailored to the context and needs of different groups.

Element 3: Approach, settings and techniques for prevention identifies specific, practical strategies that the research suggests should be drawn upon when engaging in prevention work. Drawing upon national and international research and evaluation findings.

Element 4: Prevention infrastructure explains how a collaborative national approach requires strong infrastructure to support quality cross-sectoral practice, enable policy and legislative reform and provide the leadership and coordination necessary to drive broad, deep and sustainable social change.
Element 5: Stakeholder roles and responsibilities
acknowledges that every sector, institution, organisation, community and individual has a role to play in preventing violence against women. But different stakeholders have different responsibilities, expertise and capacities, as well as varying spheres of influence and opportunities to take action.

Element 6: Stages of action and expected outcomes
notes that the goal of an Australia free of violence against women and their children is a long-term, intergenerational one requiring sequenced actions over time in order to sustain progress. Element 6 identifies short, medium and long-term phasing of collaborative activity, and the expected outcomes or signposts of success that signal what Australia will see with an increase in support for, investment and action in preventing violence against women (Our Watch et al. 2015).

Methods and scope
This report is a rapid review which is a streamlined approach to synthesizing evidence – the method is recognised as a form of knowledge synthesis (Tricco et al. 2015). Rapid reviews are typically used to inform emergent decisions faced by decision makers in health and government settings and are intended to address a need by knowledge users for timely, user-friendly, and trustworthy evidence.

Typically, a rapid review is completed in a short time-frame, in response to questions specified a-priori, using limited sources which are made explicit, and provide descriptive summaries of the evidence.

This review was completed from a search primarily of specific Australian literature, both formal and grey literature including, relevant government, non-government organisations and specific websites relevant to the case studies. Limited but important international sources from academic literature and from the World Health Organization are included where global learnings have informed Australian approaches. The purpose of the search was to locate information and knowledge in order to respond to the questions in the project brief particularly for outcomes associated with the public health methods used to respond to the issues of road trauma reduction; tobacco control and reducing the harms from exposure to tobacco; obesity prevention; and control of HIV-AIDS.

This report has not researched specific expenditure on the selected public health infrastructure, programs, research, and surveillance that have been the major contributors to the reduction in harms over the decades. This report has not researched the views of experts or stakeholders in the respective public health areas as this will be the focus of other Victorian Government activity.

The next section sets out key definitions which underpin the case studies that follow.

Key definitions
Public health is an approach to taking action aimed at saving and protecting lives (e.g. clean water, waste disposal or sewerage systems), improving health (e.g. early child development, vaccinations, immunizations), prolonging life (e.g. healthy ageing) and improving the quality of life among whole populations through policies and programs that encompass health protection, health promotion, prevention and other forms of health interventions - actions aimed at reducing risks or threats to health. Public health also includes surveillance and population health assessment, targeting of health hazards and reducing exposure, disease control, prevention, screening, the management of outbreaks, epidemics and pandemics, and emergency preparedness.

Public health is a field with, generally, a broader remit than prevention. Public health seeks to develop sustainable change on issues that are causing widespread harm to people, at community and societal levels.

Prevention is classified as primary, secondary and tertiary:

• Primary prevention aims to prevent disease or injury before it occurs. This is done by preventing exposures to hazards that cause injury, disease or illness, altering unhealthy or unsafe behaviours that can lead to disease, illness or injury, and increasing resistance to them should exposure occur.

• Secondary prevention aims to reduce the impact of an injury, disease or illness that has already occurred.

• Tertiary prevention aims to lessen the impact of an ongoing condition, disease or illness that is having lasting effects.

Paramedics save lives – one person at a time
Nurses and doctors treat conditions – one person at a time
Public Health policies, programs and professionals save lives – thousands and sometimes millions at a time.
Prevention and primary prevention refer to interventions that seek both to prevent violence from occurring in individuals who have not experienced it before and to reduce reoccurrence in those who have already experienced or used violence. The term response and secondary prevention interchangeably refers to interventions that specifically target either women who have already experienced some form of violence or male perpetrators, with the aim of reducing re-victimisation or recidivism (Ellsberg et al. 2015).

The prevention of family violence and violence against women (hereto referred to as ‘VAW’) requires both a public health and a primary prevention effort.

Primary prevention activities are delivered to the whole population (universal) or specific groups that might not be reached through population-wide actions. Some primary prevention strategies focus on changing behaviour and/or building the knowledge and skills of individuals. However, the structural, cultural and societal contexts in which violence occurs are also very important targets for primary prevention. Strategies that do not have a particular focus on violence against women but address its underlying causes (e.g. gender inequality) are considered primary prevention strategies (VicHealth 2007).

VicHealth has proposed a public health approach to drive primary prevention responses to family violence as the basis to coordinate delivery of proven methodologies:

- Direct participation programs – to increase individuals’ skills, attitudes and knowledge of respectful and equitable relationships.
- Organisational and workforce development – to create environments that model, promote and facilitate respectful and equitable gender relations.
- Community strengthening – to mobilise and support communities to address VAW and the social norms that make it acceptable.
- Communications and social marketing – to raise awareness of VAW and address attitudes, behaviours and social norms that contribute to this problem.
- Advocacy – to build collective activity and mobilisations to raise awareness and to encourage governments, organisations, corporations and communities to take action.
- Legislative and policy reform – to ensure laws and regulations complement strategies to build equitable gender relations, and to reorient policy approaches across government to address the social determinants of violence.
- Research, monitoring and evaluation – to underpin activity in the areas above by informing action, improving the evidence and knowledge base for future planning and enabling efforts to be both effectively targeted and monitored (VicHealth 2015).

Public health approaches vary, evolving in response to evidence as it has emerged over years and decades, and is informed by shifting government and community attitudes, and changing local, national and international norms.

This report assesses what has worked in other major public health efforts drawing primarily on Australian literature, reports and policy documents, informed by international literature and particularly World Health Organization reports where appropriate. The four case studies of public health action reviewed in this report are:

1. Road trauma prevention
2. Tobacco control and prevention of harms from exposure to tobacco smoke
3. Obesity prevention
4. HIV/AIDS prevention in Australia.

These case studies have been selected because they represent investments in large-scale, longer term public health programs that utilise a breadth of strategies and methods to achieve reductions in harm, and improved population health outcomes. In effect these strategies have also delivered considerable social and economic benefits to government and community.
CASE STUDIES OF PUBLIC HEALTH ACTIONS
CASE STUDY 1A  
TEENAGER KILLED IN HORROR SMASH

A 15-year-old boy has died when the car he was driving, packed with teenage passengers, crashed into a tree at Sunshine West. The boy was behind the wheel carrying four passengers along Oldfield Road when he lost control and struck a tree about 10pm. The boy died at the scene, while the passengers were all taken to hospital. A 17-year-old boy who was sitting in the front passenger seat, and a 16-year-old boy, who was in the backseat, both sustained serious injuries and were taken to the Royal Melbourne Hospital.

The remaining passengers, a 13-year-old girl and another female who is yet to be identified, sustained life-threatening head injuries. Both were taken by road to The Alfred hospital in a critical condition.


CASE STUDY 1B  
‘TWO TEEN FOOTBALLERS KILLED, THREE INJURED IN HORROR ROAD TRIP CRASH’

A road trip to spend New Year’s Eve in Queensland has left two young footballers dead, another fighting for his life and two others injured, and five families in Melbourne’s west reeling with grief...

...The five 19-year-olds – who all played football for local clubs in Werribee and Hoppers Crossing – were driving to the Gold Coast to celebrate New Year’s Eve together. They never made it...

Their car came off the Newell Highway and struck a tree in northern NSW just before 6am on Sunday.

NSW Police Assistant Commissioner John Hartley said fatigue was believed to have been a factor as the teenagers had been taking turns at the wheel. “The fourth driver in the sequence had been driving for two hours, obviously fell asleep fatigued, rolled the vehicle and killed himself and the other passenger in the front seat,” he said.

The deaths come just days before two teenage boys died in a fiery crash in Altona on Tuesday night.

Lessons learned

In Australia, high-level good practices have been expressed through legislation, road safety education/direct participation, improved road design, education/communication and social marketing, and research, monitoring and evaluation. None of these strategies would be effective if used in isolation – in other words, they are mutually reinforcing and form a package of inter-dependent approaches to prevention and many lessons have been learned.

Legislation

Laws have little chance of existence and success if the majority of the population fail to understand their objectives. The acceptance of legislation is dependent on concerted public education programs for their effectiveness.

Road safety education/direct participation

While notable improvements have been made by public education and awareness campaigns in recent decades, ongoing efforts are needed and road safety researchers and practitioners must be prepared to address both traditional and emerging alcohol-related road use problems (Fleiter et al. 2014).

Community groups frequently advocate for road safety education of young people but attempts to assess the effectiveness of road safety education have generally failed to show actual reductions in child, pedestrian or cyclist casualties (ATSB 2004).

Improved road design and road maintenance

Funding for roads is classified by the Australian Government as an Infrastructure Investment (Australian Government 2016a) based on allocations through the Roads to Recovery program to local councils. Additional grants/funding made available for roads is often analysed as showing patterns of spending that are politicised. Nonetheless, given the size of Australia’s geography, funding is never able to meet demand for improvements to roads.

Education, communications and social marketing

The World Health Organization 2004 report concluded that road safety campaigns were able to influence behaviour when used in conjunction with legislation and law enforcement but that ‘when used in isolation, education, information and publicity generally do not deliver tangible and sustained reductions in deaths and serious injuries’ (WHO 2004). Without legislative enforcement and/or education a mass media campaign has virtually no effect in terms of reducing the number of road accidents, while adding either of both those measures has demonstrated effectiveness in terms of targets for reduction (Hoekstra & Wegman 2011).

Research, monitoring and evaluation

Independent studies commissioned to measure the effectiveness of interventions and approaches are essential. Research into the causes of death and injury due to traffic and road accidents is also essential to inform strategies and interventions. In particular, research informs the necessary audience segmentation that differentiates populations into subgroups or segments of people who share needs, wants, lifestyles, behaviour, and values that make them likely to respond similarly to public health interventions. For example, the Victorian Traffic Accident Commission’s Road Safety and Marketing team manages a comprehensive research program that assesses the merits of current campaigns and programs and identifies effective messages for future campaigns (TAC 2016).

Policy and strategy with identified levels of responsibility

Australia has a National Road Safety Strategy 2011–2020 that represents the commitment of federal, state and territory governments to an agreed set of national goals, objectives and action priorities; setting out a path for action to reduce fatal and serious injury crashes on Australian roads. The previous National Road Safety Strategy was criticised for its lack of focus on the coordination of state and territory action rather than on national harmonisation of laws, signs and markings around the country and leadership, setting benchmarks in areas such as vehicle design and the construction and maintenance of national highways (Parliament of Australia 2004).

Current levels of responsibility for actions have been stratified as follows:

- **The Australian Government** is responsible for regulating safety standards for new vehicles, and for allocating infrastructure resources, including for safety, across the national highway and local road networks.
- **State and territory governments** are responsible for funding, planning, designing and operating the road network; managing vehicle registration and driver licensing systems; and regulating and enforcing road user behaviour.
- **Local governments** have responsibilities for funding, planning, designing and operating the road networks in their local areas.
Key drivers and factors creating these scenarios

There have been over 187,000 deaths on Australia’s roads since record keeping commenced in 1925. Motor vehicle mortality peaked in 1970 which remains Australia’s and Victoria’s worst year for road carnage. Per year nationally, the number of deaths has fallen from 3,798 deaths in 1970 (26.59 per 100,000 population per year) to 1,205 in 2015 (5.08 per 100,000 population per year) (BITRE 2016). In 2015, the Victoria road toll was 213 deaths but by October 2016, the toll was 239, up 12.2% on 2015. Details of the road toll are published by the Australian Government in the Road Deaths Australia – Monthly Bulletins (BITRE 2017).

The five fatal behaviours that historically and currently are the causes of road trauma are speeding, drink and drug driving, not wearing seatbelts, fatigue and driving while distracted (Salmon & Read 2015).

While the implementation of effective interventions has prevented many thousands of deaths and injuries, young people aged 17–25 years of age still represent about 28% of all traffic accident mortality and injury, and males are 2.5 times more likely to be killed than females. 45 per cent of all young Australian injury deaths are due to road traffic accidents.

Trends in life threatening road trauma injuries from 2001-2010 show that:

- Over one-quarter (26%) of those seriously injured due to road vehicle traffic crashes over the 10-year period from 2001 to 2010 sustained life-threatening injuries.
- The highest rates were for people aged 15–24 years, for both males and females. The largest increase over the 10-year period was for males aged 45–64 years.
- Rates of life-threatening cases involving motorcycle riders and pedal cycle riders rose significantly over this period, with average annual increases of 5.2% and 7.5% respectively.
- Rates of cases involving passengers of motor vehicles and pedestrians fell, with average annual decreases of 1.2% and 1.0% respectively (Henley & Harrison 2015).

The RACV highlights that in any 24-hour period, around 4,800 Australians will be involved in road crashes – 550 will be injured and four will die. Those injured are likely to need long recoveries and many sustain permanent injuries.

Despite a growing number of people and vehicles, the Victorian road toll is now less than 250 per year because of Victoria’s sustained investment in road safety. However, that figure is still regarded as 250 too many, while the emphasis is as much on serious injury which affects around 5,000 people each year in Victoria alone and about 30,000 people annually across Australia. So while Australia has seen good progress in lowering the number of road deaths, there have not been big improvements with this ‘hidden toll’ of road trauma (RACV 2016).

Significant milestones in road trauma prevention

Over time, Australia’s approach to road trauma prevention has strengthened to become one of the most successful in the world although we are still behind the Scandinavian countries, Spain and the Netherlands. Strategies and interventions for road safety have been initiated globally which has provided opportunities for many lessons for the traffic safety field, which has developed an extensive evidence base to guide policymaking and legislative reforms. Figure 1 shows some of the major milestones in road trauma prevention from 1966 to 2009 in Australia.

Social and economic impact

The estimated annual cost to the Australian economy of the social, health and economic impacts of road trauma is at least $27 billion.

- National Road Safety Strategy (Department of Infrastructure and Regional Development 2011)

Institutional infrastructure

Road safety has benefited from significant institutional arrangements. In Victoria, the government agency VicRoads is responsible for major highways while local government is responsible for providing and maintaining local infrastructure including local roads, bridges, footpaths, traffic management, as well as the safety and environmental impacts of transportation (Department of Infrastructure and Regional Development).

The Motor Accident Board (MAB) was established in 1975 to provide socially-progressive accident compensation to people injured in transport accidents. Under the Transport Accident Act 1986 (the Act) the MAB was replaced by the Transport Accident Commission (TAC) from 1 January 1987 which works in both the prevention of accidents and administers a compensation scheme “in respect of persons who are injured or die as a result of transport accidents.”
Australia has a National Road Safety Strategy 2011–2020 which represents the commitment of federal, state and territory governments to an agreed set of national goals, objectives and action priorities; setting out a path for action to reduce fatal and serious injury crashes on Australian roads. Various states have also developed strategies. Those strategies highlight the need for a shared responsibility for road safety that spans many stakeholders including road users, road and vehicle designers, policymakers, advocacy groups, road safety authorities and government (Salmon & Read 2015).

Key features of Australia’s road safety strategy are that it:

- is multi-sectoral
- is implemented across multiple settings
- has focused on changing the environments that are causal in road traffic accidents
- has focused on changing attitudes, the cultures in relation to road use, and behaviours
- has been intentionally disruptive to create change, but all with a clarity of purpose.

**Targets for reduction**

As Figure 1 shows, Australia began to take a public health approach to road safety from the late 1960s. Since then, the overall approach of the field of road safety is based on comprehensive, long-term, evidence-based efforts and targets set by the National Road Safety Strategy. In Victoria, the TAC works with VicRoads, local government, the police and other agencies to implement Victoria’s road safety strategy, which seeks to reduce death and serious injury on our roads by more than 30% by 2022 (TAC).

The recent initiation of the ‘Towards Zero’ campaign in Victoria is notable as a strategy to engage the community in what are framed as the ‘last frontier’ actions to eliminate road trauma completely (www.towardszero.vic.gov.au). This joint initiative for a ‘future free of deaths’ has been introduced only after several decades of institutional and social change and several significant reductions in road deaths and injuries, suggesting that realistic targets for change are perhaps most effective in engaging individuals and community.

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**Figure 1: Major milestones in Australia’s road trauma prevention**

1. 0.05 limit introduced in 1966
2. Compulsory wearing of seat belts
3. Random breath testing began
4. Use of hand-held radar speed cameras
5. Mandatory helmet wearing for cyclists
6. Mass media advertising campaigns
7. Mobile speed cameras introduced
8. ’Booze buses’ deployed
9. 50 km/h residential streets
10. ’Wipe off five’ Public education and expanded enforcement

Source: National Preventative Health Taskforce, 2009
Key strategies and approaches to coordinate and sustain effort

Professional and consumer advocacy groups, particularly in 1960s-1980s, have been influential on policymaking and legislation designed to reduce the trauma of road traffic incidents (Sweet & Moynihan 2007). In particular, a hospital surgeon, Dr Gordon Trinca and the police surgeon, John Birrell, campaigned from the 1960’s onwards, for random breath testing, 0.5 drink-driving laws and seatbelt legislation. They were a dominant and forceful pair who were tireless in their advocacy in an era before the internet and social media, and their work became known internationally (Royal Australasian College of Surgeons).

Each year since 1950, the World Health Organization has declared World Health Day on 7 April with a new theme each year, drawing out the significance and raising awareness about subjects of major importance to global health. In 2004, the year and World Health Day was dedicated to Road Safety Is No Accident – which indicates that road safety does not happen accidentally, but requires a deliberate effort by governments and their many partners (ATSB 2004). Australia produced a major report to mark this day (ATSB 2004) and recurrent National strategies continue to this day.

The United Nations has declared a decade of Action on Road Safety 2011-2020. In response, the Australian Road Safety Collaboration has been established to facilitate greater industry collaboration and improve road safety outcomes (Australian Road Safety Collaboration).

There has been continuous improvement to road safety as Australia has developed strategy and funded its implementation. Key strategies include:

- Advocacy by people and groups of influence.
- Legislation for:
  - 0.05 blood alcohol concentration laws (1966)
  - compulsory wearing of seat-belts. Australia was the first country to make the fitting of seat belts mandatory in all new passenger vehicles for drivers and front seat passengers. Victoria was the first state to pass seat-belt laws in 1970.
  - compulsory child restraints (1986)
  - random breath testing
  - red-light cameras and speed restrictions
  - mobile phone use by drivers.
- Behavioural programs targeting drink driving, seatbelt usage, speeding and use of mobile phones while driving.
- Motor vehicle safety improvements.
- Improved road design and road realignment.
- Reduction of proven Black Spots – the “Black Spot” program from 1996–2002 was estimated to have saved at least 32 lives and prevented a large number of injuries over the three-year period with benefits continuing to accrue (ATSB 2004).
- Reductions in urban travel speeds and lowering of highway speed limits.
- Graduated licensing.
- Public education particularly through social marketing/mass media.

All of these strategies are consistent with high-level good practices that have been shown to work in high-income, or low-income and middle-income countries:

- reducing exposure to risk through transport and land-use policies
- shaping the road network for road injury prevention
- improving visibility of road users
- promoting crash-protective vehicle design
- setting and securing compliance with road safety rules
- delivering post-crash care.

Nonetheless, while there has been significant change in the way many of these measures have impacted on road trauma, the temporal order of change, i.e. whether behaviour or attitudes change first, is not always clear. For example, in the case of drink driving in Australia, it has been argued that behaviour change occurred first as a result of enforcement through random breath testing, and that attitudinal change followed (Fleiter et al. 2014).
Resistance

Despite the evidence about the injury risks of speeding and the safety benefits of speed camera enforcement, the resistance about speed cameras as a road safety measure, in mass media and social media, is significant. Much of the anti-speed enforcement commentary is based on civil liberties arguments (Mooren et al. 2014).

Anti-“nanny state” arguments suggest that contemporary social regulation is designed to shield individuals from voluntary risk-taking behaviour (Mooren et al. 2014).

The introduction of seat belt laws was another point at which resistance was anticipated but didn’t really eventuate. Australia has high levels of restraint wearing by road users and evidence supports the role that enforcement has played, as well as the role of mass media campaigns in encouraging and promoting greater adherence (Fleiter et al. 2014). Community attitudes to drink driving laws have also been influenced positively by enforcement and mass media campaigns. Nonetheless, ‘one quarter of road fatalities in Australia are still linked to illegal blood alcohol levels and evidence suggests that there may be new and emergent road safety challenges, such as the increase in women being detected for drink-driving. In addition, youth binge drinking and the subsequent interactions that youth may have with the road system when intoxicated, whether as a drink driver or a drink walker reflect the extent to which broader alcohol-related problems in society impact upon road safety’ (Fleiter et al. 2014).

Summary

Great gains have been made in changing Australia’s traffic safety culture and road environments. The road safety effort has demonstrated clarity of purpose, engaged in disruptive change, and used multiple concurrent strategies to achieve targets. Innovation in strategy and methods has been a constant over the decades since 1970 when interventions began.

The decline in trauma levels since 1970 has occurred despite considerable population growth and a threefold increase in registered motor vehicles, demonstrating the value of well designed, multi-level and mutually reinforcing strategies and of institutional infrastructure to drive the prevention effort. However, despite continuing prevention efforts, road crashes (cars, motorbikes, bicycles, pedestrians) continue to cause large numbers of deaths and serious injuries each year.

Communication inequalities and knowledge gaps, are likely to exist between different population groups, with both gender and age differences (Guest et al. 2013).

Complacency is unwise: public health messages may not reach or impact on new generations of drivers as effectively as we wish, as demonstrated in the case study.

Heavy investment in road safety has built a strong evidence base but continued investment in the effectiveness of campaigns and programs and that identifies directions for future campaign is critical for sustained change and to inform policymaking, legislative reforms and strategies.

In the high risk behaviours of speeding, fatigue and mobile phone use while driving, change to social norms has not yet occurred at the level required to reduce road trauma as indicated by the case studies. Evidence suggests that the identification of risk associated with these behaviours is not yet occurring to the same degree as for other legislated initiatives (Fleiter et al. 2014).
Tobacco smoking is the leading preventable cause of death and disease in Victoria. It costs 4000 lives and $5 billion each and every year (VicHealth n.d.).

Tobacco control efforts in Australia are considered a public health success story with smoking prevalence in Victoria dropping from 31% in 1987 to 13.3% in 2012 (VicHealth 2014). Research shows that in 2014, the prevalence of smoking among teenagers was at its lowest since surveys began more than three decades earlier (White & Williams 2015).

However there are a number of Australian sub-groups who have smoking rates up to five times higher than the population average (Australian National Preventive Health Agency 2013). Those sub-groups include people who are unemployed, sole parents, those with a mental health issue, are in prison, have a substance use problem, are experiencing homelessness or are Aboriginal and/or Torres Strait Islander (Cancer Council Victoria; Australian National Preventive Health Agency 2013). For example, 42% of the combined Aboriginal and Torres Strait Islander population are current daily smokers, which is more than double the prevalence among the Australian population as a whole (ABS 2014).

Lessons learned

Resistance to tobacco control among the general population has dramatically changed over time as the smokers’ rights movement has been countered by the smoke-free rights movements.

No single strategy is effective but the most influential action has been to increase the taxation and pricing of tobacco products.

The quantifying of treating tobacco related illness has shifted governments to become more involved in tobacco control.

Mass media campaigns have worked directly to change behaviour and indirectly by setting an agenda for interpersonal and public discussion that can lead to changes in social norms or public policy. They increase community understanding and recognition of the harms associated with tobacco smoking and facilitate policy initiatives to reduce those harms (Commonwealth of Australia 2012).

Key drivers and factors creating this scenario

Tobacco ranks as the second leading cause of preventable death globally, behind hypertension. In Australia, smoking tobacco and being exposed to second-hand smoke are recognised as one of the largest preventable causes of death and disease, killing an estimated 15,000 Australians annually.
The marketing practices of tobacco companies, including promotion of the product and imagery with the product as well as the addictive chemicals used in tobacco products, are known to be factors that increase the uptake of smoking and resumption of smoking among those who have quit (Cancer Council Victoria 2016).

The key drivers of change over time in the proportion of people smoking and the amounts smoked by (remaining) regular smokers include the following factors:

- the increasing unaffordability of tobacco products driven by government excise, customs duties and other charges and taxes
- high levels of tobacco control activities at multiple levels including public spaces and in communities
- changing social norms based on increased public awareness of the health risks of smoking and levels of public tolerance about exposure to tobacco smoke (Cancer Council 2016).

Australia’s National Tobacco Strategy (NTS) (Commonwealth of Australia 2012) outlines the importance of separating tobacco control programs from those programs that address underlying determinants of smoking and initiatives to create environments that support people not to smoke. There is increasing understanding of the factors behind youth uptake of smoking which include family conflict, school disengagement, and socio-economic disadvantage.

**Significant milestones in tobacco harm reduction in Australia**

Australia’s response to tobacco came only after a series of studies aimed principally at trying to account for the sudden rise in lung cancer deaths, particularly among men, in the years following the Second World War. The studies especially that of Doll and Hill (1964), revealed the far-ranging mortal consequences of what is now understood to be an insidious exposure.

Smoke-free legislation in Australia is managed by the states and territories. The ACT was the first jurisdiction to enact legislation in 1994, to ban smoking ban in enclosed public places though there were exemptions such as restaurants and licensed premises. Other jurisdictions followed from 1999 and in subsequent years, the bans have become more comprehensive and wide-ranging. A summary of smoke-free legislation across Australian states and territories is available at: http://www.tobaccoinaustralia.org.au/table-15-7-1-implementation-dates-aus

Figure 3 sets out key milestones achieved to reduce smoking in Australia and its social, health and economic burden. Note that the major milestone missing from Figure 3 is the introduction of the Tobacco Plain Packaging Act 2011, which required all tobacco products sold in Australia to be sold in plain packaging from 1 December 2012. This was a world-first initiative that has received global recognition.

**Figure 2: Milestones in reducing smoking in Australia 1980–2007**

- No bulls campaign
- Phase out smoking in federal workplaces
- Vic Tobacco Act
- Pack health labelling regulations introduced
- NRT available for sale in Australia
- MCG smoke free
- C/W implement tax by stick
- Smoke free dining
- Gaming venue ban
- 1st QUIT campaigns
- 4 rotating pack health warnings
- Smoking banned on domestic airlines
- Tobacco banned in print media
- In excise duty
- Federal bans on tobacco sponsorship of sports and arts
- Age for sale of cigarettes 16 to 18
- Health warnings on packs
- Remaining tobacco sponsorship removed (exc. significant international events)
- POS advertising bans

Source: National Preventative Health Taskforce, 2009
Social and economic impact of exposure to tobacco

The estimated cost to the Australian economy in 2004-5 was $31.5 billion in social, health and economic costs (DoH 2015; Scollo & Winstanley 2016).

The Australian Bureau of Statistics (ABS) publishes the total consumption of tobacco and cigarettes from 2012 to 2015, as measured by estimated expenditure on tobacco products:

- $5.135 billion in September 1999
- $3.720 billion in December 2012
- $3.260 billion in December 2015

(Australian Government 2016b).

Institutional infrastructure

The World Health Organization Framework Convention on Tobacco Control (FCTC) was adopted at the Fifty-sixth World Health Assembly in 2003 and entered into force on 27 February 2005. The Australian Government formally ratified the WHO FCTC on 27 October 2004. It sets out internationally agreed tobacco control research priorities but has also provided significant strength on which to build Australia’s strategies for tobacco reduction.

Australia’s current NTS (2012-2018) (Commonwealth of Australia 2012) was preceded by the National Tobacco Strategy 2004-2009. The NTS is developed by the Intergovernmental Committee on Drugs Standing Committee as a sub-strategy under the National Drug Strategy 2010-2015.

National population health surveys provide surveillance and monitoring. They consistently measure smoking prevalence by age groups, and Cancer Council Victoria collects data from secondary school students. NGOs including Cancer Councils, the National Heart Foundation and the Public Health Association of Australia have provided ongoing sustained advocacy and support for government initiatives. In Victoria, the establishment of a dedicated foundation (that is, Victorian Health Promotion Foundation) has enabled the development of research, partnerships and programming with an initial focus on tobacco reduction and later on health promotion more broadly (VicHealth 2005).

Targets for reduction

Australian Governments (national, state and territory), through COAG, have set specific performance benchmarks for reduction in tobacco use. All jurisdictions have committed by 2018, to reduce the national adult daily smoking rate to 10% and halve the Aboriginal and Torres Strait Islander adult daily smoking rate to the 2008 benchmark rate of 47%. In 2010, 15.1 per cent of people 14 years or over were smoking daily. In 2013, modelling suggests that the rate of adults smoking was around 20% of males over 18 years of age and around 15% of females over 18 years of age.

Figure 3: Changes in daily smoking status of Australians aged 18 years and older by each Australian state and territory, 1998, 2001, 2004, 2007 and 2010

While Figure 3 presents data for smokers over 18 years of age, it is primarily young people who are initiated into smoking. Young people are more likely to initiate smoking if their parents, siblings or friends are smokers. In 2011, the overall rate of current smoking among Australian students aged 12 to 17 years was 6.7% (QUIT Victoria).

The constant monitoring of changes across Australia’s states and territories is a strong facilitator of effectiveness. Figure 2 illustrates one way in which changes are monitored but there is also extensive data available about the age groups at which smoking is more prevalent, the population groups where smoking rates are higher and are therefore, targets for change. Data collection is funded nationally through the tri-annual National Drug Strategy Household Survey collected by the Australian Institute of Health and Welfare (AIHW 2016).

The progress being made by states and territories in the laws and by-laws necessary to limit illegal sales of tobacco, and reduce exposure of populations to second-hand smoke, is also monitored by Cancer Councils, research groups and the Intergovernmental Committee on Drugs which reports to the Minister for Health.

Key strategies and approaches to coordinate and sustain effort

Tobacco control initiatives have been extensively researched, with a constantly developing evidence base about what works. These include:

- the impact of tax and price policies
- tobacco cessation interventions
- the economic impact of tobacco use and evaluation of the economic impact of tobacco control (e.g. on jobs, healthcare costs and productivity)
- the inter-relationships between tobacco use and poverty, including the role of tobacco use in causing poverty through the compromises on other spending
- the differential effect of tobacco control policies and program on the poor
- effective messaging in overcoming misinformation spread by tobacco companies building/strengthening social norms against tobacco, and
- building support for tobacco control policies and program.

Of particular relevance to youth smoking prevention, Australia’s NTS endorses broader government policies and programs that address the underlying causes of youth disadvantage in our community including reductions in family conflict and improvements in school effectiveness to keep young people engaged in school. These measures have strong potential to improve the proportion of students feeling a connectedness with school, and to improve academic achievement, both of which are highly protective against smoking uptake.

Other key strategies include:

- Cessation of all forms of tobacco advertising and promotion: the first voluntary tobacco advertising code was introduced in 1966; in 1972, mandatory health warnings for radio and television tobacco advertisements were introduced; a full ban on tobacco advertising came into effect on 1 September 1976, not without some opposition from within the government of the day (National Archives of Australia). The NTS seeks to eliminate remaining advertising, promotion and sponsorship of tobacco products.
- Reduction of exposure to tobacco: tobacco products cannot be sold or supplied to persons under 18 years old, but there is no legal age to use them.
- Reduction of exposure to second-hand smoke: All levels of government have responsibilities for passive smoking bans. Federal law bans smoking in all Australian Commonwealth government buildings, public transport, airports, and international and domestic flights. States and territories have banned smoking in vehicles with children, in some enclosed public places, workplaces, and most enclosed restaurants. The NTS seeks to reduce exceptions to smoke-free workplaces, public places and other settings.
- Applying downward pressures on smoking rates: actions intended to lower smoking rates in all age groups include health warnings on tobacco packets, increased taxation, restrictions on smoking opportunities, support for the rights of non-smokers, and information and education programs.
- Increasing taxation on and pricing of tobacco products: there is strong evidence that the most effective tobacco control measure is in increasing tobacco taxes and prices (Taurus et al. 2014).

There is wide recognition that cross-sector and multi-level actions are necessary to increase the effectiveness of actions for tobacco control.

The language of tobacco control has broadened over time, to ‘reducing tobacco-related harm’ and includes actions to address passive smoking as described in the case study. To achieve this, Australia’s NTS identifies nine best-practice priority areas:

1. Protect public health policy, including tobacco control policies, from tobacco industry interference.
2. Strengthen mass media campaigns to: motivate smokers to quit and recent quitters to remain quit; discourage uptake of smoking; and reshape social norms about smoking
3. Continue to reduce the affordability of tobacco products.
4. Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander people.
5. Strengthen efforts to reduce smoking among people in populations with a high prevalence of smoking.
6. Eliminate remaining advertising, promotion and sponsorship of tobacco products.
7. Consider further regulation of the contents, product disclosure and supply of tobacco products and alternative nicotine delivery systems.
8. Reduce exceptions to smoke-free workplaces, public places and other settings.
9. Provide greater access to a range of evidence-based cessation services and supports to help smokers to quit.

Resistance

Tobacco companies are powerful, wealthy and constantly seek to maintain their market position, protect their products and sustain their viability.

“They have demonstrated strategic and financial collaboration at the highest level.

In Australia and internationally, the tobacco industry has developed a comprehensive, multi-faceted, multi-level approach to defending its interests.

In Australia and internationally, the tobacco industry has developed a comprehensive, multi-faceted, multi-level approach to defending its interests.

The NTS supports Australia’s engagement in international partnerships to maximise the effectiveness of global tobacco control efforts, and to learn and share best practice approaches to reducing tobacco-related harm.
<table>
<thead>
<tr>
<th>Tactic</th>
<th>Goal</th>
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<tbody>
<tr>
<td>Intelligence gathering</td>
<td>To monitor opponents and social trends in order to anticipate future challenges.</td>
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<td>Public relations</td>
<td>To mold public opinion, using the media to promote positions favourable to the industry.</td>
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<tr>
<td>Political funding</td>
<td>To use campaign contributions to win votes and legislative favours from politicians.</td>
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<tr>
<td>Lobbying</td>
<td>To make deals and influence political processes.</td>
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<td>Consultancy program</td>
<td>To recruit supposedly independent experts critical of tobacco control measures.</td>
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<tr>
<td>Funding research – including universities</td>
<td>To create doubt about existing evidence of the health effects of tobacco use.</td>
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<tr>
<td>Smokers’ rights groups</td>
<td>To create an impression of spontaneous, grass roots public support.</td>
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<tr>
<td>Creating alliances and front groups</td>
<td>To mobilise farmers, retailers, advertising agencies, hospitality industry, ‘grass roots’ and anti-tax groups with a view to influencing legislation.</td>
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<tr>
<td>Intimidation</td>
<td>To use legal and economic power as a means of harassing and frightening opponents who support tobacco control.</td>
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<tr>
<td>Philanthropy</td>
<td>To buy friends and social respectability from arts, sports and cultural groups.</td>
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<tr>
<td>Corporate social responsibility</td>
<td>To promote voluntary measures as an effective way to address tobacco control and create illusion of being a ‘changed’ company and to establish partnerships with health interests.</td>
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<tr>
<td>Youth smoking prevention and retailer education programs</td>
<td>To appear as being onside with efforts to prevent children from smoking and to frame smoking as an adult choice.</td>
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<tr>
<td>Litigation</td>
<td>To challenge laws and intimidate tobacco industry opponents.</td>
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<tr>
<td>Smuggling</td>
<td>To undermine tobacco excise tax policies and marketing and trade restrictions and thereby increase profits.</td>
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<tr>
<td>International treaties and other international instruments</td>
<td>To use trade agreements to force entry into closed markets and to challenge the legality of proposed tobacco control legislation.</td>
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<tr>
<td>Joint manufacturing and licensing agreements and voluntary policy agreements with governments</td>
<td>To form joint ventures with state monopolies and subsequently pressure governments to privatise monopolies.</td>
</tr>
<tr>
<td>Pre-emption</td>
<td>To overrule local or state level of government by taking away its power to act.</td>
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CASE STUDIES OF PUBLIC HEALTH ACTIONS

CASE STUDY 3
‘SHOCKING STATISTICS THAT ILLUSTRATE AUSTRALIA’S OBESITY PROBLEM’

Extract from article:

In 2014-2015, a staggering 63.4 percent of Australian adults were overweight or obese – well over half of our nation’s population. That’s almost two in three adults. This is an increase from 1995, which was 56.3 percent, illustrating that the problem is getting worse.

The medical world generally defines ‘overweight’ when a person’s weight is 10 to 20 percent higher than a body mass index (BMI) of 25 to 30. ‘Obesity’ is defined as a condition in which a person’s weight is 20 percent or more above a BMI of 30 or more. ‘Morbid obesity’ refers to an individual who is either 50 to 100 percent over ‘normal’ weight, or sufficiently overweight to the point that their condition interferes with health or normal functioning.

The Australian Institute of Health and Welfare warns that excess weight – especially obesity – is a major risk factor for cardiovascular disease, Type 2 diabetes, some musculoskeletal conditions and some cancers. As the level of excess weight increases, so does the risk of developing these conditions. In addition, being overweight can hamper the ability to control or manage chronic disorders.

Twenty-two percent of Aussies in 2012 had cardiovascular disease, which is the number one cause of death and sickness in our country, while 280 Australians develop diabetes every single day. That’s one person every five minutes. Men have slightly more reason for concern, with 70.8 percent of adult males being overweight or obese compared with 56.3 percent of women. Evidence shows that we’re passing on our bad habits to our kids, too. Around one in four (27.4 percent) of children aged 5-17 were overweight or obese.

When it comes to our diets, nearly one in two (49.8 percent) of adults met the Australian Dietary Guidelines for the recommended serves of fruit, however only seven percent met the guidelines for serves of vegetables. That’s 93 percent of Aussies who aren’t getting enough veggies every day.

We’re fairly divided as a nation when it comes to exercising. Just over half (55.5 percent) of 18-64 year olds participated in ‘sufficient physical activity’ in the last week -- defined as more than 150 minutes of moderate physical activity or more than 75 minutes of vigorous physical activity, or an equivalent combination of both, including walking. Nearly one third did not complete enough training to be classified as ‘sufficient’, and 14.8 percent did nothing at all.

Of men aged 45 years and over, almost four in five (79.4 percent) were overweight or obese, while two in three women of the same age fell into the same bracket. Interestingly, socioeconomic factors play a role for women, but not men. More women living in areas of most disadvantage in Australia were overweight or obese than women living in areas of least disadvantage, though for men, it made no difference. The fiscal cost to our country is harder to put in perspective. In the medical sector alone, diabetes costs Australia an estimated $14.6 billion each year, while cardiovascular disease is our country’s most costly disease. We are, quite literally, buckling under the weight of the biggest health and medical issue we have ever faced (Campbell 2016).

Lessons learned

Obesity is a complex problem that requires multifaceted approaches across many different sectors.

The obesity prevention effort is diffused and lacking leadership. This is reflected in the numbers and trends discussed in the case study.

The free market environment in which the food industry has flourished is proving to be detrimental to population health. Government policies are needed to change the ground rules in favour of population benefits (Swinburn 2008).

Key drivers and factors creating this scenario

Australia has one of the highest rates of obesity in the world. Concern about the rising average weight of Australians emerged in the 1990s with increasing intensity since then. Numerous reports document the prevalence and trends in the weight of Australians highlighting the impact of unhealthy weight on rising chronic disease rates particularly type 2 diabetes, high blood pressure and coronary heart disease, stroke, joint problems, and some cancers (ABS 2011; Australia’s Preventative Health Taskforce 2009).

Obesity is thought to be a good example of genes interacting with lifestyle and environment. The main drivers of what has been called an ‘obesity epidemic’ are attributed to the increased availability of more affordable food and rising incomes which in turn, have led to changes in dietary patterns. This process is facilitated by multinational food corporations and their ready access to fast food markets and open slather marketing, the industrialization of agriculture and an increased dependence on purchased and processed food, which is increasingly controlled by multinational retailers (Branca et al 2007).

Individual risk factor and drivers for obesity are identified as physical inactivity, excessive dietary intake and poor nutritional choices, particularly foods high in sugar and energy dense foods.

Social and economic drivers include low/poor levels of education and low health literacy1, financial stress, rurality, limited availability of fresh food and the availability of green space (Australia’s National Preventive Health Agency 2014).

Social and economic impact

The costs are estimated as direct and indirect as well as health and wellbeing costs to individuals, families and Australians in general. The economic costs are calculated as cumulative and marginal, and include the impact of chronic disease even though the direct costs of chronic disease cannot be entirely attributed to obesity. It is likely that increasing mortality among obese individuals is more likely to be related to comorbid conditions, rather than obesity per se, which diffuses the prevention effort required to curb the costs and impact. Nonetheless, the costs and impact of obesity are not well understood (Branca et al. 2007).

Price Waterhouse Coopers (PwC) have estimated that if no further action is taken to curb the growth in obesity, there will be a total of $87.7 billion in additional direct and indirect costs to Australia accumulated across the 10 years 2015-2025 (PwC 2015). These costs take account of the costs of chronic diseases including diabetes and its complications, and cardiovascular disease.

Institutional infrastructure

The response to obesity seems more dispersed than either road trauma reduction or tobacco harm reduction.

ANPHA undertook considerable development work for an obesity prevention strategy but the strategy was not developed as the responsibilities of ANPHA were absorbed in the Department of Health in 2014 (ANPHA 2014). Other literature has also outlined potential elements of a prevention strategy. However, there is no systematic, coordinated approach to the targeting and prioritisation of preventive strategies. Further, the evidence base for obesity interventions is for the most part small, narrow in approach, limited in impact, and lacking in cost-effectiveness and equity information (Branca et al 2007).

The Commonwealth Government sets physical activity recommendations across the lifespan (Commonwealth of Australia 2016) and nutrition guidelines for healthy eating (Commonwealth of Australia health star rating (Commonwealth of Australia n.d). Local governments in Victoria have responsibilities to establish supportive environments for physical activity. Accordingly, within their

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1Australia’s population has low levels of health literacy as do many countries globally. Health literacy is “the degree to which people are able to access, understand, appraise and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course. Health literacy is based on the interaction of the individual’s skills with health contexts including the health care system, the education system, and broad social and cultural factors at home, work and in the community”. Health literacy is an outcome of literacy and of determinants including education, employment and income. Low health literacy is more common among the population than good health literacy; literacy levels are strongly correlated with health outcomes.
Municipal Public Health and Wellbeing Plans (MPHWP) which are a statutory requirement, LGAs identify their roles and responsibilities for increasing the infrastructure for physical activity, and have been supported in that work by VicHealth (VicHealth 2012).

Various NGOs and Universities play a role in both research and intervention development and testing. Their work is limited by available funding so most of it is relatively short-term and not at scale.

The Australian Government established the Food and Health Dialogue in 2009 with a primary goal to “raise the nutritional profile of foods” which was to be achieved “through reformulation, consumer education and portion standardisation”. The Dialogue was recognized as establishing a framework for collaboration between government, public health groups and industry but in the first 4 years, no targets had been achieved. Nor was there evidence that any education programs had been implemented by the Dialogue. The conclusion reached was that while the Dialogue had highly creditable goals, the mechanism for delivering on them has proved to be inadequate (Elliot et al 2014).

The Dialogue was replaced in 2012 by the Healthy Food Partnership which is described as a mechanism for government, the public health sector and the food industry to cooperatively tackle obesity, encourage healthy eating and empower food manufacturers to make positive changes (Department of Health 2016). Observers would like to see the Partnership establish explicit processes and define the outcomes to be delivered within defined timelines, along with a clear plan for remediation if those outcomes are not achieved (Department of Health 2016).

Numerous research and advocacy groups work on physical activity and healthy eating, some coalitions exist and NGOs such as Cancer Council, the Heart Foundation and Diabetes Australia also develop policy positions and evidence reviews and fund research, but there is little by way of formal mechanisms to provide the visibility and coherence seen in other public health issues. Many obesity prevention policy measures are being developed without knowing for certain which are most effective (Swinburn 2008).

Some researchers now argue that concerted action is needed from governments in four broad areas:

- provide leadership to set the agenda and show the way
- advocate for a multi-sector response and establish the mechanisms for all sectors to engage and enhance action
- develop and implement policies (including laws and regulations) to create healthier food and activity environments

- secure increased and continued funding to reduce obesogenic environments and promote healthy eating and physical activity’ (Swinburn 2008)

Targets for reduction

Obesity as a risk-factor is related to Australian National Health Priority Areas (NHPA) but is not a NHPA itself. The World Health Organization has set targets of returning to and maintaining the 2010 obesity prevalence levels. Australia does not appear to have set specific targets for obesity reduction but has developed guidelines and recommendations for physical activity and healthy eating (Commonwealth of Australia 2016).

Key strategies and approaches to coordinate and sustain effort

Environments influencing obesity and therefore, guiding interventions/strategies include:

- physical availability (or not) of food products
- economic (the financial factors)
- policy (the ‘rules’)
- socio-cultural (the attitudes, beliefs, perceptions, values and norms of the societal or cultural group) (Swinburn 2008).

The World Health Organization identifies the range of micro-environmental and macro-environmental determinants of the various contributing factors to obesity which can also be mapped onto socio-economic inequalities (Branca et al 2007). The breadth of those factors points to the multi-causal factors in obesity and in turn, the breadth and scope of actions required for prevention. It also means that there are multiple stakeholders in obesity prevention but their capacity to work effectively on population level interventions is affected by weak infrastructure.

Micro-environmental interventions are community-based interventions limited to a particular setting such as a retail outlet (e.g. in a school or sports club), school canteen or point-of-sale information about particular products.

Social marketing campaigns for increased physical activity levels and healthy eating initiatives to address the obesity crisis have been fragmented. For example, ‘more than $35m was spent on social marketing initiatives such as the balloon man, Eric, and his “Swap It, Don’t Stop It!” campaign but it is not clear how the campaign was evaluated and whether it will have any impact on the obesity epidemic without other major, well-funded initiatives’ (Zimmet 2012).
Macro-environmental includes regulatory interventions such as restrictions on food advertising to children, taxes on unhealthy food, and improvements to food labelling.

While both micro- and macro-environmental interventions are recommended in various studies, the evidence base about their effectiveness is still emerging (Sacks & Cameron 2014).

**Resistance**

The food industry is dominated by wealthy multinational companies with massive vested interests in maintaining their market share. They form the focus of resistance to public health efforts to change food environments, but other forms of resistance come from government in terms of food policy reform, and consumers whose resistance is evident in their purchasing and eating habits.

Consumer resistance has also been attributed to the risks that are the focus of interventions that target body shape and size. The associated media targeting of obesity creates negative effects, which increases stigma and the messages become lost (Walls et al. 2011). Further, obesity prevention is characterized by uncertainty and complexity, with significant gaps in the evidence about effectiveness (Sweet & Moynihan 2007) which is confusing for consumers.

Nonetheless, the research about obesity risks is clear, but the research about how to intervene is not as well clarified as the research that informs road trauma reduction or tobacco control. Causal pathways are not clear:

Obesity, either independently or not, is recognized as an important risk factor for cardiovascular disease and heart failure. However, not all aspects of that association have been clarified - some studies have shown that people who are classified as overweight or with mild obesity have had fewer hospitalizations and lower mortality as compared to those with lower BMI (Azevedo et al. 2015).

Achieving dietary improvements at a population level has been a perennial concern for public health professionals and health departments. Over the past two or three decades, public health programs have focused on changing individual behaviour through social marketing campaigns, community-based interventions and primary healthcare education.

These have met with varied success. Often resource-intensive, they have been short-term interventions and at best provide an indication of short-term impacts only.

Evaluating the population impact of specific initiatives is especially difficult if there are concurrent public health strategies in place. Additionally, the multifactorial and distal nature of chronic disease adds another layer of complexity to measurement (NHFA 2012).

While there is abundant research naming the problem and its impact, the research about the long-term impact of interventions is not definitive or strong, so the potential to advocate for policy about population level approaches is diminished.

While public health advocates have undertaken significant effort to involve the food industry in reforms that affect population health, this has not developed strongly.

**Summary**

The obesity prevention effort may not be reaching consumers with the same clarity of purpose as road trauma reduction or tobacco control.

The regulatory environment for obesity appears weak.

Partnerships with industry and industry-led efforts have conflicts because of vested interests and are unlikely to yield benefits.

There is concern that the obesity prevention effort has had little success in engaging communities or populations in disruptive change.

Stronger regulatory reform is required with careful evaluation of the impact of different types of intervention.
Extract from article:

Australia’s peak AIDS organisations and scientists have announced an end to the AIDS epidemic, as the country joins the few nations in the world to have beaten the syndrome. The number of annual cases of AIDS diagnoses is now so small, top researchers and the Australian Federation of AIDS Organisations have declared the public health issue to be over.

Since the 1990s, treatment that stops HIV from progressing to AIDS – which damages the immune system to the extent that it can no longer fight off infection – has become more effective. AFAO CEO Darryl O’Donnell said AIDS cases have dropped to small enough numbers to no longer be routinely recorded.

“AIDS is over in the way we knew it,” he said. “We’ve got access to treatment that has had extraordinary effect, and community activism since the very early years of AIDS in the ’80s and ’90s has helped the efforts to fight it.”

Professor Sharon Lewin, director of the Peter Doherty Institute, told the ABC that anti-retroviral medications had been crucial to the epidemic’s decline, allowing people diagnosed with HIV to live healthy, long lives. “I’ve actually seen a dramatic transformation of HIV from a universal death sentence to now a chronic, manageable disease,” Professor Lewin said.

However, Mr O’Donnell said Australia still has a major challenge in addressing HIV. “We still have a huge task in dealing with the 1100 to 1200 cases of HIV per year,” he said. “These are avoidable infections.” Mr O’Donnell stressed the importance of getting tested, with early diagnosis the best chance of treating HIV.

He said he expected the pre-exposure prophylaxis Truvada, a once-a-day pill taken to prevent HIV, to be a game-changer comparable to the impact of the contraceptive pill.

“We need urgent action from the Australian government to subsidise this pill,” he said, adding that Truvada would see HIV cases halved in a year. AIDS bodies have also advocated for more focus on the regional impact of the syndrome.

“We’re incredibly fortunate here in Australia that we have an excellent healthcare system. In the Asia-Pacific, 180,000 people die from AIDS each year and of the 5 million living with HIV, only 2 million have access to treatment,” Mr O’Donnell (Jeong 2016).


Lessons learned

A multi-faceted, bipartisan approach based on evidence and continuous learning, is vital for the effective management and control of HIV/AIDS.

The early formation of a National Strategy was pivotal in guiding actions and investments at both National and State levels.

Constant monitoring of progress including cost-benefit analysis of different approaches has led to a strong evidence base about what works (and what doesn’t work) in reducing risk and managing outbreaks.

Over time, improved access to screening, treatment and support together with decriminalisation of homosexuality and illicit drug use have led to much more supportive environments than existed prior to those measures and laws being introduced.
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<thead>
<tr>
<th>Year</th>
<th>Milestone</th>
</tr>
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<tbody>
<tr>
<td>1982</td>
<td>First person with AIDS diagnosed in Australia.</td>
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<tr>
<td>1983</td>
<td>National AIDS Task Force established, replacing the NHMRC working party. A ministerial advisory committee, the National Advisory Committee on AIDS (NACAIDS) formed to advise on educational, social and legal issues. Donor Declaration Forms introduced at all blood banks. Commonwealth commenced funding of State-based non-government organisations providing education, counselling and support services to higher risk groups.</td>
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<tr>
<td>1984</td>
<td>National Health and Medical Research Council (NHMRC) established a working party on AIDS.</td>
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<tr>
<td>1985</td>
<td>Australian Health Ministers’ Conference endorsed the National Health Strategy for AIDS Control. HIV test became available and Australia became one of the first countries to have universal blood donor screening. Australian Federation of AIDS organisations (AFAO) established to represent AIDS Councils at the national level. Commonwealth and States agree to 50:50 cost sharing of funding for State-based non-government organisations under the new Matched Funding Program.</td>
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<tr>
<td>1986</td>
<td>NACAIDS adopted a national education strategy on AIDS that provided the framework for its national education campaign. National AIDS Task Force recommended the provision of needles and syringes to intravenous drug users.</td>
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<tr>
<td>1986</td>
<td>Needle and Syringe Exchange Programs commenced. Grim Reaper campaign commenced on Passion Sunday in April. Commonwealth required at least 50 per cent of amounts spent under the Matched Funding Program to be directed to prevention, education and counselling.</td>
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<tr>
<td>1989</td>
<td>1st National HIV/AIDS Strategy implemented with funding for four years.</td>
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<tr>
<td>1993</td>
<td>2nd National HIV/AIDS Strategy implemented with funding for three years, supporting a change in emphasis from Commonwealth to State/Territory responsibility for direct program planning and delivery.</td>
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<tr>
<td>1996</td>
<td>3rd National HIV/AIDS Strategy implemented for three years. Australian National Council on AIDS and Related Diseases (ANCARD) is formed to replace ANCA. Matched Funding Program terminated at the end of 1996–97, with Commonwealth specific purpose payments to the States for eight public health areas including HIV/AIDS being broadbanded in the new Public Health Outcome Funding Agreements (PHOFA) in 1997–98.</td>
</tr>
<tr>
<td>1999</td>
<td>Review of Third National HIV/AIDS Strategy recommends that educational and advertising material should be directed at particular groups or populations.</td>
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<tr>
<td>2005</td>
<td>5th National HIV/AIDS Strategy 2005–2008 identified five priority areas for action to be addressed over the life of the Strategy: development of a targeted prevention education and health promotion program for HIV; improving the health of people living with HIV/AIDS; developing an effective response to the changing care and support needs of people living with HIV/AIDS; a review of the National HIV Testing Policy; and the provision of a clearer direction for HIV/AIDS research.</td>
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<tr>
<td>2014-2017</td>
<td>7th National HIV/AIDS Strategy 2014–2017 sets the direction for Australia to reverse the increasing trend of new HIV diagnoses and works towards the virtual elimination of HIV transmission by 2020. For the first time, the national HIV strategy includes a range of discrete targets, informed by the United Nations 2011 United Nations Political Declaration on HIV/ and AIDS (the UN Declaration) [22] to which Australia is a signatory.</td>
</tr>
<tr>
<td>2016</td>
<td>AIDS epidemic ‘over’ in Australia.</td>
</tr>
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</table>

Source: Public Health Programs to Reduce HIV/AIDS, Applied Economics
Significant milestones in AIDS prevention in Australia

The first Australian case of HIV/AIDS was notified at St Vincent’s Hospital, Sydney in October 1982, and the first AIDS-related death occurred nine months later in Melbourne. Australia quickly mobilised a national collaboration of governments, clinicians, researchers, community advocates and activists, policymakers, public health experts and, crucially, people with HIV. The human immunodeficiency virus, HIV, was identified in 1982. Between 1984 and mid-1985 in Australia there was a 540 percent increase in HIV infections (NAPWHA 2015).

Institutional infrastructure

Two national groups, National Advisory Council on AIDS (NACAIDS) and the AIDS Task Force, were established in 1984. The AIDS Task Force was a peak body for HIV/AIDS clinical and scientific expertise. These two groups became the government’s peak advisory committees on prevention education, care and treatment of those living with HIV/AIDS. Together with consumer activist groups, they developed social policy for the Australian population and groups at high risk of acquiring HIV infection.

With the emergence of consumer activist groups for HIV/AIDS and drug users, the Federal Government and governments in states and territories funded them to provide education, care, treatment, and other support services to their members and supporters. ‘Over time, many of these community activists were recruited into government departments, where they became senior program administrators and policy developers. The quality and depth of Australia’s response to HIV/AIDS were greatly improved as a result’ (Bellev 2006).

As early as 1985, Parliamentary Liaison Groups on AIDS (PLG AIDS) were formed at the national level and later by state and territory governments which brought together politicians of all parties with an interest in HIV/AIDS policy. They were provided with briefings on the evolution of the epidemic and policy options and became a valuable conduit through which HIV/AIDS organizations could brief and lobby members of parliaments and exchange views and concerns (Bellev 2006).

The Australian Government established the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis in 2003 providing for three expert sub-committees and administrative support. MACASHH is the key advisory body to the Minister for Health and Ageing on policies and national strategies in relation to HIV/AIDS, Indigenous sexual health, sexually transmissible infections (STIs) and viral hepatitis. The Committee is responsible for establishing alliances such as those between HIV/AIDS and hepatitis C prevention and the prevention of illicit drug use, and for coordination of a whole-of-government response to HIV/AIDS and hepatitis C (MACASHH 2015). In addition, the Kirby Institute administers The Surveillance and Evaluation Program for Public Health with responsibility for the public health monitoring and evaluation of patterns of transmission of specific blood-borne viral and sexually transmissible infections including HIV/AIDS (The Kirby Institute 2011).

The Seventh National HIV Strategy 2014–2017 is one of Australia’s five national strategies that set the direction for a coordinated, national response to HIV, hepatitis B, hepatitis C, sexually transmissible infections, and blood-borne viruses and sexually transmissible infections in the Aboriginal and Torres Strait Islander population until 2017.

The national strategies are endorsed by all Australian Health Ministers and, for the first time, contain modest targets to stimulate a renewed focus for action and provide a framework for accountability.

‘Each national strategy identifies the priority actions that will support achievement of the targets across the areas of prevention; testing; management, care and support; workforce; protection of human rights; and surveillance, research and evaluation’ (Department of Health 2014).

Rates and targets

An estimated 27,150 people in Australia live with HIV/AIDS. The annual number of new HIV diagnoses has gradually increased from 719 diagnoses in 1999 to 1,081 in 2012. The number of new HIV diagnoses in Australia has remained stable, with just over 1,000 new cases of cases of HIV being diagnosed each year from 2012–2014 (Australian Federation of AIDS Organisation 2015). The majority of new HIV diagnoses (75%) of Australians has occurred among gay and bisexual men but in addition to the newly diagnosed
cases of HIV in 2014, there were 252 HIV cases previously diagnosed overseas with a confirmatory test conducted in Australia.

Around 25% of all diagnoses between 2009 and 2013 were among people born in countries with high rates of HIV. A large proportion of these diagnoses were among heterosexuals. Among 242 women with HIV who have given birth in the five-year period 2010-2014, the transmission rate to newborns was 1.7%.

As Table 2 shows, the 7th National HIV/AIDS Strategy aims to eliminate HIV transmission by 2020.

Key strategies and approaches to coordinate and sustain effort

Australia’s actions to contain what has been an enduring epidemic in many countries is characterized by a bipartisan and multi-faceted approach, and within a relatively short timeframe have led to the achievements described in the case study.

The emergence of politically active groups about HIV/AIDS occurred spontaneously and Australian governments saw the good sense early in the emergence of HIV/AIDS of engaging them in policy formulation and development (Bellew 2006), and in education and awareness raising.

Civil society organisations and activists quickly realized that the quality of reporting in the media generally reflects the quality of the information inputs and that the more accurate the information put into the public domain, the better and more informed the debate would be, and in turn, would inform the quality of public policymaking.

Access to clinical care funded by Medicare (Australia’s national health insurance scheme) greatly facilitated screening and treatment programs while the Pharmaceutical Benefits Scheme provided affordable access to pharmaceutical treatments.

Bellew (2006) documents the ‘radical’ measures that government supported from the 1980s:

- peer-based, direct, and explicit preventive education campaigns directed both at high-risk groups and the general public
- widespread introduction of subsidized needle and syringe exchanges
- rapid expansion of methadone maintenance treatment
- access to free, anonymous, and universal HIV testing
- subsidized access to azidothymidine (AZT) and subsequent ARV treatment
- general advocacy of the need to adopt safer sexual practices, especially the use of condoms
- promotion of widespread availability of condoms
- creation of an enabling political environment that encouraged socially marginalized groups (IDUs, sex workers) to be involved in the national response
- removal of political and legislative barriers to enable effective preventive education and action—e.g., the passage of legislation to prevent discrimination on the grounds of sexual orientation or HIV status
- building of strong scientific and social research capacity and institutions.

These policies were based on a number of basic principles:

- the need to minimize risk to the general population
- recognition of the importance to policymaking of empirical research and evidence—especially in the fields of epidemiology, clinical treatment, retrovirology, and the social sciences
- respect for human rights, buttressed as required by legislation
- collaboration and partnership between all stakeholders
- long-term over short-term thinking (Bellew 2006).

Education for prevention and awareness raising has been facilitated by consecutive National HIV/AIDS Strategies and their articulation of desired strategies and goals over time. A series of strategies and approaches was introduced from the mid-1980’s which was relatively early in the context of the emergence of HIV/AIDS. Australia’s current strategies have been adapted from the UN Declaration to the Australian context.

The 1st National HIV/AIDS Strategy identified four target groups: Aboriginal and Torres Strait Islander peoples, MSM, injecting drug users, and the general community, which remain a strong focus for outreach and education as well as sex workers and prison populations although there has been limited access provided to the latter groups.

Pioneering needle and syringe programs for injecting drug users were introduced in the early 1980’s, for injecting drug users across the country. As a result, only 1.9 percent of HIV infections in Australia are attributable to injecting drug use (IDU). In contrast, the US has an IDU HIV infection rate of 20 percent (NAPWHA 2015).
Research was established to collect cost effectiveness data systematically. These studies were a world-first and demonstrated the savings in treatment costs resulting from the prevention of HIV by needle and syringe programs, as well as demonstrating that the NSP programs more than offset the operating costs of the programs (Bellew 2006).

Securing of the blood supply was an early strategy to both contain the potential for rapid transmission of the virus and to ensure public confidence in the Australian Red Cross Blood Service.

Educating the population about the virus and the consequences of infection included targeting both high-risk sub-groups in the population (e.g. men who have sex with men (MSM) and injecting drug users), and also targeted the general population. Perhaps the most high-profile education activity aimed at the general population was the Grim Reaper campaign of 1987 to which there was a mixed reaction. From the early 1980s, AIDS activists developed relationships with journalists and worked effectively with them to reconstruct the public image of HIV-AIDs and reframe the messaging (Power 2011).

Anti-discrimination legislation, particularly the decriminalization of homosexuality and of illicit drug use, is a facilitator of mobilising against HIV/AIDS, and of outreach programs (whether for HIV, STIs, blood-borne viruses) to affected communities and communities of people at risk of infection. If people fear seeking health care or fear discrimination within health systems, their access to screening, treatment and education programs is affected.

Media responses to HIV/AIDS reflected the fears, prejudices and concerns of broader society as well as being a conduit for difficult conversations and more positive, accurate information (Bellew 2006).

**Summary**

Innovation in strategy and methods has been a constant over the decades since 1980.

Several civil society groups were established in the 1980s-1990s to provide advocacy and support for people living with HIV/AIDS and were quickly seen by government as a practical conduit for health promotion and prevention messaging, care and treatment programs.

As government funding for HIV/AIDS education has decreased, so have public education campaigns declined in their reach across sub-populations.

If public education campaigns lose their effectiveness in promoting safer sex practices for target groups, people with a propensity for risk-taking behaviours are at risk of infection.

Researchers and activists have noticed HIV fatigue and increasing rejection of safer sex practices among older gay men (Bellew 2006).

National surveillance systems, funded by the Commonwealth, have been critical for providing direction to research funding and program resources.

Strong partnerships between government, NGOs, researchers and consumers has also been critical in containing HIV/AIDS in Australia.

The HIV/AIDS effort has a clarity of purpose, engaged in disruptive change, and used multiple concurrent strategies to achieve targets.

**Resistance**

Many issues related to HIV/AIDS have been difficult for the Australian population because they raised controversial social questions about sexuality and human rights that had not previously been openly discussed.

Pockets of resistance to HIV/AIDS campaigns and funding for various strategies was apparent in the 1980s but were swiftly addressed by strategically prepared joint responses from government with civil society organisations.

Long-term thinking is a key to success in reaching targets and in the constant research necessary to refine prevention messaging and the effectiveness of programs.


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