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The decades since 1986 have seen this organisation mature into an international institute in infection and immunity. The Kirby Institute will play a crucial part in advancing and attaining the SDGs. Brilliant science and outstanding social policy will chart the way.

The past 30 years have seen great progress. But the best achievements lie ahead.

When HIV is controlled and the new treatments for hepatitis C have turned around the epidemic in Australia, there will still remain many diseases to engage the Institute.
Together we overhauled clinical trials regulation in Australia, and access to unapproved drugs.

David Cooper

The crucial collaborations: Together we are strong

Every segment of the population has been affected by thirty years of HIV infection, but some have borne a far greater share than others. The gay community, haemophiliacs, sex workers and people who inject drugs were the first notable groups to suffer the shocking emergence of HIV in Australia in the mid-1980s. Later, other groups such as rural and regional communities, with little exposure to the education campaigns and limited access to testing and related health care, were also affected. Over time, the Kirby Institute (then the National Centre in HIV Epidemiology and Clinical Research) collaborated with all these groups and with many research groups internationally, but none was as important and crucial to good research outcomes as the links with Australia’s gay communities.

A number of people at the Kirby Institute participated in the earliest days of forging links with the community. David Cooper, Garret Prestage and Basil Donovan all recall the start of the co-operation and respect between medical researchers and community. The first ten years of the epidemic were the most difficult, with the constant spectre of illness and death in the absence of effective treatments. The turning point, which wasn’t much, and why they needed, no, why we needed, to set up a cohort study. That study was eventually called SAPS, the Sydney AIDS Perspective Study, and was one of the most influential early studies internationally in the response to HIV.

“It led soon after to the setting up of the National Centre in HIV Epidemiology and Clinical Research, now the Kirby Institute, under David’s leadership from the beginning. So, the Kirby’s very foundation was based in a direct and strong relationship between researchers and community.”

“The support of the community, we developed mechanisms to allow expanded access.” Cooper said. “Together we overhauled clinical trials regulation in Australia, and access to unapproved drugs.” Cooper nominated Bill Whittaker, the first executive director of ACON, and Peter McDonald as two centrally important figures of that period. McDonald was chairman, and Peter McDonald as two centrally important figures of that period. McDonald was chairman, and Whittaker a member, of the review task force which recommended sweeping changes to the clinical trials approval in Australia.

Cooper also pointed to the extensive network of committees and working groups established through the 1980s and 1990s as giving the community a strong voice. “There was an evolution in the community responses over the years,” he said. “The dread and understandable frustration, the angry activism of ACT UP, segued into more constructive ways of working together.

“Reforming the clinical trials mechanisms and the special access for drugs really heralded a true co-operation where the community input was both valuable and welcome. That was clearly demonstrated in getting improved protocols and better research process.”

The role of the National Centre, and particularly Cooper, in the international research effort that led to HAART and its announcement in 1996, is sometimes overlooked in the long list of the National Centre’s achievements.

“The impact this had on the gay community, especially in Sydney, was utterly fundamental,” Prestage said. “A community that was unendingly traumatised by constant illness and death, and its apparent inevitability, was suddenly presented with new hope. People spoke of the Lazarus effect, but among gay men that was a very real thing.”

The Kirby’s partnerships with community have continued ever since. The most recent example is the launch of EPIC-NSW, an expanded PrEP study following 2015’s Prelude demonstration study at eight sites, at Mark Graham in 2016, EPIC (Expanded PrEP Implementation in Communities) combines rapid roll-out with population-level monitoring, with the largest of reaching 3700 high-risk men through sexual health-clinics and specialist GPs.

“This trial presents an exciting opportunity to dramatically reduce HIV diagnoses in New South Wales,” Cooper said. “New South Wales Health has committed crucial resources for this trial and insider together key partners. We’re looking to be working again with ACON, Positive Life NSW and AIVM, to this partnership approach that is the principal strength of this trial.”

Another important example is a new historic memorandum of understanding signed between the Kirby and Burnet Institute. The Australian Hepatitis C Elimination Program creates opportunities to undertake joint research, education, professional training and program design and evaluation. The collaboration provides for the two institutes to engage with Australian and international agencies for research and program funding with the ultimate aim of eliminating hepatitis C virus in Australia by 2030.

Together we are strong
Health is a fundamental human right. But it’s still not equally accessible to all.

It’s why for 30 years we’ve never stopped asking the tough questions, working in partnership with some of the world’s most marginalised and vulnerable communities.
The Kirby Institute’s armoury of weapons in the ongoing war against infectious diseases, blood-borne viruses and sexually transmissible infections is substantial.

From 1990, the National Centre entered a period of rapid expansion of its participation in clinical trials, both within Australia and in increasingly large international collaborations. After an outpouring of the Australian drug evaluation process, the clinical trials activity includes antiretroviral therapy, opportunistic infections, HIV-associated malignancies, immune- based therapies, vaccines and laboratory developments. The rate of research publications becomes greatly increased and the National Centre’s reputation and expertise continue to grow.

The Australian HIV Surveillance Report begins publication in 1990 and the following year the National Centre establishes collaborations with the Australian Red Cross Blood Transfusion service, with the Australian Defence Force, Departments of Corrections, and with services designed for people who inject drugs.

The years of work leading up to 1995 and 1996 brought about the most significant development in the search for an enduring treatment which could not just delay morbidity and mortality but might make the virus a manageable condition. Cooper told the International AIDS conference in 1996 that 1995 saw the demise of monotherapy and the ascendancy of combination therapy, but warned that in the absence of hard data, a rush to combination therapy held the “danger of patients getting anecdotal combinations”.

The large number of available or soon-to-be- available drugs meant that the years following 1996 saw large numbers of clinical trials testing a range of innovative drug combinations in many different situations. Protocols are now largely agreed on which drugs to prescribe and when they should be used.

Three decades on, the Kirby Institute’s armoury of weapons in the ongoing war against infectious diseases, blood-borne viruses and sexually transmissible infections is substantial. The many lessons from early HIV research, in particular the use of combination therapy, have been translated into many other disease fields, including viral hepatitis. Once HIV had evolved from a terminal diagnosis to a chronic manageable condition, the scope for the Kirby also broadened to wider issues.

The areas of expertise are comprehensive and are grouped into four fluid areas: clinical science including clinical trials; basic science, taking in the lab; epidemiology/public health, including long-running behavioural research, and national surveillance, producing vitally important data which in turn influences policy decisions, funding and research directions. Within each of these areas are a wide range of research topics, ranging from hepatitis C treatment and prevention to HIV-related cancers to pre-exposure prophylaxis to the ongoing work for a vaccine, which thirty years later still remains the Holy Grail of HIV research.
1983
The Sydney AIDS Study Group, formed by David Cooper and Julian Gold, begins the Sydney AIDS Prospective Study (SAPS), a prospective immune-epidemiological study of gay men, to determine the natural history of AIDS and its epidemiology in Australia. SAPS will go on to provide the largest body of prospectively collected data on sexual behaviour in gay men in Australia and will give rise to similar periodic studies in most capital cities of Australia, still underway thirty years later.

1985
David Cooper is lead author on a publication describing the acute retroviral syndrome of primary HIV-1 infection.

1986
Three research centres are established by the Australian Government in response to the emergence of HIV/AIDS. David Cooper is appointed the inaugural director of the centre in Sydney initially called the NHMRC Special Unit in AIDS Epidemiology and Clinical Research. The Special Unit conducts the first study of HIV prevalence among people who inject drugs and develops a technique to screen returned syringes for HIV antibodies.

1987
AZT becomes available for prescription in Australia. The Special Unit is charged with monitoring its usage and starts preparing to recruit 600 participants for a national study of open-label AZT.

1988
The Clinical Trials Unit published the first data on incidence of AIDS and the risk factors associated with the development of AIDS in the SAPS network.

1989
The first National HIV/AIDS Strategy is adopted and establishes a network of collaboration with health departments and other health organisations nationally. To reflect its expanded role under the Strategy, the NHMRC Special Unit is renamed the National Centre in HIV Epidemiology and Clinical Research (NCHECR). The NCHECR conducts the first national study of HIV prevalence in babies from 1988-1989 and finds no cases of HIV infection among 10,000 live births.

“We were all scared, and hungry for information, and for some sign that we could do something.” - Garret Prestage
Enrolments into SMASH (Sydney Men and Sexual Health) pass 1,000. 90% of the cohort agree to participate in the clinical arm of the study and are allocated among 236 medical practitioners. Of the 930 clinical participants, 212 are HIV positive. More than half of SMASH participants know someone who had died following AIDS in the previous six months.

1994

The Sydney Men and Sexual Health Study (SMASH) is established in collaboration with the National Centre in HIV Social Research and the AIDS Council of New South Wales (ACON).

1992

Using data from the National AIDS Registry, the first major analysis of AIDS incidence in Australia 1982-1992 is published. Cumulative HIV incidence to the end of 1993 is estimated at approximately 15,200. AIDS incidence is estimated to plateau at approximately 850 cases in 1995.

1993

The Delta study reports on the benefits of combination therapy. Survival of people who are treatment-naïve in Delta 1 is significantly better with combination therapy, with an estimated reduction in mortality of 38%. The evidence is now decisive that the use of at least two antiretroviral drugs in combination must now be the recommended treatment. David Cooper declares that 1995 marks a turning point in HIV clinical trials.

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1996

The Australian HIV Observational Database (AHOD) is established, starting in June, using a number of hospital and primary care sites nationally. It looks at treatment uptake and outcomes, and will provide information on patterns of use of ART.

1997

This is the fifth year of the SMASH (Sydney Men and Sexual Health) study. One of the most important findings in 1997 was a radical change among HIV-positive men in treatment use. Prior to 1996, SMASH data indicated decreasing levels of treatment use, but in the first half of 1996, news about the effectiveness of combination therapy was a rapid uptake.

1998

A report based on work by the Hepatitis C Projections Working Group is published, giving an alarming indication of the extent of Hepatitis C in Australia. By the end of 1997, there were an estimated 196,000 people living with HCV in Australia, with 11,000 new infections that year. In related work, a national hepatitis C surveillance strategy was developed to improve the national surveillance of HCV.

1999

The Australian National Council on AIDS (ANCA) convenes a Working Party on the Availability of HIV/AIDS Treatments, chaired by Peter McDonald. The final report in late 1998 leads to increased Commonwealth funding to expand the clinical trial infrastructure.

The Clinical Trials and Treatments Advisory Committee (CTTAC) is formed to advise the NCHECR management committee. It is a major collaboration between HIV specialists, clinical trials experts, general practitioners and community organisations.
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**2000s**

2000
This year’s surveillance report showed, for the first time in a decade, an increase in survival following an AIDS diagnosis, but also a lesser than expected impact of preventive interventions for mother-to-child HIV transmission. Country of birth was associated with some AIDS-defining illnesses, including tuberculosis. AIDS diagnoses have dropped 85 percent in the past ten years, from 355 cases in 1994 to 41 cases in 1996.

2001
The 8th annual surveillance report indicated the ongoing fall in the occurrence of AIDS, due largely to five years of combination therapy: the increased proportion of heterosexually acquired cases of HIV infection that had an association with a country of high prevalence, and the continuing high rates of HIV transmission among people injecting drugs. HCV appears to have overtaken HBV as the leading indication for liver transplant.

2002
The Australian Thai Vaccine Consortium continues enrolment of gay men in the HIM study and reaches more than 165 by the end of 2002. Development progresses on the first clinical trial for the vaccine.

An analysis of hepatitis A and B showed that overall levels of immunity were about 70%, but only half of gay men aged below 25 were immune.

2003
Through funding from the American Foundation for AIDS Research, NICHECR is designated to be the point of co-ordination for an observational database that includes a number of countries in the region.

Enrolment into the first clinical trial of the Hepatitis B Vaccine Program, HBV/DIP, began in 2003. The study examined the natural history of acute hepatitis C infection and the use of pegylated interferon for the treatment of acute HCV infection among IDUs.

2004
The first results are published from the HIM cohort, funded through the Australia-Thailand Vaccine consortium, which completed enrolment of 1,420 men by the end of 2004. An analysis of hepatitis A and B showed that overall levels of immunity were about 70%, but only half of gay men aged below 25 were immune.

2005
Involvement with research partners continues strongly in Thailand and Cambodia through in-country placements. The TREAT Asia network, sponsored by amfAR, has the technical support of the Biostatistics and Database Program. amfAR and NICHECR were successful in applying to be the Asia-Pacific regional cohort in the NIH-sponsored program of international cohorts for the epidemiological evaluation of HIV disease outcomes, globally known as IeDEA.

2006
2006 marks the twentieth year of the NCHECR’s operations. It is also the tenth year of publication of the Annual Surveillance Report.

The most significant international trial to which NICHECR is contributing, SMART, was terminated prematurely in January due to increased mortality in the drug conserving or interruption arm, which showed twice the increased mortality in the drug conserving arm, which showed twice the risk of disease progression.

2007
The major new HIV therapeutic trial for 2007 is ALTAF, a randomised comparison of three regimens of combination antiretroviral therapy in treatment-naive subjects.

Recruitment classes for ATAC are the largest study in the world of the treatment and natural history of acute hepatitis C infection among people who inject drugs (PWID). Preliminary findings on treatment outcomes are released.

2008
2008 saw the establishment of two new NICHECR programs: STI research was expanded into a new Sexual Health Program. The Aboriginal and Torres Strait Island Health Program began planning for a community-randomized trial of VT in 21 remote communities. Designed to support primary health care services to achieve best practice in STI care.

2009
The Therapeutic and Vaccine Research Program raises a total of $1.9 million ($1.45 million) from the Bill & Melinda Gates Foundation to support a research project with the potential to extend drug therapy to millions of HIV-infected people worldwide. The project, dubbed ENCORE, will study the effectiveness of suppressed doses of HIV drug treatment.

2010
The second phase of the SMART pilot study commenced in 46 sites across 13 countries; and the CORAL and Encore2 studies were completed and presented at national and international meetings. The START pilot phase of enrolment is completed in mid-2010. As a consequence of achieving this key milestone, the Division of AIDS at the US NIAID announced in September that the study would proceed into the definitive phase, with the number of sites globally being tripled in order to achieve the target enrolment of 4500 participants before the end of 2012.
Discover 17
Timeline Discover
Once HIV had evolved from a terminal diagnosis to a manageable condition, the scope for the Kirby also broadened to wider issues.

2000s

2011

The National Centre in HIV Epidemiology and Clinical Research celebrates its 20th anniversary. The Institute for infection and immunity Research by changing its name to the Kirby Institute. The first annual National Trachoma Surveillance Report, edited by the National Trachoma Surveillance and Reporting Unit (NTSRU), was produced in 2011. Australia is the only developed country where trachoma is still endemic.

The first edition of the Kirby Institute’s PUBLIC HEALTH in HIV (PHIH). Ten years since the impact of immediate ART on the landscape of HIV treatment.

The Kirby Institute announces a world-first study to develop a ‘treatment as prevention’ strategy for people living with HIV.

2014

The Kirby Institute launches a new initiative to increase HIV testing and uptake of treatment in Merlin, The Kirby Institute of Infectious Diseases Emergencies (APPRISE) Partnership for Preparedness Research on Infectious Diseases Emergencies (APPRISE) are forming partnerships with five key affected populations.

Kirby researchers lead a world-first study to evaluate curative hepatitis C treatments for people living with hepatitis C in Indonesia. The Test and Treat program is launched at the Kirby Institute.

2015

The Surveillance and Evaluation Program for Public Health (SEPPH) is restructured to include the Surveillance and Evaluation Program for Public Health (SEPPH). The Kirby Institute announces a world-first study to develop a ‘treatment as prevention’ strategy for people living with HIV.

2016

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The sum of our energies is so much greater than the parts. Every day we use our global reach and expertise to better equip those at the front line of epidemics with the knowledge and tools they need to respond effectively.
RESEARCH AND COMMUNITY EMPOWERMENT

Scientia Professor John Kaldor

“Nothing about us without us” and “no survey without service” are just two examples of slogans that have been used by communities to express the way they have felt about research and, by extension, the researchers who have come calling. Many communities have a good understanding of what research can achieve, but want to be empowered to ensure that it addresses health issues that are priorities for their members. They also want to see research conducted in a way that maximises both short and long-term benefits and minimises potential harms to community members. Much of the Kirby Institute’s work involves infectious diseases that are associated with particular communities, so we aim to give prominence to community authority and ensure that we respect these principles in our research practice. That means not only talking to communities about our research projects, but working with them to improve the ways we design and implement projects.

Research partnerships have to work in both directions, with the researchers learning about communities at the same time as communities learn about research. To make this happen, we have made it our practice to set up project advisory committees and steering groups in which community representatives have prominent roles. More recently, we have entered into formal collaborations with community organisations, through mechanisms such as NHMRC Partnership Grants. In fact many community organisations, through mechanisms we have entered into formal collaborations with community organisations, through mechanisms such as NHMRC Partnership Grants. In fact many community organisations, through mechanisms such as NHMRC Partnership Grants. In fact many community organisations, through mechanisms such as NHMRC Partnership Grants. In fact many

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Exact the same principles of community empowerment apply to our collaborations in low and middle-income countries, but in this context our approach has more often been to engage with communities through our local research collaborations. They are better placed than us to do so from a linguistic and cultural perspective, and are more likely to be there for the longer term. What we can bring to these relationships is the experience that we have had in successfully working in researcher-community partnerships in Australia. While the types of organisations and relationships may be very different, the underlying premise is the same: Ensure that communities are empowered to be part of shaping and running the research, and that the collaboration is genuine, with communities having real input into decision-making processes.

Our first venture into the Asia-Pacific region was the HIV-NAT collaboration with the Thai Red Cross, which after 20 years has grown into an internationally recognised Thai-led centre of research excellence, renowned for its outstanding science as well as its strong community partnerships. We have applied the same principles to our collaborative undertakings in other countries of the Asia-Pacific region (with particular long-term involvements in Cambodia, Indonesia and Papua New Guinea), and to all of the training programs that we have offered to our counterparts from low and middle income countries. Those who emerge from our programs, whether they are short courses or doctoral degrees, inevitably have a strong sense of how research and communities fit together.

The 30th anniversary of the Kirby Institute is a time to celebrate our scientific contributions to improving the health of communities by building a stronger evidence base for prevention and treatment. But we can also reflect on what we have learned about the ways in which we have worked with communities. The scientific literature provides extensive guidance on what are often referred to as the technical aspects of research methodology: How to select and recruit participants, what laboratory tests or questionnaires should be used, the correct statistical methodology for analysing the results. It is much harder to find information about how to build and sustain effective research partnerships with communities, so we also aim to share our experience and build on it. We have not always got it right the first time, but believe that our relationships with communities are such that they are able to let us know quickly and frankly when this happens, and work with us to improve our community processes. We also recognise that these relationships depend on having robust and adequately resourced community organisations to act as our counterparts.

We have now entered into a new decade, committed to advancing knowledge and practice in this area, just as we do in the so-called technical aspects of research, and applying the lessons of three decades to next 30 years of our work.
REFLECTIONS FROM THE FRONT LINE

Some of our research leaders reflect on their work and the future our research.
Q: What is the focus of your research?
A: My focus is on conducting research that is robust, withstands scrutiny, and informs high-quality health policy. For 30 years, the Kirby Institute has played a leading role in challenging dogma and hyperbole and insisting that health policy reflects real-world evidence.

Q: What inspires you?
A: Very simply - making a difference.

Q: What brought you to the Kirby Institute?
A: A sense of adventure. Doing something different. Building a model for collaborative endeavour. In the initial years of the HIV epidemic there was little infrastructure and a non-permissive regulatory environment that worked against providing people with HIV/AIDS with access to experimental drugs. The Kirby was pivotal in developing both the coordinating infrastructure and the domestic network that quite literally provided access to thousands of Australians to drugs that were subsequently licensed for the treatment of HIV. This saved lives.

Q: What progress or transitions has your area seen in 30 years?
A: First, I think it is fair to say that progress has been astounding. HIV is now a manageable chronic disease – a remarkable feat. And also, the origins of therapeutic research were firmly vested in partnership with the pharmaceutical sector. Inevitably the processes of drug development moved away from academic partnerships and the residual infrastructure moved inexorably toward greater independence and pursuit of more strategic objectives linked to improving outcomes of treatment. Defining better strategies was life-saving mechanisms that could be deployed readily in resource-limited environments was not a goal shared by the private sector. The Kirby Institute led that exercise.

Q: What are the next steps for your research?
A: Enabling lifelong HIV treatment in low and middle-income countries. Conducting research that results in people living longer and healthier lives.
What is the focus of your research?

My research focuses on infectious disease prevention in vulnerable populations – people who inject drugs, female sex workers, people living with HIV, marginalised youth and homeless people. Much of my work has focused on the prevention and reduction of drug-related harms.

What inspires you?

I am inspired by the potential to make a difference and the resilience of those for whom injustice and suffering are everyday realities.

What brought you to the Kirby Institute?

I first came to the NCHECR in 2004 to work with John Kaldor as part of my NHMRC Fellowship. One of the things that attracted me at the time was the absence of social and qualitative research and the potential for multi-disciplinary collaborations to add value by increasing understanding of people’s lived experiences.

Another thing that attracted me was the potential to continue to develop the system of HIV and hepatitis C surveillance, needle and syringe program attendees established by the late Dr Margaret McDonald. With the help of colleagues and collaborators, and the leadership of Dr Jenny Iversen, this has become an internationally recognised model of best practice for effective and responsive surveillance among PWID.

What progress or transitions has your area seen in 30 years?

We now have the knowledge and the tools to prevent and treat HIV and hepatitis C. However knowing what works doesn’t mean we can make a difference. In many settings we still lack the political will, financial resources and community support to address these infections, particularly among vulnerable populations.

What are the next steps for your research?

Translating knowledge into practice and in particular, using our knowledge of what works to inform sustainable, high-coverage HIV and hepatitis C prevention and treatment programs in low- to middle-income countries. Trialsing a vaccine to prevent chronic hepatitis C infection. Testing HIV prevention interventions for female sex workers in Cambodia. Estimating the incidence of HIV and other STIs among MSM in Vietnam. Research on non-medical pharmaceutical opioid use among young people in Australia.
Q: What is the focus of your research?
A: Using statistical and mathematical models to optimise treatment and prevention of HIV and STIs.

Q: What inspires you?
A: What keeps me going is that, after all the bluff and bluster, expert opinion, shameless self-aggrandisement, mindless sloganeering and aspirational targets – ultimately simple data, from well-designed studies, analysed appropriately, will tell the truth.

Q: What brought you to the Kirby Institute?
A: The honest answer is that I always fancied seeing a bit of the world, and NCHECR advertised a stats job in The Guardian. It took me a while to realise I had really fallen on my head. I think what is special about Kirby is that pretty much any question you might have about HIV, HCV, HBV, and STIs you can find a proper international expert in the building who can help.

Q: What progress or transitions has your area seen in 30 years?
A: Everything in HIV has changed – treatment, prevention, outcomes. It’s extraordinary. It’s nice to have played a small part in that.

Q: What are the next steps for your research?
A: I’m hopeful that there will be renewed interest in long-term treatment outcomes in HIV-positive people. Whatever anyone says, there isn’t going to be a cure or vaccine, and new infections will continue to occur (see earlier comment about data telling the truth). There is a lot to learn yet about ageing and HIV.
Q&A

**What is the focus of your research?**

A The main focus of my research is on HIV prevention and related issues, particularly HIV-related cancers, as it affects gay and bisexual men.

**What inspires you?**

A Doing work that makes a difference to my community’s life.

**What brought you to the Kirby Institute?**

A As a gay man and young doctor growing into adulthood in the early 1980s, HIV was really the issue at the centre of my early life. It was not just a societal threat, it was a direct and personal threat, and working against it seemed like the best defence. I left Adelaide, where I did my medical degree, in 1986, before I had seen a single person with HIV on the medical wards.

After four years becoming an epidemiologist in London, Sydney was the right place to come back to — and the NCHECR was growing as the place to be in Australia for people who wanted to contribute to the HIV medical research response. In 1980s Australia, homophobia was pretty rampant but never an issue within this Institute and within the HIV response more generally in Australia.

**What progress or transitions has your area seen in 30 years?**

A I started work at the Kirby Institute (then NCHECR) in 1995. I had an office with a window overlooking Victoria Street in Darlinghurst. In 1995, about 1000 people, mostly gay men, died of AIDS in Australia, and many of them walked to St Vincent’s Hospital along Victoria Street below my window. It was a really sobering place and time to be — the evidence that a horrible tragedy was befalling gay men in Australia was everywhere to be seen.

One of my first international AIDS Conferences was the 1996 meeting in Vancouver, where the first evidence that this potent inhibitor class of antiretroviral drugs might be able to reverse the progress of HIV/AIDS. Within a few short years the streets of Darlinghurst changed — many people with HIV but unfortunately not all gained weight and started being well again. It was so quick. As a member of the gay community it was like a miracle. As a doctor and a medical researcher it was astounding to see the real-world effect of successful research unfold before me. It has been a privilege to live through.

**What are the next steps for your research?**

A Ending HIV! The new combination of biomedical tools that we have for HIV prevention actually means that we have the chance to dramatically reduce HIV transmission. My group is involved in research in rolling out new methods of HIV prevention (such as PrEP) and in monitoring the population-level results. In addition, we are addressing the unacceptably high rates of anal cancer in gay men with and without HIV, and are developing screening and vaccination approaches to prevent this disease.
Q: What is the focus of your research?
A: My work is focused on addressing the significant rates of STIs and bloodborne viruses affecting the Aboriginal and Torres Strait Islander population in Australia. Of course, this cannot be done without the collaboration of the NGO sector including the Aboriginal community controlled sector, as well as government agencies.

Q: What inspires you?
A: I am an Aboriginal woman and medical practitioner with a strong passion for addressing the significant disadvantage of the Indigenous population within Australia. I acutely understand the significant inequities of not only the social determinants of health including education, employment, and housing, but the larger picture of the upstream determinants including how society is structured and organised.

Q: What brought you to the Kirby Institute?
A: KI has a great reputation for research, particularly in HIV medicine. This job opportunity was a way to practice my Public Health Medicine skills as well as a great introduction to the world of competitive research.

Q: What are the next steps for your research?
A: The most important priority for me is to see a significant shift in health outcomes for the Aboriginal population in the area of STIs and BBVs, through carefully considered, collaborative, transitional and sustainable changes in the way research is carried out, which is inclusive of all those, both Aboriginal and non-Aboriginal, who are equally passionate about making a difference.

DOCTOR
MARLENE KONG

Head Aboriginal and Torres Strait Islander Health Program
Q: What is the focus of your research?
A: I enjoy leading and participating in national surveillance networks that enable us to evaluate population health interventions for STIs and blood-borne viruses. I also have a longstanding interest in how public policy affects sexual health, particularly in vulnerable populations. More recently, I have also had a focus on the molecular epidemiology and antimicrobial resistance of STIs.

Q: What inspires you?
A: I delight in keeping my patients vertical and free to do what they like.

Q: What brought you to the Kirby Institute?
A: I was drawn to KI by the calibre and vision of the people who work here. The dedication to all human rights — not just the right to good health — pervades the place. It is no accident that the Kirby is the only medical research institute in the world that is named after a non-billionaire lawyer and a champion of human rights.

Q: What progress or transitions has your area seen in 30 years?
A: I have had the privilege of witnessing HIV cease to be a fatal illness; observed the disappearance of vaccine-preventable diseases caused by other STIs such as HBV, HAV, and HPV; and overseen advances in clinical services and human rights relevant to sexual health.

Q: What are the next steps for your research?
A: I work across a broad range of research fields, from molecules to populations, with many irons in the fire. I would love to see more STI vaccines in the pipeline.
ASSOCIATE PROFESSOR
REBECCA GUY

Head of the Surveillance Evaluation
and Research Program

Q What is the focus of your research?
A I am interested in infections that are transmitted by sex or blood contact, including HIV and other sexually transmitted infections, and hepatitis B and C. My research into the control of these infections has two main strands that are interconnecting. One strand is driven by my interest in trying out new technologies in routine health care settings, while the other involves compiling large scale data sets, so I can understand what is happening to infection rates in populations. The ultimate measure of success for me is being able to demonstrate through population level data that a novel technology, whether it is new diagnostic test, a new treatment, or new patient management software, is helping to reduce disease rates.

Q What inspires you?
A I am inspired by the commitment of my colleagues, whether in the next door office, or in government health departments, community organisations or the front line of clinical care to work together on the prevention of sexually transmitted and blood borne viral infections.

Q What brought you to the Kirby Institute?
A I completed my PhD in 2008 and was awarded an early career fellowship. I was attracted to the Kirby Institute as an ideal place to undertake my fellowship due to its long history of success in large scale national and international public health and clinical research, the potential to make a difference at a population level.

Q What progress or transitions has your area seen in 30 years?
A First, human papillomavirus (HPV) infection is an important cause of cancer that is now largely preventable by vaccination. A highly effective prophylactic HPV vaccine was licensed in 2006, and the world’s first national vaccination program implemented in 2007 in Australia.
Second, new prevention strategies for HIV have emerged, including pre-exposure prophylaxis (PrEP), which protect people from the risk of HIV infection. There has been a huge advance in technology to enable people to have diagnostic tests at health services and receive their results while they wait. This can make a massive difference for remote communities, where people have had to wait weeks for a result in the past.

Q What are the next steps for your research?
A Over the next five years, I will translate the findings from my studies into real-world programs and provide opportunities for the next generation of researchers to advance their careers.
A global research institute is made up many people, doing a hundred different things to make the place work. Here is a glimpse of the different kinds of people who make up the Kirby.

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**WE ARE KIRBY**

**The Clinical Trials Coordinator**
**Hepatitis C**
**Pip Marks**

I was doing clinical trials in gastro-intestinal cancer and after six years I wanted a new challenge. I wanted to be doing research that really mattered to people. And I wanted work in a disease area where the patients needed the most help. Hep C patients are among the most marginalised populations and I felt I could make a real impact to their lives. I also wanted to work with world-class academics and Professor Greg Dore certainly fits that bill. And finally, I wanted to work at an institution with a great culture where people are accepted and appreciated for the work they do, where people can be true to themselves and where people’s voices are encouraged, regardless of what level they are paid at, and a place where debate and a variety of ideas are welcomed.

The work the Viral Hepatitis Clinical Research Program has done on treating people who inject drugs for their hep C infection has been world-leading. In the early days this population was excluded from treatment. Our ATACH, ATACH II and ACTIVATE studies have produced the evidence that has contributed to change in policy both nationally and internationally and we’ve led the development of international HCV treatment guidelines for people who inject drugs. The result is that Australia is one of very few countries in the world currently providing universal access to new direct-acting antiviral therapies regardless of injecting status or disease stage.

The Kirby Institute is focused on helping the most marginalised people in society. We approach our research in an open and non-judgemental way. Kirby treats their staff in exactly the same manner. The diversity at Kirby is fantastic and I think all staff and students feel truly welcome, appreciated and accepted regardless of gender, race, religion and sexuality.

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**The PhD Candidate - Laboratory of HIV Biology, Immunovirology and Pathogenesis**
**Andrew Wong**

The Kirby Institute’s excellence in scientific research into HIV was what drew me to pursue further studies as a PhD student. I feel fortunate to be delighted in waking up every morning, and to be surrounded by people of extraordinary talent and intellect.

The people at Kirby are its greatest asset. My peers are benevolent with their time, and unfailingly offer support; be it moral, academic or mentorship. I’ve so far made inroads into the production of vectors that can mediate gene therapy—a possible avenue to permanently treat HIV infection. We’re finding ways of improving our success at genetically manipulating T cells to establish a safeguard against HIV, and this may perhaps offer people with a life-long protection from the virus.
We are Kirby
present at international conferences. We dazzle at the Mardi Gras parade and then go on to contribute to the writing process. Prominent roles in the manuscript have allowed statisticians from all over Asia to have more opportunities to contribute. This project was methodologically based, which is why my work involved only statisticians within a network. I have worked on many projects, but the most rewarding one was leading a research project that involved only statisticians within a network. I knew that the Kirby collaborated with many Thai hospitals. I was interested in undertaking a PhD in social research, and Kirby had an opening to work on the Opposites Attract study. At the moment I am conducting the interviews for the Opposites Attract study and I have proven to be extremely interesting and informative. The relaxed and non-corporate environment of the Kirby is great: everyone is treated to do their own work and encouraged to work in a way that best suits their own personality and needs. The office is full of friendly faces – people are more than happy to join in, but also leave you alone if you want to be. We have a particularly close team in the HIV Epidemiology and Prevention Program. I have always felt so lucky and privileged to work with such talented people. To think that when I started in 1995 the talk was about particular drug therapies to extend life, statistics and LTRP (long-term non-progressors). To think that in 2016 we are talking about ending HIV. It is utterly mind-blowing. It has been a true honour for me to provide the support for amazing people to ensure that they can carry on with their research.

I came to the Kirby on a six week temp assignment, and 21 years later I’m still here. When I started there were only 48 people employed. To think that now we have more than 250 staff/students. How we have grown! On that first day I remember when I walked into level 2, 376 Victoria Street Darlinghurst, what greeted me was a shabby rundown building with orange and brown carpet with many holes and splits in it which was all stuck together with gaffer tape, and blue/grey walls with patches everywhere. Regardless of the look of the place, it was filled with the most amazing people who made me feel incredibly welcome and pretty much straight away. I felt I was in a uniquely special place. I have always felt so lucky and privileged to work with such talented people. To think that when I started in 1995 the talk was about particular drug therapies to extend life, statistics and LTRP (long-term non-progressors). To think that in 2016 we are talking about ending HIV. It is utterly mind-blowing. It has been a true honour for me to provide the support for amazing people to ensure that they can carry on with their research.
Now is not the time to stand still. We are on the precipice of major breakthroughs in our quest to end HIV, hepatitis C and other infectious diseases. But there’s more to do.

Lasting change requires brave determination, not merely to test existing boundaries but to completely reshape them.
In the past 30 years, The Kirby Institute has grown to employ more than 200 full-time staff.

**YEAR 10**

- **53** staff members

**YEAR 20**

- **150** staff members move to new office

**YEAR 30**

- **200** staff members
- **55** students

**FACTS & STATS**

**Quick statistics**

- **$30 MILLION**
  - Annual budget of over $30 million

- **5X**
  - Every dollar of Department of Health funding leverages five dollars of external funding.

- **38,000**
  - Over 21 years (1995-2015), approx 38,000 individuals have participated in the Annual Needle and Syringe Program Survey

- **125**
  - Research projects around the world
COLLABORATIONS

We collaborate actively with over 650 organisations in more than 41 countries on 6 continents.

<table>
<thead>
<tr>
<th>650+</th>
<th>42</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisations</td>
<td>Countries</td>
<td>Continents</td>
</tr>
</tbody>
</table>

- To: Facts & Stats
- From: Innovate
The challenge

UNAIDS estimates that 769,000 people die each year from AIDS; however, this number could be vastly reduced if everyone infected with HIV began treatment immediately. To meet this goal, World Health Organization (WHO) guidelines mean that more people can be treated for the same amount of money. It will have a profound impact on the health and well-being of millions of people around the world, who will now have access to life-saving treatment. The biggest impact of this development will be felt in low and middle-income countries, where there is often limited access to life-saving drugs and treatment programs come at a time when funding is static and likely to reduce. How we are helping

Between 2010 and 2014, Professor Sean Emery and his team conducted a clinical trial, known as ENCORE1, with 630 participants in 13 countries across Africa, Asia, Australia, Europe and Latin America. They reduced the dose of efavirenz, an important HIV drug therapy, by one third and observed that participants regularly over the course of two years to gauge whether the lower dose of drugs was strong enough to suppress HIV replication.

Results

The results showed that a reduced dose is both safe and effective in suppressing HIV and results in fewer drug-related side effects, compared to the standard dose recommended at the time of the study. Impact

Following the study, the World Health Organization (WHO) has updated international treatment guidelines endorsing a lower daily dose of efavirenz. The new WHO guidelines mean that more people can be treated for the same amount of money. It will have a profound impact on the health and well-being of millions of people around the world, who will now have access to life-saving treatment. The biggest impact of this development will be felt in low and middle-income countries, where there is often limited access to life-saving drugs and treatment programs come at a time when funding is static and likely to reduce.

The Kirby Institute, in partnership with three other international research centres, coordinated the world’s first large-scale randomised controlled trial to clearly define the best time for HIV-positive people to begin ART. The START study enrolled 4,685 people at 215 sites in 35 countries, including Australia.

Results

In 2015, START was terminated ahead of schedule after interim results provided conclusive evidence that immediate treatment of HIV extends survival and prevents serious disease complications and death.

Impact

The findings have global implications for the treatment of people living with HIV. In 2015, approximately 36.7 million people worldwide were living with HIV, with only 46% (17 million) receiving treatment.

The Kirby Institute is collaborating with three other international research centres to provide conclusive evidence that immediate treatment of HIV extends survival and prevents serious disease complications and death.

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Maternal and newborn health

In Papua New Guinea, as in many low-income countries, curable STIs and genital infections such as chlamydia and gonorrhoea are common among pregnant women. If left untreated, STIs can lead to serious problems during pregnancy.

**The challenge**

In Papua New Guinea, the incidence of HIV, malaria and other infections among both pregnant women and their newborns is rising. The Kirby Institute will assist in the development of a new model of care to eliminate STIs and other infections in a targeted and efficient manner.

**How we are helping**

Researchers at the Kirby Institute in collaboration with other researchers, community organisations, government and laboratories are leading a world-first trial called TANGO. This trial is targeted at young men, the point of entry for most new HIV infections.

**Impact**

With more than 400 participants, TANGO will have an impact on the lives of young men and their partners. It will also provide valuable data for the development of future interventions.

Funded under the Joint Global Health Trials initiative, established by the UK Department for International Development, the Medical Research Council UK and the Welcome Trust.

**THE KIRBY IMPACT**

**EPIC-NSW** has the potential to change the face of HIV transmission in NSW, the first state in Australia to implement such a rapid and large-scale trial of this prevention strategy. If successful, it will pave the way for the widespread use of PrEP.

**1 IN 4**

People diagnosed with HIV in Australia (2015) the previous year has substantial damage to their immune system

**TTANGO**

**The challenge**

TTANGO is funded by the Australian National Health and Medical Research Council.**

**TTANGO**

**The challenge**

TTANGO is an international clinical trial investigating the potential of latency reversing agents to be used in HIV eradication efforts.

**Impact**

The study tested a single HDACi, romidepsin, on patients, the point-of-care testing was as accurate as laboratory tests and point-of-care testing significantly reduced the time to treatment. The final analysis is planned for late 2016, followed by health economic analyses to make the case for a Medicare Rebate. The program has been expanded to a large network of health services in WA, NT, SA and QLD.

**Fund**

The Kirby Institute has partnered with scientific collaborators from 22 institutions around the world on a joint initiative to accelerate the search for an effective HIV vaccine. The European AIDS Vaccine Initiative brings together a multidisciplinary team of leading HIV researchers from public organisations and biotech companies from across Europe, Australia, Canada and the USA in a focused effort to develop protective and therapeutic HIV vaccines. The Kirby Institute’s Professors David Cooper, Anthony Kelleher and Miles Davenport are part of the Australian contingent currently working on creating an effective HIV vaccine in our laboratories.

**Forces unite in the quest for an HIV vaccine**

**The challenge**

In Australia, HIV has largely become a chronic, manageable infection - but chronic HIV disease management is not the end goal. Despite the tremendous successes we’ve made in the prevention and treatment of HIV, the development of an effective vaccine to prevent HIV infection remains elusive.

**How we are helping**

**The Kirby Institute** has increased the use of new technologies initially created to test for tuberculosis, with over half of antenatal women having one or more of these infections. Among these women, 70% were not identified as having an STI based on clinical grounds alone.

**Impact**

Now that we know that point-of-care STI testing and treatment in routine antenatal clinic settings is feasible in PNG, researchers will start to roll out a large-scale field trial. By continuing to demonstrate this approach not only increases the detection and treatment of STIs, but actually improves pregnancy outcomes, the trial will have a potentially major impact on policy and practice in all high-burden, low-income settings.

**Fund**

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**Research Results**

HIV ‘wakes up’ only once a week under treatment

**The challenge**
Researchers have been looking for ways to reduce latent HIV infection in the body, in order to create a remission to allow drug therapy to be suspended. However it was unknown how long it takes for latent HIV cells to reactivated after treatment suspension. Previous modelling suggested that the virus was activated four to five times a day, and estimated that the number of latent cells would need to be reduced 2000 times to produce an average one-year remission after treatment cessation.

**How we are helping**
The study combined patient data on time to viral rebound, after treatment interruption, with mathematical modelling and statistical analysis. Data from the Kirby Institute’s PULSE study was analysed with data from three smaller patient cohorts undergoing ART suspension. Mathematical modelling is used to estimate the average frequency of viral rebound.

**Results**
The study found that HIV cells in the body of a person receiving antiretroviral treatment become activated 24 times less frequently than previously thought. The results were consistent across all four cohorts, indicating that virus rebound after treatment interruption occurs once every five to eight days. This research provides the first direct estimate of the rate of HIV reactivation and indicates that latent cell numbers need to be reduced by 50-70 times to produce a one year remission.

**Impact**
This finding has the potential to inform future research into biomedical interventions for HIV control.

**Research Results**

Gay men, aging and HIV

**The challenge**
In the current era of effective HIV treatments, HIV-positive people are living longer and healthier lives, but they appear to be at higher risk of age-related illnesses compared with HIV-negative people.

**How we are helping**
Researchers at the Kirby Institute are investigating whether older gay men living with HIV age differently to gay men without HIV. The APPLE3S (Australian Positive & Aged Longevity Evaluation Study) study aims to determine whether being HIV-positive increases risk of illness, or whether the differences seen between HIV-positive and HIV-negative individuals are caused by other factors, such as lifestyle, diet or other health conditions.

**Impact**
Knowledge gained from the research will inform the development of evidence-based, client-centered care, including screening, prevention and advocacy programs for the larger numbers of older HIV-positive people in Australia.

**31%**

**New Centre for Research Excellence in Offender Health**

**The challenge**
In Australia there are over 33,000 people in prison at any one time. Prison populations are transient; more than 50,000 people cycle through Australian prisons annually and we have an estimated 400,000 ex-prisoner population of at least 400,000 nationally. Prisoners have some of the worst health outcomes of any population group and are one of the most marginalised and stigmatised groups in Australia. Aboriginal and Torres Strait Islander people are overrepresented in Australian prisons, and Aboriginal women are the fastest growing group in Australian prisons. Almost all prisoners return to the community after relatively short periods in detention, thereby imposing this substantive disease burden on the wider community. For this reason, improving the health of offenders is not only important because it has a positive impact on the individual offender, but has significant consequences for society as a whole.

**How we are helping**
The Kirby Institute was successful in its application to establish an NHMRC national Centre for Research Excellence (CRE) in Offender Health. The centre brings together a team of internationally recognised researchers to address infectious diseases and mental health (including neuropsychiatric illness) among offender populations.

**Impact**
The CRE will strengthen collaborative relationships with other correctional jurisdictions across Australia to help us to ensure the gains established in NSW can be rolled out effectively in other states.

**31%**

**New approach to estimating trends in chlamydia**

**The challenge**
Chlamydia is the most common notifiable STI in Australia. Untreated, it can lead to poor reproductive health outcomes including infertility. Because chlamydia often has no symptoms, the infection often remains undiagnosed and untreated. We need to understand incidence to determine the impact of an infection in a community. However, calculating incidence at a population level on an ongoing basis is difficult and costly as it involves repeat testing of a large cohort of people.

**How we are helping**
Researchers at the Kirby Institute developed an alternative approach to measure incidence. They used mathematical modelling based on a probabilistic tree where branches represent acquiring or not acquiring the infection, developing or not developing symptoms, being tested, treated and being notified as a case. Using routine population data, each individual in the population is assigned a probability for each step along the branch over the course of each year.

**Results**
The model, researchers estimate that the total number of people acquiring chlamydia in 2013 was 4.3 times the number of reported diagnoses. Results from this study suggest that more than three quarters of new infections remain undiagnosed.

**Impact**
These results can tell us how control efforts are working, and how we should target future prevention strategies. This model can be replicated in other countries that collect similar notification data on chlamydia and help to establish a more accurate understanding of population level incidence of chlamydia.
MAKING A difference WITH YOUR SUPPORT
## 2015 FUNDING

### National Health and Medical Research Council (NHMRC)

#### Program Grants

<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>AUD$</th>
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<tbody>
<tr>
<td>Sexually transmitted infections - causes, consequences and interventions</td>
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<tr>
<td>Discovery and translation of interventions to control sexually transmitted infections and their consequences</td>
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<tr>
<td>Hepatitis C infection: epidemiology, pathogenesis, and treatment</td>
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<tr>
<td>HIV latency, pathogenesis and immunity</td>
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#### Project Grants

<table>
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<tr>
<th>Project</th>
<th>Description</th>
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<tr>
<td>A randomised trial of rapid point-of-care tests for chlamydia and gonorrhoea infections in remote Aboriginal communities</td>
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<tr>
<td>A randomised trial to determine the safety and efficacy of early versus deferred treatment of HIV</td>
<td>$235,785</td>
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<td>Viral load, HIV treatment and HIV transmission in serodiscordant male homosexual couples</td>
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<td>The Encore1 Study: the pharmacokinetic, pharmacodynamic and pharmacogenomic outcomes of reduced dosage of Efavirenz</td>
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<td>HIV-1 transcriptional gene silencing by promoter targeted si/shrnas</td>
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<td>The efficacy of mass drug administration strategies to control scabies in a highly endemic population</td>
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<td>Point-of-care diagnosis of sexually transmitted infections to improve maternal and neonatal health outcomes in resource-limited, high-burden settings</td>
<td>$314,140</td>
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<td>HIV treatment as prevention: a longitudinal assessment of population effectiveness</td>
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<td>Dissecting the dynamics of malaria infection</td>
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<td>New strategies to increase testing and treatment for endemic sexually transmitted infections in remote Aboriginal communities</td>
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<td>Health outcomes and service utilisation in a cohort of people who inject drugs, sex workers and at-risk youth - a record linkage study</td>
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<td>Regulation of F-actin during HIV spread</td>
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<tr>
<td>Identifying undiagnosed HIV infection among Australian gay men: delivering HIV testing through a national, community-based study</td>
<td>$73,792</td>
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<td>Sexual and reproductive health and behaviours of young offenders (14-18 years) in NSW and QLD</td>
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<td>Can preventive care activities in general practice be sustained when financial incentives and external audit plus feedback are removed</td>
<td>$60,000</td>
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### National Health and Medical Research Council (NHMRC) Continued

- **Evaluation of a model for assessment and treatment of hepatitis C virus among injecting drug users in the opioid pharmacotherapy setting (ETHOS)** | $26,707 |
- **The HIV prevention revolution: measuring outcomes and maximising effectiveness** | $280,922 |
- **Surveillance and treatment of prisoners with hepatitis c (stop-c)** | $246,137 |
- **Uptake, sustainability and impact of scaling up point-of-care testing for sexually transmissible infections in remote and regional Aboriginal communities (Tango 2)** | $314,072 |
- **Striveplus: refinement and translation of an intervention designed to improve sexual health service delivery in remote communities** | $394,581 |
- **Reducing impulsive behaviour in repeat violent offenders using a selective serotonin re-uptake inhibitor** | $1,324,589 |

### Centres of Clinical Research Excellence

#### Fellowships

- **Offender Health**
  - Dr Jason Grebely (Career Development Fellowship) | $113,373 |
  - Dr Gail Matthews (Career Development Fellowship) | $113,373 |
  - Dr Mark Boyd (Career Development Fellowship) | $113,373 |
  - A/Prof Vanessa Vertel (Career Development Fellowship) | $64,482 |
  - A/Prof Rebecca Guy (Career Development Fellowship) | $113,373 |
  - Dr Huachen Zou (Early Career Fellowship) | $52,441 |
  - Dr Hammad Ali (Early Career Fellowship) | $6,482 |
  - Dr Jennifer Iversen (Early Career Fellowship) | $78,661 |
  - Dr Mary Poynten (Postdoctoral Training Fellowship) | $33,241 |
  - Dr Bradley Mathers (Postdoctoral Training Fellowship) | $92,816 |
  - Prof. Basil Donovan (Practitioner Fellowship) | $121,462 |
  - Prof. Greg Dore (Practitioner Fellowship) | $121,462 |
  - Prof. Anthony Kelleher (Practitioner Fellowship) | $121,462 |
  - Prof. Andrew Grulich (Principal Research Fellowship) | $162,993 |
### 2015 FUNDING

#### National Health and Medical Research Council (NHMRC) Continued

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<th>Fellowships (Continued)</th>
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<td>Prof. John Kaldor (Senior Principal Research Fellowship)</td>
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<td>Prof. Lisa Maher (Senior Research Fellowship)</td>
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<td>Prof. Miles Davenport (Senior Research Fellowship)</td>
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<td>A/Prof. David Wilson (Senior Research Fellowship)</td>
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#### Postgraduate Scholarships

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<td>Robert Monaghan</td>
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<td>Lise Lafferty</td>
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<td>Angie Pinto</td>
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#### Federal Department of Health

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<thead>
<tr>
<th>Research</th>
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<tbody>
<tr>
<td>Research activities for blood borne virus and sexually transmissible infections</td>
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<tr>
<td>Establishment and maintenance of a trachoma surveillance and reporting unit</td>
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<td>Extended genital warts surveillance network</td>
<td>$120,178</td>
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<tr>
<td>National trachoma surveillance and reporting 2015 - 2017</td>
<td>$181,848</td>
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#### Australian Government Continued

<table>
<thead>
<tr>
<th>Australian Government Continued</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Development, implementation and management of a national HPV genotype specific surveillance system</td>
<td>$41,605</td>
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</table>

#### NSW Office of Medical Research

<table>
<thead>
<tr>
<th>Institute of Virology infrastructure funding</th>
<th>Amount</th>
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<tbody>
<tr>
<td>$26,472</td>
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#### NSW Ministry of Health

<table>
<thead>
<tr>
<th>Health Project</th>
<th>Amount</th>
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<tbody>
<tr>
<td>NPA-IIECD Aboriginal sexual/reproductive health project</td>
<td>$37,594</td>
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<tr>
<td>NSW needle and syringe program enhanced data collection</td>
<td>$56,965</td>
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<tr>
<td>The HIV Seroconversion Study</td>
<td>$88,191</td>
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<tr>
<td>ACCESS-Plus – a national sentinel surveillance system for STIs</td>
<td>$7,471</td>
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<tr>
<td>NSW HIV rapid testing evaluation framework</td>
<td>$20,000</td>
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<tr>
<td>Male Sex Workers and HIV and STI risk project</td>
<td>$10,000</td>
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<tr>
<td>Implementation of HIV pre-exposure prophylaxis with antiretroviral medications among people at high risk for HIV infection</td>
<td>$145,286</td>
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<tr>
<td>The NSW Research Program for HIV, STIs and viral hepatitis</td>
<td>$691,712</td>
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<tr>
<td>Pilot implementation study of patient delivered partner therapy (PDPT)</td>
<td>$127,273</td>
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<tr>
<td>The HIV prevention revolution: measuring outcomes and maximising effectiveness</td>
<td>$318,000</td>
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#### Other State Departments

<table>
<thead>
<tr>
<th>Department</th>
<th>Project</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Australian collaboration for chlamydia enhanced sentinel surveillance</td>
<td>$67,645</td>
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<tr>
<td>Study of risk factors for HIV seroconversion (Queensland Health)</td>
<td>$21,726</td>
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<tr>
<td>Systematic review peer-reviewed &amp; grey literature-prison cell size &amp; health effects</td>
<td>$39,572</td>
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</tr>
<tr>
<td>National prison entrants bloodborne virus survey (Dept of Justice, Corrective Services NSW)</td>
<td>$22,173</td>
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<tr>
<td>The relationship between psychotic mental illness and offending in NSW (Mental Health Commission of NSW)</td>
<td>$36,133</td>
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</tr>
<tr>
<td>Liverlife: a liver health campaign for marginalised populations (Southeastern Sydney Local Health District)</td>
<td>$25,600</td>
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</tbody>
</table>
## 2015 FUNDING & DONATIONS

### National Institutes of Health, USA

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Funding</th>
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<tbody>
<tr>
<td>Asia Pacific HIV research collaboration: cancer studies (subcontract with American Foundation for AIDS Research)</td>
<td>$6,730</td>
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<tr>
<td>INSIGHT - Leadership (subcontract with University of Minnesota)</td>
<td>$319,274</td>
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<tr>
<td>INSIGHT - FLU 002 &amp; FLU 003 (subcontract with University of Minnesota)</td>
<td>$653,050</td>
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<tr>
<td>START study (subcontract with University of Minnesota)</td>
<td>$1,509,491</td>
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<tr>
<td>TREAT Asia HIV Observational Database (subcontract with American Foundation for AIDS Research)</td>
<td>$473,233</td>
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<tr>
<td>TREAT Asia pediatric HIV observational database (TAPHD) (subcontract with American Foundation for AIDS Research)</td>
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<tr>
<td>Treatment of recently acquired hepatitis C virus infection - (ATAHC-2)</td>
<td>$1,130,725</td>
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<tr>
<td>Cambodia integrated HIV and drug prevention implementation (subcontract with University of California)</td>
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<tr>
<td>Hepatitis C Virus (HCV) (subcontract with American Foundation for AIDS Research)</td>
<td>$12,760</td>
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<tr>
<td>Opposites Attract study (subcontract with American Foundation for AIDS Research)</td>
<td>$59,675</td>
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<tr>
<td>Mechanisms limiting neonatal immunity (subcontract with Cornell University)</td>
<td>$12,626</td>
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<tr>
<td>Anti-influenza Hyperimmune Intravenous Immunoglobulin (FLU - IVIG) international</td>
<td>$325,727</td>
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<tr>
<td>International collaborative of prospective studies of HIV and hepatitis in IDU</td>
<td>$80,541</td>
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<tr>
<td>(subcontract with University of New Mexico)</td>
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### Other Grants and Contracts

#### Australian

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Funding</th>
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<tbody>
<tr>
<td>Monitoring transfusion transmissible infections among blood donors (Australian Red Cross Society)</td>
<td>$25,000</td>
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<tr>
<td>Support for clinical and epidemiological HIV research capacity in Indonesia (AusAID/Australian Society for HIV Medicine)</td>
<td>$183,403</td>
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<tr>
<td>Preventing morbidity and mortality from anal cancer (Cancer Council NSW)</td>
<td>$21,180</td>
</tr>
<tr>
<td>Reducing Australia’s Aboriginal prisoner population using justice reinvestment - Assessing the public’s views to treatment versus incarceration using citizen’s juries (Lowieja Institute)</td>
<td>$19,696</td>
</tr>
<tr>
<td>HCC outcome improvements through translational research in western Sydney (Westmead Millennium Institute)</td>
<td>$21,995</td>
</tr>
<tr>
<td>Evidence check for NSW STI strategy (The Sax Institute)</td>
<td>$24,600</td>
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<tr>
<td>Global intensive professional program in HIV (AusAID)</td>
<td>$21,995</td>
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</tbody>
</table>

#### International

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Funding</th>
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<tbody>
<tr>
<td>ENCORE: Evaluation of novel concepts in optimization of antiretroviral efficacy (Bill and Melinda Gates Foundation, USA)</td>
<td>$491,386</td>
</tr>
<tr>
<td>Evaluation of HIV epidemics and programs in Asia (World Bank, USA)</td>
<td>$1,186,976</td>
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<tr>
<td>The DAD Study, Data Collection on Adverse Events of Anti-HIV Drugs (Copenhagen HIV Programme)</td>
<td>$43,850</td>
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<tr>
<td>Implementation of “Test and Treat” strategies for HIV treatment and prevention (World Health Organisation)</td>
<td>$1,817,596</td>
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<tr>
<td>Development of a mathematical model based on HIV case reporting (UNAIDS)</td>
<td>$184,353</td>
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<tr>
<td>Modelling resource needs to optimise impact of the global efforts to ending AIDS by 2020 (UNAIDS)</td>
<td>$15,122</td>
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<tr>
<td>European Network of HIV/AIDS cohort studies to coordinate at European and international level clinical research on HIV/AIDS: ‘EuroCoord’ (University College London)</td>
<td>$12,592</td>
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<tr>
<td>Scholarship Alison Marshall (Canadian Institutes of Health Research)</td>
<td>$5,302</td>
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<tr>
<td>Scholarship Evan Cunningham (Canadian Institutes of Health Research)</td>
<td>$24,708</td>
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### Pharmaceutical Industry

<table>
<thead>
<tr>
<th>Company</th>
<th>Funding</th>
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<tbody>
<tr>
<td>CSL Limited</td>
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<tr>
<td>Gilead Science Pty Ltd</td>
<td>$304,563</td>
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<tr>
<td>Gilead Science Inc (USA)</td>
<td>$1,241,569</td>
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<tr>
<td>Janssen Cilag Pty Ltd</td>
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<tr>
<td>Merck Sharp &amp; Dohme</td>
<td>$235,157</td>
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<tr>
<td>Pfizer Inc</td>
<td>$2,247,146</td>
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<tr>
<td>AbbVie Pty Ltd</td>
<td>$441,858</td>
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<td>Callimmune Australia Pty Ltd</td>
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### TOTAL

<table>
<thead>
<tr>
<th>Category</th>
<th>Funding</th>
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<tbody>
<tr>
<td>Donations 2015</td>
<td>$36,653,231</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$8,553,518.31</td>
</tr>
</tbody>
</table>
DONOR SPOTLIGHT

Capital Campaign for Kirby

It is through the valued support of our funders that the Kirby Institute is able to conduct leading-edge research that is improving health outcomes in Australia and around the world.

This year marked the successful conclusion of an ambitious capital campaign for the Kirby Institute. Launched in 2011, the campaign was dedicated to securing funds for new, world-class research facilities in the redeveloped Wallace Wurth Building on UNSW’s Kensington campus and in the new Translational Research Centre on the St Vincent’s Hospital campus.

The cutting-edge new facilities were made possible by State and Federal Government grants, UNSW funding, and philanthropic gifts. Most notable among the philanthropic gifts was a $10 million pledge from the Atlantic Philanthropies to match all donations made to the Kirby dollar for dollar.

Inspired by this matched funding challenge and the vital work the Kirby Institute is doing to alleviate global health challenges, other significant contributions were made by the Estate of the late Peter Ikin, through the Curran Foundation, the Berg Family Foundation, The Glendonbrook Foundation, the Roth Charitable Foundation, Mr Geoffrey Alder, the Estate of the Late Dr Lynn Joseph, and an anonymous donation of $1,000,000.

Such bold support has raised the bar for philanthropic support of medical research in Australia.

The Kirby Institute’s new facilities are an asset to the local health district; to New South Wales; and to Australia more broadly, and they are critical to the global reputation of the Kirby Institute.

For 30 years, the Kirby Institute has remained focused on breaking new ground in the response to epidemics.

The Kirby Institute would like to thank the following individuals and organisations for their generous support and contribution to the Atlantic Philanthropies match campaign:

New South Wales Government
Australian Government
The Atlantic Philanthropies
Estate of the Late Peter Ikin
Anonymous
Berg Family Foundation
The Glendonbrook Foundation
Mr Jillian Segal AM, Mr John Roth and The Roth Charitable Foundation
Mr Geoffrey Alder
Estate of the Late Dr Lynn Joseph

The Kirby Institute

For 30 years, the Kirby Institute has remained focused on breaking new ground in the response to epidemics.
Kirby Institute Students 2015-16

PhD candidates

Adeshina Adelakure
Ogungbana Amosun
Hamed Ahmadi Robati
Rosemary Anigo
Steven Badman
Sahar Bajie
Saleh Bakhtiari
Ben Baxton
Nabila Chowdhury
Evan Cunningham
Nicole De La Mata
Ian Down
Michael Doyle
Brigitte Gerstl
Sian Goddard
Bui Thi Minh Hao
Mohamed Hammoud
Muhammad Jamil
Shane Kelly
Reem Khaliel
Johannes Janssens
Audrey Khampheng
Samantha McAllery (University of Sydney)
Neil Petrie (SoMS)
Kathryn Dinh
Linh-Ve Le (SPHCM)
Preston Leung (SoMS)
Rebecca Lorch
Kylie-ann Mallitt
Skye McGregor
Maria Catalina Mendez Ortega
Elizabeth Minchew
Christa Mirra
Lisa Naidi
Doug Olivera
Mahesh Rekha-Khetabashabazi
Lucas Rembi
Siomee Shokar
Winnie Wong Yin Tong
Philip Wood
Yin Xu

Masters Students

Lee Knight
Kazuma Matsutani

Supervision of non-Kirby Institute Students

David Boettiger
Louse Causer
Damian Conway
Andrew Craig
Anna Charisse Farr
Belinda Chessell
Ben Bavinton
Nabila Chowdhury
Evan Cunningham
Nicole De La Mata
Ian Down
Michael Doyle
Brigitte Gerstl
Sian Goddard
Bui Thi Minh Hao
Mohamed Hammoud
Muhammad Jamil
Shane Kelly
Reem Khaliel
Johannes Janssens
Audrey Khampheng
Samantha McAllery (University of Sydney)
Neil Petrie (SoMS)
Kathryn Dinh
Linh-Ve Le (SPHCM)
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Doug Olivera
Mahesh Rekha-Khetabashabazi
Lucas Rembi
Siomee Shokar
Winnie Wong Yin Tong
Philip Wood
Yin Xu

Continued from our Q&A section

Professor Miles Davenport

Professor Miles Davenport heads up the Infection Analytics Program at the Kirby Institute. Miles and his team use insights in mathematicians, computer science and physics to design and optimise treatment and vaccination for major infectious diseases.

Professor Tony Butler

Professor Tony Butler is head of the Justice Health Research Program. Their work involves surveillance of blood-borne viruses and STIs in the prison setting, and a focus on developing interventions and examining the health antecedents of offending. The health and human rights component associated with this area of research has obvious synergies with the work of the Institute’s Patron.

Professor Greg Dore

Professor Greg Dore is head of the Viral Hepatitis Clinical Research Program - an international leader in basic viral research, with projects on various stages of the HIV infection, including transmission and the body’s defence against the virus, and how these are modulated by therapies. They conduct clinical and natural history studies in unique populations of patients with hepatitis C, such as those rare individuals who control HIV infection without therapy. Identifying the reasons why this group remain healthy, without damage to their immune systems, is extremely important for understanding control of HIV infection, and for developing new therapeutic interventions and preventative vaccines.

Professor Andrew Lloyd

Professor Andrew Lloyd is head of the Viral Immunology Systems Program. The collaborative team of clinicians and scientists use interdisciplinary approaches to study the complex interactions between pathogen, host, and environment, which underpin viral human infections, particularly hepatitis C.