



**2010 - 2015**

**AIDS COUNCIL OF SOUTH AUSTRALIA  
STRATEGIC PLAN**

**ACSA acknowledges the traditional owners of country throughout South Australia, their diversity, histories and knowledge and their continuing connections to land and community. We pay our respect to all Australian Aboriginal peoples and their cultures, and to elders of past, present and future generations.**

ISBN 978-0-9808084-4-5

Darling House  
64 Fullarton Road  
Norwood, SA 5067  
Reception: (08) 8334 1611  
Toll Free: 1800 888 559  
Facsimilie: (08) 8363 1046  
Email: [information@acsa.org.au](mailto:information@acsa.org.au)  
Website: [www.acsa.org.au](http://www.acsa.org.au)

© AIDS Council of South Australia (ACSA), 2010

This publication is copyright. Apart from fair dealing for the purpose of private study, research, criticism or review, as permitted under the Copyright Act, no part may be reproduced by any process without written permission. Enquiries regarding this publication should be addressed to the Chief Executive Officer, AIDS Council of South Australia.



# CONTENTS

5	Introduction
7	About ACSA
8	Our clients and communities
21	Our strategic directions
27	Objectives and key performance indicators
31	Acronyms





# President's Message

As we begin our 25th year, it is appropriate that we do so with a revitalized vision, full of enthusiasm and energy, and it is with this in mind that the Directors of the Board present the Strategic Plan 2010 - 2015. In developing the plan the Board took close guidance from the Ottawa Health Charter. The Charter lists five action areas for health promotion, these are, building a healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorientating health care services toward prevention of illness and promotion of health. ACSA is proud of its history in achieving many of the objectives of the Charter and the Board is confident that the Strategic Plan 2010 – 2015 has set an ambitious but achievable plan to ensure that ACSA continues to affirm its commitment to the communities we serve.

The years have seen ACSA grow from an agency with a mainly volunteer workforce to one where much of the work is done by professionals. However, the initial peer-based focus remains integral to the work of the organization. Members of the GLBT, HIV positive, injecting drug use and sex worker communities serve in both volunteer and professional capacities at all levels of the agency. The new Strategic Plan, as well as setting out the five broad key result areas to be achieved, also gives specific and measurable objectives from which key performance indicators have been drawn, giving both paid and unpaid staff a clear direction. In addition to directing the agency, the Plan gives our communities of interest and other stakeholders a means by which to assess our accomplishments and/or failures.

There is no doubt that as a society Australia has become entrenched in the digital era. The need for ACSA to develop its uses of digital technology is self-evident, particularly if we are to reach members of our younger demographic. The task may appear daunting to some of us; however, the potential of the new technology is breath-taking and hence it is strongly reflected in the Strategic Plan. This, to me, is a particularly exciting aspect of the Plan and I am confident that this is where we will find many of the answers to the challenges we have faced and are yet to face in the future.

There have been significant contributions from staff members, volunteers and other community members over the past twelve months in the development of the Plan. I would like to take this opportunity to thank everyone for their contributions.

The Strategic Plan 2010 – 2015 is an exciting plan for the next five years; now it remains for us to take it to our hearts and really make it work. I commend the plan to you.

**Erik Michielsen**  
**President**



# About ACSA

2010 marks the beginning of the 25th year of ACSA. Our early response to HIV/AIDS was marked by community mobilisation and is very different from the type of work we do today. The one enduring feature of our organisation is that we remain firmly grounded in the communities we serve and represent.

The response to HIV/AIDS in South Australia was initiated by people from the gay community several years before there were any known cases of HIV/AIDS in the state. Acting on reports from overseas and interstate of a new disease affecting gay men, the community was quick to take action with the formation of the SA AIDS Action Committee (SAAAC) in 1983. Made up of existing gay community groups as well as the Venereal Diseases Control Clinic, they acted as a sub-committee of the Gay Community Centre. SAAAC produced safe sex information resources, held education sessions and promoted the use of condoms by gay men.

By 1986 the SA AIDS Action Committee had reformed as the AIDS Council of South Australia Inc (ACSA), and received funding to take over the running of Carrington 130, a centre opened by the Gay Counselling Service in 1985, which provided HIV/AIDS education sessions to the gay community. ACSA and the Gay Counselling Service (now Gay and Lesbian Community Services) shared the building, and a number of joint projects begun at this time, such as the community library and referral database, continue to this day.

In addressing such a wide range of HIV-related issues, ACSA drew on close working relationships with related community organisations such as SA Voice for IV Education (SAVIVE), the Prostitutes Association of South Australia (PASA), the Gay & Lesbian Counselling Service and the Bobby Goldsmith Foundation.

In 1994 PLWHA (SA) formed and ACSA altered its constitution to provide a dedicated Board position for a PLWHA (SA) representative. Two years later PLWHA (SA) opened a new Positive Living Centre, and ACSA handed over many of the services for positive people and re-focused most of its attention on HIV/AIDS education and prevention.

Today those most affected by HIV/AIDS remain integral to the work of the Council, and this is reflected at all levels across the organisation. More of the work of the Council is performed by paid staff now than at its inception, but the organisation remains steadfastly peer-based. Members of the GLBT, HIV positive, injecting drug use and sex worker communities serve as volunteers, staff, management, Board Members and Program Committee members.



# Our clients and communities

The determinants of health inequities for our communities are largely outside the health system, and relate to the inequitable distribution of social, economic and cultural resources and opportunities. The communities that ACSA serve have traditionally experienced both a long history of social and economic exclusion, and therefore poorer health outcomes: this is the socio-economic gradient in health.

Health inequities are the result of the interaction of a range of environmental factors. These include: politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors.

In pursuit of social justice, we direct our resources primarily towards bridging the health socio-economic gradient.

# MSM:

a recognisable acronym for men who have sex with men but do not identify as gay

## Gay men/MSM

With a low prevalence rate for HIV in South Australia, gay men can be proud of what has been achieved in the last 25 years, as can the workers and volunteers who have assisted them in this journey.

Prior to 1985, with no confirmed South Australian AIDS cases, the extent of the local epidemic remained unclear. However it was devastatingly highlighted later that year with the introduction of the new HIV antibody test. The urgent need to continue prevention work to educate gay men as to how to protect themselves from contracting HIV formed the basis of the Gay Men's Health Program.

Early prevention practices were largely peer volunteer driven and set out to mobilise the gay community to take ownership of this issue, and to ensure the response was comprehensive. As it became apparent that changing individual behavioural patterns to include safe sex norms would be a long and difficult transition for many, the importance of keeping gay men central to this effort was a defining characteristic of the times, and is a crucial strategy that persists to this day.

Whilst it remains true that condom use is still the best protection against HIV, those early messages needed clarification to take into account the real life choices and risks men continued to take in the late 80's, the early 90's and today. As notions of negotiated safety, sero-sorting and other HIV risk reduction techniques emerged, gay men's education had to become increasingly sophisticated. Gay Men's education today has retained many of its essential characteristics and continues to retain a large peer element, but has also seen increasing numbers of peer-based health professionals join the sector. The strategic approach to HIV prevention amongst gay men has evolved to include internet-based education, national prevention campaigns, a greater appreciation of the diversity within the community and a more holistic understanding of gay men's health and well-being needs.

While HIV remains a threat to our collective well-being and more always needs to be done, ACSA can make sure we do this by keeping gay men in South Australia central to the management of the issues that affect their lives.



# PLHIV

Life for people living with HIV has changed since the first SA person was diagnosed with HIV 25 years ago. In the beginning there was no treatment, only care and support until inevitable death. The first treatments bought hope but extremely debilitating side effects. The advent of highly active anti-retroviral therapy (HAART) in 1996 changed the face of treatment and provided hope for the future, but not without its costs. Complicated medical compliance regimes meant that many people's lives were totally consumed by heavy treatment burdens. Longer term health impacts of HAART are now becoming more obvious: organ diseases, diabetes and facial wasting, to name a few. The natural ageing process brings with it conditions such as cardiovascular disease and cancers: people with HIV are at increased risk of these conditions, and experience them earlier in life than the rest of the population. These impacts are as significant as the social and economic costs that accompany living with HIV for many diagnosed prior to HAART. Many had to leave the workforce, reduce their career goals and have had difficulty in re-engaging in employment and training. Only around half of HIV positive people are in employment, with the rest on benefits or retired: many are living in poverty.

On a more positive note, few people with HIV will progress to, or die from, an AIDS-related illness. Someone diagnosed with HIV in 2010 will most likely be able to stay in the workforce longer than they would have in the past, and they will have a close to average life expectancy. Treatments are becoming less intrusive on people's lives. Whatever age or stage of HIV, people will have to continue to deal with emotional and mental turmoil, intractable stigma and discrimination, and potential criminalisation issues.

Health services such as ACSA are faced with new challenges in our ability to suitably respond to the unique and complex needs of all people living with HIV: wherever they are in the spectrum from newly diagnosed to living with HIV/AIDS long term. ACSA aims to position ourselves to meet these challenges.

# Sex workers

Before HIV, condoms in the sex industry were considered an optional extra, used mainly for birth control and to satisfy 'fussy' customers. At this time the sexual health regime for sex workers was to conduct visual sexual health checks on clients and get tested very often (every two weeks). STI's were considered an occupational hazard and STI's were very high among sex workers.

At the beginning of the HIV epidemic sex workers feared for their lives. They believed that it was just a matter of time before they would catch the dreaded disease and face certain death. They watched those sex workers among us who were HIV positive become vilified and locked up to 'protect the public'. Many workers got educated and started using and talking about condoms. Getting condoms into businesses was difficult: they were underground, often masked as visiting or massage services. They did not openly admit to providing sexual services, let alone allow condoms on premises or even STI information that could indicate that illegal activities were occurring. At the same time, sex workers were engaging in informal peer education. In work rooms all around the state, sex workers were talking about HIV, condoms and how to convince, trick, educate or coerce condoms onto clients. Sex workers became a major source of information on sexual health and eroticizing safe sex to large numbers of men - not the transmission of HIV as had been predicted. By 1987 there had been a complete turn around with condoms for all forms of intercourse, including oral, becoming part of the normal sex industry culture. The Sex Industry Network (SIN) began as the Prostitutes Association and was formed as a response to the police harassment of sex workers, but in 1989 received a small amount of funding and partnered with ACSA to begin delivering outreach peer education services to sex workers.

Sex work is still criminalised and condoms are used as evidence of criminal behaviour in South Australia. We are still working with businesses that are not able to be open about the sexual nature of their work and so deny their workers access to information and resources. We are still working in a highly stigmatised industry where sex workers often only identify as sex workers when they are at work : they are not able to openly discuss their sexual practices with their GP's, health practitioners, friends, family and often even their partners. There are the added stresses of the internet, mobile phones and a transient workforce that makes it possible for people to engage in sex work in very isolated ways. Sub communities of sex workers with specialised needs have emerged.

While rates of HIV remain extremely low in the Australian sex industry, it has the potential to change if efforts are reduced. Sex workers have a lot of sex with many different people, and with a highly transient, hidden and stigmatised community we must remain vigilant and contemporary in our approach to HIV prevention.

# People who inject drugs

Prevalence of HIV among injecting drug users in SA is very low, and the injecting drug user program of ACSA, established 21 years ago, can take credit for this. It was clear then that the most effective way to reduce the spread of HIV amongst injectors was to provide clean needles in conjunction with HIV education. ACSA was provided with funding to establish both a mobile and fixed site service to distribute clean needles and condoms to users. The success of this program, to be called South Australian Voice for Intravenous Education (SAVIVE), was based on the employment of peers. If users were going to trust the program and find credibility in the information provided, then the people providing the information and giving out the needles needed to be users too.

In the early years, the focus was on getting the word out to the injecting community that they could access clean needles from SAVIVE. For a community that had never been provided with accurate information on injecting before, health promotion messages were short and to the point: i.e. New Fit, Every Hit (No Shit).

SAVIVE has grown to keep pace with the needs of the injecting community and the growing number of clients. Needle and Syringe Programs and Peer Education projects like SAVIVE have been proven to reduce the spread of blood borne viruses. This resulted in an Australia-wide policy of harm reduction in relation to injecting drug use. Health promotion messages and education have become more sophisticated in response to hepatitis C (HCV), which is more prevalent amongst injectors than HIV. We now know that practicing safer injecting goes beyond using a clean syringe and that to reduce the risk of HCV, people need to use all of their own equipment, not just a new fit. SAVIVE now provides a much wider range of injecting equipment than the 1ml syringes provided in the early days.

SAVIVE continues to raise awareness of users' issues in order to reduce discrimination and stigma associated with injecting, break down some of the barriers to accessing services and improve the overall health and wellbeing of users.

# GLBT people

It's not so long ago that being homosexual was considered a mental illness, and we know that this has contributed to health related disparities amongst GLBT people as compared to the rest of the population. Studies have shown that negative social, institutional, familial, political, cultural and religious norms are detrimental to the development of social connectedness and of positive experiences of health and wellbeing.

While the research is clear, the policy response in South Australia has so far been inadequate in both recognising and addressing these health disparities. Currently, South Australia has no specific policy, plan or consultative mechanism to address health inequities for GLBT people; nor are these populations cited within other more encompassing health policies that include references to addressing health inequities within other disadvantaged populations.

The absence of references to health inequities within GLBT populations renders these groups invisible to policy and decision makers. ACSA commits to working with allied GLBT organisations and policy makers to remedy this.

## **GLBT:**

a recognisable acronym to collectively refer to a group of identities that includes gay, lesbian, bisexual, intersex and trans/transgender people and other sexuality, sex and gender diverse people, regardless of their term of self-identification

## Aboriginal People

Prevalence of HIV among Aboriginal people is similar to prevalence among non-Aboriginal people. However, Aboriginal people have much higher rates of STI's generally, particularly chlamydia, syphilis and gonorrhoea, which act as cofactors in HIV transmission. The pattern of infections among Aboriginal people significantly differs, and thus requires a more tailored response. A higher proportion of infections has been attributed to heterosexual contact and injecting drug use, although gay men and men who have sex with men still account for over 50% of Aboriginal people diagnosed with HIV. Health promotion and harm reduction services can be difficult for Aboriginal people to access.

ACSA commits to accessible, culturally appropriate prevention and support services through our diversity strategy.

## People from culturally and linguistically diverse (CALD) backgrounds

People from CALD backgrounds have emerged as a population experiencing disproportionate risk of contracting HIV, and at being at higher risk of late HIV presentation and of associated poorer health outcomes. Prevention needs of different communities are complex.

These people include those coming to Australia to live permanently, those on temporary work visas, and international students. As our work with communities becomes broader, we must similarly broaden our commitment to working with people from CALD backgrounds.

In the plan we commit to developing a community diversity strategy: we will ensure our own services are accessible and culturally appropriate, whilst advocating that policy makers, health promotion practitioners and other HIV education agencies need to develop culturally appropriate resources to assist in the prevention of HIV transmission.

## Women

Globally, HIV/AIDS is the leading cause of death among women of reproductive age. In South Australia, women account for a relatively low percentage of people living with HIV: of the 130 women diagnosed with HIV in SA between 1985 and 2009, 32 reported injecting drug use and 78 reported heterosexual transmission. Women face particular challenges in dealing with HIV — they may experience different illnesses and treatment side effects, for example; and women who become pregnant must take special precautions to prevent transmission of HIV to their children.

ACSA will ensure that the voices of positive women are heard and valued through our diversity strategy.

## Young people

Prevention education and health promotion for young people within ACSA's communities are managed across the Government and non Government sector in South Australia. While ACSA has not had specific youth programs, we do deal with many young people coming to us for support and advocacy. As it is becoming increasingly difficult to get sexual health messages through to young people, we will ensure we use the right tools to help inform young people about HIV/STI prevention, as well as enabling young people to participate at all levels in the organisation through our diversity strategy.

## South Australian travellers

South Australian residents who acquire HIV while travelling or working in countries with a high prevalence of HIV are an emerging population for HIV prevention. In the five years 2005-2009, overseas heterosexually acquired HIV accounted for more than 15% of new cases. Little research or data is available about these populations, their behaviours or service needs.

ACSA will advocate for research to better inform prevention planning with this population.

In correctional environments, there are often systemic and other barriers to best practice blood borne virus prevention. Although the prevalence of HIV among people in custodial settings remains relatively low, the potential exists for it to increase. Incarceration in South Australia is escalating, and our already overextended criminal justice system is beginning to shudder under the weight of prison overcrowding and the skyrocketing costs of over-incarceration and longer sentences. The incidence of HIV in prisons is a contentious one. It is generally recognised that the prison environment has all the ingredients for the spread of HIV due to sexual activity, sexual assault, drug injecting, overcrowding and high stress.

ACSA advocates for an evidence based harm reduction approach to custodial populations, including opioid maintenance programs and access to safe sex and safe injecting equipment.

## People in custodial settings

## **We take a social view of health**

**“Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity<sup>1</sup>.”**

## **Prerequisites for Health**

The prerequisites for health are:

- peace
- shelter
- education
- food
- income
- a stable eco-system
- sustainable resources
- social justice and equity

## **Definition of Health Promotion**

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

1 Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no. 2, p. 100) and entered into force on 7 April 1948.

# AIDS COUNCIL OF SA STRATEGIC PLAN

## 2010 - 2015

### **Our vision**

Equity, health and human rights

### **Our purpose**

To improve the quality of life of our clients and our communities.

To reduce the transmission of HIV and supporting the growth of strong, resilient and healthy GLBT people, HIV positive people, people who inject drugs and sex workers.

### **Our commitment**

We will

- advocate and campaign — individually and systemically in pursuit of our vision
- engage community and help build capacity
- educate and raise awareness
- deliver holistic health promotion activities
- analyse and develop public policy
- undertake research that is informed by our lived experiences

We are committed to the principles and practice of peer education in all of our work.

### **Our work**

Following the action areas of the Ottawa Charter for health promotion, we

- Advocate for the provision of services that improve the health outcomes, opportunities and quality of life of our communities.
- Conduct and disseminate research into issues of importance to our communities.
- Encourage and facilitate meaningful engagement and representation in ACSA's activities.
- Plan, develop, deliver and coordinate a range of services in response to changing needs.
- Promote empowering health-promotion messages.
- Raise awareness in the relevant professions, and the wider community, of the health and well-being needs of our communities.
- Represent issues of concern and provide policy advice at local, state and national levels.
- Work in strategic partnerships to achieve common objectives.

# Our Beliefs and Values

## Community

strengthening our community

## Confidentiality

respect for the privacy and dignity of the individual

## Courage

to challenge discrimination and injustice

## Affinity

for those we work with and for

## Integrity

acting in the best interests of our communities

## Partnership

working with allied organisations, governments and businesses to pursue common goals

## Peer based practice

valuing the privileged position of peers in developing and delivering programs and services

## Positive health promotion

guided by the Ottawa Health Charter

## Self determination

encouraging our communities to speak for themselves and to participate at all levels in the organisation



The first International Conference on Health Promotion, meeting in Ottawa on the 21st of November 1986, developed a Charter for action to achieve Health for All by the year 2000 and beyond. This Charter continues to guide much of ACSA's work.

## The Ottawa Charter for Health Promotion

### Action Areas

The Charter provides **five action areas** for health promotion, these are:

**1. Building healthy public policy:** health promotion policy combines diverse but complementary approaches, including legislation, fiscal measures, taxation and organisational change. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and the development of ways to remove them.

**2. Creating supportive environments:** protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy. Work, leisure and living environments should be a source of health for people.

**3. Strengthening community action:** community development draws on existing human and material resources to enhance self-help and social support, and to develop flexible systems for strengthening public participation in, and direction of, health matters. This requires full and continuous access to information and learning opportunities for health, as well as funding support.

**4. Developing personal skills:** through information and education skills enabling people to learn (throughout life) to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings.

**5. Reorientating health care services toward prevention of illness and promotion of health:** the role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Reorientating health services also requires stronger attention to health research, as well as changes in professional education and training.

## **Our strategic directions**

Over the next five years, we will work towards the following key result areas

### **Key Result Area 1**

#### **Quality client and community services**

We will deliver services that are accessible, relevant and responsive to need.

### **Key Result Area 2**

#### **Community engagement and capacity building**

Our communities are engaged, motivated and empowered to make an active contribution to their health and wellbeing.

### **Key Result Area 3**

#### **Leadership, advocacy and representation**

We are a leading voice in South Australia in shaping and monitoring policies that are socially just, informed by peer experience, based on sound evidence and which represent best professional practice in supporting our communities.

### **Key Result Area 4**

#### **Workforce development**

We have a motivated and skilled workforce, committed to best practice and responsive to changing needs.

### **Key Result Area 5**

#### **Organisational sustainability and innovation**

We are well governed, managed and resourced, capable of delivering our key result areas and of meeting new challenges.

## **Key Result Area 1**

### **Quality client and community services**

We deliver services that are accessible, relevant and responsive to need.

#### **Priority Actions**

- Develop and implement transparent systems for agreeing on priorities and allocating resources.
- Develop and implement strategies to ensure service access and equity.
- Implement regular consultation with our communities to ensure that our services are relevant and responsive to emergent needs.
- Develop a coordinated approach to service planning and delivery to maximise effectiveness and efficiency.
- Continuously monitor and evaluate service effectiveness and quality, including service user feedback.

#### **Objectives**

- 1.1 Increase individual support services to clients in our communities
- 1.2 Reduce the rate of unsafe sex among gay men and msm
- 1.3 Increase the number of people in our communities who know their HIV, STI and other BBV status
- 1.4 Reduce the physical, social and cultural factors which have a negative impact on our communities' health and wellbeing
- 1.5 Reduce rates of HIV and STIs among gay men and sex workers
- 1.6 Reduce the rate of BBVs among people who inject drugs
- 1.7 Increase the capacity of people living with HIV to maintain good health and to prevent onward HIV transmission

## Key Result Area 2 Community Engagement and Capacity Building

Our communities are engaged, motivated and empowered to make an active contribution to their health and wellbeing.

### Priority Actions

- Create opportunities for recruitment and active involvement of our communities in ACSA's structures.
- Develop and implement peer based approaches.
- Develop and implement a strategy for community engagement, and capacity building with our communities.
- Build partnerships and collaborative relationships with stakeholders in the wider community.

### Objectives

- 2.1 Increase the number of community members accessing our services and participating in our structures
- 2.2 Increase the representation of new and diverse populations of our communities: lesbian, transgender and HIV positive people, Aboriginal and Torres Strait Islander people, younger and older people and people from CALD backgrounds
- 2.3 Increase community confidence in our ability to deliver our services
- 2.4 Increase the number of community partnership agreements
- 2.5 Increase our use of new and emerging technologies for health promotion
- 2.6 Increase general community awareness of HIV, STIs and other BBVs

## **Key Result Area 3**

### **Leadership Advocacy and Representation**

We are a leading voice in South Australia in shaping and monitoring policies that are socially just, informed by peer experience, based on sound evidence and which represent best professional practice in supporting our communities.

#### **Priority Actions**

- Develop skills and capacities internally for effective leadership and advocacy externally
- Build collaborative, wide-ranging and strategic relationships with key allies in the sector and in government
- Strengthen partnerships with academic and research-based organisations
- Develop a pro-active media profile on agreed priority issues
- Establish ways of giving voice to our communities
- Advocate for research and policies that serve the interests of our communities

#### **Objectives**

3.1	Enhance ACSA's position as an advocate for our communities in seeking equity in health and human rights
3.2	Remove sex work from illegal occupations in SA
3.3	Increase the visibility of LGBT health policies
3.4	Increase social inclusion for our communities
3.5	Increase the number of strategic alliances and effective collaborations across the broader health, social services and business sectors
3.6	Strengthen and play a unifying role in the BBV, GLBT, sex work and injecting drug use sectors
3.7	Improve our engagement with research

## **Key Result Area 4 Workforce development**

We have a motivated and skilled workforce, committed to best practice and responsive to changing needs. We are well governed, managed and resourced, capable of delivering our key result areas and of meeting new challenges.

### **Priority Actions**

- Provide professional development opportunities for staff and volunteers
- Develop a work culture that values and supports the contribution of staff and volunteers
- Build staff and volunteer capacity to respond effectively and innovatively to changes in our communities
- Develop and implement recruitment pathways within our communities

### **Objectives**

- 4.1 Enhance our commitment to peer based programming
- 4.2 Increase the number of staff with formal qualifications
- 4.3 Increase the recruitment and retention of volunteers
- 4.4 Enhance ACSA as an employer of choice

## **Key Result Area 5 - Organisational sustainability and innovation**

We are well governed, managed and resourced, capable of delivering our key result areas and of meeting new challenges.

### **Priority Actions**

- Implement the Board Development Plan
- Design and implement a Board review process for strategic planning
- Develop a Quality Action Plan for achievement of an appropriate accredited quality system
- Develop a Future Options Plan in light of key policy and funding shifts in the sector
- Develop a Financial Strategy for a diversified income base
- Explore strategies for increasing autonomy and independent activity

### **Objectives**

- 5.1 Increase our independence in funding and resourcing
- 5.2 Ensure ACSA's structures and premises meet the changing nature of our clients' and communities' needs and expectations
- 5.3 Enhance our commitment to quality services
- 5.4 Reduce our carbon footprint

## Key Performance Indicators

### Key result area 1 -Expanding Quality Client and Community Services

We deliver services that are accessible, relevant and responsive to need

Objectives	Key Performance Indicators
1.1 Increase individual support services to clients in our communities	<ul style="list-style-type: none"> <li>• Development of a comprehensive intake, assessment and referral process for all individual clients accessing services</li> </ul>
1.2 Reduce the rate of unsafe sex among gay men and msm <ul style="list-style-type: none"> <li>• Enhance the normalization of condom usage</li> <li>• Promote a culture of sexual care between gay men/msm</li> <li>• Enhance understanding of HIV and STI transmission</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease in rates of unsafe sex as reported by gay men/msm</li> </ul>
1.3 Increase the number of people in our communities who know their HIV, STI and other BBV status <ul style="list-style-type: none"> <li>• Improve access to testing, including community testing locations</li> <li>• Advocate for the rollout of rapid HIV and STI testing</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in the number of our community members who have had a comprehensive sexual health and BBV check in the previous 12 months</li> </ul>
1.4 Reduce the physical, social and cultural factors which have a negative impact on our communities' health and wellbeing <ul style="list-style-type: none"> <li>• Support our communities to adopt safe behaviors through adult and community education, peer support and counseling</li> <li>• Increase knowledge of risk reduction strategies</li> <li>• Design targeted programs and services that address the social determinants of health, such as income, housing, employment and education</li> <li>• Design targeted programs that increase knowledge skills and the ability to detect, manage and provide support to others dealing with mental health issues</li> </ul>	<ul style="list-style-type: none"> <li>• A reduction in the number of people in our communities who report key indicators such as mental health issues, unstable housing, violence or alcohol other drug use</li> <li>• An increase in wellbeing for our communities</li> <li>• An increase in the number of community members accessing our services</li> <li>• Identification and prioritization of addressing the social determinants of health that have a negative impact on safe behaviours, and of the acquisition of new risk reduction knowledge</li> <li>• Number of targeted advocacy and consumer orientated activities that increase our communities' ability to adopt safe behaviours and more comprehensive risk reduction strategies</li> </ul>
1.5 Reduced rates of HIV and STI's among gay men and sex workers <ul style="list-style-type: none"> <li>• Increase knowledge of relationship between HIV and STI's</li> <li>• Reduce syphilis infection and reinfection, especially among HIV positive gay men</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease in HIV and STI notifications</li> <li>• Decrease in syphilis co-infection in positive gay men</li> </ul>
1.6 Reduce the rate of BBVs among people who inject drugs <ul style="list-style-type: none"> <li>• Continue to improve the access and availability of our clean needle programs, so that people who inject drugs view us as a trusted source of information, support and referral</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease in BBV notifications among PWID</li> </ul>
1.7 Increase the capacity of people living with HIV to maintain good health and to prevent onward HIV transmission <ul style="list-style-type: none"> <li>• Enhance access to Red Ribbon Bobby Goldsmith Fund</li> <li>• Deliver programs that improve the capacity of HIV positive people to connect, and remain connected to, social and community supports</li> </ul>	<ul style="list-style-type: none"> <li>• An increase in knowledge of healthy lifestyles (smoking, nutrition, exercise) and of HIV prevention</li> <li>• An increase in the number of HIV positive people in contact with community services</li> </ul>

## Key result area 2 Community engagement and capacity building

Our communities are engaged, motivated and empowered to make an active contribution to their health and wellbeing

Objectives	Key Performance Indicators
2.1 Increase the number of community members accessing our programs and services, and participating in our structures	<ul style="list-style-type: none"> <li>• Development and implementation of the ACSA Client Service Commitment</li> <li>• Comprehensive consumer and volunteer engagement strategies implemented as part of ACSA's Community Engagement Strategy</li> </ul>
2.2 Increase the representation of new and diverse populations of our communities: lesbian, transgender, HIV positive people, Aboriginal and Torres Strait Islander people, younger and older people and people from CALD backgrounds	<ul style="list-style-type: none"> <li>• Community diversity strategy developed and implemented</li> <li>• Increased recruitment and representation of new and diverse populations on all relevant consumer and program planning working groups</li> </ul>
2.3 Increase community confidence in our ability to deliver our services	<ul style="list-style-type: none"> <li>• Establishment of community confidence measures and mechanisms to continuously monitor increased confidence levels</li> </ul>
2.4 Increase the number of community partnership agreements	<ul style="list-style-type: none"> <li>• 100% increase in the number of community partnership agreements</li> </ul>
2.5 Increase our use of new and emerging technologies for health promotion	<ul style="list-style-type: none"> <li>• Digital engagement strategy written and implemented</li> <li>• Development of a central website register of GLBT community groups and ongoing maintenance of this register</li> </ul>
2.6 Increase general community awareness of HIV, STIs and other BBVs <ul style="list-style-type: none"> <li>• Increase the profile of AIDS Awareness Week</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of a AAW rural awareness program for rural populations.</li> </ul>

### Key result area 3 Leadership, advocacy and representation

We are a leading voice in South Australia in shaping and monitoring policies that are socially just, informed by peer experience, based on sound evidence and represent best professional practice in supporting our communities

Objectives	Key Performance Indicators
3.1 Enhance ACSA's position as an advocate for our communities in seeking equity in health and human rights	<ul style="list-style-type: none"> <li>• Participation in relevant advocacy organisations – AFAO, NAPWA, SACOSS</li> <li>• Number of campaigns delivered related to identified advocacy issues: in particular, stigma reduction programs and services</li> </ul>
3.2 Remove sex work from illegal occupations in SA	<ul style="list-style-type: none"> <li>• Develop and implement the sex work law reform strategy</li> </ul>
3.3 Increase the visibility of LGBT health policies	<ul style="list-style-type: none"> <li>• An SA GLBT Health and Wellbeing plan is developed and implemented</li> </ul>
3.4 Increase social inclusion for our communities	<ul style="list-style-type: none"> <li>• Develop and implement the ACSA communities ageing strategy, diversity strategy</li> </ul>
3.5 Increase the number of strategic alliances and effective collaborations across the broader health, social services and business sectors	<ul style="list-style-type: none"> <li>• Identification of key Interagency Forums in SA and participation in relevant forums</li> </ul>
3.6 Strengthen and play a unifying role in the BBV, GLBT, sex work and injecting drug use sectors	<ul style="list-style-type: none"> <li>• Further enhance the role of the HIV Interagency Taskforce to coordinate strategic actions across sector organisations</li> </ul>
3.7 Improve our engagement with research	<ul style="list-style-type: none"> <li>• Increase number of existing research collaborations with HIV National Centres</li> <li>• Number of publication summaries of relevant Australian major research reports issued</li> <li>• Number of local presentations of research findings</li> </ul>

## Key result area 4- Workforce Development

We have a motivated and skilled workforce, committed to best practice and responsive to changing needs

Objectives	Key Performance Indicators
4.1 Enhance our commitment to peer based programming	<ul style="list-style-type: none"> <li>Increased number of peer identified staff and volunteer positions within ACSA</li> <li>Increased number of staff completing accredited training in peer service delivery</li> </ul>
4.2 Increase the number of staff with formal qualifications	<ul style="list-style-type: none"> <li>Staff professional development plan designed and implemented with increased number of staff attending and completing further education</li> </ul>
4.3 Increase the recruitment and retention of volunteers	<ul style="list-style-type: none"> <li>Volunteer engagement and retention strategy developed and implemented as part of ACSA Community Engagement Strategy</li> </ul>
4.4 Enhance ACSA as an employer of choice	<ul style="list-style-type: none"> <li>Negotiate and finalise a new enterprise agreement</li> </ul>

## Key result area 5- Organisational sustainability and innovation

We are well governed, managed and resourced, capable of achieving our key result areas and of meeting new challenges

Objectives	Key Performance Indicators
5.1 Increase our independence in funding and resourcing	<ul style="list-style-type: none"> <li>Increase non Government funding to 20% of income</li> </ul>
5.2 Ensure ACSA's structures and premises meet the changing nature of our communities needs and expectations	<ul style="list-style-type: none"> <li>Review constitution and organisational governance structure</li> <li>Secure long term accommodation</li> </ul>
5.3 Enhance our commitment to quality services	<ul style="list-style-type: none"> <li>Achieve base level quality assurance accreditation</li> </ul>
5.4 Reduce our carbon footprint	<ul style="list-style-type: none"> <li>Develop and implement an organisational environment policy</li> </ul>

## Acronyms

<b>ACSA</b>	<b>The AIDS Council of SA</b>
<b>AFAO</b>	<b>Australian Federation of AIDS Organisations</b>
<b>AIDS</b>	<b>Acquired Immune Deficiency Syndrome</b>
<b>BBV</b>	<b>Blood Borne Virus</b>
<b>GLBT</b>	<b>Includes Gay, Lesbian, Bisexual, Trans/ Transgender.</b>
<b>HCV</b>	<b>Hepatitis C Virus</b>
<b>HIV</b>	<b>Human Immunodeficiency Virus</b>
<b>MSM</b>	<b>Men Who Have Sex With Men</b>
<b>PLHIV</b>	<b>People/Person Living With Hiv</b>
<b>PLWHA</b>	<b>People/Person Living With HIV/AIDS</b>
<b>PLWHA-SA</b>	<b>People Living with HIV/AIDS - SA</b>
<b>PWID</b>	<b>People/Person Who Injects Drugs</b>
<b>SACOSS</b>	<b>SA Council of Social Service</b>
<b>SAVIVE</b>	<b>SA Voice for Intravenous Education</b>
<b>STI</b>	<b>Sexually Transmitted Infection</b>

