Consultation on the Draft National Strategies for Blood Borne Viruses and Sexually Transmissible Infections

AFAO comments on *draft Seventh National HIV Strategy 2014 – 2017*

AFAO's approach to providing feedback for this consultation

AFAO makes the following comments on the understanding that given the proposed referral of the draft Strategies to the AHPPC in early May, shortly after the consultation closes, there will be limited opportunity for major revisions to the Strategy. We have therefore made suggestions, where possible, for minimal revisions that would either address concerns we have with the current text or at least go part-way to addressing those concerns. We have attempted to make our suggestions as clear as possible by generally copying the current text, striking through words to be deleted and highlighting replacement wording in yellow.

The exception to this approach is for section 7, Prevention, for which we are proposing replacement text for the section, in green. We have also provided suggested revisions to the current text for section 7., as we accept that the tight time-frame means major revisions may not be possible.

Development of the draft

AFAO is concerned that the current draft of the Strategy fails to address fundamental issues identified by AFAO which were raised during early consultations with the Department last year, and outlined in written submissions.

In late 2013 various organisations and individuals were asked by the Department to provide expert input into development of key sections of the draft strategy. AFAO was specifically asked by the Department to review a previous draft of the strategy and provide additional text for a redraft of the Prevention section. We were pleased to provide a substantial redraft of this section, incorporating carefully considered priority issues and actions, these issues and actions having been identified by AFAO and its members in development of the discussion paper *Implementing the United Nations Political Declaration On HIV/AIDS in Australia's Domestic HIV Response: Turning Political Will Into Action*.

The suggested text provided by AFAO for this section has not generally been incorporated, and the priority issues and actions set out on the current draft do not reflect AFAO's input during the consultations. Particularly disappointing is that the Sixth HIV Strategy's Prevention section is stronger than the current prevention section draft for the Seventh Strategy, primarily because the draft of the seventh strategy fails to identify priority issues and actions for each of the priority populations. The result that this section is generally weak and unfocused and its priority actions are inadequate to the task of addressing the priority issues affecting HIV prevention among and across priority populations.

Overarching comments

Sustaining the partnership: enabling meaningful community input

- A hallmark of the Australian response has been the mobilisation of the gay community. It is important that gay men be named in the Strategy introduction and that throughout the strategy, references to gay men not be conflated with MSM. The term MSM refers to a behaviour, whereas the term gay identifies a community. Gay men constitute the primary community that needs to be mobilised in responding to HIV across Australia; and the community in fact has a crucial role to play in defining and sustaining the vision that will sustain the ongoing response, particularly regarding how best to develop health promotion incorporating combination prevention. There is a lack of reference in the Strategy to the evidence-base on the success of health promotion that seeks to engage gay men and the evidence of behavioural change among gay men. The Strategy fails to support the need to resource community organisations such that they may sustain this engagement.

- The draft strategy needs to clearly place the onus on all jurisdictions to work meaningfully and collaboratively with affected communities, and the organisations that represent them. This is particularly the case in relation to gay men, where the strategy needs to make it clear that "working with the affected communities" means engaging with gay men's organisations (and indeed other organisations that represent affected communities) in developing policy and health promotion programs, and working with those communities and organisations on their implementation and service needs. Our concern is that although most jurisdictions (including the Commonwealth) has done this well and continue to do so, there are others where this engagement is non-existent. The Strategy should be revised to include specific references to jurisdictional responsibilities in respect of the funding and resourcing of community organisations that represent all affected communities, to facilitate meaningful community input into the HIV partnership, and to achieve the key National HIV Strategy priority actions.

- Underpinning Guiding Principles of the strategy need to include the need for bipartisanship and adequate resourcing of the priority actions required to give effect to those principles. The strategy should include specific references to jurisdictional responsibilities in respect of the funding and resourcing of community organisations that represent affected communities, to facilitate meaningful community input into the HIV partnership.

- The draft states that there are no indicators available to measure progress in reducing stigma, discrimination and in addressing human rights issues. This is not the case; these issues have been identified and objectives, actions and indicators need to be developed to ensure that steps are taken to address these issues within the life of this strategy. We propose that meaningful actions and indicators be included in the strategy to address discrimination and human rights issues, reflecting recommendations made by the MACBBVS Legal and Discrimination Working Group in the set of seven papers released in 2013.

- The Commonwealth has a clear role to play in facilitating the availability of new and better HIV tests, STI tests and treatments by resourcing the TGA, PBAC and MSAC and supporting the streamlining of approval processes. Actions to ensure such funding and policy reforms are crucial if the prevention and treatment targets of the UNPD and the Seventh National HIV Strategy are to be met.

- The Strategies needs to better define cross-strategy intersections regarding priority populations and actions, and define the lead strategy/strategies in respect of these. For example, AFAO has proposed that the HIV Strategy, the A&TSI BBVs and STIs Strategy, and the National STIs Strategy must each support the development of a national education curriculum, including comprehensive sexual health (HIV and STI) education that is inclusive of sexuality and gender diversity, to ensure that LGBTI youth receive appropriate and relevant sexual health education. The HIV Strategy and A&TSI BBVs and STIs Strategy should name the priority actions set out in the STIs Strategy and spell out the need for education regarding HIV to form part of sexual health/sexuality components of the national high school curriculum.

General comments on actions: terminology and focus

- Words such as "explore" and "examine" are not useful in the context of action-setting. Actions need to be concrete and meaningful, with responsibilities clearly delineated and assigned. The action sections in all of the priority areas for action need strengthening, to ensure accountability, measurement and evaluation.

- The Strategy should reflect the changing nature of the HIV epidemic and priority actions should facilitate the development of responsive and innovative prevention programs targeting new and emerging priority populations and sub-populations.

- The role of peer education and support programs has not been sufficiently highlighted in the draft Strategy. With appropriate training and support, people from affected communities are well placed to communicate prevention messages and peer education and support has been a core element of the success of the Australian HIV response. The statements regarding the crucial role of peer support contained in the draft National Hepatitis C Strategy also apply in relation to HIV prevention, education and testing programs, and should be similarly included in the HIV Strategy.

- The review of the National HIV Testing Policy is currently being finalised. The final HIV Strategy needs to reflect the revised Testing Policy and actions should enable timely responses to future technical opportunities; recognition of the role of community peers in HIV and other testing in community settings; and facilitate the approval of HIV rapid tests for self-testing.

- Recent and ground breaking research, such as the HPTN 052 Study, is part of the ongoing treatment as prevention context and should be highlighted in the Strategy.

- Reference to "combination prevention" needs to be added to the Introduction – including a definition/explanation of the concept in the introduction that clearly distinguishes it from "treatment as prevention".

- Whilst reinforcing condom use as the primary prevention tool for HIV sexual transmission, the Strategy should include a broad set of actions to support the roll-out of targeted campaigns promoting combination prevention. This requires that the Strategy include a commitment to increased government investment in the streamlining of PBS processes, and to the development of targeted health promotion campaigns at both the national and jurisdictional level.

- Reference to "point of care testing" should be to "HIV rapid testing in point of care, community and other non-laboratory settings", to avoid ambiguity regarding use of HIV rapid testing devices in community settings that are not "point of care", as per pending changes to the National HIV Testing Policy 2014.

- Condom use and terminology: the Centre for Disease Control in the USA has recently changed the definition of the term 'unprotected sex' to refer to more than sex without condoms and enable better assessment of the role of effective risk reduction strategies in HIV prevention. This reflects that not all sex without condoms is a heightened HIV risk and that other forms of protection are available and effective. This is an important language change that should be reflected in this strategy and in the indicators.

1 Introduction (p.3)

The introduction contextualises development of the Seventh Strategy around the UNPD "targets" (plural), yet the only target referred to is reduction of sexual transmission of HIV by 50% by 2015. The UNPD target of universal access to treatment is not referred to until page 17 of the draft Strategy, paragraph 2 of p.17 stating that:

> "Recent estimates of the treatment continuum (2) in Australia (diagram below) suggest that 30 to 50 per cent of people who know they are living with HIV are not receiving antiretroviral treatment. A proportion of these people are either not linked to HIV care or are not retained in care. We need to address these gaps show (sic – should presumable be "now") if we are to achieve the target of 90 per cent treatment uptake." (underlining ours)

Whilst AFAO supports the focus on the UNPD in the Introduction, we note that the UNPD targets relate to 2015 – one year into the three year Strategy. Given that the Strategy runs to 2017, the Introduction needs to provide focus and context for goals and actions for the balance of the life of the Strategy.

Paragraph 5 notes that to meet UNPD targets (plural), Australia needs to address "individual, social and structural barriers" to "testing, treatment, care and support" (underlining ours), yet nowhere in the draft are structural barriers to achieving universal access to treatment in Australia identified – these including PBS policies precluding universal access to PBS subsidised ART, and jurisdictional differences in policies for providing ART to Medicare/PBS ineligibles. As a result there are no actions geared to enhancing access by either legislative reform such as allowing people on long-stay temporary visas such as 457 visas or study visas access to the PBS, or Commonwealth

support for jurisdictional policy reforms to enhance access to treatment under state/territory programs.

- Suggested changes to Introduction:

  - Include the paragraph now at p.17, commencing "Recent estimates …" (copied above), or similar, in the Introduction.
  - include a target for the percentage of positive people on ART by 2017.

Current paragraphs 2 and 4

At a number of points throughout the Strategy a view of health promotion as 'dose and response' is implied. This is overly simplistic. Health promotion occurs in complex lived settings where a variety of factors and meanings come into play. The shift in gay men's sexual practice may be associated with a range of factors including condom fatigue, new ways of finding and practising sex and shifting meanings of gay community. Health promotion must adapt to these changes but it cannot entirely control behaviours that are borne of various factors.

- Suggested change to current paragraph 2:

  "Evidence of increasing rates of high risk sexual behaviour among some gay men and men who have sex with men suggests that gay men's sexual practice and the meaning and salience of HIV has changed in recent years. ~~messages around the importance of safe sex practices for preventing HIV transmission are having less impact~~. At the same time, HIV testing among gay men has been decreasing. The average time from infection to diagnosis remains too long at approximately 4.5 years."

- Suggested change to current paragraph 4:

  "The targets come with enormous challenges.

  - Reducing sexual transmission of HIV by 50% by 2015 will require considerable effort given Australia's relatively low HIV prevalence, and high testing and treatment coverage. Modelling shows that to achieve this, a doubling of the current rate of HIV testing would be required, and 95% of people diagnosed with HIV would need to be using antiretroviral therapies, up from the current estimate of 70% (2).
  - Achieving the goal of universal access to timely initiation of quality antiretroviral treatment will require structural reforms to ensure that all people with HIV in Australia, including people on long-stay temporary visas, have ready access to affordable antiretrovirals. This will require policy reform to address individual, social and structural barriers to early initiation of treatment, and identifying and addressing issues affecting people with HIV who are ineligible for PBS subsidised antiretrovirals."

Current paragraph 5

The Strategy appropriately emphasises the need to reduce barriers to testing, treatment and care throughout. However achieving sustained behaviour change is not simply a matter of removing barriers but also promoting health. This implies an additional incentive and effort for behaviour change.

- Suggested change:

  "To achieve the targets, we need to address the range of individual, social and structural barriers that we know impact negatively on prevention, testing, treatment, care and support for people living with and at risk of HIV. We also need to reinvigorate health promotion to implement programs that fully engage with changing sexual practices and emerging technologies."

Current paragraph 6

Paragraph 6 implies that the strong partnership approach was unique to the 1980's, when this is clearly not so. It is crucial that the seventh strategy continues to strongly embed the partnership as fundamental to Australia's HIV response.

- Suggested change:

  "The strong partnership approach that has produced such an effective response ~~in~~ since the 1980s is required now more than ever. The partnership approach has seen new strategies and approaches implemented in recent times, key examples being a national community mobilisation campaign (Ending HIV) and the implementation of community-based sexual health/HIV testing activities. Australia's world recognised partnership approach will remain central to our response to blood borne viruses and sexually transmissible infections."

Paragraph 8

The word "complacency" has been over-used by commentators/the media. The term in this context is value-laden and alienating.

- Suggested change:

  "Yet there is a risk that ~~complacency~~ misconceptions about the seriousness of this disease can continue to undermine the significant progress already made in this country."

Paragraph 10

In health promotion, 'impact' has a very specific and narrow meaning that is not intended here.

- Suggested change:

"Together, we need to implement the solutions that will raise community awareness that HIV can be defeated, increase the effectiveness ~~impact~~ of prevention messages, increase testing rates, reduce the time between infection and diagnosis, link people into treatment and support, and increase the number of people who stay on treatment."

2 HIV in Australia (p.5)

Paragraph 5

This paragraph suggests that particular migrant communities constitute a mode of transmission rather than an affected community/population. It is important that the Strategy not inadvertently feed HIV-related stigma, a fundamental issue to be addressed in developing programs targeting people from high-prevalence countries.

- Suggested change:

"While the HIV epidemic in Australia remains concentrated, primarily focused and resurgent among gay men and other men who have sex with men, there are also clear indications of smaller but important epidemics emerging. An important example is the recent increase in heterosexually acquired HIV among some communities of people who have migrated from high-prevalence African or Southeast Asian countries, and the sexual partners of people from these locations. Projected demographic modelling indicates ~~this mode~~ that ~~of~~ HIV transmission among people in these communities may become increasingly more important, particularly in Western Australia."

3 Achievements (p. 6)

- Suggested changes:

  - Australia signed the United Nations Political Declaration on HIV/AIDS Community led mobilisation of the HIV sector in response to the UNPD and the changing prevention landscape
  - ~~The~~ Therapeutic Goods Administration registered the first rapid HIV test for use in non-laboratory settings
  - Community based HIV rapid testing clinics were established at several sites across Australia
  - Decision to remove the CD4 + <500 count criteria for prescribing HIV treatment, as a result of community submissions
  - Ongoing low rates of HIV transmission among sex workers and people who inject drugs
  - Innovative programs funded ~~implemented~~ by governments ~~states and territories~~ and implemented in partnership with community based organisations to promote prevention among gay and bisexual men

- Enhanced primary health care linkages with specialist and allied health services
- Improved systems implemented for monitoring and surveillance of HIV
- Continued investment in behavioural, clinical, epidemiological, and social research to inform policy and priority setting in the response
- First HIV Stigma Audit documenting the experiences and effects of stigma on the lives of people living with HIV in Australia

4.2 Objectives (p.7)

Number 6 is poorly worded, implying that human rights is a negative impact and suggesting that it is the negative impact of stigma and discrimination that needs eliminating rather than stigma and discrimination per se.

- Suggested change:

"Eliminate discrimination, address human rights issues, and identify and address issues that stigmatise people with HIV and people among affected communities."

4.4 Indicators (p.8 - 9)

AFAO cannot agree that there are no indicators available to measure progress in reducing stigma, discrimination and in addressing human rights issues. Many of these issues, affecting access to BBV/STI testing and to health and support services have been identified. Objectives, actions and indicators need to be developed to ensure that steps are taken to address these issues within the life of this strategy. Without such a focus there is a real risk that this strategy will go no way toward enabling actions to address the known issues, and only enable further identification of issues – to little effect.

We propose that this section of the Strategy be refocused to align with the other strategies in the suite, including by adding meaningful actions to address discrimination and human rights issues identified by the MACBBVS Legal and Discrimination Working Group in the set of seven papers released last year.

- Suggested change for last set of boxed objectives/indicators (p. 9)

"Objective:	to identify and address human rights, discrimination and stigma issues affecting people with HIV and among priority populations"
Indicator:	(we propose that meaningful actions to address discrimination and human rights issues affecting each of the Strategy's be drawn from the set of seven papers produced by the MACBBVS Legal and Discrimination Working Group last year.

5. Guiding principles underpinning Australia's response (pp 10-11)

➢ Suggested changes for the Guiding Principles are outlined below.

- **Human rights**
  The last sentence should be followed with affirmation of the individual's right to choose whether and when to commence treatment:
  - "Fundamental to these rights is acknowledgement that it is the individual's right to decide when to commence treatment, in consultation with their doctor."

  Whilst copying a standard set of principles across the national HIV, STI and BBV strategies ensures complementarity, there is a need to recognise and address the human rights and discrimination issues faced by communities affected by particular BBVs/STIs. For the HIV strategy we propose adding the sentence:

  - "The particular stigma and discrimination issues affecting people with HIV, gay men, sex workers and people who inject drugs must be addressed."

- **Prevention**
  We propose replacing the first sentence with these two sentences:
  - "The transmission of HIV is preventable through the appropriate use of combinations of evidence-based biomedical, behavioural and social approaches. The optimal combination must be tailored to the mode of HIV transmission and the behaviour and culture of affected individuals and groups."

- **Partnership**
  Underpinning principles need to include the need for bipartisanship and adequate resourcing of the priority actions required to give effect to those principles. The Strategy should include specific references to jurisdictional responsibilities in respect of the funding and resourcing of community organisations that represent affected communities, to facilitate meaningful community input into the HIV partnership. We propose adding additional dot points after "This includes":

  - "non-partisan support for the pragmatic social policy measures necessary to control HIV, STIs and viral hepatitis
  - adequate resourcing of all members of the partnership to effectively participate and deliver the range of programs that will ensure delivery of the Strategy's goals
  - cross-jurisdictional commitment to work meaningfully and collaboratively with affected communities, including by funding and engaging with organisations that represent affected communities in developing policy and health promotion programs and working

with those communities and organisations on implementation and service needs. "

- **Meaningful involvement of affected communities**
  It is essential that the meaningful involvement of affected communities be included as a Guiding Principle, immediately after "Partnership". We propose the following wording:
  - "The meaningful participation of people living with HIV, Hepatitis C and B and of affected communities in all aspects of the response is pivotal to the partnership response to HIV and is essential to the development, implementation, monitoring and evaluation of programs and policies. This participation is essential to ensure that program and policy development is effective, evidence-based, and informed by the experiences of people with HIV and by affected communities."

- **Commitment to evidence-based policy and programs**
  Australia needs to be able to respond to changing evidence and new technologies and commitment to evidence-based policy and programs should be included as a Guiding Principle. We propose the following:
  - "In order to respond to new challenges and monitor and evaluate current and new initiatives, an effective response will maintain and continuously add to the evidence base by supporting and using research and evaluation from across the partnership of research, clinicians, community and government."

6 Priority Populations (pp.11-12)

The introductory paragraph for this section should make reference to the differences and overlaps between the priority population groups. Revision to reflect population overlaps should be made across the Strategies.

- Suggested sentence:

  "The following priority populations are not mutually exclusive. For many people there is overlap across more than one priority population".

Gay men and other men who have sex with men

- Suggested change:

  "Gay men and other men who have sex with men, such as bisexually and homosexually active men who do not identify as being gay, are the population group most affected by HIV in Australia with the highest prevalence and risk. HIV transmission among men who have sex with men in Australia has been increasing nationally since 1999. Addressing this resurgence of HIV transmission is fundamental to achieving the goal and targets of this strategy. Men under the age of 25 years are

a particular focus given increasing rates of HIV diagnosis. ~~evidence of increasing unsafe sex practices and low rates of testing~~."

People in custodial settings

- Suggested change:

"People in custodial settings are at risk of HIV transmission through unsafe injecting drug use, unsafe tattooing and unprotected sex (including through sexual assault) as these behaviours increase risk of HIV transmission. If HIV is acquired in the custodial setting and there is a delay in diagnosis, there is also a ~~an increased~~ risk of transmission to others on their return to the community. Barriers to HIV prevention in custodial settings include lack of access to the means of prevention, including sterile injecting and tattooing equipment, and condoms. It is also crucial that barriers to treatment access for people in custodial settings who are living with HIV are identified and addressed. "

7. Priority areas for action (p.13)

Paragraph 5

- Suggested additional paragraph:

" 'Combination prevention' is the application of multiple prevention interventions to achieve a common outcome – the prevention of HIV transmission. Elements of combination prevention include: safe behaviours and condom use; testing and counselling; and linkage of people with HIV to ~~and retention in~~ care and treatment, thereby increasing the proportion of people with HIV who have undetectable viral load. The success of this approach, which is increasingly being discussed and implemented internationally, relies on implementation of all the components."

Whilst reinforcing condom use as the primary prevention tool for HIV sexual transmission, this Strategy includes a broad set of actions to support the roll-out of targeted campaigns promoting combination prevention. Given recent research regarding biomedical prevention there is a need to support regulatory reform required to make PrEP available to defined at-risk populations, and actions to identify and address policy barriers to PEP access. This requires a commitment to increased government investment in the PBS at the national level, and in the development of targeted health promotion campaigns at both the national and jurisdictional level."

Paragraph 6

Given that HIV rapid testing is being rolled out in non-clinical community settings, and given revision of the National HIV testing Policy to enable further roll-out in community settings utilising trained peer staff, it is important that the Strategy does not imply that HIV rapid testing is only supported in care/clinical settings. The terms "HIV point of care testing" and "HIV rapid testing" are not interchangeable and using "point of care" testing as a coverall term is misleading.

- Suggested change

"The introduction of HIV ~~'point of care' or~~ 'rapid' testing in non-laboratory settings is a significant development which has great potential to increase the rate of voluntary and appropriate testing among priority populations. Implementation of HIV rapid testing at point of care and in non-clinical community settings in Australia ~~to date~~ is underway and is evaluating well. Given the disproportionately high contribution to HIV transmission by people who do not know they are infected, efforts such as this to enhance access to testing and link people to treatment, care and support are crucial."

7. Prevention

As noted above, AFAO is concerned that the current draft of section 7 fails to address the core issues raised by AFAO during consultations with the Department. AFAO is particularly concerned that the priority issues and actions set out on the current draft do not reflect AFAO's and its members' input during the consultations. The Prevention section is pivotal to the Strategy yet the draft fails to identify priority issues and actions for each of the priority populations, with the result that this section is generally weak and unfocussed, and its priority actions are inadequate to the task of addressing priority issues affecting HIV prevention among and across priority populations.

- AFAO proposes that the current draft of section 7 be removed and replaced with the text below (in **green**).

7. HIV prevention targeting priority communities and populations

To respond to rises in HIV infections and meet Australia's commitments under the 2011 UNPD, this Strategy seeks to revitalise prevention as the cornerstone of the national response. Targeted HIV prevention is cost effective, and is cost saving to the national economy. Investment in HIV prevention shows higher returns than other comparable health promotion programs, including tobacco control and prevention of heart disease.

As highlighted in the UNPD, strategies for responding to HIV must be underpinned by and include actions to enhance human rights protections and provide an enabling legal and legislative environment for people with HIV, people who inject drugs, sex workers, and gay men and other men who have sex with men.

Significant scientific advances in the treatment and prevention of HIV mean that we now have the potential to dramatically reduce new HIV infections. Research has found that antiretroviral treatments not only have significant health benefits for individuals, but that they greatly reduce the risk of HIV transmission. Treatment as prevention is a new concept to many people with HIV. People with HIV and their sexual partners need to be kept informed of treatment developments.

Although recent advances in HIV treatment provide additional strategies for preventing HIV transmission, their potential beneficial impact is predicated on maintaining cultures of safe sex practice in priority populations. Therefore the promotion of safe behaviour to prevent transmission should continue to be valued alongside new approaches such as treatment as prevention and pre-exposure

prophylaxis. Prevention strategies should be used together in combination and should not be seen as mutually exclusive alternatives.

The rapidly changing landscape of HIV prevention, testing and treatment requires renewed efforts in education at all levels, including people with HIV, other priority populations, the general community and the healthcare workforce. Developments such as rapid testing, PrEP and treatment as prevention that are potentially of value to Australia's HIV response will be monitored over the life of this strategy to ensure a coordinated, considered and evidence-based approach to evaluating their impact.

This Strategy provides for development of HIV prevention programs targeted to priority populations, including:

- provision of information and equipment to support safe sex and safe injecting practices;
- skills building in individuals around the range of HIV risk reduction strategies;
- community development, social change and peer-based health promotion;
- reducing the prevalence of STIs that act as a cofactor in HIV transmission;
- working with mainstream services to address the health factors that compound HIV vulnerability including alcohol and other drug use, depression and other mental health issues among people with HIV and priority populations;
- attention to the social determinants of health that affect HIV prevention efforts, including social marginalisation, access to health promotion and health services, and law and policy frameworks;
- reduction of HIV-related stigma and discrimination.

The Strategy seeks to identify and address significant barriers to accessing early treatment, including restrictions such as Pharmaceutical Benefit Scheme (PBS) and Medicare eligibility criteria (which preclude non-residents, including people living in Australia on long-stay work or study temporary visas); varying requirements for co-payments in states and territories; and lack of availability through community pharmacies.

Prevention will focus on populations experiencing resurgent epidemics, while also strengthening efforts focused on populations where the epidemic has largely to date been prevented (particularly sex workers, people who inject drugs and people in custodial settings) and guarding against emerging epidemics (particularly Aboriginal and Torres Strait Islander people who inject drugs and people from priority CALD communities). The evidence internationally for concentrated epidemics is conclusive that effective HIV prevention must be focused towards those communities and populations most at risk and most affected by HIV rather than spread evenly throughout the population. Targeted resourcing of the prevention response is highly efficient and critical to the success of the national response, but may need increased support to reach highly marginalised populations.

New complexities need to be addressed including changing community perceptions about HIV, the impacts of new therapies, increasingly diverse and diffuse gay communities, a growing and ageing population of people living with HIV and

challenges in reaching particular populations with emerging or re-emerging epidemics. A continued strong focus on gay men will be coupled with recognition of increasing diversity in the populations most at risk of HIV.

When targeting young people, the focus will be on those most at risk of HIV who fall within the priority groups identified above. Universal programs for youth in the general population will be implemented through the STI Strategy.

The following populations are priorities for prevention. These populations are not mutually exclusive.

7.1 Gay and other men who have sex with men

Addressing the resurgence of HIV transmission among gay men and men who have sex with men requires strengthened prevention approaches, including combination prevention approaches. This represents the highest priority of this Strategy.

A disproportionate number of HIV infections come from those who do not know they are HIV positive, with a significant proportion of infections from those who are in primary HIV infection - the initial period after someone becomes infected with HIV, when their viral load will be at its highest. Current guidelines for STI testing for MSM recommends testing for HIV (and other STIs) at least once a year, and 3–6 monthly if they have had a larger number of partners or participated in certain types of sex.

Increasing the frequency of testing to multiple times per year, especially for gay men and other men who have sex with men at higher risk of HIV acquisition, will reduce infection rates. This increase in frequency would also be important for detecting people in primary HIV infection, given its relatively short duration. If testing rates were much higher, and many of the people who were found to be HIV positive were offered and received treatment, the benefit would be even greater with a further reduction in infections. This requires addressing persisting structural barriers to HIV testing (such as cost, location, confidentiality/anonymity, opening hours, and the need to return to collect test results), along with psychological barriers (such as fear of results, not wanting to tell others, a reluctance to discuss risk behaviours with a doctor, and HIV being highly stigmatised in an individual's community).

Prevention programs need to be re-energised with a focus on safe behaviours, increasing HIV testing rates and promotion of the benefits of early treatment. Current examples of innovation in the HIV sector can be looked to as models for reinvigoration. Programs should reflect the diversity of the gay community and include targeted programs for sexually adventurous or highly sexually active gay men, men in HIV serodiscordant relationships, Aboriginal and Torres Strait Islander gay men, transgender people, sistergirls, gay men from CALD backgrounds, male sex workers, and men with cognitive, intellectual or psychiatric disability.

Improved access to rapid HIV testing and the potential TGA approval of rapid test kits for self-testing can help increase the frequency and regularity of HIV testing among gay men, and help reduce undiagnosed infections. Increasing testing rates among

gay men and other MSM will increase the number of people aware of their HIV status and minimise delays between infection and diagnosis, thereby reducing the number of onward transmissions. Increased testing and more people being aware of their HIV status will also improve health outcomes and reduce health impacts of late diagnosis.

During the life of this strategy, there needs to be improved access to rapid HIV testing in a range of community settings and the TGA's consideration of kits for self-testing needs to be facilitated.

Consistent condom use remains the most effective means of preventing HIV transmission. The majority of gay men continue to consistently use condoms with casual partners, but there has also been an increase in the proportion reporting some unprotected anal intercourse. Gay men who are sexually adventurous or highly sexual active men may be at increased risk of HIV infection. As gay men are increasingly using other non-condom based strategies to reduce HIV risk, prevention programs will need to respond to the need for information and education regarding these strategies. An important new prevention tool in this context is pre-exposure prophylaxis (PrEP). PrEP also has the potential to aid efforts by preventing HIV transmission among those who are at greatest risk. Research has demonstrated its efficacy in reducing the risk of HIV transmission. While some barriers exist to its implementation, including policy and funding, it has the potential to reduce the risk of transmission for gay men at high risk of HIV infection.

Treatment as prevention and new developments such as rapid testing and PrEP, are potentially of great value to Australia's HIV response. Research findings will be monitored over the life of this strategy to ensure a coordinated, considered and evidence-based approach to their potential implementation. Implementation of these strategies will require integration into existing health promotion activities.

While these advances offer great potential, promoting condoms and safe behaviour needs to remain a central focus. At the same time prevention programs will need to focus on increasing the frequency and regularity of HIV testing rates, to ensure that people diagnosed with HIV are made aware of advances in HIV treatment and the benefits of early treatment. Prevention strategies should be used together in combination and should not be seen as mutually exclusive alternatives.

Priority actions for gay men and other men who have sex with men

Prevention

- Using the expertise of community sector agencies within the partnership, develop and implement comprehensive core prevention programs that focus on ongoing consistent condom use and other risk reduction strategies
- Continued investment in targeted prevention programs, including peer-led education programs, with specific strategies for those who may be at greater risk of HIV infection

- Commonwealth support for establishment of demonstration projects for biomedical interventions, including providing access to PrEP to people at high risk of HIV, and fast-tracking of TGA licensing and PBS funding of ART for effective PrEP.

Testing

- Substantially increase access to and uptake of voluntary HIV testing among gay men and other MSM through expanded access to rapid HIV testing, including in community-based settings, and make conventional HIV testing more accessible
- Develop and implement health promotion based HIV testing programs targeting populations that face structural, legal, policy and/or psychological barriers to regular testing
- Fund, develop and implement innovative HIV testing technologies and programs for community-based testing using point-of-care tests, including self-use rapid HIV test kits
- Review the National HIV Testing Policy to allow the TGA to approve the sale and distribution of rapid HIV tests for self-testing and
- Address regulatory barriers that unnecessarily delay TGA approval processes.

Treatment

- Develop and implement education activities informing gay men and other men who have sex with men of the individual and public health benefits of earlier treatment
- Pending policy reform to broaden access to the PBS and Medicare, work with the states/territories to ensure access to treatment for people living with HIV who are Medicare/PBS ineligible.

Enabling Environments

- Ensure that the use of new technologies does not have negative implications on voluntary testing, informed consent, privacy and criminalisation in practice
- Invest in research to better understand the Australian epidemic and to inform policy and program development on new prevention technologies prior and following their introduction.
- Invest in specific program and policy evaluation and evidence-building research activities to support evidence-based and innovative policy and program decisions.
- Continue professional development of the HIV prevention and health promotion workforce, including investing in a new generation of peer education and prevention workers.

7.2 People living with HIV

Prevention plays a role in supporting people with HIV to optimise their health, and live productive and fulfilling lives, while also supporting their role in preventing the further transmission of HIV.

Preventing HIV transmission is a shared responsibility of all individuals, irrespective of HIV status. Sexual and reproductive rights, regardless of HIV status, must be recognised. Decisions around testing must be made by the individual, in consultation with their doctor.

If late diagnosis rates are to be addressed, it is important that regular HIV testing is made as easy and convenient as possible, with programs targeted to affected communities so as to address structural and psycho-social barriers to regular testing.

Priority actions for people living with HIV

- Promote understanding of scientific advances in HIV treatment and prevention so that individuals can make informed choices in consultation with their doctors/clinicians
- Promote understanding of scientific advances in HIV treatment toward substantially increasing the number of people with HIV accessing antiretroviral treatment
- Make ART more widely available at community pharmacies and reduce the price of obtaining this medication by removing co-payments for people on low incomes.
- Establish programs to provide ART to people with HIV who are ineligible for PBS/Medicare
- Expand PBS and Medicare residential criteria such that HIV-positive people in Australia on long-stay temporary visas (including 457 visas and student visas), may access subsidised ART and health care
- Develop targeted strategies to address late diagnosis rates among gay men and among CALD communities of people from high HIV prevalence countries.

7.3 Aboriginal and Torres Strait Islander people

Data and analyses from the 'Blood borne virus and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance and Evaluation Report 2012' will guide the development of Strategy actions. Key findings for 2011 included that:

- People among Aboriginal and Torres Strait Islander communities continue to be over-represented in reports for STIs and viral hepatitis, with disproportionately high chlamydia and gonorrhoea reports particularly notable. Remote and very remote Aboriginal and Torres Strait Islander communities continue to experience substantially higher rates of chlamydia, gonorrhoea and infectious syphilis compared with regional and urban centres

- Diagnoses of infectious syphilis increased in Aboriginal and Torres Strait Islander communities, particularly in Queensland among 15 to 19 year olds
- Diagnoses of newly acquired hepatitis C and newly acquired hepatitis B are reported at disproportionately high rates among Aboriginal and Torres Strait Islander communities
- HIV continues to be diagnosed at a similar rate to the non-Indigenous population although there are substantial differences in exposure categories.
- While only 3% of HIV transmissions between 2007 and 2011 were attributed to injecting drug use for the general population, HIV transmission was attributed to injecting drug use for 16% of cases among people from Aboriginal and Torres Strait Islander communities over that period.

Although Aboriginal and Torres Strait Islander populations have rates of HIV similar to the general population, Aboriginal and Torres Strait Islander people continue to be named as a priority population under this Strategy. This is for a number of reasons, including the potential for an acceleration of the HIV epidemic among Indigenous communities given:

- the high prevalence of sexually transmissible infections (increasing the likelihood of HIV transmission) in many remote and very remote communities
- higher rates of injecting drug use and sharing of injecting and other equipment
- the ongoing incidence of HIV amongst sistergirls and gay and bisexual Aboriginal and Torres Strait Island men, which is exacerbated by a tendency for later diagnosis than their non-Indigenous counterparts
- limited access to culturally appropriate HIV care and prevention services
- the over-representation of Aboriginal and Torres Strait Islander men and women in prisons and juvenile detention, increasing the likelihood of injecting drug use
- the geographical, cultural and social circumstances of many communities, including high mobility, lower health literacy, and issues such as shame and underlying poor health status
- the movement and interaction of people between Australia and the Western Province of Papua New Guinea via the Torres Strait Islands and the Top End.

This Strategy has strong linkages to the Fourth Aboriginal and Torres Strait Islander BBVs and STIs Strategy, and complementary actions to address rising rates of injecting drug use among Aboriginal and Torres Strait Islander people, particularly among people in custodial settings, are prioritised. Notably, given that HIV transmission occurs more easily in the presence of STIs, addressing increases in STI diagnoses among people from Aboriginal and Torres Strait Islander communities must remain a priority under the seventh HIV Strategy as well as under the fourth Aboriginal and Torres Strait Islander strategy.

This Strategy includes actions to address the inadequacy of available information on the population characteristics of Aboriginal and Torres Strait Islander people accessing HIV testing, to supplement that collected through social and behavioural data about gay men and MSM. Baseline testing rates in Aboriginal and Torres Strait Islander communities are not known; this information is crucial to identifying barriers

to HIV testing for Aboriginal and Torres Strait Islander people and for the development of properly targeted strategies to promote testing among A&TSI people who are at risk of STI and/or BBV acquisition.

Ensuring that a wide range of strategies to distribute sterile injecting equipment, including NSPs, are available in Aboriginal and Torres Strait Islander communities is a priority. Bacterial STIs will be addressed through detection and treatment. The HIV Strategy will complement those efforts. Both Strategies will seek to address the high levels of stigma associated with HIV and STIs, particularly in remote communities, which leads to fears of disclosure and heightened secrecy and to protect Aboriginal and Torres Strait Islander women from HIV.

The high levels of stigma associated with HIV and STIs, particularly in remote communities, should be addressed. Health promotion and harm reduction services can be difficult for Aboriginal and Torres Strait Islander populations to access. Strategies will be put in place to provide services that are accessible, culturally appropriate and which better meet their health needs. This includes support for retaining an appropriately trained clinical, prevention and health promotion workforce. Cultural awareness and sensitivity to Indigenous practices and beliefs are required as well as capacity development in sexual health promotion, community development, peer education, clinical care and research. This includes support for retaining an appropriately trained clinical, prevention and health promotion workforce.

Cross-border issues with Papua New Guinea are a significant concern affecting Torres Strait Island communities. The heightened risk of HIV and STI transmission associated with the movement and interaction of people between Australia and the Western Province of Papua New Guinea is acknowledged, and efforts should continue to address the increased burden on health services and the need for improved coordination of public health programs. This issue has received increasing attention since 2007 and is also addressed in the Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy. This Strategy acknowledges the heightened risk of HIV, STI and tuberculosis transmission associated with the movement and interaction of people between Australia and the Western Province of Papua New Guinea, and the importance of continued efforts to address the increased burden on health services and the need for improved co-ordination of public health programs.

Priority actions for Aboriginal and Torres Strait Islander People

- Ensure that harm reduction principles underpin priority actions set out in the strategies
- Development and resourcing of targeted initiatives to enhance access to needle and syringe programs (NSPs) and drug treatment programs
- Development and resourcing of targeted pre-and post-release BBV prevention programs for prisoners from Aboriginal and Torres Strait Islander communities.

- Workforce development for services delivering in HIV/BBV/STI prevention programs for people among Aboriginal and Torres Strait Islander communities must include the development *of culturally effective health promotion programs.*

7.4 People who travel and priority culturally and linguistically diverse populations

Australian residents who acquire HIV while travelling and working in countries or regions with high HIV prevalence are a diverse group that includes people holidaying, working overseas or visiting friends and relatives. The group includes gay and other men who have sex with men, people who inject drugs, and sex workers who work while travelling, heterosexual travellers and expatriates and Australians from high prevalence countries returning to their country of origin for visits. More research in this area is required, to inform tailored health promotion interventions to target specific groups travelling to particular countries.

There is a need to target programs to travel-related prevention and to work with migrant and expatriate communities within Australia including Papua New Guinea communities in far north Queensland and people working and studying in Australia and overseas. There are also opportunities for collaboration between domestic and regional organisations working in the HIV area, as well as across portfolios with migrant and settlement services and through Australian AID and other development partners.

In Australia, people from high prevalence countries are often diagnosed later than people born in Australia, but there is a lack of data on baseline testing rates among people from these communities.

Priority actions for people who travel and priority culturally and linguistically diverse populations

- Reform migration law to bring Australia in line with international human rights standard and public best practice
- Review and reform health requirement and waiver policies to ensure a more transparent, fair and streamlined process
- Develop and implement, in partnership with multicultural health organisations, and private industry sectors and services, highly targeted social marketing campaigns for Australians travelling or working in regions with high HIV prevalence, including to people travelling in the Australia/PNG border Treaty Zone
- Develop and implement, with migrant community agencies, targeted messaging to migrants from high prevalence countries returning for holidays or work
- Continue to address stigma in HIV awareness and health promotion campaigns in migrant and refugee communities
- Work with clinical practitioners to promote voluntary HIV testing among people from or who travel to high prevalence countries

- Identify how to best to develop and promote HIV prevention and care and support of people targeting people from high prevalence countries as part of migrant/refugee settlement programs, and how to best address HIV-related stigma among people from high prevalence countries.

7.5 People who inject drugs

Ensuring a supportive and enabling environment to both maintain and expand access to harm reduction and peer-based services and programs will help prevent any further increases in HIV infection rates among people who inject drugs. The identification, monitoring and resolution of problems in relation to the quality, coverage and accessibility of NSPs are therefore supported.

The need to improve access to primary health care and to reduce the level of discrimination experienced by people who inject drugs as a result of stigma within the health care system is a priority. It is important to provide additional support for the group of people who inject drugs who may have difficulty adhering to complex HIV treatment regimens. These issues will be addressed through community education, training programs for health care workers and the development of supportive systems at local levels.

Workforce development will be supported to ensure NSPs meet the needs of diverse population groups that require access to services.

Priority actions for people who inject drugs

- Increase and diversify the coverage and accessibility of sites from which sterile equipment is available
- Improve access to sterile equipment by diverse population groups who have more limited access
- Provide legal and regulatory environments that support the delivery of evidence-based public health programs.

7.6 People in custodial settings

In the correctional environment, there are often impediments to best practice BBV prevention. These problems are exacerbated by higher levels of co-infection with HIV and hepatitis C in this population. Effective HIV and other BBVs prevention and health promotion requires a whole-of-government approach enlisting those concerned with juvenile detention centres as well as adult prisons.

Each state and territory has its own separate, independent system of police, courts, prisons and juvenile institutions. Health services are provided variously by health or justice jurisdictions and supplied directly, or contracted, by public and private custodial facilities. Australia's prison systems are relatively small and isolated from each other. This presents challenges for the coordination of policy development, implementation and evaluation, research and education. However these challenges have been overcome within the custodial environment to enable effective responses to a number of key public health issues including BBV and STI initiatives such as

provision of condoms, access to bleach, provision of opioid pharmacotherapies, the National Prison Entrants BBV & Risk Behaviour Survey, etc.

The provision of sterile injecting equipment in Australian prisons is a controversial issue for some in the community. An increasing number of international jurisdictions have implemented or are actively contemplating the implementation of needle and syringe programs in prisons. To date there is no evidence of adverse outcomes associated with these programs. However, several positive or beneficial outcomes have been documented from programs that have undergone evaluation, including: no documented increase in illicit or injecting drug use; significant reductions in equipment reusing/sharing; no documented attacks or violence; no documented seroconversion for HIV or hepatitis; and acceptance of the program by staff and prisoners.

In view of the well documented return on investment and effectiveness of Australian community-based needle and syringe programs, combined with the international evidence demonstrating the effectiveness of prison needle and syringe programs it is appropriate throughout the life of this strategy for State and Territory Governments to identify opportunities for trialling the intervention in Australian custodial settings.

HIV prevention among people who inject drugs has been highly successful in Australia. This success has been underpinned by the early introduction and maintenance of NSPs and the contribution of peer-based education and drug user organisations in HIV prevention. Opportunities for trialling needle and syringe programs in prisons need to be pursued.

In addition, it is essential that the full range of BBV & STI prevention strategies are maintained in Australian custodial settings, including:

- increasing the provision of, and access to bleach and disinfectants where no other safer alternatives are provided for decontaminating spills, surfaces or equipment;
- easily accessible education and counselling including peer education and support on HIV & STIs, hepatitis B and hepatitis C and injection drug use as a fundamental health promotion technique to support risk reduction practices; and
- increasing access to drug treatment programs including opioid pharmacotherapy programs which have been demonstrated to reduce blood borne virus transmission in custodial settings as well as detoxification and drug rehabilitation programs.

Strategies should also be explored for developing and promoting Australian infection control standards for tattooing and body art to reduce the risk of transmission of blood borne viruses via those means in custodial settings.

Drug treatment and drug substitution programs are effective when coupled with good accessibility and strong support for people who are willing to initiate them. These programs are highly important in the HIV response and are supported by this Strategy, including for custodial settings.

Priority actions for people in custodial settings

- Scale up corrections based blood-borne virus prevention initiatives, including access to new injecting equipment, and bleach and disinfectants, and development of appropriate infection control standards.
- Ensure good access to drug treatment programs, including opioid pharmacotherapy, in custodial settings.
- Identify opportunities for the trialling of access to sterile injecting equipment for people in custodial settings
- Identify and address issues affecting aces to ART for people with HIV in custodial settings.

6.7 Sex workers

Ensuring sex workers are supported to maintain safe sex practices requires education and community development approaches by sex worker organisations within the context of occupational health and safety in the sex industry. Treatment as prevention is not a suitable strategy for the sex worker community. Prevention strategies must be maintained and expanded through enhanced investment, including increased resourcing of sex worker peer education and outreach. Significant increase in funding is necessary for community-led sex worker organisations to allow for effective peer education delivery incorporating all sex workers including CALD, migrant, IDU, Male, trans*, Aboriginal and Torres Strait Islander, HIV-positive and street-based sex workers.

Decriminalisation of sex work remains the best practice approach to sex work legislation and necessary to support effective health promotion delivery and public health outcomes. Legal empowerment of sex worker communities underpins effective HIV responses. For effective HIV prevention, barriers to health promotion and access to services must be eliminated. This includes licensing, criminalisation of HIV, registration of sex workers and law enforcement practices (entrapment, corruption, use of condoms as evidence of sex work) that pose barriers to health promotion, peer education and human rights. Anti-discrimination protections for sex workers must be available and effective across all jurisdictions. Implementation of a National Training and Assessment Program has provided important national support and development opportunities to sex worker peer educators to extend and receive accreditation for their skills. It supports sex worker self-determination and peer education. Attention will continue to be given to the professional and workforce development needs of sex worker peer educators under the training program.

Priority actions for sex workers

- Continue to provide community based peer education and outreach to sex workers, and work to ensure occupational health and safety standards within the sex industry.
- Recognise voluntary testing as the optimum approach to HIV and STI testing and monitor any potential negative impact on sex workers with the increasing availability of rapid HIV testing.

- Programs and services recognise the diversity of sex workers, including CALD and migrant workers, and the increasing diversity of the sex industry.
- Recognise decriminalisation as the evidence based model of sex industry regulation that best supports effective health promotion, public health outcomes and the human rights of sex workers.
- Work to ensure legal and regulatory environments for sex work and the sex industry support the delivery of evidence-based public health programs.
- Review and reform anti-discrimination laws to promote sex workers legal rights to protection from discrimination in employment, and access to health care and other services.

➢ ***In the alternative, in the event that substantial changes to the text cannot be made at this stage, we make the following recommendations for the Prevention section.***

Box, p. 14

Although the text on p.16 notes the relationship between increasing testing rates/frequency among gay men/MSM and prevention, the boxed Priority actions do not include any action to facilitate increasing rates of testing. It is essential that an action be added to facilitate increased access to testing and increased testing rates/frequency, particularly among gay men.

➢ We propose the following additional dot points:

- Using the expertise of community sector agencies within the partnership, develop and implement comprehensive core prevention programs that focus on ongoing consistent condom use and other risk reduction strategies
- Continued investment in targeted prevention programs, including peer-led education programs, with specific strategies for those who may be at greater risk of HIV infection.
- Support and resource the rollout of rapid HIV testing, including in non-clinical community settings, across jurisdictions and settings; and support policy reform to facilitate TGA approval of rapid tests for self-testing, in accordance with the National HIV Testing Policy as periodically updated.

This section needs a paragraph highlighting the need to respond to the changing nature of the HIV epidemic and facilitate the development of responsive and innovative prevention programs targeting new and emerging priority populations and sub-populations, and supporting the roll-out of targeted campaigns promoting combination prevention. The final paragraph of the Prevention section (on p. 15) needs to refer to PrEP and there needs to be a related action in the boxed actions on p.14. The Strategy should reflect recent research supporting biomedical prevention and incorporate actions to support regulatory reform required to make PrEP available to defined at-risk populations, and actions to identify and address policy barriers to PEP access.

- We propose the following additional dot points:

  - Support the establishment of demonstration projects for biomedical interventions, including providing access to PrEP to people at high risk of HIV, and fast-track of ART for effective PrEP
  - Support regulatory reform of TGA licensing processes and address PBS policy barriers to ensure that PrEP is made available to defined at-risk populations
  - Identify and address Commonwealth and jurisdictional barriers to PEP access.

Current dot point 1 in box, p. 14

- Suggested change:

  "~~Increase the use of~~ Strengthen health promotion and prevention activities focusing on safe sexual and safe injecting practices in priority populations, particularly ~~among~~ targeting gay men and men who have sex with men, and people in Aboriginal and Torres Strait Islander communities."

Dot point 2 in box

- Suggested change:

  "Build knowledge, ~~and~~ skills and capacity in priority populations, primary care providers, policy makers and the general community in establishing innovative HIV risk reduction programs and activities"

Paragraph 2, p.14

- Suggested change:

  "Evidence of increasing rates of high risk sexual behaviour among some gay men and men who have sex with men suggests that gay men's sexual practice and the meaning and salience of HIV has changed in recent years. These changes have had an impact on the effectiveness of HIV prevention messages. ~~the impact of messages around the importance of safe sex practices for preventing HIV transmission is waning.~~ This demands an innovative response from health promotion that actively explores new methods of communication to bring about behaviour change. ~~a move away from traditional health promotion activities to alternative means of communication to bring about behaviour change.~~ We need to re-invigorate cultures of safe sex practices among gay men and men who have sex with men, including through community-driven and peer-based education and support approaches. Prevention efforts need a renewed focus on young men who have sex with men, given evidence showing an increase in ~~risk behaviours~~ HIV incidence and reduced levels of testing among this group. We need to establish a greater level of knowledge of new prevention and treatment options and the importance of testing among this population group."

New paragraph

This section needs a paragraph regarding treatment as prevention, talking to boxed dot point 3. Following is proposed new paragraph (for insertion after paragraph 2, p.14).

- Suggested paragraph

  "Evidence for the efficacy of treatment as prevention continues to emerge. A number of clinical studies will further report during the life of this strategy. It will be important to critically assess the applicability of such findings to the Australian epidemic and context. It will also be crucial to develop a health promotion response that informs gay men and other key affected populations about treatment as prevention and provides effective guidance on its appropriate use as a risk reduction strategy."

Next paragraph

- Suggested paragraph

  "Evidence of increasing rates of high risk sexual behaviour among some gay men and men who have sex with men suggests that the impact of messages around the importance of safe sex practices for preventing HIV transmission is waning. This demands a move away from traditional health promotion activities to alternative means of communication to bring about behaviour change. We need to re-invigorate cultures of safe sex practices among gay men and men who have sex with men, including through community-driven and peer-based education and support approaches. We need to establish a greater level of knowledge of new prevention and treatment options and the importance of testing among this population group. Prevention efforts need a renewed focus on young men who have sex with men, given evidence showing an increase in risk behaviours and reduced levels of testing among this group. Prevention efforts must include development of national and state/territory sex and sexuality education curricula for schools that include education regarding sexually transmitted BBVs and STIs."

Next paragraph

"Messages also need to be better tailored to meet the needs of ~~new Australians~~ people from high HIV prevalence countries. Patterns of infection, including infections which may occur on visits to the country of origin or from partners who travel to Australia on temporary arrangements, are not well understood and require more research. We need to explore these issues with communities, and identify and address barriers ~~such as~~ relating to lack of resources, stigma and discrimination and the lack of culturally appropriate initiatives and services."

Paragraph 1, p.15

- Suggested change (incorporating wording from the draft ATSI BBV and STI Strategy)

  "HIV prevention approaches targeting Aboriginal and Torres Strait Islander people need to respond appropriately to social, cultural and environmental contexts. Prevention efforts should prioritise young people and people living in remote and very remote communities given the sustained high prevalence of STIs and the associated increased risk for HIV transmission; and people who inject drugs given high rates of HIV transmission among this population through injecting drug use. Efforts to engage young people need to be contemporary, culturally appropriate, supported by the community and should be inclusive of young people both within and outside the

school environment. Given the high burden of STIs among young ATSI people, the relatively high pregnancy rate among ATSI teenagers and the population profile of the community, particular consideration should be given to targeting young ATSI people in the development of national and state/territory sex and sexuality education curricula for schools. Access to sex and sexuality education for school age ATSI people not in school is also critical."

7.2 Testing (p.15)

This section needs to reflect and support further revisions to the National HIV Testing Policy, particularly regarding the need to identify and address policy barriers to scale up community-based testing services targeting gay men. The Strategy should include clearly defined actions to enhance access to testing by supporting increased HIV testing rates and increase testing frequency, especially among gay and other men who have sex with men and among people from emerging priority populations such as people from and/or who travel to countries with high prevalence of HIV.

Box

- Proposed for new dot points:

  - identify and address access barriers for conventional testing
  - substantially increase access to and uptake of voluntary HIV testing among gay men and other MSM, including in community-based settings and make conventional HIV testing more accessible
  - fund and promote the development of innovative community testing models for gay men and other MSM, utilising new testing technology
  - Identify and address psycho-social and structural barriers experienced by gay men and other MSM to undertaking timely and regular HIV testing
  - develop and implement HIV testing programs targeting populations that face structural, legal, policy and/or psychological barriers to regular testing
  - identify and address regulatory barriers that unnecessarily delay TGA approval processes for testing devices and new technologies
  - Review the National HIV Testing Policy to allow the TGA to approve the sale and distribution of rapid HIV tests for self-testing and address regulatory barriers that unnecessarily delay TGA approval processes
  - provide Commonwealth support for the development and roll-out of community testing models and biomedical prevention tools, in particular post and pre exposure prophylaxis (PEP and PREP)

Current first dot point 1

This is not an action, it is a goal or objective and the dot points should be the priority actions to achieve that goal/objective.

- Proposal for replacement dot point 1

"Identify structural barriers to testing among gay men and MSM

- In the paragraph commencing "This may require …", reference to "exploring new testing model" should be to "facilitating the rollout and scale up of …"
- Reference to "point of care testing" should be to "HIV rapid testing in point of care, community and other non-laboratory settings", to avoid ambiguity regarding use of HIV rapid testing devices in community settings that are not "point of care", as per pending National HIV Testing Policy 2014.
- The last paragraph is too waffly and sits oddly. The point regarding the potentially stigmatising effect of some initiatives should be made but elsewhere - and in the context of the need not to fuel stigma that may undermine prevention and care initiatives.

7.3 Management, Care and Support (p.16)

Priority actions box:

- A target should be set for the percentage of positive people on ART.
- Some challenges that currently exist for treatment access are mentioned, yet nothing is said about how the Commonwealth, or others in the partnership, are to address these barriers. This is particularly pertinent as the commonwealth has the power/responsibility to address a number of these barriers – particularly Medicare/PBS ineligibility based on migration status.

Priority actions

These actions need to ensure that policy barriers to universal and equitable access to treatment are identified and addressed. Some challenges that currently exist for treatment access are mentioned, yet nothing is said about how the Commonwealth, or others in the partnership, are to address these barriers. This is particularly pertinent as the commonwealth has the power/responsibility to address a number of these barriers – particularly Medicare/PBS ineligibility based on migration status

- Proposed changes:

    - ~~Promote~~ Support treatment uptake by addressing barriers to commencing or continuing antiretroviral medications, and retention in care

- Develop and implement education activities informing gay men and other men who have sex with men of the individual and public health benefits of earlier treatment
- Identify and address legislative and policy barriers affecting access to and uptake of antiretroviral medications at earlier stages of infection, including by working with the jurisdictions to ensure universal treatment access for people in Australia, regardless of their visa status
- Investigate opportunities to increase access to treatment for people living with HIV who are Medicare ineligible
- Ensure that priority populations and health care professionals are aware of new treatment approaches including treatment as prevention
- Increase the use and effectiveness of shared care models between General Practitioners and HIV specialists
- Promote the use of evidence-based clinical guidelines.

Paragraph 2, p.17

- Proposed changes:

  "Recent estimates of the treatment continuum (2) in Australia (diagram below) suggest that 30 to 50 per cent of people who know they are living with HIV are not receiving antiretroviral treatment. A proportion of these people are either not linked to HIV care or are not retained in care. We need to take action to address these gaps ~~show~~ if we are to achieve the target of 90 per cent treatment uptake.

Paragraph 3, p.19

- Proposed changes:

  "The workforce supporting HIV ~~point of care~~ rapid testing needs to be able to adjust to new technologies, particularly in non-specialist HIV services and community-based organisations. Inclusion of HIV ~~point of care~~ rapid testing competencies should be considered in incorporated into existing training packages ~~or~~ and in new qualifications.

7.4 Workforce

This section should specifically refer to the need to resource the community sector's health promotion workforce, in developing education, training and professional development programs. In doing so, "information provision" and "education" should be distinguished from health promotion.

- Proposed changes:

  - Replace references to the "health education and health care workforce" with health education, health promotion and health care workforce
  - The term "point of care" should only be used where the context/setting of testing is one of care. Revise paragraph 3., p. 14 to: "The workforce supporting HIV rapid testing at PoC and in other non-laboratory settings needs to …" (or revise as per final wording used in 2014 revision of the National HIV testing Policy)
  - Reference to training competencies for HIV rapid testing needs to cite/cross-reference the National HIV Testing Policy
  - Priority actions need strengthening, similarly to the other sections, and these need to identify who is to undertake the actions and how needs identified are to be addressed. Role of community orgs must be acknowledged; and commitment to providing resources to build the capacity to train non-HIV workforce needs resourcing/programming

7.5 Removing barriers

Priority actions box

The boxed priority action at dot point 1 is a goal, not an action; and dot point 3 constitutes a process rather than an action.

Overall this section is weak and despite AFAO's and its members' submissions that the enabling legal environment actions of the Sixth Strategy were too vague, this section is far weaker than the equivalent section of the Sixth Strategy.

As stated above, many of the issues affecting access to BBV/STI testing, and to health and support services have been identified and objectives, actions and indicators need to be developed to ensure that steps are taken to address these issues with the life of this strategy. This section needs meaningful actions to address discrimination and human rights issues drawn from the MACBBVS Legal and Discrimination Working Party's seven papers on the impacts of discrimination and criminalisation on public health approaches BBVs and STIs.

These papers outline the impacts of discrimination and criminalisation on public health approaches to BBV and STI prevention and treatment, and make specific recommendations for the reform of laws and policies that impede HIV prevention for people among affected communities, and the care and support of people with HIV. AFAO strongly recommends that new suite of National HIV,STI, HCV, HBV and Aboriginal strategies include complementary priority actions that specifically reflect and give effect to the recommendations made in these papers

1. Aligning criminal laws and law enforcement practices with the public health objectives of the National Strategies

2. Addressing Discrimination against people living with blood borne diseases
3. Addressing Discrimination in immigration law and policy
4. Criminalisation of people living with HIV for non-disclosure, HIV exposure and HIV transmission
5. Criminalisation of people who inject drugs
6. Sex work regulation, human rights and alignment with evidence
7. Removing legislative and policy barriers to NSP and injecting equipment access

In particular we note the need for the Strategy to set out clearly defined actions to address the arbitrary application of the criminal law in respect of non-disclosure of HIV-positive status and/or HIV exposure where there is no intention to transmit HIV.

Boxed priority actions (p.19)

- Suggested boxed priority actions (p.19)

  - Develop an action plan to address human rights, discrimination and stigma issues affecting people with HIV and among priority populations, which provides for staged consideration and implementation of the recommendations made by the MACBBVS Legal and Discrimination Working Group in the set of seven papers released in 2013
  - Identify and address policies and practices fuelling stigma experienced by people with HIV and people among affected communities in community and health care settings
  - Support the development of programs to empower priority populations to increase individual and community resilience
  - Remove institutional, regulatory and systemic barriers to equality of care for people with HIV and for people among communities affected by HIV in the health sector
  - Establish a cross-jurisdictional/cross-portfolio working party to consider and implement actions to reduce systemic discrimination and the stigmatisation of people with HIV and people among affected communities in the health and other sectors
  - Ensure that the introduction of new technologies do not have negative implications on voluntary testing, informed consent, privacy and criminalisation in practice
  - Investment in research to understand the Australian epidemic and to inform policy and program development on new prevention technologies prior and following their introduction
  - Invest in specific program and policy evaluation and evidence-building research activities to support evidence-based and innovative policy and program decisions.
  - Continue professional development of the HIV prevention and health promotion workforce, including by investing in a new generation of peer education and prevention workers

Last paragraph, p.20

- Suggested changes

"~~Implementation of this strategy rests within the health system. However, m~~Many of the barriers to access and equal treatment of affected individuals and communities fall outside the remit or influence ~~responsibility~~ of the HIV partnership. ~~health system.~~ For example, it could be argued that criminalisation perpetuates the isolation and marginalisation of priority populations and affects ~~limits~~ their ability to seek information, access support and health care. It is important that the ~~health sector~~ HIV partnership enters into a respectful dialogue with other sectors to discuss impacts of wider decisions on the health of priority groups, particularly where those decisions fuel stigma and undermine prevention, care and support initiatives."

7.6 Surveillance, research and evaluation.

This section fails to fully identify ongoing challenges epidemiologically, for example the increasing population of PLHIV and the increased number and proportion of gay men with HIV who are sexually active.

Boxed priority actions, p. 20

The box collapses what should be three groups of actions - for surveillance, research and evaluation.

- Suggested changes:

- Create three sets of actions within the box - for surveillance, research and evaluation.
- Include a dot point regarding research on condom use and use of other risk reduction strategies.

Dot point 4

This point is unclear. Apart from assessment, what is the proposed action to ensure that appropriate technologies are utilised?

Dot point 6

- Suggested change:

"Continue to evaluate health promotion, testing, treatment, care, support and education and awareness programs and activities to ensure they are effective"

Dot point 7

- Suggested change:
  "~~Explore options for~~ Develop a method to assess how and to what extent discriminatory legislation, policy and regulation fuels stigma and impedes equal access to health care."