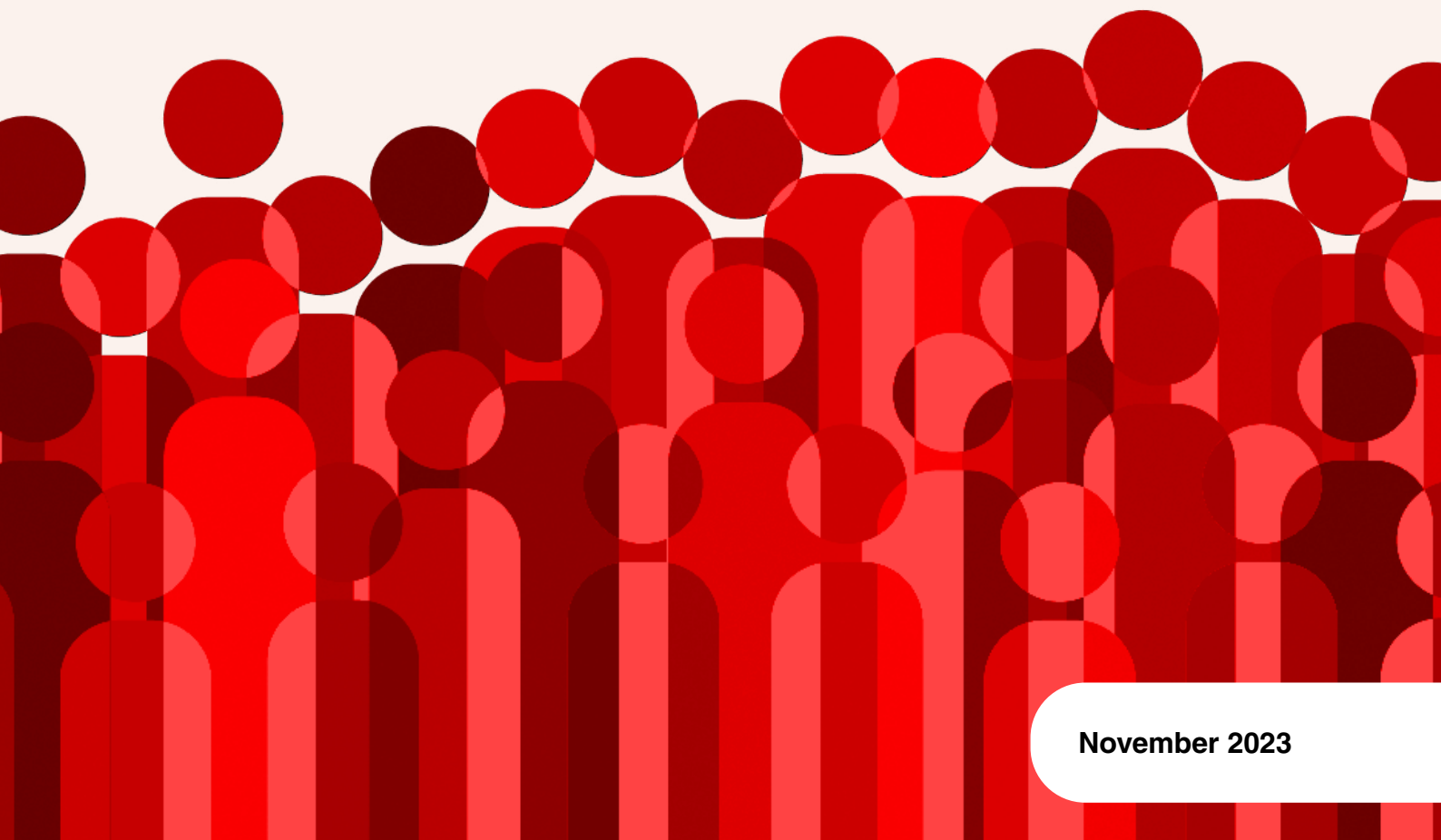
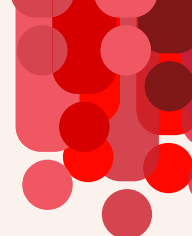


HIV TASKFORCE **REPORT**



November 2023



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Acknowledgment:

The HIV Taskforce extends its thanks to the generations of people with HIV who have shared their experiences, advocacy and community fellowship, and put themselves forward to advance research and science. We are indebted to them.

Acronyms and abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARTG	Australian Register of Therapeutic Goods
BBVSTI	bloodborne viruses and sexually transmitted infections
CALD	culturally and linguistically diverse
GBMSM	gay and bisexual and other men who have sex with men
GP	general practitioner
HIV	human immunodeficiency virus
MBS	Medicare Benefits Schedule
NGO	non-government organisation
PBS	Pharmaceutical Benefits Scheme
PEP	post-exposure prophylaxis
POCT	point-of-care testing
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
STI	sexually transmitted infections
TGA	Therapeutic Goods Administration
UNAIDS	Joint United Nations Programme on HIV/AIDS
U=U	undetectable=untransmittable

Introduction

HIV/AIDS has wrought global devastation. UNAIDS estimates that more than 40 million people have died from AIDS-related illness since the early 1980s (UNAIDS 2023). The impact the epidemic has had on generations of people is impossible to quantify, and the after-effects of the losses, fear and disenfranchisement still reverberate.

Australia was not exempt from the epidemic, and the country came together to empower communities which saved lives and supported the people affected. Australia can be proud of its world-leading response, characterised by partnership and collaboration between governments, people living with and communities affected by HIV, non-governmental organisations (NGOs), clinicians and academia.

From the start of the epidemic, affected communities including people with HIV, gay men, sex workers and people who inject drugs, implemented peer-based initiatives leading the response to HIV/AIDS. Due to these collaborative efforts, Australia has avoided a more widespread epidemic seen in other countries and the rate of decline in HIV notifications is now among the fastest in the world.

The first national HIV/AIDS collaborations in the mid-1980s focused on education and awareness. Collaborations continued with the creation of the National People Living with AIDS Coalition (now the National Association of People with HIV Australia) and the Australian Federation of AIDS Organisations (now Health Equity Matters) as the peak NGOs addressing HIV/AIDS in Australia.

Notifications started to decrease in the 1990s, largely because of efforts over the previous decade. This included national awareness campaigns, mainstream media advertising, sex worker peer education and outreach, and needle exchange programs for people who inject drugs. For people living with HIV/AIDS, the year 1996 marked the beginning of access to more effective treatments, including triple-combination drugs and protease inhibitors. These promised a real chance at a life free from HIV-induced illness.

The early to mid-2000s saw a rise in notifications, followed by a decline which lasted until the 2010s when a steady increase was reported. As a result, the Seventh National HIV Strategy sought to address the social, structural and individual barriers to successful prevention, testing, treatment, care and support. Health promotion campaigns focused on changing high-risk sexual practices, increased testing and engaging in law reform. Since then, engagement efforts have been designed to increase HIV testing rates, enable access to pre-exposure prophylaxis (PrEP) and promote Treatment as Prevention.

Australia has always taken an evidence-based approach to HIV/AIDS and support for the U=U (Undetectable = Untransmittable) principle is absolute. The Australian Government publicly endorsed the U=U message to a global audience at the 12th International AIDS Science Conference in Brisbane in 2023.

U=U is a simple concept that begins with the individual and benefits the wider community. When a person living with HIV is taking treatment and has an undetectable viral load, they cannot sexually transmit HIV. This revolution in understanding HIV transmission is changing the narrative for people living with HIV, who can make decisions about their sexual and reproductive health lives in a way that was never before possible. As well as shifting the understanding of HIV prevention, U=U provides another tool to fight entrenched HIV-related stigma.

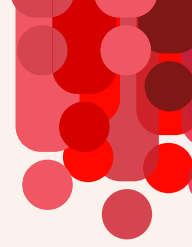
Australia is also a leader in the global response to HIV/AIDS, being a co-facilitator of the UNAIDS 2021 political declaration on HIV and AIDS, which set ambitious targets to guide the global response (UN 2021). In

this role, Australia fought for the inclusion of evidence-based and human rights-focused action that addresses gender inequalities, stigma, discrimination and criminalisation, liberalised trade of medication, and comprehensive sexual and reproductive health and rights.

As a partner in the Global Fund to Fight AIDS, Tuberculosis and Malaria, Australia contributes significant funding to replenishment rounds every 3 years.

Within the region, Australia's five-year (2022–27) \$620 million Partnerships for a Healthy Region initiative will support the Pacific and Southeast Asia to build resilient and equitable health systems and address communicable and non-communicable disease threats, including HIV.

Reflecting on the history of the HIV epidemic and Australia's response sheds light on the next steps needed for eliminating HIV transmission, including the need for deeper engagement with other affected communities.



Key events in the HIV response, 1982–2023

1982 First case is recorded in Sydney	1983 AIDS Action Committee (AAC) are formed in Melbourne and Sydney, and progressively in all states and territories
1985 First notification and transmission laws come into effect	1987 First class of treatment drugs becomes available
Australian Federation of AIDS Organisations (AFAO) is formed (now Health Equity Matters)	1988 World AIDS Day is founded
1988	1989 1st National HIV Strategy is published
1990 National Association of People Living with HIV/AIDS is formed (now the National Association of People With HIV Australia)	1992 Disability Discrimination Act 1992 comes into force
1993 National anti-discrimination campaign is launched	1994 2nd National HIV Strategy is published
1996 3rd National HIV Strategy is published Triple combination therapy and viral load testing becomes available	1997 Post-exposure prophylaxis (PEP) becomes available
2001 UN General Assembly convenes first ever special session on HIV/AIDS	2002 Global Fund to Fight AIDS, Tuberculosis and Malaria is established
2005 5th National HIV Strategy is published	2010 6th National HIV Strategy is published
2014 7th National HIV Strategy is published UNAIDS launches the 90–90–90 care cascade targets	2016 Therapeutic Goods Administration approves pre-exposure prophylaxis (PrEP) in Australia
2018 8th National HIV Strategy is published PrEP is listed on the Pharmaceutical Benefits Scheme	2021 Australia co-facilitates the development of the Political Declaration, which was adopted at the UN General Assembly High-level Meeting on HIV/AIDS
2023 Joint government program to fund treatment for people living with HIV who are ineligible for Medicare is implemented Work on the 9th National HIV Strategy is underway	

The next goal: eliminating HIV transmission by 2030

Australia is seeking to virtually eliminate HIV transmission by 2030. This goal is ambitious, but within our reach. Some regions of Australia, such as inner-city Sydney, have already achieved virtual elimination, which is the absence of sustained endemic community transmission. This success shows what can be achieved through community-led partnerships. It provides a model for meaningful engagement and leadership by the people and communities affected by HIV. Replicating this success Australia-wide will be an historic achievement and the culmination of decades of work by communities and governments.

The HIV epidemic has taken too much from too many for too long. Virtual elimination will mean HIV is no longer a public health threat in Australia, equivalent to a 90% reduction in new diagnoses since 2010, or less than 91 new HIV notifications per year. With wide and equitable access to prevention and testing, thousands of people will avoid acquiring HIV and the need for ongoing treatment, translating into significant savings for the healthcare system. The quality of life for people living with HIV is also fundamental, and people living free of stigma while able to access treatment and care must be in the forefront of all efforts.

Following the lifting of COVID-19 era restrictions on social behaviour and movement there has been an increase in HIV transmission and diagnoses. Eliminating HIV transmission will require renewed efforts to increase prevention, testing, diagnosis, care and treatment, especially among priority populations including overseas-born gay and bisexual and other men who have sex with men (GBMSM), young people and

First Nations communities. Sustaining the gains Australia has already made is also critical. Expanded access to treatments and testing must be accompanied by a targeted communications strategy to raise awareness and promote the uptake of prevention, testing and treatment.

Continued efforts to break down stigma are crucial to any HIV response. HIV-related stigma exists at multiple levels. It is internalised by individuals, affecting their self-worth and wellbeing. It manifests interpersonally in attitudes, language and behaviours. And it is reinforced by policies and structures, such as legislation, cultural norms and media representations. Fear and stigma about HIV itself intersect with identity-based stigma, such as homophobia, sexism, racism, and prejudice against sex workers and people who use drugs.

Young people diagnosed with HIV report that stigma from family members, social networks and even healthcare professionals contributes to depression and social isolation. Stigma discourages people from seeking HIV prevention, testing, treatment and care.

The quality of life for people living with HIV can be improved in part by the reduction of stigma, which in turn can improve adherence to treatment and reduced HIV transmission.

The HIV Taskforce

The HIV Taskforce was established in 2023 to renew Australia's efforts to end the HIV epidemic and achieve virtual elimination of HIV transmission in Australia by 2030. The taskforce is made up of representatives from government, community organisations, peak bodies, researchers, advocates and medical experts (Table 1).

The taskforce was charged with considering HIV issues and trends and advising on the steps needed to end the transmission of HIV in Australia. It met 4 times in 2023, to discuss a range of issues including education, prevention, testing, treatment, workforce, legal issues, stigma and discrimination, and government relations. The taskforce's thinking was informed by presentations from experts, the input of young people at a HIV Youth Roundtable, and the proceedings of the 12th International AIDS Society Conference on HIV Science.

This report sets out the taskforce's findings and recommendations, organised into 6 sections addressing prevention, testing, treatment, awareness, decriminalisation and partnership.

Increasing the use of pre-exposure prophylaxis (PrEP)

PrEP is an antiretroviral medication taken by people who are at risk of acquiring HIV during periods of potential exposure. PrEP is a powerful tool in the fight against HIV, and increasing its uptake and use is vital to virtually eliminating HIV transmission by 2030. Achieving this means lowering barriers to access, opening new supply channels and exploring changes to prescribing and monitoring requirements.

Oral PrEP was registered on the Australian Register of Therapeutic Goods (ARTG) in 2016. It was listed on the Pharmaceuticals Benefits Scheme (PBS) in April 2018 and became widely available to people with a valid script, transforming Australia's response to the HIV epidemic.

The introduction of oral PrEP contributed to a dramatic decrease in the rate of new HIV diagnoses. There were 555 HIV notifications in Australia in 2022, almost half the number of cases in 2016 (1,006) (Kirby 2023).

As a single preventive medication, PrEP reduces the risk of acquiring HIV through sexual activity by 99% (US CDC 2023). The majority of new HIV notifications in Australia are occurring in people who have never taken PrEP.

PrEP has changed the lives of many people already

Lowering financial and social barriers can expand PrEP access further for those at risk of acquiring HIV. The use of oral PrEP has declined and now sits below the national target of 75% usage by the proportion of eligible people on PrEP (DoHAC 2019). Uptake is lower among certain groups, such as GBMSM under 25 years, GBMSM who were born overseas or who live outside of inner-city areas and transgender people.

Cost is one factor that is limiting uptake and ongoing use of oral PrEP. Although PrEP is subsidised through the PBS, there is a co-payment.¹ To access the medication, a person must also pay for an initial GP or sexual health clinic appointment, unless it is bulk-billed. Young people report that increasing healthcare costs, including co-payments, are discouraging them from using PrEP.

¹ Co-payments can be up to \$30 for a one-month supply of PrEP.

PrEP costs are higher for overseas born GBMSM. People who are ineligible for Medicare, such as temporary residents on work or education visas, do not receive the PBS subsidy and pay the full costs of PrEP, putting this group at heightened risk for transmission (Tieosapjaroen et al. 2023).

Subsidising PrEP for people who are ineligible for Medicare could reduce cost barriers and increase uptake in the short term. Over the medium to long term, fewer infections would reduce pressure on the public healthcare system, providing considerable savings. For those eligible for Medicare, waiving co-payments would reduce the cost barrier to starting, maintaining or resuming PrEP use.

Boosting awareness of PrEP will also help us to achieve optimal uptake. Although awareness is strong among GBMSM connected to the community, some people who could benefit from PrEP underestimate their risk of acquiring HIV, do not know about PrEP, or have misconceptions about its effectiveness. HIV-related stigma, cultural issues and knowledge gaps in some primary care settings also continue to be a barrier to PrEP access.

Expanding prescribing and dispensing could make starting and continuing PrEP easier

To access oral PrEP currently, a person must obtain a script from a section 85 prescriber and have the medicine dispensed at a pharmacy that stocks it.

Some at risk people are unaware that public sexual health clinics can prescribe PrEP. Some people have difficulty accessing timely GP appointments, including newly arrived overseas-born GBMSM who are not eligible for Medicare, and people living in regional and remote areas. Further complicating access, some GPs are unaware of PrEP, do not know that they can prescribe it, or lack the confidence to do so (Smith et al. 2021). Solutions to improving access to comprehensive general practice services are being addressed through the recommendations of the Strengthening Medicare Taskforce (DoHAC 2022).

Prescribing and dispensing restrictions on PrEP should be examined

Allowing PrEP to be prescribed by pharmacists, nurses² and/or peers, might increase access, ease pressure on primary care and sexual health clinicians, and align with recent announcements on scope of practice reforms.

For the cohort of GBMSM who effectively maintain an established PrEP regime, the level of monitoring and clinical oversight creates an unnecessary burden on both the individual and the system. For the individual, this monitoring and clinical oversight can be a barrier to continued use of PrEP.

Trials for pharmacist-prescribed oral PrEP are currently planned for Queensland, New South Wales and Victoria. The outcomes of these trials could inform the rollout of pharmacist-prescribed oral PrEP across all of Australia.

2 This refers to nurses who currently cannot prescribe Schedule 85 medications

Trials of peer-supported dispensing are already planned in some jurisdictions. New South Wales is considering dispensing oral PrEP at existing peer-led HIV testing services. In Victoria, a planned peer-facilitated dispensing trial – ‘Buddy PrEP’ – will involve trained peers discussing PrEP with friends and partners, offering a pack with on-demand PrEP³, a point-of-care HIV test and a link to ongoing care. Lessons from these trials could inform the implementation of similar programs across the country, helping to ensure greater access for all who could benefit.

State and territory regulatory changes could also enable oral PrEP to be supplied by registered nurses in state-funded sexual health clinics, women’s health or other primary care settings. Importantly, this would improve access to PrEP in locations served only by nurses, such as some rural and remote communities.

Formalising telehealth arrangements for blood borne viruses and sexual and reproductive services (BBVSR) could also improve access to PrEP. Current BBVSR telehealth Medicare Benefits Schedule (MBS) items will cease on 31 December 2023. These MBS items are not subject to the established clinical relationship which applies to most GP telehealth items, meaning a person can have an appointment with any GP in Australia regardless of location without a pre-existing relationship. This provides greater options for people seeking PrEP and supports privacy and confidentiality needs.

A review of MBS telehealth services has been undertaken by the Medicare Benefits Schedule Review Advisory Committee (MRAC). The Australian Government will consider the MRAC findings and recommendations by the end of 2023. The outcomes of the review could inform future options for BBVSR telehealth services.

Expanding oral PrEP dispensing could help us reach our target of virtual elimination by 2030, but the workforce will need education and training to ensure risks are appropriately managed and that opportunities for broader sexual health support are not lost. New prescribing approaches should be monitored and evaluated to ensure safety and effectiveness.

Updated monitoring requirements and long-acting options can support higher rates of ongoing use of PrEP

Monitoring requirements can discourage continuation of oral PrEP. Ongoing oral PrEP use requires a medical consultation every 3 months. An individual is required to see a GP and return the results of HIV and STI tests before receiving a new script for oral PrEP. This necessitates two separate primary care engagements (medical consultation with GP and a pathologist). These monitoring requirements were put in place due to concerns that continued use of oral PrEP after acquiring HIV could contribute to HIV resistance to antiretroviral treatment (ART). However, current research shows that the real-world risk is low.⁴

3 <https://prepguidelines.com.au/goals-of-prep/on-demand-prep/>

4 This level of testing is disproportionate to the very low incidence of HIV in PrEP users: 1.2/1000 people per year over 5 years for people accessing PrEP through the PBS. Medland N 2023, unpublished

Extending the prescription and monitoring cycle to 6 or even 12 months would make ongoing PrEP use less onerous and reduce costs to the individual and Medicare. Many PrEP users are experienced, especially GBMSM in inner cities. Giving these experienced, health-literate PrEP users more autonomy to manage their PrEP use would also reduce strain on public and community services.

A Medicare Rule 3 exemption may be appropriate. This allows a single pathology request form to cover repeat testing for specific conditions and treatments. The addition of PrEP as a treatment would allow a pathology form to cover repeat pathology tests for up to six months, saving the individual from repeat clinician visits to receive the required pathology form.

Long-acting, injectable PrEP has also been developed, offering users two months of protection from HIV with a single injection. Once it becomes available in Australia, this innovative option has the potential to reach PrEP users who might be unable to use a daily oral regime.

A better understanding of PrEP use will support uptake and ongoing use

Although some barriers to PrEP use are known, better understanding will inform Australia's efforts to increase uptake and ongoing use. More research is needed to fully understand all the barriers. Research or consultation should explore both real and perceived barriers to PrEP and investigate why some people never start PrEP despite being at increased HIV risk, and why some people stop and do not resume treatment. This knowledge will help Australia maximise the effectiveness of interventions by targeting specific barriers.

Increased access to PrEP should accompany other prevention strategies

PrEP is not a solution for all communities affected by HIV. For example, sex workers in Australia have maintained consistently high condom usage and have reported no need, intention or desire to replace condom use and peer education with PrEP (Cox 2015).

Increased access to PrEP should accompany other effective prevention strategies, such as peer education, outreach, and condom distribution. Communities should feel empowered to use their preferred prevention strategies.

Recommendations

1. Partner with states and territories to design a program that provides subsidised access to oral PrEP for people who are ineligible for Medicare.
2. Explore possibilities for extending the PrEP prescription and monitoring cycle to ease time and cost burdens on users.
3. Investigate options to allow the prescribing or supply of PrEP through pharmacists, nurses and peers.
4. The Australian Government should consider fast-tracking the availability of long-acting, injectable PrEP on the Australian market to reach PrEP users and to support ongoing use.
5. Investigate barriers that discourage people who have used PrEP from continuing or resuming use.
6. Resource ongoing information campaigns to increase demand for PrEP within the community and to build the capacity of healthcare workers, particularly in clinical settings with lower PrEP caseloads and outside of inner-city urban areas and gay communities, to engage in conversations about PrEP.
7. Support making the temporary blood borne viruses and sexual and reproductive telehealth MBS items permanent following the outcomes of the MRAC review.

Increasing testing rates

Identifying people with undiagnosed HIV is critical to eliminating transmission. By taking full advantage of game-changing advances in testing technology and expanding access to a mix of effective accessible and convenient testing options, greater choice of when and how to test will be available and can underpin efforts to lift testing rates. At the same time, reviewing health-related immigration policies could encourage testing among overseas-born GBMSM.

Australia has high rates of HIV testing in GBMSM who are well-connected to the gay community, especially in inner-city areas. Elsewhere, however, testing rates are not as high. As a result, overall, Australia is not meeting its target of 95% people living with HIV being diagnosed.

Low rates of testing in many communities are contributing to rising rates of late diagnosis (ASHM 2023). Among GBMSM, late diagnosis continues to be disproportionately high for men from culturally and linguistically diverse (CALD) communities, men who have sex with both men and women, men over 50 years, men in remote areas, and men born overseas⁵. Late diagnoses are also higher among people who inject drugs, First Nations people, people having heterosexual contact, and people born in high-prevalence countries.

Late diagnosis can have severe consequences, including complex health problems and even death. Late diagnoses also highlight missed opportunities for testing and intervention. Typically, people who reach this late stage of infection have usually had multiple points of contact with the health system. Promotion of routine opportunistic HIV testing could be pursued when a person presents to a clinical setting with HIV related symptoms.

Vulnerable populations may already be targeted for screening and testing for a range of communicable and non-communicable diseases, so opportunistic HIV testing will need to be well-integrated into culturally appropriate and accessible primary care.

More needs to be done to expand testing options on the market and increase demand

More work is needed to determine the best mix of testing options for Australia. In determining this mix, consideration must be given not only to efforts to increase available testing options and demand, but also the potential flow-on effects and what is needed for effective implementation. For example, increasing in-person testing needs to be considered in relation to service capacity constraints, while efforts to increase self-testing should not replace or compromise necessary comprehensive BBVSTI testing.

5 Defined as diagnosed 4 years or more after seroconversion.

New HIV self-tests can help reach more people and increase testing rates

New HIV testing technologies are potential game-changers, boosting testing rates for at-risk groups. Safe, convenient and highly effective, HIV self-tests make it possible for people to test privately and anonymously using a finger prick or oral fluids.

Self-testing can reach people who may not test for HIV. Recent pilots demonstrate the value of expanding access to self-testing. For example, CONNECT self-test vending machines in greater Adelaide are successfully reaching GBMSM (including overseas-born students) and, as well as people who identify as heterosexual.

Self-testing options remain limited and inconsistent in Australia. There is only one self-test on the local market⁶. It can be bought online or in person through a limited number of stockists or accessed through a small number of local and national programs. Oral fluid self-tests are not available in this country— although a recent Australian study found that this was the preferred testing option for migrant GBMSM (Zhang et al. 2022).

Point-of-care testing can complement laboratory-based testing

Like self-testing, point-of-care testing (POCT) has the potential to increase access to testing for crucial target populations. POCT involves rapid presumptive screening

performed near the person being tested, which is not done under the supervision of a trained laboratory professional. An evaluation of ACON Health's community-led POCT a[TEST] indicated it could be effective in reaching at-risk and priority groups.⁷ POCT testing has also been found to reach people who have not tested for HIV before (Mutch, Lui, et al. 2017), and lead to timely uptake of treatment in priority populations. This includes First Nations Australians, people in rural and remote areas and GBMSM.

Two POCT options are available on the Australian market. Newer, innovative tests are not yet available here, such as the INSTI Rapid HIV Test, which gives a result within a minute and could be incorporated into standard HIV or STI consultations. Factors which contribute to the success of POCT models include being peer/community led, support from a strong workforce and engaged clients. As POCT is not Medicare-subsidised, there are challenges integrating it into routine primary care.

More must be done to incentivise manufacturers to enter the Australian market

HIV tests are classified as in vitro diagnostic medical devices. Unless exempt, they must be approved by the Therapeutic Goods Administration (TGA) and listed on the ARTG before they can be imported into or supplied in Australia. Self-tests and POCT must meet the same clinical performance requirements as laboratory tests demonstrating over 99.5% accuracy.

6 The only self-test approved and available for use in Australia as of 2023 is the Atomo HIV Self-Test, which uses a finger prick. The test is extremely accurate, correctly identifying 99.6% of HIV negative and HIV positive samples in laboratory testing.

7 The a[TEST] made up only 1.3% of HIV tests in New South Wales between 2015 and 2019, it accounted for 13.4% of diagnoses (and 19.9% of diagnoses for people born overseas).

Although these mechanisms are set up to protect Australians, incentives available to manufacturers need to be reviewed to enable the supply of a range of low-cost, convenient testing options. Development, regulatory and supply costs – combined with the small size of the market – disincentivise companies from seeking entry into the Australian market. Closer examination of the barriers to market entry, including TGA processes, could give Australians new options for HIV testing.

The Australian Government and state and territory governments should also partner on initiatives to remove barriers, expand access to, and promote the use of, the self-testing and POCT options that are already available.

As access to and use of HIV self-testing increases, it is also critical people have the necessary connection to care. Self-testing options need to be accompanied by digital information – such as websites, social media, apps, and digital vending machines – and connect people who receive a positive result to care and support through mechanisms such as helplines.

Immigration requirements should not discourage HIV testing and treatment

There are false perceptions among visa holders and applicants living in Australia that a positive HIV diagnosis will result in cancellations and even deportation. The Australian Government should do more to inform visa applicants of the process and revisit immigration requirements that discourage HIV testing among temporary and permanent visa applicants.

The migration health requirement helps to contain public expenditure and protect the Australian population from health risks.

A positive HIV result triggers a further assessment of the applicant's likely medical services and pharmaceuticals costs over the next 10 years. If likely costs are above the 'significant cost threshold' (currently \$51,000), the person's visa may be refused. Because the costs of HIV are above the threshold, applicants living with HIV do not meet the health criteria and, if no waiver is available, their applications are refused.

The Department of Home Affairs is reviewing the significant cost threshold and the immigration health requirement. The review will strive to align the requirement and threshold with current treatments and contemporary attitudes to disability and health conditions, while ensuring that health and community services remain sustainable for Australian residents. As part of this review, Home Affairs will consider impacts on people living with HIV and their families, communities and employers.

Public Health Acts that discourage testing should be reviewed

Public health laws vary across each state and territory creating a difficult landscape for people living with HIV to understand and navigate. For example, some jurisdictional Public Health Acts make it an offence to fail to take reasonable precautions to prevent exposure to HIV, regardless of whether HIV transmission occurs. Recent changes to sexual consent laws could be seen to consider misrepresentation of health status, including HIV status as fraud. These laws create an incentive for some people to remain unaware of their HIV status as they perceive that this would protect them from possible prosecution (NAPWHA 2023).

Recommendations

8. Partner with clinical and community stakeholders to develop a framework that identifies the optimal mix of testing types and access points, including opportunistic testing, to raise testing levels nationally.
9. Identify incentives to encourage manufacturers to bring innovative technologies for concentrated, low-prevalence epidemics onto the Australian market.
10. Examine options for a community-supported application to the Medical Services Advisory Committee for an MBS item for HIV POCT.
11. Work with state and territory governments to expand access and promote POCT and self-testing, including the implementation of local and regional testing initiatives and peer-outreach models.
12. Using the outcomes of the migration health requirement and significant cost threshold review, consider ways to reduce immigration barriers for people living with HIV.
13. Work with state and territory health officials to encourage discussions with jurisdictional policymakers and lawmakers to examine legislation that may be seen to criminalise HIV status.

Ensuring access to treatment

Access to antiretroviral therapy (ART) has already delivered a major reduction in HIV transmission in Australia. Making HIV medicines free Australia-wide would help ensure the cost of medicines is not a barrier to treatment.

Not all people diagnosed with HIV are receiving treatment. In line with the UNAIDS Fast-Track Targets (UNAIDS 2014), Australia has been aiming to increase the proportion of people diagnosed with HIV who are on treatment to 95%. Although Australia is a global leader at 92%⁸, the target has not yet been reached (Kirby 2022).

Reducing or removing co-payments would support universal access to HIV medicines

While Australian governments have worked together to make HIV medicines free for many people, some gaps remain. Like PrEP, HIV ART is subsidised through the PBS. A co-payment remains, which some state and territory governments fund on behalf of patients. The Closing the Gap PBS co-payment program for Aboriginal and Torres Strait Islander people excludes HIV medicines, meaning First Nations people living with HIV are subject to the co-payment arrangements in their state or territory. While a recent government initiative subsidised

HIV medicines for people without access to Medicare, there are inconsistencies between states and territories on whether a client pays for the clinical appointment and pathology service.

For some people living with HIV, the cost of medicines, travel and appointments are a barrier to treatment. These costs can discourage treatment for vulnerable and marginalised populations, such as First Nations people, people who inject drugs, people with mental health issues, and people who are unemployed and/or homeless. Young people also reported that the costs associated with treatment can be a barrier.

Reducing or removing co-payments for HIV medicines across Australia would lower costs and support more equitable access to treatment. This would align with Australia's approach to treatment for tuberculosis and serious vaccine-preventable diseases, which are not subject to co-payment requirements as a public health measure.

8 The Kirby Institute estimates that in Australia in 2021, 92% of people diagnosed with HIV were retained in care, and 92% were receiving antiretroviral treatment (ART). Almost all (98%) of those receiving ART had achieved viral suppression. Concerningly, however, 8% of people who had been diagnosed were not receiving ART

Better surveillance data can help us understand why some people are not accessing treatment

The UNAIDS 95-95-95 targets⁹ were established in 2014 (UNAIDS 2014). Australia's progress against these achievable targets is measured using surveillance data, which provides a population-level understanding of HIV. Surveillance data also helps to identify trends and also understand why some people are not receiving treatment. This allows us to focus interventions where they are most needed.

However, each of Australia's 8 jurisdictions contribute data separately and at different times. This is time-consuming and inefficient, creating a lag in interpreting and presenting data. Improving the collection of this information will provide crucial intelligence on the cohort of people who have been diagnosed but are not being treated. The establishment of the Australian Centre for Disease Control may provide an avenue to further address the timeliness and efficiency of data across all communicable diseases, including HIV.

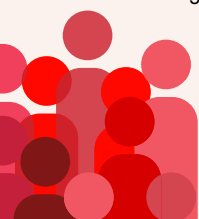
In the future, genetics-based strategies such as cluster-based surveillance, molecular epidemiology and phylogenetics could be used to track HIV transmission. However, as this can be used to determine how HIV is transmitted in the community, there are significant legal, ethical, privacy and logistical issues to be worked through before these beneficial technologies can be implemented.

Stigma remains a barrier to treatment

Another powerful barrier to treatment is HIV-related stigma, which intersects with homophobia, racism, and prejudice and criminalisation of sex work and drug use. This discourages people from seeking treatment and makes them more likely to discontinue treatment if they do start.

Stigma also has a great impact on quality of life for people living with HIV and is one of the best predictors of poorer outcomes (Mendonca 2023). Youth roundtable participants reported that stigma experienced with some clinicians discourages treatment-seeking and can lead to lack of adherence to medication. Better access to treatment therefore needs to be accompanied by efforts to dismantle stigma and improve quality of life for people living with HIV.

⁹ The 95-95-95 targets aim to diagnose 95% of all HIV-positive individuals, provide antiretroviral therapy (ART) for 95% of those diagnosed and achieve viral suppression for 95% of those treated by 2030.





Recommendations

- 14.** Partner with state and territory governments to investigate options for reducing or removing co-payments for HIV medication.
- 15.** Engage with surveillance and research partners to better understand stigma and its effects on the response in Australia and, improve the accuracy and timeliness of data capture and reporting, with a focus on measuring progress against the 95–95–95 targets.
- 16.** Work with professional and sector bodies to reduce stigma and build cultural competency in all healthcare settings.

Extending HIV awareness

By driving rapid and sustained behavioural change, Australia's health promotion response to HIV helped minimise the impact of the epidemic. To end the transmission of HIV in Australia, successes need to be built on, raising awareness to people most at risk of acquiring HIV and promoting the evidence underpinning HIV prevention and care.

Collaborative health promotion efforts have been central to Australia's HIV response since the beginning of the epidemic. In partnership with government, researchers and the health sector, key communities of gay men, sex workers, PWID and people living with HIV mobilised to tackle stigma and spread awareness of HIV prevention, testing and treatment.

As a result, the understanding of HIV is generally stronger in these communities today. They understand that HIV is now a preventable and manageable chronic illness. With treatment, people with HIV can reach viral suppression, which means they cannot sexually transmit HIV. This is a great legacy of the dedicated, community-led health promotion efforts over many years.

HIV awareness must be expanded to more vulnerable populations

Not all communities share the same understanding of HIV. Some groups of people are more vulnerable to acquiring HIV because of myths and misconceptions about HIV transmission and illness. Gender inequity, homophobia, cultural sensitivities and stigma about discussing sex and sexual orientation also drive a reluctance to seek information, support and health care. Due to the low prevalence of HIV in Australia, some people underestimate their risk of acquiring HIV, and therefore fail to take preventive measures or test.

Data released by the Kirby Institute shows incredible progress in certain areas of Australia. For example, inner-city Sydney where HIV was once most prevalent, has recorded the biggest reduction in diagnoses. However, the proportion of notifications among people who have recently arrived from overseas – notably South, East and Southeast Asia, Central and South America and Sub-Saharan Africa – is increasing.

An overarching national HIV communications strategy should examine successes while acknowledging that other communities may need different approaches. Efforts need to be dedicated to improving understanding in all affected communities, particularly those that have been historically unreached, to deliver on prevention, testing and treatment targets.

While HIV health promotion and communications should continue to focus on GBMSM, there has been an increase in the proportion of HIV diagnoses in women, and younger MSM and men in older age groups, especially those that travel overseas to high-prevalence countries. The communication strategy needs to address these groups, as well as people who receive a late HIV diagnosis. This an increasing issue that presents greater health care challenges.

Past successes can inform our communications strategy

During the COVID-19 pandemic, the most successful communications strategies gave communities the tools and support to develop relatable and culturally relevant messaging and materials themselves, rather than merely transplanting or translating generic messages. Targeted content should be communicated through the channels relevant to the audience, shared organically and delivered by trusted voices and peers through community-based activities.

Wherever possible, approaches that are already demonstrating success should be amplified. With more investment, existing communications platforms, campaigns and resources could grow their reach and effectiveness. For example, Emen8 is a national online platform that delivers essential HIV and sexual health information to MSM. Delivered in multiple languages, Emen8 content is community-driven and is developed by diverse peers. The platform is well-placed to build its overseas born audience with highly targeted and relevant content.¹⁰

Existing programs that build gay community connection among men who have recently arrived in Australia from overseas could be expanded. As could support for Aboriginal Community Controlled Health Organisations to develop and deliver culturally appropriate HIV and bloodborne virus and sexually transmitted infection (BBVSTI) education to First Nations people.

Health professionals have helped drive Australia's success, but ongoing contemporary education is needed

Australia needs a health workforce that is regularly updated on HIV, including the epidemiology of who is at risk. Primary care providers should be confident in providing comprehensive and culturally safe services to people living with and at risk from HIV regardless of sexual orientation or gender identity.

More training, education and awareness is needed for health professionals who do not specialise in sexual health or HIV and are not fully informed about HIV risk factors, prevention, testing, treatment and support. There are already several organisations developing creative ways to work with GPs, including new GPs and those still training.

The HIV Online Learning Australia platform (HOLA) delivered by Health Equity Matters and the National Association of People with HIV Australia, and clinical guidelines and training from ASHM, are examples of successful workforce awareness and education programs.

Wide implementation of the updated standard asymptomatic check-up as formalised in the Australian STI management guidelines (ASHM 2023) will provide a way to reach populations who may not identify as at risk of HIV. These guidelines recommended asymptomatic STI testing, including HIV and syphilis, for all populations at risk of infection.

¹⁰ Recent user data shows that 23% of users of Emen8 were born overseas.

Recommendations

- 17.** Increase investment in existing and further expand HIV awareness products, resources and platforms developed and delivered by community to improve effectiveness and reach.
- 18.** Work with health-sector partners to enhance education, training and development materials and guidelines to promote current and emerging technologies in HIV prevention, testing and treatment, and in the delivery of culturally sensitive LGBTIQ+ and culturally safe health services.
- 19.** As part of the implementation of the Ninth National HIV Strategy, develop an HIV communications strategy to shape long term communication activities to 2030.

Decriminalising HIV

Although Australia's response to HIV has emphasised an evidence-based public health approach, some of our laws indirectly criminalise HIV transmission, exposure and misrepresentation of HIV status. These laws reinforce stigma while discouraging testing and health-seeking behaviour. These laws must be reviewed alongside current HIV evidence to support Australia's efforts to eliminate transmission.

People living with HIV should be free from fear of prosecution because of their HIV status. However, laws still exist that reflect fear and prejudice towards people living with HIV, the gay community, people who inject drugs and sex workers. These views and the associated stigma are perpetuated by media coverage which ignores the contemporary medical reality of HIV.

Laws that indirectly criminalise HIV are hampering efforts to reduce HIV-related stigma and discrimination

In Australia, no criminal law specifically criminalises transmission of or exposure to HIV. But under various provisions in state and territory criminal acts, charges can be brought against a person for intentionally or recklessly transmitting, or exposing another person to the risk of acquiring, a communicable disease. HIV is often perceived to be 'worse' than other communicable diseases due to stigma, and HIV is the only BBV or STI prosecuted under these laws in practice. Sex workers have some of the lowest rates of HIV and STI of any group in Australia, yet laws that criminalise sex work also contribute to HIV-related stigma.

Some public health laws in states and territories also require people with HIV to take precautions to prevent exposure. Additionally, 6 Australian jurisdictions have mandatory disease testing laws that allow

a person to be subject to HIV testing if their bodily fluids come into contact with police or emergency services personnel. More recently, Australian states and territories are adopting affirmative consent laws. While these laws bring an important focus on mutual affirmative consent, deception provisions that address 'sexual activity due to fraud' could criminalise misrepresentation of HIV status even when a person is on HIV treatment and has a suppressed viral load, meaning they cannot transmit HIV. Some consent laws already include or propose exemptions for misrepresentations on income, wealth and feelings. Expanding these exemptions to include HIV where a person is virally suppressed should be considered.

Australia's public health response to HIV has always been led by evidence. These laws are out of step with the modern science of HIV and its treatment, particularly the science of U=U. The World Health Organization has confirmed the science showing that virally suppressed people have 'zero' risk of transmitting HIV is definitive (WHO 2023).

Unfortunately, this is not well understood across the wider community. More specifically, the new affirmative consent laws fail to recognise that people who are receiving treatment and have undetectable viral loads, cannot transmit HIV. Over 90% of people living with HIV in Australia have achieved viral suppression (Kirby 2022).

Some laws may actually increase the risk of transmission

Laws that criminalise nondisclosure, or affected communities, also cause anxiety and can make transmission more likely. By creating fear of prosecution, such laws can disincentivise getting tested for HIV, discourage open discussion about HIV between sexual partners and with clinicians (Bourne et al. 2022), and make people less likely to confidently access the treatment that they need to maintain an undetectable viral load.

The introduction of molecular epidemiology techniques to support the HIV response is also hindered by these laws. Until public health codes and criminal laws are changed, there are ethical concerns that named notification and contact tracing data could be subpoenaed and used to prosecute people for HIV transmission. Consequently, a highly effective new technology is unable to be used for our public health response.

Progress is slow, but possible

Ending HIV transmission in Australia is a public health issue, not a criminal one. Australia's last HIV-specific criminal legislation was repealed in 2015. With the repeal of such laws, it was acknowledged that deliberate HIV transmission was more effectively addressed through a public health approach.

The health sector must be empowered to support shifting perceptions of HIV, by adopting and adapting to a public health perspective that is informed by the science of U=U. The health sector can lead the movement to address HIV and the law, however this will take time as progress is hampered by system complexities and jurisdictional differences. Responsibility lies with all institutions to address and undo institutionalised stigma and outdated perceptions of HIV.

Recommendations

- 20.** Engage with state and territory governments, including through the Australian Health Protection Principal Committee, to initiate discussions with jurisdictional policymakers and lawmakers (including law reform bodies) to promote the use of current HIV science in the creation and implementation of law and policy, and identify how laws and policy are contributing to stigma which undermines the public health response and impacts negatively on the community, including on people living with HIV.
- 21.** Challenge historic misunderstandings about HIV by promoting the science and meaning of U=U and explaining the role of treatment as prevention in achieving virtual elimination. Disseminate the U=U message to the wider community and in communications targeted to justice, health care and education settings.
- 22.** Australian, state and territory governments partner with people living with HIV to develop a pathway for the adoption of molecular epidemiology techniques, named notification and enhanced public health contact tracing

Partnering on a national response

Collaboration has been at the heart of Australia's response since the start of the HIV epidemic. It is only by continuing these partnerships that the transmission of HIV in Australia can be eliminated and sustained.

Australia prides itself on a coordinated, evidence-driven HIV response. This has been achieved through a committed partnership between multiple levels of government and the community. Implementing the recommendations in this report will rely on a continued – and strengthened – collaborative effort. It will require investment from government and commitment all parts of the Australian community. Together, Australia can achieve the virtual elimination of HIV transmission.

Virtual elimination will be driven by government with the community

Australia's achievements in HIV awareness, prevention, testing and treatment have been driven in large part by the community including researchers, the healthcare workforce, NGOs including HIV peak bodies, and crucially, people living with HIV and affected communities. For more than 4 decades, the relationships between government and community have been characterised by consultation, cooperation and collaboration. To inform and deliver prevention, testing and treatment initiatives, governments will need to continue collaborating with people living with HIV, affected communities and their NGOs.

Multicultural organisations can make a valuable contribution to expanding awareness about HIV in their communities and are critical to the development of targeted campaigns that will deliver messages that are meaningful and culturally appropriate. Similarly, Aboriginal Community Controlled Health Organisations can help to develop and deliver culturally appropriate HIV and BBVSTI education to First Nations people. Targeted campaigns should be designed and delivered by the community to ensure messaging is effective and impactful.

All levels of government can collaborate and partner to make a difference in Australia's HIV response

The shared commitment of Australian, state and territory governments to ending HIV transmission will be cemented in the Ninth National HIV Strategy in 2024. However, all levels of government should continue to look for new ways to build and improve collaboration. Inner-city Sydney and female sex workers have achieved virtual elimination, and other communities can aim to do the same. As communities achieve virtual elimination at different points, cooperation will need to be sustained to maintain elimination.

National coordination around needle exchange programs and condom provision can help prevent transmission

Needle exchange programs are vital for preventing transmission of bloodborne infections, including HIV, for PWID. Similarly, the promotion and availability of condoms has been a primary prevention method for sexual transmission of HIV and other STI. Such harm reduction programs need to continue to be encouraged, expanded and normalised. Although such harm

reduction programs are readily accessible in metropolitan areas, rural and remote areas continue to have less access.

Expanding access to needle exchange programs and condom availability needs to occur across Australia. Such programs are shown to be cost-effective and contribute to reduced HIV transmission. The Australian Government should partner with state and territory governments to ensure harm reduction programs are available for everyone in Australia, regardless of geographic location.

Recommendations

- 23.** Continue working in partnership with state and territory governments to deliver a national response to HIV and finalise and implement the Ninth National HIV Strategy.
- 24.** Support and empower the HIV sector, multicultural organisations and First Nations organisations to partner in the delivery of the national HIV response.
- 25.** Partner with state and territory governments to maintain and expand access to needle exchange and condom programs.

Recommendations of the HIV Taskforce

1. Partner with states and territories to design a program that provides subsidised access to oral PrEP for people who are ineligible for Medicare.
2. Explore possibilities for extending the PrEP prescription and monitoring cycle to ease time and cost burdens on users.
3. Investigate options to allow the prescribing or supply of PrEP through pharmacists, nurses and peers.
4. The Australian Government should consider fast-tracking the availability of long-acting, injectable PrEP on the Australian market to reach PrEP users and to support ongoing use.
5. Investigate barriers that discourage people who have used PrEP from continuing or resuming use.
6. Resource ongoing information campaigns to increase demand for PrEP within the community and to build the capacity of healthcare workers, particularly in clinical settings with lower PrEP caseloads and outside of inner-city urban areas and gay communities, to engage in conversations about PrEP.
7. Support making the temporary blood borne viruses and sexual and reproductive telehealth MBS items permanent following the outcomes of the MRAC review.
8. Partner with clinical and community stakeholders to develop a framework that identifies the optimal mix of testing types and access points, including opportunistic testing, to raise testing levels nationally.
9. Identify incentives to encourage manufacturers to bring innovative technologies for concentrated, low-prevalence epidemics onto the Australian market.
10. Examine options for a community-supported application to the Medical Services Advisory Committee for an MBS item for HIV POCT.
11. Work with state and territory governments to expand access and promote POCT and self-testing, including the implementation of local and regional testing initiatives and peer-outreach models.
12. Using the outcomes of the migration health requirement and significant cost threshold review, consider ways to reduce immigration barriers for people living with HIV.
13. Work with state and territory health officials to encourage discussions with jurisdictional policymakers and lawmakers to examine legislation that may be seen to criminalise HIV status.

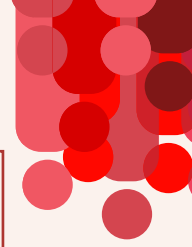
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- 14.** Partner with state and territory governments to investigate options for reducing or removing co-payments for HIV medication.
 - 15.** Engage with surveillance and research partners to better understand stigma and its effects on the response in Australia and, improve the accuracy and timeliness of data capture and reporting, with a focus on measuring progress against the 95–95–95 targets.
 - 16.** Work with professional and sector bodies to reduce stigma and build cultural competency in all healthcare settings.
 - 17.** Increase investment in existing and further expand HIV awareness products, resources and platforms developed and delivered by community to improve effectiveness and reach.
 - 18.** Work with health-sector partners to enhance education, training and development materials and guidelines to promote current and emerging technologies in HIV prevention, testing and treatment, and in the delivery of culturally sensitive LGBTIQ+ and culturally safe health services.
 - 19.** As part of the implementation of the Ninth National HIV Strategy, develop an HIV communications strategy to shape long term communication activities to 2030.
 - 20.** Engage with state and territory governments, including through the Australian Health Protection Principal Committee, to initiate discussions with jurisdictional policymakers and lawmakers (including law reform bodies) to promote the use of current HIV science in the creation and implementation of law and policy, and identify how laws and policy are contributing to stigma which undermines the public health response and impacts negatively on the community, including on people living with HIV.
 - 21.** Challenge historic misunderstandings about HIV by promoting the science and meaning of U=U and explaining the role of treatment as prevention in achieving virtual elimination. Disseminate the U=U message to the wider community and in communications targeted to justice, health care and education settings.
 - 22.** Australian, state and territory governments partner with people living with HIV to develop a pathway for the adoption of molecular epidemiology techniques, named notification and enhanced public health contact tracing
 - 23.** Continue working in partnership with state and territory governments to deliver a national response to HIV and finalise and implement the Ninth National HIV Strategy.
 - 24.** Support and empower the HIV sector, multicultural organisations and First Nations organisations to partner in the delivery of the national HIV response.
 - 25.** Partner with state and territory governments to maintain and expand access to needle exchange and condom programs.

Table 1. HIV Taskforce members

Member	Organisation
The Hon Mark Butler MP (Chair)	Minister for Health and Aged Care
The Hon Ged Kearney MP (Deputy Chair)	Assistant Minister for Health and Aged Care
Senator Louise Pratt	Senator for Western Australia
Senator Dean Smith	Senator for Western Australia
Dr Jason Agostino	Medical Advisor, National Aboriginal Community Controlled Health Organisation
Mr Aaron Cogle	Executive Director, National Association of People with HIV Australia
Scientia Professor Andrew Grulich	Program Head HIV Epidemiology and Prevention Program, The Kirby Institute, UNSW
Mr Scott Harlum	President, National Association of People with HIV Australia
Professor Margaret Hellard AM	Deputy Director, Burnet Institute
Ms Tina Hosseini	Research Fellow, Swinburne University of Technology
Ms Penny Kenchington	Vice President, Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine
Professor Michael Kidd AO	Director, UNSW Centre for Future Health Systems
Dr Christopher Lemoh	Infectious Disease and General Physician, Western Health Victoria
Adjunct Professor Darryl O'Donnell	Chief Executive Officer, Health Equity Matters
Mx Mish Pony	Chief Executive Officer, Scarlet Alliance Australian Sex Workers Association

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