



APRIL 2022 | OCCASIONAL PAPER 4

**IMPLEMENTING THE 2021
UN POLITICAL DECLARATION
ON HIV IN AUSTRALIA**

This is the fourth in a series of occasional papers produced by AFAO designed to disseminate information and analysis on HIV and key populations in the Asia-Pacific region. The papers build on AFAO's *Consensus Statement on Australia's International Leadership Role on HIV*, jointly endorsed by Australian HIV organisations working internationally, and are available at afao.org.au.

This paper has been jointly developed by AFAO and the National Association of People with HIV Australia (NAPWHA) to disseminate information and analysis on issues relevant to HIV and key populations in the Asia-Pacific region.

About AFAO

AFAO is the peak organisation for Australia's community HIV response. We are recognised nationally and globally for our leadership, expertise and programs, and have worked in partnership with successive Australian governments for over 30 years to implement Australia's *National HIV Strategy*. Since the early 1990s, AFAO has strengthened civil society responses to HIV, health and human rights and contributed to effective policy engagement in Asia and the Pacific. AFAO's regional work today, led from our Bangkok office, includes the Sustainability of HIV Services for Key Populations in South East Asia (SKPA) program, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Acknowledgements

AFAO and NAPWHA thank the community organisations and key informants who so generously contributed their time and expertise in the development of this paper.

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About NAPWHA

NAPWHA is Australia's peak non-government organisation representing community-based groups of people living with HIV. NAPWHA's membership of national networks and state-based organisations reflects the diverse make-up of the HIV-positive community and enables NAPWHA to confidently represent the positive voice in Australia.

NAPWHA provides advocacy, policy, health promotion, effective representation, and outreach on a national level. Its work includes a range of health and education initiatives that promote the highest quality standard of care for HIV-positive people. NAPWHA also contributes to clinical and social research into the incidence, impact and management of HIV.

NAPWHA's vision is of a world where people with HIV live their lives to their full potential, in good health and free from discrimination. NAPWHA's mission is to provide national advocacy, leadership and representation across the diverse needs of all people living with HIV in Australia.

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Summary – Areas for Action

The United Nations' (UN) 2021 *Political Declaration on HIV/AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030* is a bold and ambitious declaration. Australia is recognised internationally as having a leading response to the HIV epidemic, and has made significant progress in its drive to end HIV transmission. Australia exceeds many of the commitments and expectations outlined in the declaration, but concrete actions need to be taken to continue the momentum towards achieving our national goals.

- **Optimise access to combination prevention** – An enhanced and expanded national targeted prevention program is required to maximise reach among gay and bisexual men, including subgroups of men who are benefiting less from combination prevention. Australia can help ensure prevention, testing and treatment are more readily available by removing restrictive conditions or costs to consumers on the grounds of public health.
- **Strengthen community-led responses with greater national coordination and investment** – Innovative community-run and peer-led HIV and sexual health testing services in many states have proved acceptable and effective at reaching gay and bisexual men, but could be even more impactful with national investment and scale-up.
- **Implement evidence-based strategies to address stigma and discrimination** – More focus is required on developing evidence-based interventions that are effective at decreasing stigma and discrimination experienced by people living with HIV, and affected communities, to increase uptake of HIV prevention, testing and treatment and improve quality of life.

- **Strengthen social enablers by removing social and legal barriers** – Human rights and access and equity are guiding principles in Australia's strategy, but more is required to safeguard the rights of people living with and affected by HIV, including reviewing Australia's migration, public health, criminal and policing laws in relation to HIV to better align them to public health goals.
- **Fill gaps in monitoring and surveillance and strengthen community data collection** – Australia's HIV surveillance and research programs are robust and world-leading, but further enhancements are required to ensure diverse population groups are reflected in the data. Community organisations need to be supported to collect meaningful, consistent and timely data that captures the unique impact of community programs.

Australia exceeds many of the commitments and expectations outlined in the declaration, but concrete actions need to be taken to continue the momentum towards achieving our national goals.

1 Introduction

In June 2021, the UN General Assembly held its quinquennial High-Level Meeting on HIV/AIDS. That meeting produced the *Political Declaration on HIV/AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030*, a significant international agreement that received overwhelming majority endorsement, including by Australia.

Australia can be proud of the key role it played in producing the declaration as co-facilitators of the meeting with Namibia. AFAO and NAPWHA applaud the Australian Government's leadership in the High-Level Meeting and welcome the political declaration as a bold and ambitious call to action.

Given Australia's global leadership in the development of the political declaration, there is strong impetus for Australia to demonstrate how its statements, goals and targets are being progressed in its domestic HIV response. Much in the declaration translates readily to

the Australian HIV response and addresses areas in which Australia meets or exceeds its commitments.

This paper identifies where further efforts are required in the six priority areas for action identified in the eighth *National HIV Strategy 2018–2022*: education and prevention; testing, treatment and management; equitable access to and coordination of care; workforce; addressing stigma and creating an enabling environment; and data, surveillance research and evaluation.

Australia is commencing the development of its ninth *National HIV Strategy*, an ideal time to consider how we can achieve the political declaration commitments and targets by 2030. We hope this paper will be a valuable input to the development of the Strategy.

2 Education and prevention

UNPD 60

Commit to prioritize HIV prevention and to ensure by 2025 that 95 per cent of people at risk of HIV infection, within all epidemiologically relevant groups, age groups and geographic settings, have access to and use appropriate, prioritized, person-centred and effective combination prevention options by:

UNPD 60(b)

Tailoring HIV combination prevention approaches to meet the diverse needs of key populations, including among sex workers, men who have sex with men, people who inject drugs, transgender people, people in prisons and other closed settings and all people living with HIV.

Improving the availability of HIV testing, pre-exposure prophylaxis (PrEP) and antiretroviral treatment (ART), as well as continued support for condom use, is critical to ensure combination prevention is available to all people in Australia. Australia can improve access to combination prevention by removing restrictive conditions or costs to the consumer on public health grounds.

The Australian Government has recently committed to making ART available to all people in Australia, regardless of visa status, on public health grounds (see UNPD 61). Ensuring all people with HIV living in Australia have access to treatments and have an undetectable viral load will help lower rates of HIV transmission in Australia.

Although PrEP use among gay and bisexual men in Australia is among the highest levels globally, it needs to increase if we are to end HIV transmission. Strategies to enhance access

Australia can improve access to combination prevention by removing restrictive conditions or costs to the consumer on public health grounds.

are needed, including making PrEP easier to access and available to at-risk individuals who are Medicare ineligible (see UNPD 60c).

Targeted prevention education for gay and bisexual men is required, particularly in areas of relatively low HIV prevention success or where behavioural differences have emerged. Priority populations include men living in outer-urban or rural areas, men who are overseas-born (particularly those who arrived in Australia in the last four years), and young (under 25) and older men (55 and over). Most community-led HIV organisations have small education teams staffed by individuals who specialise in working with one population or delivering one aspect of community-led work. The sector lacks capacity to reach a range of subgroups of gay and bisexual men, which will require highly nuanced programming informed by their needs. For these reasons, enhanced investment in national education campaigns is needed, alongside tailored messaging, supported by local action, for subgroups of gay and bisexual men.

Recommendation – Key Areas for Action

- Enhance investment in targeted national education campaigns for gay and bisexual men, recognising the need to reach those at highest risk of HIV frequently and with repeated and regularly updated messages that drive demand for HIV prevention tools and promote testing and treatment uptake.

- Implement supplementary campaigns with tailored messaging and distribution channels for subgroups of gay and bisexual men, including trans and gender diverse men and men who have arrived in Australia recently, who are not experiencing the full benefits of combination prevention, to help reduce undiagnosed HIV within the community, challenge outdated notions of HIV and overcome barriers to prevention, testing and treatment.

UNPD 60(c)

Ensuring the availability of pre-exposure prophylaxis for people at substantial risk of HIV and post-exposure prophylaxis for people recently exposed to HIV by 2025.

The Australian Government has provided PrEP through the Pharmaceutical Benefits Scheme (PBS) since April 2018 – among the most equitable access to PrEP in the world. PrEP had rapid uptake among gay and bisexual men prior to and following subsidisation, becoming the most utilised option in the suite of HIV prevention strategies for individuals at risk of HIV transmission. HIV notifications have declined by 37% in Australia since 2016.¹

Although the overall trend is down, the proportion of new HIV diagnoses in Australia that occur in overseas-born people is large and increasing. Over the past 10 years, overseas-born gay and bisexual men have made up almost 50% of HIV notifications in Australia.² People in Australia on temporary visas who are ineligible for Medicare are unable to access

subsidised PrEP to protect themselves from HIV. Even if they meet PrEP eligibility criteria, people who are ineligible for Medicare can only access PrEP by paying the full costs (which are substantial) or importing PrEP drugs from overseas (which is difficult). These are significant barriers to overcome.

A lack of access to subsidised PrEP means fewer at-risk people on PrEP, resulting in lower population coverage. Most people on long-term temporary visas either return to their country of origin or transition to Medicare eligibility within three years. Making PrEP available equitably to people in Australia, regardless of visa status, is essential if Australia is to end HIV transmission. It is also likely to be cost-saving by averting the long-term costs of treatment and health care for people diagnosed with HIV.

Any Australian resident with a Medicare card has easy access to PrEP; their general practitioner (GP) can write a prescription which any pharmacy can dispense. For someone taking daily PrEP, this requires a minimum of four clinical visits per annum. Requiring a prescription can be a barrier, because not all GPs have sufficient knowledge of PrEP, and some are unwilling to prescribe it. Given its proven safety, further steps could be taken to de-medicalise PrEP to increase access, convenience and individual control. Such steps might include nurse-led or peer-led services, telehealth or providing PrEP as an over-the-counter medication.

If our ambitious national target to eliminate HIV transmission is to be achieved, the proportion of people at risk of HIV using PrEP must increase. Australia's *National HIV Strategy* aims to "increase the proportion of eligible people who are on PrEP, in combination with STI prevention and testing to 75 per cent", but a more ambitious goal is required if we are to end HIV transmission in Australia.

Given its proven safety, further steps could be taken to de-medicalise PrEP to increase access, convenience and individual control.

In addition to PrEP, post-exposure prophylaxis (PEP) is an important HIV prevention intervention for people who may have been exposed to HIV; it must be made easily available to all who need it. However, significant barriers to access mean PEP uptake is far lower than it should be. Only 5% of gay and bisexual men report using PEP in the previous six months.³ As with PrEP, there may be ways to de-medicalise PEP to improve access; this is particularly important because PEP must be taken within 72 hours of a potential exposure. Options include changing regulations to enable PEP availability in a variety of settings, such as general practice, over-the-counter from pharmacies, and rapid HIV testing clinics.

Recommendation – Key Areas for Action

- Implement a sustainable solution to provide subsidised PrEP to individuals who meet eligibility criteria but who are ineligible for Medicare.

- Investigate innovative measures, including regulatory change, to de-medicalise PEP and PrEP, to make them more easily accessible to all people in Australia.

Recommendations – Targets

- Adopt a new national and ambitious target on PrEP: 95% of people for whom PrEP is beneficial to use it.

In addition to PrEP, PEP is an important HIV prevention intervention for people who may have been exposed to HIV; it must be made easily available to all who need it. However, significant barriers to access mean PEP uptake is far lower than it should be.

3 Testing, treatment and management

UNPD 61

Commit to achieve the 95–95–95 testing, treatment and viral suppression targets within all demographics and groups and geographic settings, including children and adolescents living with HIV, ensuring that, by 2025, at least 34 million people living with HIV have access to medicines, treatment and diagnostics.

People living with HIV on treatment, with an undetectable viral load, cannot transmit HIV sexually (known as Undetectable = Untransmissible, or U=U). High rates of testing, treatment and viral suppression can achieve the virtual elimination of HIV in Australia.

In Australia in 2020, 91% of people diagnosed with HIV were receiving ART and, of these, 97% had a suppressed HIV viral load.⁴ To eliminate HIV transmission in Australia, Australia must exceed the political declaration's 95–95–95 targets.

Achieving these targets requires a focus on population groups in which testing, treatment and viral suppression are suboptimal. Migrants to Australia from Southeast Asia, Eastern Asia and Europe have larger gaps in their HIV treatment and care cascades than non-migrants. Culturally and linguistically diverse populations are significantly less likely to commence ART within six months of HIV diagnosis than people born in Australia.⁵ A further target to consider is the gap between diagnosis and commencement of treatment. Research has found commencing ART within 14 days of HIV diagnosis is associated with better clinical outcomes and a higher rate of suppressed HIV viral load at 12 months.⁶ Other than for exceptional reasons, people diagnosed with HIV should be prescribed treatment immediately, and treatment commenced in no more than 14 days.

The Australian Government has committed funding to make ART available to all people in Australia, regardless of visa status. These arrangements need to be finalised and implemented, in partnership with states and territories. Providing treatment for people living with HIV in Australia who do not have access to Medicare is not only healthier for those individuals, but important to Australia's public health response and to achieving lower rates of HIV transmission.

Recommendation – Key Areas for Action

- Implement new arrangements to ensure all people living with HIV in Australia, including those who are ineligible for Medicare, have access to the treatment they need.
- Increase HIV testing in recently arrived overseas-born priority population groups, and link all newly diagnosed people to treatment, peer support and care.

Recommendations – Targets

- That the *National HIV Strategy* adopt the following targets:
 - 95% of people with HIV have been diagnosed, including among all priority population groups
 - 98% of all people diagnosed with HIV are taking ART
 - 98% of people with HIV on treatment have undetectable viral load
 - 90% of people diagnosed with HIV commence ART within 14 days of diagnosis.
- Targets should be reviewed during the life of the *National HIV Strategy* with the intention of working towards the goal of all people with HIV having been diagnosed.

UNPD 61(a)

Establishing differentiated HIV testing strategies that utilize multiple effective HIV testing technologies and approaches, including point-of-care early infant diagnosis and HIV self-testing, and rapidly initiate people on treatment shortly after diagnosis.

The *National HIV Strategy* aims to improve the frequency, regularity and targeting of testing for priority populations and decrease rates of late diagnosis. Australia uses multiple HIV testing modalities, including laboratory testing (antibody/antigen testing), rapid HIV testing and HIV self-test kits.

Priority populations at risk of HIV, including most gay and bisexual men, are testing for HIV at lower than recommended frequencies. HIV testing must be convenient and accessible for all priority populations if Australia is to meet its goal of ending HIV transmission and achieve its obligation to diagnose 95% of people with HIV in Australia by 2030.

Australia has adopted community-run rapid HIV testing services (see 64e) and self-testing strategies to support increased HIV testing. The political declaration highlights the importance of HIV self-testing, and the World Health Organization recommends HIV self-testing as a core element of comprehensive HIV programming.

An HIV self-test kit was approved for use in Australia in April 2019, considerably later than in comparable international jurisdictions. Conditions attached to the approval of

the HIV self-test kit restricted its sale to the manufacturer's website and specialist organisations, and Australia's Therapeutic Goods Advertising Code effectively prevented education about the HIV self-test; these restrictions were only lifted in late 2021. They have resulted in low awareness and use of the kits among priority populations, with fewer than 1% of respondents in a study of gay and bisexual men reporting using self-test kits in previous 12 months.⁷

In October 2021, the Therapeutic Goods Administration eased conditions on the registration of Australia's only approved HIV self-test kit (Atomo), allowing individuals to buy the device over-the-counter in pharmacies and removing the requirement to watch an instructional video. In addition, new advertising permissions allow retailers, AFAO and its members to promote the approved device.

All HIV testing options are important, because different options will suit individuals depending on their circumstances, preferences and access to services. Given that COVID-19 restrictions disrupted consumer engagement with health care, leading to a decline in the number of HIV tests in Australia, HIV self-test kits can help to restore testing rates to pre-pandemic levels.

Recommendation – Key Area for Action

- Expand the awareness and use of HIV self-test kits among priority populations as part of comprehensive efforts to increase the frequency of HIV testing.

UNPD 64(e)

Increasing the proportion of HIV services delivered by communities, including by ensuring that, by 2025, community-led organizations deliver, as appropriate in the context of national programmes:

- **30 per cent of testing and treatment services, with a focus on HIV testing, linkage to treatment, adherence and retention support, and treatment literacy;**
- **80 per cent of HIV prevention services for populations at high risk of HIV infection, including for women within those populations;**
- **60 per cent of programmes to support the achievement of societal enablers.**

HIV testing must be convenient and accessible for all priority populations if Australia is to diagnose 95% of people with HIV and meet its goal of ending HIV transmission.

General practice and other primary health care providers are priority settings for the delivery of testing and treatment services. Publicly funded sexual health clinics play an important role in providing services to priority populations and people who are not accessing primary health care providers. More recently, several state governments have begun funding provision of rapid HIV and STI testing at community-run and peer-led services, adding considerable capacity to the HIV testing options available in Australia. These services have helped reach infrequent and first-time testers and have demonstrated a high level of acceptability among gay and bisexual men. They have proved effective at reaching populations at high risk of HIV who would otherwise not know their HIV status.⁸ The proportion of HIV positive tests in these services is higher than that observed through other testing models.⁹

Many recently arrived overseas-born gay and bisexual men access community-run HIV testing services and publicly funded sexual health clinics because they are ineligible for Medicare. As noted previously, overseas-born gay and bisexual men are significantly over-represented in HIV notifications. There is an urgent need to strengthen access to community-run HIV testing services for these men.

Given community-run HIV testing services have been evaluated rigorously and demonstrate proven benefits, and help ease the burden on primary health care (and, in some respects, are superior to primary health care services), there is ample evidence to support their scale-up and expansion. Community HIV testing services are available in only some states and territories, and in those, their geographic coverage could be expanded. Currently, these services rely upon ad hoc grants that mean service volumes are limited by the availability of funds, and do not reflect supply capacity or user demand. National investment is appropriate given primary health care services are within the Commonwealth remit.

Recommendation – Key Areas for Action

- Undertake a costing study and prepare a business case for new investment to pilot community-run rapid HIV testing services in states and territories that do not yet have them and expand existing services.
- Develop a sustainable funding model for the delivery of community-run rapid HIV testing services to enable their scale-up in different geographic locations across all states and territories.
- Commission a review of HIV testing arrangements to identify options for increased peer engagement in the provision of HIV testing and to further normalise HIV testing.

4 Equitable access to and coordination of care

UNPD 61(e)

Ensuring that the needs of older persons living with HIV are met through the provision of available, acceptable, accessible, equitable, affordable and quality health care, and related services, free from stigma and discrimination, that support independence and social interaction, health and well-being, including mental health and well-being, and the maintenance of HIV-related treatment and care and the prevention and treatment of comorbidities and coinfections.

Providing accessible, equitable and affordable care is a particular issue for people who have been living with HIV over the long term. Eliminating co-payments for people diagnosed with HIV would reduce financial stress and improve personal and public health outcomes.

People living with HIV long term are highly likely to be taking multiple medications to combat comorbidities, and combinations of ART (to combat resistance) that cannot be purchased in single-pill formulations. People with HIV have higher rates of multi-morbidity than the general population.

Older people living long term with HIV are more likely to experience financial stress and difficulty in affording prescription medications.

Eliminating co-payments for people diagnosed with HIV would reduce financial stress and improve personal and public health outcomes.

One third of people with HIV experience significant financial stress, a much higher proportion than in the general population.¹⁰ Further, older people living with HIV are likely to have had employment breaks due to illness in the days before HIV treatments were available, and many drew heavily on their superannuation in anticipation of shortened life expectancy. Stigmatising and homophobic responses from family and friends resulted in many HIV-positive people, particularly gay and bisexual men, being socially isolated from support networks. Thus, older people living with HIV may be significantly poorer than HIV-negative people of the same age, with fewer family and friendship networks to provide assistance and support.

Generally, treatment and its associated costs (such as travel to clinics) has been found to be associated with treatment cessation and interruption for HIV-positive people.¹¹ Interrupting or ceasing treatment is significantly associated with poorer health outcomes, results in increased risk of HIV transmission, and ultimately creates more avoidable pressure on health care services.

The cost of the co-payment is a factor in sub-optimal adherence to HIV treatment, alongside housing insecurity, poor mental health, substance use and stigma. Eliminating the co-payment will help ensure equitable access to treatments among different groups of people living with HIV, such as:

- People from a culturally and linguistically diverse background, who are less likely to commence treatment within six months of HIV diagnosis than people born in Australia¹²

- Migrants to Australia from Southeast Asia, Eastern Asia and Europe, who have larger gaps in the cascade of care than non-migrants¹³
- Aboriginal and Torres Strait Islander people, who typically commence treatment and achieve an undetectable viral load later than non-Indigenous Australians¹⁴
- People who inject drugs, who commence treatment later than Australian-born gay and bisexual men who are diagnosed with HIV.¹⁵

Critically, eliminating the co-payment will also rectify an inequity experienced by people with HIV. The medication co-payment levied on people with HIV is at odds with public health arrangements for other communicable diseases such as tuberculosis, STIs and vaccine-preventable diseases on the National Immunisation Schedule. The treatment of these diseases is rightly recognised as essential for the protection of public health, with medication provided free of charge. Such arrangements were also adopted early in the COVID-19 pandemic, with vaccines provided free of charge as a public health measure.

HIV, however, remains subject to co-payment arrangements, with no waiver provided in recognition that HIV treatment is a public good and no arrangements in place supporting those who cease and do not commence treatment for cost reasons. This inequity is a legacy from the period before it was recognised that effective HIV treatment also prevents onward HIV transmission. With clear evidence and a global consensus that effective HIV treatment prevents HIV transmission (that is, Undetectable = Untransmissible), co-payments for HIV treatment are a legacy arrangement and contrary to effective public health.

An estimated 9% of people diagnosed with HIV (around 2,600 people) are not presently taking treatment for HIV. To eliminate HIV transmission in Australia, co-payments for HIV treatment must be eliminated.

Recommendation – Key Area for Action

- Establish a scheme that removes the need for hospital and community pharmacies to charge the consumer for a PBS co-payment when purchasing HIV ART.

UNPD 67(h)

Expanding the delivery of primary health care, which is a cornerstone of efforts to achieve universal health coverage, through people-centred, community-based services and strengthening referral systems between primary and other levels of care.

Delivering people-centred, community-based services and strengthening the link between primary health care and other levels of care can reduce the time between diagnosis and treatment commencement. People living with HIV who do not have access to HIV treatment or cannot achieve viral suppression may have complex social and comorbid health issues and/or may have difficulty accessing appropriate peer support and health services.

Specific populations do not benefit from advances in prevention and treatment science and peer support programs. These include gay and bisexual men with infrequent HIV testing practices, people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people, women living with HIV, people living away from inner-urban centres and people with HIV who are not engaged in care.

There are compelling reasons to support new and innovative peer-led models that provide contact tracing and wrap-around support for people at the time of diagnosis. Such models could identify additional people with undiagnosed HIV, increase the rate of immediate initiation of HIV treatment and reduce the risk of individuals being lost to care. Evidence from community-led testing models shows peer-led service delivery is highly acceptable, preferred by clients and attracts people who would otherwise not engage with health services.¹⁶

Contact tracing is an essential tool for identifying potentially undiagnosed partners of people who are diagnosed with HIV. It requires highly nuanced, culturally appropriate and sensitive approaches, particularly because it occurs during the period in which a person is experiencing the distress of an HIV diagnosis. Effective contact tracing requires that individuals share personal information about sexual and drug-using practices that are highly stigmatised, may be associated with shame, and in the case of drug use, criminalised.

Peer workers have lived experience of the factors that put communities at risk of HIV transmission. They are well connected to communities, and are able to establish trust

and rapport quickly with those they support. Peer workers are cost-effective, and research shows immediate connection to peers after diagnosis reduces the time between diagnosis and treatment uptake and improves resilience in newly diagnosed people with HIV.

To support the deployment of peers in clinical settings, in collaboration with community organisations and with the input of clinical services and government public health officers, we must develop standards for peer-led models that incorporate peer-led contact tracing approaches, use of peer support and peer navigator models, and integrated clinical care, and minimise systemic barriers that prevent access to care.

Recommendation – Key Areas for Action

- Commission the development of standards for peer-led contact tracing and pilot and evaluate this model, with a view to scale-up.
- Commission the development of a model for wrap-around clinical and peer support to ensure all people diagnosed with HIV can commence and maintain HIV treatment and remain connected to care, and pilot, monitor and evaluate this model, with a view to scale-up.

5 Workforce

UNPD 64(f)

Encouraging the strengthening of peer-led responses and the scaling-up of efforts to promote the recruitment and retention of competent, skilled and motivated community health workers as well as to expand community-based health education and training in order to provide quality services to hard-to-reach populations.

Community organisations and peer-led responses are critical for effective and targeted prevention efforts, for increasing access to testing and treatment, and for reducing ongoing stigma and discrimination.

There is significant turnover within the community workforce, with one third having had two years or less experience in the HIV sector. Staff have different levels of experience and backgrounds upon commencing in the HIV sector, including lived experience; as a result, levels of knowledge and understanding of HIV prevention and programming differ. In a rapidly changing environment with new challenges arising for the community workforce, such as combination prevention and multiple HIV testing and prevention technologies, the need to build the knowledge and skills of the workforce is clear.

A high priority for health promotion programs is reaching population groups that may not be benefiting from developments in HIV prevention, testing and treatment, including culturally and linguistically diverse populations and Aboriginal and Torres Strait Islander people. This requires that the community workforce has access to continuous information and support to achieve best practice with diverse populations.

While the clinical and research workforces have well-established pathways for learning and professional development (through universities and continuing professional development required for professional registration requirements), there are no formalised equivalents for the community HIV workforce. The Department of Health has recognised this gap by funding the AFAO and NAPWHA HIV Online Learning Australia (HOLA) program. Early evaluation results from the HOLA program show strong workforce engagement and uptake of learning initiatives. The program is funded for an initial two-year period; community workers have identified several areas in which expansion is needed.

Recommendation – Key Area for Action

- Continue and expand national training and workforce development to support the peer-led and community workforce to respond to evolving demands in HIV education, prevention, support and advocacy for priority populations.

In a rapidly changing environment with new challenges arising for the community workforce, such as combination prevention and multiple HIV testing and prevention technologies, the need to build the knowledge and skills of the workforce is clear.

6 Reducing stigma and creating an enabling environment

UNPD 65

Commit to eliminating HIV-related stigma and discrimination and to respecting, protecting and fulfilling the human rights of people living with, at risk of and affected by HIV, through concrete resource investment and development of guidelines and training for health care providers.

UNPD 65(e)

Working towards the vision of zero stigma toward and discrimination against people living with, at risk of and affected by HIV, by ensuring that less than 10 per cent experience stigma and discrimination by 2025, including by leveraging the potential of Undetectable = Untransmissible.

HIV-related stigma and discrimination continue to be a central part of the lives of many people with HIV across Australia. That stigma is driven by a range of factors, including outdated notions of HIV and misinformation about transmission and transmissibility. Stigma and discrimination can risk achieving our public health goals of reducing HIV transmission, because they can deter HIV testing and reduce willingness to disclose HIV status and engage in HIV treatment.

There is a substantial body of knowledge about the prevalence, nature and impact of HIV-related stigma, but there has been little investment in innovative interventions to address stigma and discrimination.

The *National HIV Strategy* prioritises efforts to reduce HIV stigma and discrimination. It contains a strong commitment to stigma reduction, with a target to reduce by 75% the reported experience of stigma among people with HIV, and expression of stigma, in relation to HIV status.

In Australia, more comprehensive implementation research could identify effective interventions. There is a substantial body of knowledge about the prevalence, nature and impact of HIV-related stigma, but there has been little investment in innovative interventions to address stigma and discrimination. In fact, there is little research to inform the design of a multilevel program of stigma reduction; much of the research to date focuses on interpersonal strategies, and cannot guide interventions at organisational or structural levels. As identified in the political declaration, concrete resource investment is required.

Recommendation – Key Areas for Action

- Fund implementation research that can help identify interventions that are effective at reducing stigma and discrimination in different settings, particularly in the provision of health care, as well as within the general community, and at individual, interpersonal, organisational and structural levels.
- Support the scale-up of stigma and discrimination reduction interventions that have proved to be effective.
- Publish progress reports on the achievement of HIV-related stigma targets, and evidence of interventions that have been effective or show promise in combating HIV stigma.

Recommendations – HIV stigma targets

- Adopt new and ambitious targets for HIV-related stigma:
 - 95% of people living with HIV report no stigma in the last 12 months
 - 95% of people living with HIV report health care workers do not treat them negatively/differently in the last 12 months.

UNPD 65(a)

Creating an enabling legal environment by reviewing and reforming, as needed, restrictive legal and policy frameworks, including discriminatory laws and practices that create barriers or reinforce stigma and discrimination such as age of consent laws and laws related to HIV non-disclosure, exposure and transmission, those that impose HIV-related travel restrictions and mandatory testing and laws that unfairly target people living with, at risk of and affected by HIV, with the aim of ensuring that less than 10 per cent of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services by 2025.

The social, policy and legal environment can support an effective public health response to HIV. However, there remain significant areas for law reform in Australia.

Mandatory HIV testing is a component of Australia's immigration process, but is at odds with the guiding principles of the *National HIV Strategy*, which emphasise human rights, access and equity. Section 52 of the *Disability Discrimination Act 1992* exempts immigration matters from anti-discrimination laws.

For people living with HIV, applying for permanent residency, which requires a waiver of Australia's migration health requirement, can be a long and exhausting process. Ineligibility for Medicare and the PBS undermines HIV

There is clear evidence of harms associated with the global 'war on drugs', and a rapidly growing policy consensus that more progressive approaches to personal drug use are required.

prevention strategies (see UNPD 61). Migrants already living in Australia and considering applying for permanent residency may not seek regular HIV testing due to concerns about how an HIV-positive diagnosis may affect their migration status. These policies feed the stigma associated with HIV within new and emerging culturally and linguistically diverse communities and undermine prevention strategies targeting people from high-prevalence countries. Australian migration laws require review and reform.

Many state and territory laws also impede HIV public health goals. While the decriminalisation of homosexuality was recognised as an important strategy for HIV prevention, reform of laws criminalising drug use and criminalising or regulating sex work has been slow.

Several states and territories have taken steps toward sex worker law reform, including New South Wales, the Northern Territory and Victoria, with recent or current legislative reform considered in South Australia and Queensland. The trend of these reforms is to decriminalise sex work and thereby recognise sex work as work, remove exceptional provisions that treat sex work differently to other occupations, and to introduce anti-discrimination and other protections for sex workers.

There is clear evidence of harms associated with the global 'war on drugs', and a rapidly growing policy consensus that more progressive approaches to personal drug use

are required. Drug use law reform remains, nonetheless, at its early stages in Australia. The Australian Capital Territory is currently considering reforms related to the personal use of illicit drugs.

Legacy public health laws criminalising actual or possible HIV transmission remain in place in many jurisdictions. Even where not expressed exceptionally in law, that is, as specific to HIV, they tend to be applied only in relation to HIV.

Other legislative change impeding HIV public health is more recent. States and territories have increasingly adopted laws allowing the mandatory HIV testing of people in circumstances where law enforcement or other personnel are exposed to body fluids; these laws are regressive and contrary to public health. They have emerged from pressure by police and other unions concerned for the welfare of members who have experienced distress after occupational incidents. They each reflect a failure of governments to implement basic arrangements for the appropriate care of law enforcement and other personnel in the rare instances of actual exposure to body fluids that may represent a risk of HIV or other blood-borne virus transmission.

At present, public health officials and advocates lack a framework and consolidated evidence base for responding to legislative proposals that may affect public health. The development of guidance and consolidation of evidence would assist policymakers and advocates to respond to jurisdictional legislative proposals.

Recommendation – Key Areas for Action

- Review immigration health screening policies to ameliorate their impact on at-risk populations seeking out HIV testing and treatment services.
- Fully decriminalise sex work in all states and territories and enact consistent anti-discrimination protections for sex workers throughout Australia.
- Decriminalise the purchase and possession of small amounts of illicit substances for personal use.
- Commission an examination of Commonwealth, state and territory laws that affect HIV and broader communicable diseases public health goals, with a view to promoting legislative uniformity and alignment.

7 Data, surveillance, research and evaluation

UNPD 64 (d)

Supporting monitoring and research by communities, including the scientific community, and ensuring that community-generated data are used to tailor HIV responses to protect the rights and meet the needs of people living with, at risk of and affected by HIV.

The *National HIV Strategy* prioritises the need for continuous improvement in data collection and systems, and the value of evaluation of services and programs. Further strengthening data collection at community level will help ensure effective programs are supported by evidence and best practice programs can be scaled up appropriately.

Community organisations need to be supported to collect meaningful, consistent and timely data that captures the unique impact of community programs, particularly ensuring HIV prevention programs are effective at reaching all groups of people.

Recommendation – Key Area for Action

- Support the timeliness, consistency and quality of community-collected data, through investment in training, better linkages to national surveillance measures and improved processes, to build a strong evidence base about what prevention and health promotion programs work.

UNPD 69 (b)

Establishing epidemiological, behavioural, programmatic, resource tracking, community and participatory monitoring and evaluation systems that generate,

collect and use the estimates and granular, disaggregated data needed to reach, support and empower all populations, with an urgent focus on people living with HIV and other people that are still being left behind.

Australia has robust HIV surveillance and research systems that help guide and inform our policies and programming. Researchers, government, people living with HIV and affected communities have a long and successful history of working collaboratively on surveillance and research programs.

AFAO and NAPWHA believe community involvement in research is critical to producing research that is ethical, empowering and effective at generating useful insights. Ongoing consultations are required to enable affected communities to collaboratively set the agenda for social, behavioural, epidemiological and clinical research.

HIV notifications have declined gradually in Australia over the past five years, but there remains a need for enhanced surveillance and behavioural research to identify which groups of people are not being reached or engaged by HIV prevention programs. Better knowledge will ensure that in the drive towards ending HIV transmission, no priority population groups (such as people from culturally and linguistically diverse backgrounds) are left behind.

Recommendation – Key Area for Action

- Implement enhanced surveillance and research to fill gaps in data and identify which groups of people require more targeted HIV programs.

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List of abbreviations

AFAO	Australian Federation of AIDS Organisations
ART	antiretroviral treatment
GP	general practitioner
HOLA	HIV Online Learning Australia
NAPWHA	National Association of People with HIV Australia
PBS	Pharmaceutical Benefits Scheme
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
STI	sexually transmissible infection
UNPD	United Nations Political Declaration
UN	United Nations

