AUSTRALIAN FEDERATION OF AIDS ORGANISATIONS
Leading the community response to HIV

Religious Discrimination Bill 2019: Second Exposure Draft

AFAO Submission

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Australian Federation of AIDS Organisations

The Australian Federation of AIDS Organisations (AFAO) is the national federation for the HIV community response in Australia. AFAO works to end HIV transmission and reduce its impact on communities in Australia, Asia and the Pacific. AFAO's members are the AIDS Councils in each state and territory; the National Association of People with HIV Australia (NAPWHA); the Australian Injecting & Illicit Drug Users League (AIVL); Anwernekenhe National HIV Alliance (ANA); and Scarlet Alliance, Australian Sex Workers Association. AFAO's affiliate member organisations – spanning community, research and clinical workforce – share AFAO's values and support the work we do.

The Australian Federation of AIDS Organisations (AFAO) welcomes the opportunity to provide feedback on the *Religious Discrimination Bill 2019: Second Exposure Draft* (the Bill).

Executive Summary

While the second exposure draft contains changes, we are very disappointed the concerns we raised in our previous submission have not been considered and incorporated into the second exposure draft. AFAO remains deeply concerned that the provisions in the Bill will prioritise the religious beliefs of healthcare workers over the healthcare needs of marginalised individuals and communities who are living with or at increased risk of HIV and who require sensitive and specialist health services. Our concerns are that:

1. the Bill privileges religious expression to the exclusion of other beliefs and practice including clinical standards of practice;

2. this privilege creates a tension between Australia's pursuit of public health objectives to reduce HIV transmission, through significant federal government investment in new technologies such as Pre-Exposure Prophylaxis (PrEP)[1] and effective HIV treatment, and the refusal of health services based on religious belief; and

3. in practice, the Bill will place Australia's domestic and international obligations to leave *no one behind* in our endeavour to end HIV transmission, in jeopardy.

Key Points

AFAO recommends the following clauses be deleted:

- Sub-sections 8(3)-(5):
  These provisions will allow healthcare professionals, doctors, nurses, midwives, pharmacists and psychologists, to make discriminatory statements of religious belief outside of their employment or professional body affiliation. It also prevents employers from providing inclusive and safe workplaces for employees and patients.

- Sub-sections 8(6) and (7)
  These provisions prevent healthcare providers from developing conduct rules stopping doctors, nurses, pharmacists and psychologists from conscientiously objecting to provide a range of services to an individual if the they deem a medical procedure, service or treatment to be inconsistent with their religious beliefs.

- Section 42:
  This section overrides federal, state and territory anti-discrimination laws and protects people who express prejudicial or discriminatory views about a range of Australians, including: people with HIV, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people, sex workers, people who use drugs and unmarried people and single mothers based on their religious beliefs, from prosecution.

[1] Pre-Exposure Prophylaxis (PrEP) is the use of HIV medication by an HIV negative person at risk of HIV. For more information see https://www.afao.org.au/about-hiv/hiv-prevention/prep/

The Australian Federation of AIDS Organisations

AFAO is the national federation for the HIV community response. We are recognised nationally and globally for the leadership and expertise we provide. Through advocacy, policy and health promotion, we champion awareness, understanding and proactivity around HIV prevention, education, support and research. AFAO provides a voice for communities affected by HIV and leads the national conversation on HIV.

In Australia, communities most affected by HIV include people with HIV, gay and bisexual men, transgender and gender diverse people, Aboriginal and Torres Strait Islander people, sex workers, people who use drugs, people from or who travel to high prevalence countries, and people in custodial settings. Our membership includes organisations who represent these communities in each state and territory in Australia, and affiliate member organisations – spanning community, research, public health and clinical workforce – who share AFAO's values and support the work we do.

We advocate for a strong and bold vision to prevent HIV and its impacts, and work with governments, clinicians, researchers and the community to achieve that vision.

HIV Policy Context

Australia is a signatory nation of the United Nations Political Declaration on HIV/AIDS. This declaration commits nations to the goal of ending the HIV epidemic by 2030.[2] The Australian Government has acted upon the declaration through a bold new eighth *National HIV Strategy 2018-2022* (the Strategy) to virtually eliminate HIV in Australia by 2022.[3] In advance of the federal election, the federal Liberal National Coalition committed to meeting this ambitious goal by having 95% of people living with HIV diagnosed, 95% of people diagnosed with HIV accessing treatment and 95% of people on HIV treatment having an undetectable viral load.[4] Australia is currently on track to meet these ambitious targets but the Bill puts this success in jeopardy.

The Strategy codifies Australia's international obligations to end the global HIV epidemic by setting the framework and direction for Australia's domestic HIV response. The Strategy sets ambitious targets to reduce HIV transmission and increase the percentage of people with HIV on antiretroviral treatment.[3] The Strategy prioritises eight populations who together carry the greatest burden of HIV or who experience heightened vulnerability to transmission. These populations include:

- people with HIV
- gay and bisexual men
- trans and gender diverse people
- people who inject drugs
- sex workers
- Aboriginal and Torres Strait Islander people
- culturally and linguistically diverse people from high HIV prevalence countries.

The Strategy has multi-partisan support and is endorsed by the federal and all state and territory Ministers for Health.

[2] UNIADS. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 [Internet]. New York City: United Nations, 2016 [cited 30 Sept 2019]. Report No.: A/RES/70/266 Available from: https://www.unaids.org/en/resources/documents/2016/2016-political-declaration-HIV-AIDS

[3] Department of Health. Eighth National HIV Strategy 2018-2022 [Internet]. Canberra: Department of Health, 2018 [cited 30 Sept 2019]; Available from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1//$File/HIV-Eight-Nat-Strategy-2018-22.pdf

[4] Liberal Victoria. Liberal National Commit to 95-95-95 UNAIDS Targets 5 Years Early [Internet]. Melbourne: Liberal Victoria, 2018 [cited 30 Sept 2019]; Available from: https://vic.liberal.org.au/News/2018-10-24/liberal-nationals-commit-to-95-95-95-unaids-target-5-years-early

The opportunities and challenges for Australia's HIV response are articulated in the guiding principles in the Strategy. These highlight the need for:

- equitable access to healthcare services and medicines
- the delivery of culturally appropriate and high-quality services across Australia
- effective partnerships characterised by consultation, cooperative effort, empowerment, respectful dialogues and appropriate resourcing.

HIV in Australia

Australia's HIV response is internationally recognised for its success in sustaining a national HIV incidence that is lower than comparable high-income countries.[5] Central to this success is the partnership between the Australian Government, state and territory governments, communities, researchers and clinicians.

In Australia, HIV is largely transmitted through sexual contact. The majority of people with HIV in Australia are gay and bisexual men, reflecting the success of efforts by this community in stemming the broader flow of the epidemic. While rates of HIV among this population are declining, subpopulations of gay men, such as newly arrived Asian born gay and bisexual men, are experiencing rises in HIV notifications.[6]

Rates of HIV transmission among Aboriginal and Torres Strait Islander people and people newly arrived in Australia are stable or increasing. Considerable efforts are being made to ensure these communities, along with gay and bisexual men, have access to health services across Australia that are culturally sensitive, non-judgemental and free from discrimination.

Low rates of HIV among some priority populations – sex workers and people who inject drugs – have been achieved through community-driven policies and initiatives that create and sustain safe, inclusive and culturally appropriate clinical and community healthcare settings.

The critical role of sensitive and inclusive healthcare in Australia's HIV response

As noted above, the guiding principles of the Strategy highlight access to safe, inclusive and sensitive healthcare as essential to Australia's response to HIV. Significant investment from federal, state and territory governments has enabled world's best practice healthcare across the HIV prevention, testing and treatment continuum. These efforts ensure priority populations can access services for routine HIV screening, Pharmaceutical Benefits Scheme (PBS)-subsidised prevention tools such as Pre-Exposure Prophylaxis (PrEP) and HIV treatment[7] and Post Exposure Prophylaxis (PEP)[8], which is funded by state and territory governments.

[5] The Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia, Annual Surveillance Reports 2017 [Internet]. Sydney: University of New South Wales, 2017 [cited 30 Sept 2019]; Available from: https://kirby.unsw.edu.au/sites/default/files/kirby/report/SERP_Annual-Surveillance-Report-2017_compressed.pdf

[6] The Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia, Annual Surveillance Reports 2018 [Internet]. Sydney: University of New South Wales, 2018 [cited 30 Sept 2019]; Available from: https://kirby.unsw.edu.au/sites/default/files/kirby/report/KI_Annual-Surveillance-Report-2018.pdf.

[7] The use of HIV treatment by a person with HIV has the dual benefit of ensuring an individual remains healthy and well and also preventing the onward transmission of HIV. For more information see https://www.afao.org.au/about-hiv/hiv-treatment/

[8] Post-Exposure Prophylaxis (PEP) is a four-week course of HIV medication commenced within seventy-two hours of an exposure to an episode of HIV risk. For more information see https://www.afao.org.au/about-hiv/hiv-prevention/pep/

Non-inclusive and insensitive healthcare is a barrier to service access. Experiences of insensitive healthcare reinforce internalised shame, homophobia, transphobia, stigma and discrimination. These experiences are associated with reduced engagement with healthcare, or a reluctance in patients to disclose characteristics such as sexual orientation[9], gender identity and sexual practices in a medical consultation for fear of being judged against the expectations of a healthcare worker's religious beliefs.[10,11,12] In the context of HIV this means less frequent testing among priority populations, increased undiagnosed and late diagnosed HIV, and people eligible for PrEP not commencing or continuing PrEP.

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AFAO is deeply concerned that the Bill prioritises the religious beliefs of healthcare workers over the healthcare needs of marginalised individuals and communities, many of whom are at increased risk of HIV and require sensitive and specialist health services. Healthcare workers have played a leading role in supporting efforts to address HIV. Biomedical prevention technologies such as treatment as prevention,[13] PEP and PrEP have magnified the critical role of healthcare workers in supporting the use of these tools among priority populations. The Bill also disempowers marginalised individuals and communities, including people with HIV, LGBTI people, women and people with disabilities, by removing access to state and territory anti-discrimination protections when healthcare providers make statements of religious belief that are discriminatory.

Conscientious Objection

Sections 8(6) and (7) of the Bill stops healthcare providers and employers from enforcing conduct rules against healthcare professionals who conscientiously object to providing procedures or treatment on the grounds of their religious belief. These provisions allow doctors, nurses, midwives, pharmacists and psychologists to refuse a range of services if the healthcare worker deems a medical procedure, service or treatment to be inconsistent with their religious beliefs. The Bill does not clarify what steps a healthcare practitioner exercising a conscientious objection needs to take to ensure the individual can access immediate healthcare, either, in the same healthcare clinic, or at another clinic in close proximity.

AFAO is deeply concerned by the implications of sections 8(6) and (7). Under these proposed provisions, healthcare providers and employers will not be able to enforce conduct rules prohibiting workers who refuse sexual health services to an individual because their religious belief does not recognise, for example, sex outside of marriage and, when within marriage, only between a man and a woman for the purposes of reproduction. **Given the predominant mode of HIV transmission in Australia is through sexual contact, sections 8(6) and (7) of the Bill are at odds with the Strategy's goals to reduce HIV transmission and improve the quality of life for people with HIV as they will likely embolden healthcare practitioners to conscientiously object to individuals on the grounds of religious belief.**

[9] Callander D, Bourne C, Pell C, Finlayson R, Forssman B, Baker D, de Wit J, Hocking J, Stoove M, Donovan B, Kaldor J, Guy R (2015). Recording the sexual orientation of male patients attending general practice. *Family Practice,* 32(1), 35-40. Doi: 10.1093/fampra/cmu061

[10] Leonard W, et al. Private Lives 2: The second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians. Monograph Series Number 86 [Internet]. Melbourne: The Australian Research Centre in Sex, Health & Society, La Trobe University, 2012 [cited 30 Sept 2019]; Available from: https://www.latrobe.edu.au/__data/assets/pdf_file/0020/180425/PrivateLives2Report.pdf

[11] Mooney-Somers J, Deacon RM, Scott P, Price K & Parkhill N. Women in contact with the Sydney LGBTQ communities: Report of the SWASH Lesbian, Bisexual and Queer Women's Health Survey 2014, 2016 [Internet]. Sydney: Sydney Health Ethics, University of Sydney, 2018 [cited 30 Sept 2019]; Available from: https://www.acon.org.au/wp-content/uploads/2019/03/Sydney-SWASH-Report-2014-16-18_FA.pdf.

[12] Smith E, et al. From Blues to Rainbows: Mental health and wellbeing of gender diverse and transgender young people in Australia [Internet]. Melbourne: The Australian Research Centre, 2014 [cited 30 Sept 2019]; Available from: https://www.latrobe.edu.au/__data/assets/pdf_file/0007/598804/from-blues-to-rainbows-report-sep2014.pdf

[13] Treatment as prevention is the use of HIV medication by an HIV positive person to prevent onward transmission of HIV. For more information see https://www.afao.org.au/about-hiv/hiv-prevention/treatment-as-prevention/

The provisions as drafted mean people at risk of HIV, particularly gay and bisexual men, could be denied immediate access to prevention technologies, such as PrEP or PEP, because their doctor's religious belief does not recognise sexual relations between men and sex outside of marriage. **A refusal to, or delay in, assessing a person's appropriateness for HIV prevention technologies needlessly exposes them to the anxiety associated with an HIV diagnosis, and the healthcare system to the lifetime treatment and medical costs associated with managing a person diagnosed with HIV.**

Similarly, a trans, gender diverse or non-binary person may be denied access to hormone therapy or a referral to a specialist to discuss gender affirming care on the grounds that the provider's religion only recognises two genders, male and female, and sex characteristics, such as the vulva or penis, to determine gender. **The provision permits the denial of access to a range of healthcare services that relate to gender affirmation care and other health services, such as HIV and STI screening, and leaves the individual at risk of poor physical and mental health outcomes.**

Section 8(7) restricts health sector employers and professional healthcare bodies from intervening and preventing a healthcare professional from denying care when it does not cause 'unjustified adverse impacts' on the service or the patient's health. The Bill does not outline when an adverse impact on a patient's health or on the service is justified. Religious belief should not take precedence over the right of a person to receive appropriate healthcare.

> Studies show that LGBT people delay seeking treatment out of a fear of discrimination or reduced quality of care and are more likely to be under-screened for a number of common heath conditions.[14] Recent Australian research shows that 20.2% of gay or bisexual identifying men have not told their doctor about their sexuality, and 22.2% of these men have never been tested for HIV and are very concerned about the prospects of discussing their sex life with their doctor.[15] This Bill has the potential to intensify gay and bisexual men's concerns about disclosing their sexuality to their doctor and further discourage them from disclosing medical concerns for fear of rejection and discrimination. Central to achieving the goals of the Strategy is healthcare access that is inclusive and sensitive. When individuals feel safe to share personal information with a healthcare professional, the healthcare professional in turn can make informed decisions and provide optimal care.[16]

AFAO is concerned by the specific impacts of the provision which include:

- the direct effect of denial of healthcare on individuals through their experience of rejection resulting in poorer health outcomes.
- the direct effect of denial of healthcare in inhibiting the person from accessing the care they sought.
- the erasure of the assumption individuals rightly hold that they may expect healthcare to be provided in respectful, non-judgemental and non-discriminatory ways.
- the chilling effect created when individuals must contemplate the potential for healthcare denial, or judgement or discrimination from a healthcare professional based on that professional's religious belief.
- the diversionary effect of people orienting to healthcare professionals who they believe will be non-judgemental and non-discriminatory when Australians should be entitled to primary and other healthcare in all settings. This is compounded for people in regional, rural and remote areas of Australia where diversion to another service may be

[14] Leonard W, et al. Private Lives 2 [cited 30 Sept 2019]
[15] Hammoud M A, et al. Following Lives Undergoing Change (Flux) Study: Implementation and Baseline Prevalence of Drug Use in an Online Cohort Study of Gay and Bisexual Men in Australia. *International Journal of Drug Policy* 2017;41:41-50.
[16] Callander D, Bourne C, Pell C, Finlayson R, Forssman B, Baker D, de Wit J, Hocking J, Stoove M, Donovan B, Kaldor J, Guy R (2015). Recording the sexual orientation of male patients attending general practice. *Family Practice,* 32(1), 35-40. Doi: 10.1093/fampra/cmu061

costly, an impost on time or not be possible. This may also further strain the demand on accident and emergency departments in public hospitals where alternative services are not available.

We would also like to highlight Equality Australia's position in their submission[17] to the first exposure draft on the conscientious objection clauses in the Bill. The relative lack of provisions concerning the right of a health professional to conscientiously object to the provision of a healthcare service in state and territory laws prohibits healthcare professionals from imposing their personal views (religious or not) on the services they provide. In the instance that conscientious objection is outlined in state and territory laws, there are mechanisms in place preventing the conscientious objection from compromising the care a patient requires. Sub-sections 8(6) and (7) of the Bill do not provide provisions that recognise and prioritise a patient's care over a healthcare professional's personal views.

These sub-sections also remove the authority and lawfulness of a professional body's guidance to their members on conscientious objection, such as the Australian Medical Association (AMA) and the Australian Nursing and Midwifery Federation (ANMF). In their policy *Conscientious Objection – 2019*[18], the AMA emphasises a doctor's ethical obligation to a patient is to ensure minimal disruption to the care they receive and where emergency care is needed a doctor should always provide necessary care irrespective of their personal beliefs or values. Highly effective HIV prevention technology such as PrEP and PEP are time sensitive. Conscientious objection should never be used to impede access to HIV prevention. The failure to provide service in the moment jeopardises the effectiveness of the technologies to prevent HIV transmission, and needlessly exposes an individual to the anxiety of HIV. The ANMF urges nurses and midwives to express their conscientious objection ahead of time. Further, all reasonable steps should be taken to ensure a patient receives continuous and safe care. Like the AMA, the ANMF stipulates that nurses and midwives 'must not refuse to carry-out urgent life-saving measures or procedures.'[19]

It is AFAO's view that the conscientious objection provisions be deleted.

The communities AFAO represents experience levels of alcohol and other drug dependence or problematic use, poor mental health and homelessness well above national levels. People should be able to access specialist services regardless of their HIV status, sexual orientation, gender identity, their job (in the case of sex workers), whether they are drug users or their marital status (for example, contraception for unmarried people).

AFAO is concerned the conscientious objection provisions, in combination with section 11 of the Bill, will embolden religious organisations to assert their religious beliefs to the detriment of people with HIV, LGBTI people, sex workers, people use drugs and unmarried people.

Conditions that have been deemed 'not reasonable' relating to statements of belief

Section 8(3) and (4) stops healthcare employers and professional bodies from creating codes of conduct restricting employees or members from making statements of belief outside of employment unless compliance by the employee is necessary to avoid unjustifiable financial hardship for employers or is an essential part of the person's profession. This provision allows healthcare professionals, doctors, nurses, midwives, pharmacists and psychologists, to make statements of religious belief that are discriminatory outside their employment or professional body affiliation. This exposes healthcare employers to the risk of a discrimination claim, on the grounds of religious expression, by a

[17] Equality Australia. *A freedom from discrimination, not a licence to discriminate: Equality Australia's submission to the consultation on the exposure drafts of the Religious Freedom Bills*. Equality Australia, 2019 [cited 20 Dec 2019]. Available from: https://equalityaustralia.org.au/resources/submission-religious-discrimination-bill/
[18] Australian Medical Association. *Position Statement – Conscientious Objection*. AMA, 2019 [cited 20 Dec 2019]. Available from: https://ama.com.au/position-statement/conscientious-objection-2019
[19] Australian Nurses and Midwifery Federation. *Conscientious Objection*. ANMF, 2017 [cited 20 Dec 2019]. Available from: http://www.anf.org.au/documents/policies/P_Conscientious_Objection.pdf

healthcare professional who expresses religious beliefs that are antithetical to the care they are expected to provide in their employment outside of their workplace or outside of their professional affiliations. This provision trumps inclusion and diversity policies when statements of belief are made outside of work, even if these statements of belief are made about colleagues or patients. This provision will disincentivise healthcare clinics from promoting their practises as safe and inclusive spaces for LGBTI people, people living with HIV and others who experience marginalisation, including other employees in the healthcare clinic, for fear of a discrimination claim from an employee. Such action may be adopted to avoid a discrimination claim from a healthcare professional who refused to provide sexual health or gender affirming services to an LGBTI person on the grounds their religion does not recognise sexual relationships between people of the same sex, that there are only two genders, male and female, or that people with an intersex variation need surgery to comply with the gender binary.

The potential reduction in services identifying as inclusive of LGBTI people or with health professionals willing to provide sexual healthcare has broad impacts that affect people's health. People seeking an inclusive service or denied this care are exposed to the increased time and costs associated with longer travel distances to access health services to obtain services such as PrEP or PEP. In the case of PEP, time is of the essence as individuals must commence the medication within seventy-two hours of a potential exposure to HIV. Similarly, when attempting to access PrEP, an HIV negative person who is at risk of HIV and eligible for PrEP needs to commence the medication immediately or risk the potential for ongoing exposure to HIV. If a person eligible for PrEP is denied access to a health service, or referred to another practitioner or service provider on the grounds of religious expression, the delay or denial of service prolongs the waiting period to commence PrEP, and may discourage an individual from commencing PrEP. Delays in accessing services where a potential HIV exposure has occurred, or someone is at increased risk of acquiring HIV, can lead to someone needlessly acquiring HIV.

People with HIV have complex medical needs and require ongoing medical tests and appointments with a range of healthcare professionals. For older people with HIV this need is compounded by an increase in related co-morbidities, and number and range of health professionals to manage their condition. The potential scenario whereby these individuals need to exercise increased vigilance and scrutiny of healthcare professionals to avoid exposure to discriminatory services adds complexity and cost to ensuring optimal HIV management. The cost implications include lost income due to increased travel, costs of travel, and if unemployed or on a low income, competing budgetary implications to ensure essential healthcare consultations are met. This is magnified for people with HIV living in regional, rural and remote areas where travelling significant distances to access specialist care is required, no alternative is available, or where public hospitals are the only alternative in these areas, places greater strain on their resources.

Overriding Discrimination Protections for 'Statements of Belief'

Section 42 of the Bill privileges 'statements of belief' over federal, state and territory antidiscrimination protections. This provision empowers people to make statements that are 'in accordance' with their religion. The provision exposes marginalised people and communities at risk of HIV to unmediated public interrogation and commentary from statements of religious belief made by people and winds back existing anti-discrimination protections that prevent discriminatory statements of belief. Influential leaders will have a licence to use the public domain as a platform to profile people with personal characteristics and life experiences they consider to be not recognised or disapproved of by their religion.

AFAO is very concerned that section 42 will be used by religious leaders, politicians, other high-profile individuals, media and the public to perpetuate inaccurate and dangerous stereotypes about HIV and LGBTI people, for the purposes of galvanising community support behind a specific political or religious agenda as seen during the postal

survey on marriage equality in 2017. In practice, this provision will counteract efforts to make public spaces, workplaces and other settings safe and inclusive for people with HIV and LGBTI people.

HIV

Throughout the HIV epidemic and, in particular, during the AIDS crisis in the 1980s and 1990s, HIV has been framed by some as a "punishment for sin and as a divine legitimation for proscriptions against homosexuality."[20] Australia avoided the worst impacts of such framings because of the strength of the partnership between affected communities, government and clinical and social research. Our concern is that section 42 creates an environment where these or similar comments could be casually ventilated. The implication of this situation undermines federal, state and territory government investment in health services to support the health and wellbeing of people with and affected by HIV. Such comments cast people with or at risk of HIV as careless and irresponsible when, in reality, people with HIV are pro-active in managing their health and the risk of onward transmission.[21] The situation is magnified for older people with HIV who had to live through the 'AIDS Crisis' and remain traumatised by their experiences of navigating the discriminatory practises of many healthcare practitioners in the 1980s and 1990s. For long-term survivors the impact of re-experiencing a return of those times would be particularly traumatising.

The impact of unsubstantiated and harmful comments made in the public domain reinforces HIV stigma and complicates efforts to make clinical settings more inclusive for individuals with HIV to commence conversations with a GP about treatment initiation and treatment adherence, or for people at risk of HIV who are seeking HIV testing or prevention services such as PrEP or PEP.

> Unsubstantiated and harmful comments about people with HIV persist to this day in both the mainstream media and social media. Recent research has shown that the media is a common source of stigma, with 70% of participants in a national survey of people with HIV in 2016 reporting that they had experienced stigma or discrimination from the media within the previous twelve months (including nearly 40% who indicated this 'often' or 'always' occurred).[22] Extensive evidence indicates that stigma (both experienced and anticipated) acts as a barrier to seeking HIV-related healthcare.[23,24,25]

AFAO is concerned that the provision enables an individual to defend an expression not based in fact about people with or affected by HIV on the grounds the comment is consistent with their religious belief. There is compelling evidence to show that HIV stigma significantly affects the mental health of people with HIV.[26] In practice, section 42 is

[20] Kowalewski M & Kowalewski M. Religious constructions of the AIDS crisis. *Sociological Analysis* 1990;51(1):91-96

[21] Of 28,180 people living with HIV in Australia in 2018, an estimated 90% were diagnosed by the end of 2018, 89% were receiving HIV treatment, and of those on treatment 95% had an undetectable viral load. Kirby Institute. What's new in 2018? [Internet]. Kirby Institute UNSW, Sydney [cited 19 Dec 2019]. Available from: https://data.kirby.unsw.edu.au/hiv

[22] Unpublished results from the Stigma Indicators Monitoring Project, Centre for Social Research in Health, UNSW Sydney, https://www.arts.unsw.edu.au/centre-social-research-health/our-projects/stigma-indicators-monitoring-project

[23] C Logie & T Gadalla. Meta-analysis of health and demographic correlates of stigma towards people living with HIV. *AIDS Care* 2009;21(6):742-753;

[24] S Gari, et al. Access to HIV/AIDS care: A systematic review of socio-cultural determinants in low and high income countries. *BMC Health Services Research* 2013;13(1):198

[25] I Katz et al. Impact of HIV-related stigma on treatment adherence: Systematic review and meta-synthesis. *J Int AIDS Society* 2013;16(3):18640 S2.

[26] 38% of participants had been treated differently by a healthcare worker on account of being HIV positive. Power J, et al. HIV Futures 9: Quality of Life Among People Living with HIV in Australia [Internet]. Monograph series number 116. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University, 2019 [cited 30 Sept 2019]; Available from: https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1058625/HIV-Futures-9-Exec-Summary.pdf

at odds with the Strategy target of 75% of people with HIV reporting a good quality of life and compromises efforts to meet this target.

LGBTI people

During the 2017 national postal survey on marriage equality, the LGBTI community was exposed to language and assertions that questioned their existence, their ability to raise children, and their equal place in society.[27] Personal religious views were used as a pretext to overtly discriminate against members of the LGBTI community.

> In 2018, a national survey of men who have sex with men found that over 80% of participants had experienced stigma or discrimination in the previous twelve months, and over half (55%) reported stigma in the media.[28] A study conducted immediately after the postal survey found exposure to the survey among LGBTI people was associated with increased levels of depression, anxiety and stress.[29] A substantial body of research has demonstrated that concerns about experiencing stigma from healthcare workers is associated with men who have sex with men avoiding HIV testing and health care.[30,31,32]

Two thirds of people who voted in the marriage equality survey voted in favour of marriage equality. Any unwinding of equality for LGBTI people is inconsistent with mainstream support for the proposition of equality for LGBTI Australians.

Section 42 allows people to express religious beliefs in the public domain without taking responsibility for the implications of these comments on the health and wellbeing of LGBTI people.

AFAO is deeply concerned with the Bill and the implications of the proposed reforms on Australia's investment in public health measures to end HIV transmission by 2022 and, in particular, the scale up of PrEP coverage to priority populations. These outcomes contradict the Strategy, which highlights "equitable access to healthcare services, culturally appropriate services and respectful dialogue" as guiding principles.

[27] https://www.smh.com.au/politics/federal/qa-debate-flares-over-claims-samesex-marriage-will-lead-to-new-stolen-generation-20160301-gn6yg8.html

[28] Centre for Social Research in Health. Stigma Indicators Monitoring Project: Men who have sex with men [Internet]. Sydney, Centre for Social Research in Health, UNSW, 2018 [cited 30 Sept 2019]; Available from: https://www.arts.unsw.edu.au/sites/default/files/documents/Stigma%20Indicators%20Summary%20HIV%20%2B%20MSM%202019.pdf

[29] Verrelli, Stefano et al. Minority Stress, Social Support, and the Mental Health of Lesbian, Gay, and Bisexual Australians During the Australian Marriage Law Postal Survey. *Australian Psychologist* 2019;54(4):336–346. Web.

[30] E Arnold et al. 'Triple cursed': Racism, homophobia and HIV-related stigma are barriers to regular HIV testing, treatment adherence and disclosure among young Black gay men. *Culture, Health & Sexuality* 2014;16(6):710-722

[31] K Gamarel et al. Anticipated HIV stigma and delays in regular HIV testing behaviors among sexually-active young gay, bisexual, and other men who have sex with men and transgender women. *AIDS and Behavior* 2018;22(2):522-530

[32] D Price et al. Psychological threat avoidance as a barrier to HIV testing in gay/bisexual men. *J Behavioural Medicine* 2019:42(3):534-544.