



Australian Government

Department of Health

SEVENTH  
National  
**HIV** Strategy

2014-2017

## **Seventh National HIV Strategy 2014–2017**

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SEVENTH  
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# Foreword



Australia has made great progress in addressing blood-borne viruses and sexually transmissible infections over the last three decades. Our continued response to HIV, viral hepatitis and sexually transmissible infections over the life of the new national strategies comes at a time of both unprecedented opportunity and ongoing challenge.

Scientific advances in prevention, testing and treatment are providing us with the knowledge and the means to make dramatic reductions in new infections and significant improvements in health outcomes. At the same time, these conditions still represent a significant burden of disease in this country, with the number of people affected by blood-borne viruses and sexually transmissible infections remaining too high and, for some conditions, increasing.

Australia's five national strategies set the direction for a coordinated, national response to HIV, hepatitis B, hepatitis C, sexually transmissible infections, and blood-borne viruses and sexually transmissible infections in the Aboriginal and Torres Strait Islander population until 2017. The national strategies are endorsed by all Australian Health Ministers and, for the first time, contain targets which provide a renewed focus for action and a framework for accountability.

Achieving the targets will be challenging and will require the concerted effort of all governments, affected communities, health care providers, the community sector and researchers. Together we need to take action to overcome the barriers that impede our efforts to scale up prevention, testing, management, care and support for people living with and at risk of blood-borne viruses and sexually transmissible infections.

Each national strategy identifies the priority actions that will support achievement of the targets across the areas of prevention; testing; management, care and support; workforce; protection of human rights; and surveillance, research and evaluation.

Implementing the priority actions will see evidence-based and targeted prevention activities remaining fundamental to the national response, and

efforts to increase testing rates and early diagnosis being scaled up. The role of primary care in blood-borne viruses and sexually transmissible infections management, care and support will become increasingly important, and the workforce will need to be supported accordingly. Continuing to build an enabling environment where stigma and discrimination does not prevent people from accessing health and community services will underpin success across all areas. More effective surveillance, monitoring, research and evaluation will continue to inform our national response and measure our progress.

The strong partnership approach that has been a hallmark of Australia's response to blood-borne viruses and sexually transmissible infections to date is required now more than ever. Despite the challenges, and with concerted and collective action, I am confident that Australia is well placed to step up the pace in our response to these conditions. I will be closely monitoring our progress over the coming years.



**The Hon Peter Dutton MP**

Minister for Health

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# 1. Introduction

Despite a highly successful response to HIV — built on partnership and community mobilisation and resulting in low rates of infection — Australia is now at a crossroads. We are witnessing the highest rates of new infections in 20 years. There were 1253 cases of HIV infection newly diagnosed in Australia in 2012, representing a 10 per cent increase from new diagnoses in 2011. Seventy per cent of these new diagnoses of HIV occurred among men who have sex with men [1].

Evidence of increasing rates of high-risk sexual behaviour among some gay men and other men who have sex with men suggests that gay men's sexual practice and the meaning of HIV for them has changed in recent years. At the same time, behavioural data suggests that testing rates and routines are inadequate in some population groups [21]. The estimated average time from infection to diagnosis in Australia is too long, at approximately 3.4 years [2].

The *Seventh National HIV Strategy 2014–2017* sets the direction for Australia to reverse the increasing trend of new HIV diagnoses and works towards the virtual elimination of HIV transmission by 2020. For the first time, the national HIV strategy includes discrete targets. These targets are informed by the United Nations *2011 United Nations Political Declaration on HIV/ and AIDS* (the UN Declaration) [22] and have been adapted to the Australian context.

The targets come with enormous challenges. Reducing sexual transmission of HIV by 50 per cent by 2015 will require considerable effort, given Australia's relatively low HIV prevalence and high testing and treatment coverage. Testing and treatment will both need to increase significantly, with modelling suggesting that an increase in testing by 30 per cent must be combined with an increase in treatment coverage to up to 80 per cent to achieve this [2]. It is also important that increases in testing and treatment are accompanied by an increase in safer sex behaviours.

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

The strong partnership approach that has produced such an effective response since the 1980s is required now more than ever, but in the face of increasing rates of HIV infection a business-as-usual approach will not be enough.

Partners need to review and refresh existing approaches to ensure that the impact of traditional prevention messages, and new testing and treatment options, reach the population groups where surveillance shows that rates of HIV are high or rising. These include young gay men and other men who have sex with men, people from high HIV-prevalence countries, and Aboriginal and Torres Strait Islander people who inject drugs.

Scientific advances in preventing and treating HIV have provided us with the knowledge and the means to make dramatic reductions in new HIV infections, HIV-related illnesses and deaths. People living with HIV can now expect to live long and productive lives, with HIV managed as a chronic condition.

After three decades of responding to HIV in Australia, now is the time for all Australian governments, clinicians and researchers, community and professional organisations, and individuals to step up the pace to create a future without HIV. At this point in the response, the actions and decisions taken by individuals to embrace both prevention and treatment are paramount.

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

The UN Declaration is mobilising action globally and provides direction for the actions that are needed to defeat HIV and AIDS. Australia is experiencing increasing HIV diagnoses and collectively we need to maintain our focus and step up the pace. We must harness the success of the past — the early response to HIV that has been held up internationally as a success — to meet the challenges we face in 2014 and beyond. Australia is well placed to achieve this goal.

## 2. HIV in Australia

At the end of 2012, an estimated 28 000 to 34 000 people were living with HIV infection in Australia. The incidence of HIV notifications, a marker for incidence of new infections, has been increasing since 1999, with 1000 to 1300 new cases per year since 2006. While trends in newly diagnosed HIV infection vary across state and territory health jurisdictions, the number of newly diagnosed HIV cases increased by 10 per cent in 2012; the highest number of new cases in 20 years [1].

In 2012, 73.1 per cent of people diagnosed with HIV acquired the infection through sexual contact between men, 15 per cent through heterosexual contact (approximately half of which was among people from high-prevalence countries or their partners), and 3 per cent through injecting drug use [1]. Mother-to-child transmission of HIV is very rare in Australia [1].

The prevalence of HIV infection in Australia is greatest among gay men and other men who have sex with men, at 14 per cent in this population group [21] and around 1 per cent among people who inject drugs [1]. Female sex workers, including migrant sex workers, continue to maintain very low rates of HIV [1].

Overall, the annual number of HIV notifications among Aboriginal and Torres Strait Islander people is small, and rates of diagnoses are similar to the non-Indigenous population. However, the rates of heterosexual transmission and transmission related to injecting drug use are higher than that for the non-Indigenous population, requiring action to protect against more generalised spread among Aboriginal and Torres Strait Islander people [1].

While the HIV epidemic in Australia remains concentrated, primarily focused and resurgent among gay men and other men who have sex with men, there are also clear indications of smaller but important epidemics emerging. An important example is the higher rates of heterosexually acquired HIV among some communities of people from high HIV-prevalence African or South-East Asian countries, and the sexual partners of people from these locations, than that in the Australian-born population [1]. Projected demographic modelling indicates that HIV transmission among people in these communities may become increasingly more important, particularly in Western Australia [23].

The ageing of the population of people living with HIV is an important feature of the changing epidemiology of HIV. Advances in HIV antiretroviral therapy has decreased HIV and AIDS-associated mortality and morbidity. The increasing numbers of people living with HIV and the ageing nature of this population have important implications for the healthcare system [23].

## 3. Achievements

Over the last four years, from 2010 to 2013, a number of milestones and achievements have been reached in Australia in the response to HIV. These achievements will be built on over the next four years to achieve the goals, objectives and targets of this Strategy.

Australia signed the UN Declaration and Australian health ministers endorsed the UN Declaration's targets as they are adapted to the Australian context. The targets informed the development of this *Seventh National HIV Strategy 2014–2017* and jurisdictional HIV strategies. The HIV sector mobilised around adopting and achieving these targets and approaches.

In response to a submission from community organisations, the Pharmaceutical Benefits Advisory Committee recommended the removal of the CD4+ requirement from the Pharmaceutical Benefits Scheme restrictions for initiation of first-line antiretroviral therapy. The recommended change allows the initiation of antiretroviral therapy at a CD4+ count  $>500$  cells/mm<sup>3</sup> for patients with HIV, irrespective of the presence of symptomatic disease. This change came into effect in April 2014, providing greater choice for patients and prescribers of when to initiate antiretroviral therapy.

The Therapeutic Goods Administration registered the first HIV rapid test for use in non-laboratory settings. This has enabled the introduction of rapid testing in healthcare settings such as sexual health clinics and general practice, and in community-based settings, increasing options for priority populations to access HIV testing.

A *HIV Stigma Audit Community Report* [24] documented for the first time the experiences and effects of stigma on the lives of people living with HIV in Australia. This work will inform further efforts to both address and monitor the impact of stigma and discrimination over the life of this Strategy.

Australia has maintained the virtual elimination of HIV amongst sex workers, people who inject drugs, and mother-to-child transmission of HIV. Linkages between primary care and specialist services were enhanced, and innovative programs to promote prevention among gay and bisexual men were implemented.

Continued investment occurred in behavioural, clinical, epidemiological and social research to inform policy and priority setting in the HIV response, and improved systems were implemented for monitoring and surveillance of HIV.

# 4. Measuring Progress

## 4.1 Goals

The goals of the *Seventh National HIV Strategy 2014–2017* (the Strategy) are to:

- work towards achieving the virtual elimination of HIV transmission in Australia by 2020
- reduce the morbidity and mortality caused by HIV
- minimise the personal and social impact of HIV.

## 4.2 Objectives

The Strategy has six objectives which, in combination, support achievement of its goals. The objectives are to:

1. reduce the incidence of HIV
2. reduce the risk behaviours associated with the transmission of HIV
3. decrease the number of people with undiagnosed HIV infection
4. increase the proportion of people living with HIV on treatments with undetectable viral load
5. improve quality of life of people living with HIV
6. eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health.

## 4.3 Targets

Targets are included for the first time in the Strategy, providing a renewed focus for action and a framework for accountability. These targets have been adapted to the Australian context from those in the UN Declaration, and were endorsed by all members of the Council of Australian Governments (COAG) Standing Council on Health in 2013.

The targets of the Strategy are to:

1. reduce sexual transmission of HIV by 50 per cent by 2015
2. sustain the low general population rates of HIV in Aboriginal and Torres Strait Islander people and communities
3. sustain the virtual elimination of HIV amongst sex workers
4. sustain the virtual elimination of HIV amongst people who inject drugs
5. sustain the virtual elimination of mother-to-child HIV transmission
6. increase treatment uptake by people with HIV to 90 per cent
7. maintain effective prevention programs targeting sex workers and for people who inject drugs.

Sexual transmission remains the primary mode of HIV transmission in Australia, and the primary focus to eliminating HIV transmission in Australia. A reduction of 50 per cent is a substantial challenge, given the relatively low levels of transmission in Australia, and requires major increases in both testing and treatment. The timeframe of 2015 for this target aligns with the UN Declaration, and efforts towards further reducing the sexual transmission of HIV will continue over the life of this Strategy.

A continuing emphasis on safer sex and sterile injecting practices is required to contribute to the reduction in sexual transmission and to sustain low rates of HIV transmission in the priority populations. Effective prevention programs must be maintained to achieve this.

Current estimates suggest only 50–70 per cent of people who know they are living with HIV are receiving antiretroviral treatment [3]. To maximise the potential benefits for the individual, and the prevention of transmission, treatment uptake must be improved greatly.

## 4.4 Indicators

Indicators will be used to monitor the implementation of the Strategy, report against progress in achieving targets and objectives, and inform changes in the response as required.

There are limitations in the availability and quality of indicators to measure progress against several of the Strategy's objectives and targets. The indicators identified below have an existing national collection mechanism, and can be reported on from the initiation of this Strategy.

Further work on refining and developing indicators is required, and will be progressed during the life of this Strategy. Indicators to report against each of the targets will need to be specifically defined. An important gap to be addressed is the lack of a nationally agreed indicator for measuring progress in reducing the health impact of stigma, discrimination and legal and human rights in the context of this Strategy. Other specific areas for particular revision include indicators for the measurement of treatment, and incidence measures for some of the priority populations. Further limitations and gaps are discussed in section 7.6, 'Surveillance, Research and Evaluation'.

Objective	Indicator
Reduce the incidence of HIV	Incidence of recent HIV infection among HIV diagnoses  Estimated incidence of HIV
Reduce the risk behaviours associated with the transmission of HIV	Proportion of gay men who have engaged in unprotected anal intercourse with casual male partners in the previous six months  Proportion of people who inject drugs reporting re-use of someone else's needle in previous month
Decrease the number of people with undiagnosed HIV infection	Proportion of gay men who have been tested for HIV in the previous 12 months  Proportion of people who inject drugs who have been tested for HIV in the previous 12 months  Median CD4 count at HIV diagnosis
Increase the proportion of people living with HIV on treatments with undetectable viral load	Proportion of people living with diagnosed HIV who are receiving antiretroviral treatment  Proportion of people receiving antiretroviral treatment for HIV infection whose viral load is less than 50 copies/mL
Improve quality of life of people living with HIV	Proportion of people with HIV who report their general health status and their general wellbeing to be excellent or good
Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health	

## 4.5 Implementation and Evaluation

The Strategy sets high-level directions for action over the next four years. Implementation and evaluation of the Strategy will be supported by an 'Implementation and Evaluation Plan' and a 'Surveillance and Monitoring Plan'. These plans will be developed in consultation with state and territory

governments and partners and will detail how priority actions will be implemented, including roles and responsibilities, timeframes and lines of accountability, and the ways in which the goals, targets and objectives will be monitored.

Australia's world recognised partnership approach will remain central to our response to blood-borne viruses (BBV) and sexually transmissible infections (STI). Undertaking the actions set out in this Strategy by December 2017 requires Commonwealth and state and territory governments, community organisations, service delivery organisations, professional bodies, and research institutions to work together. In doing this, we need to ensure that affected individuals and communities remain at the heart of our response and involved in activities as they are proposed, developed and implemented.

This Strategy builds on its six predecessors, which have guided Australia's response to HIV and AIDS between 1989 and 2013. It is one of five interrelated national strategies aiming to reduce the transmission and impact of BBV and STI. The other strategies are the:

- *Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy*
- *Fourth National Hepatitis C Strategy*
- *Third National Sexually Transmissible Infections Strategy*
- *Second National Hepatitis B Strategy.*

The five national strategies share common structural elements, designed to support a coordinated effort in addressing common concerns. Much of the prevention, healthcare and community responses contained in the strategies are intrinsically linked through co-infections, commonalities in risk factors and shared responsibility for the clinical management of BBV and STI. The strategies support and align with state and territory BBV and STI strategies and provide a framework to guide coordinated action in this area by jurisdictional governments and other partners until 2017.

Epidemiology, policy context and priority areas for action specific to addressing HIV in the Aboriginal and Torres Strait Islander population are included in more depth in the *Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy*.

# 5. Guiding Principles Underpinning Australia's Response

The guiding principles informing this Strategy are drawn from Australia's efforts over time to respond to the challenges, threats and impacts of HIV, STI and viral hepatitis.

## Human Rights

People with blood-borne viruses and sexually transmissible infections have a right to participate fully in society, without experience of stigma or discrimination. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.

## Access and Equity

Health and community care in Australia should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to geographic location, gender, sexuality, drug use, occupation, socioeconomic status, migration status, language, religion or culture. Special attention needs to be given to working with Aboriginal and Torres Strait Islander people to close the gap between Aboriginal and Torres Strait Islander health status and that of other Australians [4].

## Health Promotion

The Ottawa Charter for Health Promotion provides the framework for effective BBV and STI health promotion action and facilitates the active participation of affected communities and individuals to increase their influence over the determinants of their health, and formulation and application of law and public policy that supports and encourages healthy behaviours and respects human rights.

## Prevention

The transmission of HIV can be prevented through the appropriate combination of evidence-based biomedical, behavioural and social approaches. Education and prevention programs, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures.

## Harm Reduction

Harm-reduction approaches underpin effective measures to prevent transmission of HIV, including needle and syringe programs and drug treatment programs.

## Shared Responsibility

Individuals and communities share responsibility to prevent themselves and others from becoming infected, and to inform efforts that address education and support needs. Governments and civil society organisations have a responsibility to provide the necessary information, resources and supportive environments for prevention.

## Commitment to Evidence-based Policy and Programs

The national response to BBV and STI has at its foundation an evidence base built on high quality research and surveillance, monitoring and evaluation. A strong and constantly refining evidence base is essential to meet new challenges, and evaluate current and new interventions and effective social policy.

## Partnership

An effective partnership between affected communities, professional and community organisations, government, researchers and health professionals is characterised by consultation, cooperative effort, respectful dialogue, resourcing and action to achieve the goals of the strategies. It includes leadership from the Australian Government and the full cooperative efforts of all members of the partnership to implement agreed directions.

## Meaningful Involvement of Affected Communities

The meaningful participation of people living with BBV and STI and of affected communities in all aspects of the response is essential to the development, implementation, monitoring and evaluation of programs and policies.

# 6. Priority Populations

While HIV is an issue for the whole of Australian society, targeting responses to priority populations is critical to maximising the impact and sustainability of our response. The priority populations for this Strategy reflect Australia's epidemiological data and social context. Individuals may be members of more than one priority population.

Priority populations identified in this Strategy are:

- people living with HIV
- gay men and other men who have sex with men
- Aboriginal and Torres Strait Islander people
- people from high HIV prevalence countries and their partners
- travellers and mobile workers
- sex workers
- people who inject drugs
- people in custodial settings.

Further details on the main reasons for priority population status, specific subpopulations of higher prevalence and/or higher risk, and the main barriers and facilitators to effective responses are included in the Appendix.

## 6.1 People Living with HIV

People living with HIV are a diverse group requiring tailored responses, and are a priority for all action areas of this Strategy. The Strategy aims to ensure that people living with HIV benefit from appropriate, effective and high quality health and community services covering prevention, management, care and support. The meaningful participation of people living with HIV in the development, implementation, monitoring and evaluation of HIV programs and policies is central to the partnership approach and the success of the Strategy.

## 6.2 Gay Men and Other Men Who Have Sex with Men

Gay men and other men who have sex with men, such as bisexually and homosexually active men who do not identify as being gay, are the population group most affected by HIV in Australia with the highest prevalence and incidence. HIV transmission among men who have sex with men in Australia has been increasing nationally since 1999. Addressing this resurgence of HIV transmission is fundamental to achieving the goal and targets of this Strategy. Men under the age of 25 years are a particular focus given some findings of increasing unsafe sex practices, inadequate rates of testing, and increasing rates of HIV diagnosis.

## 6.3 Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander people experience HIV rates similar to the non-Indigenous population; however, a larger proportion of HIV transmission occurs through injecting drug use and heterosexual contact. There is potential for HIV rates to increase in this population due to a range of factors, including sustained high prevalence of viral and bacterial STI in many remote and very remote communities; higher rates of injecting drug use and sharing of injecting equipment; geographical, cultural and social circumstances; and over-representation in custodial settings and juvenile detention.

## 6.4 People from High HIV Prevalence Countries and Their Partners

In Australia, HIV diagnoses have been increasing among people from high HIV prevalence countries, including South-East Asia and Sub-Saharan Africa. Women from these population groups have a higher risk of HIV than women in the general population. Among cases of HIV infection newly diagnosed in Australia over the past five years, 10 per cent were in people who reported speaking a language other than English at home [1]. Targeted prevention and treatment approaches that effectively address language, cultural and gender issues are needed.

## 6.5 Travellers and Mobile Workers

People who engage in unsafe behaviours while travelling, or who travel to or from high HIV prevalence countries, are at higher risk of exposure to HIV themselves or transmission of HIV to others. People from high HIV prevalence countries who are in Australia temporarily, such as mobile workers, are emerging as a significant factor in the epidemiology of HIV in some areas, such as Western Australia.

## 6.6 Sex Workers

HIV prevention among sex workers has been highly successful in Australia and has resulted in HIV incidence rates among the lowest in the world. Sex workers remain a priority population because of the ongoing potential for an increase in HIV transmission due to occupational risks. Sex workers experience barriers to health service access, including stigma and discrimination. They face a range of legal and regulatory issues including criminalisation, licensing, registration and mandatory HIV testing in some jurisdictions.

## 6.7 People Who Inject Drugs

HIV prevention among people who inject drugs has been highly successful in Australia and has resulted in sustained low HIV prevalence. People who inject drugs remain a priority population because of the potential for an increase in HIV transmission; for example, through changes in the availability of injecting equipment. The ability to access health services and minimise the personal and social impact of HIV continues to be affected by barriers such as stigma, discrimination and social marginalisation.

## 6.8 People in Custodial Settings

People in custodial settings are at risk of HIV transmission through unsafe injecting drug use, unsafe tattooing, and unprotected sex (including through sexual assault) as these behaviours increase risk of HIV transmission. If HIV is acquired in the custodial setting and there is a delay in diagnosis, there is also a risk of transmission to others on their return to the community. Barriers to HIV prevention in custodial settings include lack of access to the means of prevention, including sterile injecting and tattooing equipment, and condoms.

## 7. Priority Areas for Action

Significant scientific advances in the prevention and treatment of HIV mean that we now have a wider range of approaches available which can be used in combination to prevent new HIV infections. New technologies are making HIV testing easier and more accessible and have the potential to significantly reduce the average time between infection and diagnosis.

The changing landscape of HIV prevention, testing and treatment has informed the development of priority actions to be undertaken over the life of this Strategy. The Strategy provides direction for how these new opportunities should be implemented in the Australian context to achieve the greatest impact, and to support our efforts to reach the goal of virtual elimination of HIV transmission by 2020 and the specific targets of this Strategy.

'Combination prevention' is the application of evidence-based biomedical, behavioural and social prevention interventions to achieve a common outcome: the prevention of HIV transmission. Elements of combination prevention include safe behaviours and condom use, testing and counselling, linkage to and retention in care, and treatment. The success of this approach, which is increasingly being discussed and implemented internationally, relies on implementation of all the components. For example, modelling shows that relatively small increases in unsafe practices will negate increases in testing and treatment [28].

Research has confirmed that antiretroviral treatments not only have significant health benefits for individuals, but that they greatly reduce the risk of HIV transmission [5]. 'Treatment as prevention' refers to the use of antiretroviral therapy for HIV-infected people at earlier stages of disease in order to reduce their infectiousness and thus reduce the risk of onward transmission. Earlier treatment has a potential population health benefit through reducing community viral load. Several studies are further defining the level of risk reduction in different population groups [25].

Other new treatment technologies include pre-exposure prophylaxis (PrEP). This is an emerging biomedical intervention that may be useful in very high risk population groups, and its place in the prevention response needs to be determined.

The introduction of HIV rapid testing in non-laboratory settings is a significant development which has great potential to increase the rate of voluntary and appropriate testing among priority populations. Implementation of HIV rapid testing at point of care and in non-clinical community settings in Australia is underway and is evaluating well. Given the disproportionately high contribution to HIV transmission by people who do not know they are infected, efforts such as this to enhance access to testing and link people to treatment, care and support are crucial [26].

## 7.1 Prevention

### Priority Actions

- Increase safer sex practices among priority populations, particularly among gay men and other men who have sex with men, through the delivery of effective health promotion and prevention activities.
- Ensure the provision of sterile injecting equipment and safe-injecting education among people who inject drugs, particularly among priority populations such as Aboriginal and Torres Strait Islander people.
- Build the knowledge, skills and capacity of priority populations, primary care providers and policy makers to establish innovative HIV risk-reduction programs and activities.
- Improve the appropriate uptake of treatment as prevention, while monitoring and evaluating the impact of implementing this approach including feasibility, acceptability and outcomes.
- Strengthen the monitoring and evaluation of innovations and advances in biomedical, social and behavioural prevention sciences to inform implementation.

HIV transmission in Australia occurs mostly through sexual contact and, to a lesser extent, through injecting drug use. Prevention strategies to date have focused on increasing the use of safer sex practices and sterile injecting practices in priority populations. Behaviour change has been supported through multilayered approaches involving community mobilisation, social marketing, health promotion, peer education and outreach, and harm-reduction strategies (including provision of sterile injecting equipment through needle and syringe

programs). These approaches remain successful in sustaining low levels of HIV transmission among people who inject drugs in the general population, and sex workers.

Evidence of increasing rates of high risk sexual behaviour among some gay men and other men who have sex with men suggests that gay men's sexual practice and the meaning of HIV for them has changed in recent years. These changes have had an impact on the effectiveness of HIV prevention messages. This demands an innovative response from health promotion that actively explores new methods of communication to bring about behaviour change.

We need to reinvigorate cultures of safe sex practices among gay men and other men who have sex with men, including through community-driven and peer-based education and support approaches. Prevention efforts need a renewed focus on young men who have sex with men, given evidence showing an increase in risk behaviours and inadequate testing rates and routines among this group. We need to establish a greater level of knowledge of new prevention and treatment options, including treatment as prevention, and the importance of testing among this population group.

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

At the same time, we need to sustain prevention efforts in priority populations where rates of HIV are low but there is a risk that HIV rates could increase, such as Aboriginal and Torres Strait Islander people, sex workers, people who inject drugs, and among mobile workers. We need to support individuals to make informed decisions about practical HIV prevention actions they can take themselves.

HIV prevention approaches targeting Aboriginal and Torres Strait Islander people need to respond appropriately to social, cultural and environmental contexts. Prevention efforts should prioritise two key groups: young people and people living in remote and very remote communities given the sustained high prevalence of STI and the associated increased risk for HIV transmission;

and people who inject drugs, given the high rates of HIV transmission among this population through injecting drug use. Efforts to engage young people need to be contemporary, culturally appropriate, supported by the community, and should be inclusive of young people both within and outside the school environment.

The success of HIV prevention among sex workers in Australia can be attributed to effective implementation of safer sex practices by sex workers, supported by effective peer education, and a culture of high levels of condom use and testing. The very low rates of HIV among sex workers, including migrant sex workers, provides evidence of the effectiveness of condoms as a prevention tool, and of peer education and outreach strategies for both informing hard-to-reach groups about HIV risk and establishing peer norms.

Preventing transmission of HIV through injecting drug use has been effectively underpinned by needle and syringe programs. The early introduction of these services, together with peer education and outreach, and opioid substitution therapy, has seen very low rates of HIV infection among people who inject drugs in Australia [1].

Research has demonstrated the effectiveness of antiretroviral treatments in reducing the risk of HIV transmission [5]. Commencing treatment at earlier stages of disease reduces the infectiousness of people with HIV and the risk of onward transmission. Treatment as prevention has the potential to produce a population health benefit through reducing community viral load.

Australia needs to continue to monitor local and international evidence on the implementation of treatment as prevention, both positive and negative, and respond accordingly to ensure that we successfully maximise the benefits of this approach along with the proven focus on safe behaviours. Studies underway which are further defining the level of risk reduction for different population groups will provide valuable evidence to inform this process.

It is important that healthcare providers, policy makers and priority populations are well informed of the range of risk reduction strategies and testing and treatment options now available so that these opportunities are maximised.

## 7.2 Testing

### Priority Actions

- Increase access to and uptake of voluntary and appropriate HIV testing among people from priority populations, particularly gay men and other men who have sex with men.
- Improve knowledge among priority populations about the personal and public health benefits of early diagnosis and the testing, treatment and support options available.
- Support high quality, safe, appropriate and accessible testing that facilitates early diagnosis through continued review of regulatory, funding, legislative and policy mechanisms associated with HIV testing.

It is estimated that 10–20 per cent of Australians living with HIV have not been diagnosed [6], and that this undiagnosed group of people contribute to a significant proportion of HIV transmission and new cases of HIV [1]. In addition, many people living with HIV in Australia are diagnosed late, with low CD4 counts reflecting later than optimal diagnosis and, in some cases, advanced disease. In 2008–2012, 39 per cent of HIV diagnoses had a CD4 count of less than 350, including 15 per cent with a CD4 count less than 200 [1].

Estimates suggest that the mean (or average) time between infection and diagnosis is approximately 3.4 years, although there is some uncertainty around this measure [2]. We need to improve testing rates to identify undiagnosed HIV infection earlier, particularly among people who don't test frequently, and ensure people receive appropriate information, management, care and support, to both meet the target to reduce new transmissions of HIV by 50 per cent and to maximise individual health outcomes [2].

In the past, Australia's rates of HIV testing in at-risk populations were among the world's best. However, gay men and other men who have sex with men now test for HIV less frequently than guidelines suggest they should [7]. Australia needs to increase the number of people who have ever been tested and ensure that testing routines are appropriately matched to level of risk.

Australian research has identified psychological and structural barriers to HIV testing for gay men; for example, anxiety caused by waiting for test results,

and co-payment costs incurred in some primary healthcare settings [8]. Similar structural issues have been identified internationally [9].

Innovative, targeted messaging is required to improve testing in at-risk population groups [10]. Initiatives aimed at informing people of the personal and public health benefits of early diagnosis, the range of testing and treatment options available, and links to health services and community support are needed. The role that community peers can play in facilitating an increase in testing, such as delivery of information and support to access testing, should be further explored and developed.

Testing models need to focus on simplifying the testing process for individuals, and addressing access and acceptability issues including cost, time and convenience. This will require continued development and expansion of existing testing methods, such as rapid testing, and exploration of new testing models, such as home self-testing.

The introduction of HIV rapid tests in Australia at both point of care (in settings such as sexual health clinics and general practice) and in non-clinical community settings is underway and evaluating well.

It is important to ensure that testing methods remain high quality, safe and appropriate while access is increased. There is a particular role for all governments to explore how regulatory, legal, policy and funding mechanisms can best work together to increase HIV testing and early diagnosis.

The principles of voluntary testing, informed consent and confidentiality underpin high rates of HIV testing in Australia, and these principles remain central to the management of HIV. The National HIV Testing Policy [11] provides guidance to those involved in testing and is reviewed regularly to accommodate changing epidemiology and technology and to reflect the needs of the sector. An updated version will be released in the life of this Strategy.

## 7.3 Management, Care and Support

### Priority Actions

- Improve access to and uptake of antiretroviral medications at earlier stages of infection.
- Address barriers to the commencement or continuation of antiretroviral medications to improve treatment effectiveness.
- Ensure that priority populations and healthcare professionals are aware of the individual and public health benefits of earlier commencement of treatment.
- Increase the use and effectiveness of shared care models between general practitioners and HIV specialists.
- Promote the use of evidence-based clinical guidance.

#### 7.3.1 Management

Antiretroviral treatments are now highly effective, generally well-tolerated and associated with lower pill burdens (in terms of daily number and frequency of doses). Scientific advances in HIV treatment indicate a benefit from early HIV treatment for the health of people with HIV, as well as the potential for a significant reduction in the risk of onward transmission of HIV [12]. Efforts to improve treatment uptake must respect decisions made by some people with HIV, in conjunction with their care providers, to defer therapy on the basis of clinical and/or psychosocial factors.

Recent estimates of the treatment continuum [3] in Australia suggest that 30–50 per cent of people who know they are living with HIV are not receiving antiretroviral treatment. A proportion of these people are either not linked to HIV care or are not retained in care. We need to take action to address these gaps if we are to achieve the target of 90 per cent treatment uptake.

For some people living with HIV, issues around side effects, adherence, treatment failure, drug resistance, cost and arrangements that restrict dispensing of antiretroviral medication to selected hospital pharmacies present barriers to commencing or continuing treatment. Individual-based support and monitoring continues to be essential to minimise these issues and maximise health and wellbeing outcomes. Systemic and structural barriers to treatment

uptake, such as dispensing arrangements and treatment access across all groups, need to be addressed by Commonwealth, state and territory governments.

Extending the availability of antiretroviral treatment at earlier stages of infection in Australia increases treatment options for people living with HIV and their healthcare professionals. Clinical guidance in Australia [13] has recently been updated to support the initiation of earlier treatment, while recognising the importance of decisions being tailored to individual needs and circumstances. This guidance plays an important role in supporting and enhancing knowledge of healthcare providers, and should be disseminated and implemented more broadly.

### **7.3.2 Care and Support**

The needs of people living with HIV often vary over time. For those with complex needs, the provision of comprehensive care requires a team-based interdisciplinary approach which includes general practitioners, specialists, nurses, allied health teams, community-based services, pharmacists and other healthcare providers. It is critical that models of care, service delivery and resourcing are reviewed and updated to ensure that the evolving needs of people living with HIV are met.

Co-infection with a hepatitis virus has important implications for the management of people living with HIV. Respondents to the *HIV Futures Seven* report indicated that 15.7 per cent have had hepatitis C [14]. Hepatitis C is more severe in people with HIV and may progress more rapidly to liver disease. People with co-infection of hepatitis C and HIV have specific issues in relation to prevention, management and treatment that need to be addressed.

Approximately one-quarter of people with HIV are diagnosed by a general practitioner who has not previously diagnosed HIV [15]. This indicates the need to provide support for general practitioners, linked to the testing process, which enhances their capacity to provide an informed diagnosis, initiate contact tracing, and refer to specialist and support services as required.

Specialist services and publicly funded sexual health services continue to provide an essential service, including management for people with more complex needs, and support for the primary healthcare and community workforce. Innovative arrangements must be implemented to overcome existing

gaps in the availability of specialist services, such as where there are no or a limited number of general practitioners accredited to prescribe antiretroviral medications. It would be of benefit to explore ways that general practitioners and HIV specialists can work together more effectively to provide better management of people with HIV in the community.

Clear protocols and pathways would ensure management, care and support is delivered in a cohesive and comprehensive way across a range of medical and community settings. These need to address early referral to treatment services, strategies to retain newly diagnosed patients in care, and efforts to re-establish links to services for people with established HIV infection.

The effectiveness of antiretroviral therapy means there are more people with HIV living longer and surviving into old age. There is a growing body of evidence that HIV can substantially impact on people as they age; for example, diseases normally associated with ageing can occur at younger ages [16]. HIV models of care need to facilitate the monitoring, care and support of people living with HIV to manage the comorbidities associated with living with HIV infection long-term and the natural ageing process [23].

## 7.4 Workforce

### Priority Actions

- Ensure that HIV testing and treatment providers have adequate training and support to deliver appropriate services.
- Work together with relevant organisations to ensure delivery of responsive and coordinated training, continued education, and professional support programs, including in regional and remote areas and for new workforce entrants.
- Improve collaboration between mental health, drug and alcohol, disability, clinical and community services to address the care and support needs of people with HIV.
- Support the capacity and role of community organisations to provide education, prevention, support and advocacy services to priority populations.

Ensuring that the health promotion and healthcare workforce is sustainable, appropriately skilled and sufficiently resourced is critical to the provision of quality HIV prevention, testing, treatment and long-term care and support services. Effective support needs to be maintained across the range of healthcare providers, including in non-government and community organisations.

Workforce issues include the recruitment and retention difficulties for Section 100 general practitioner prescribers and clinicians with an interest in HIV, and the importance of ongoing training, support and financial resources for medical, nursing and healthcare professionals [27]. Professional development should address multidisciplinary team roles, effective case management, and the delivery of culturally appropriate services for priority populations.

HIV care is accessed in mainstream services, and shared-care audits and protocols have been implemented. Strategies need to be explored for encouraging existing community Section 100 general practitioner prescribers to maintain their HIV practice and to encourage new prescribers and healthcare providers in shared-care arrangements to enter the field.

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

HIV education to address stigma and discrimination should be included in training programs for staff of all specialist, primary healthcare and community service providers. It is also important that training of mental healthcare workers includes promoting awareness of interactions between HIV and psychiatric medications and understanding of the nature of HIV-related conditions.

Peer-support programs offering HIV education will be used to enhance education and improve engagement in HIV assessment and treatment. The role of peer educators and counsellors trained to undertake HIV tests in helping to increase testing rates will be further explored. Such a service could be linked into community health services and needle and syringe programs.

## 7.5 Enabling Environment

### Priority Actions

- Eliminate stigma and discrimination in community and healthcare settings and empower priority populations.
- Remove institutional, regulatory and systems barriers to equality of care for people infected and affected by HIV in the health sector.
- Work towards addressing legal barriers to evidence-based prevention strategies across jurisdictions.
- Establish a dialogue between health and other sectors aimed at reducing stigma and discrimination against HIV-infected and affected individuals and communities.

Enabling social and legal environments are important in ensuring access to HIV prevention, treatment, care and support. HIV continues to attract stigma that can have negative consequences for psychological wellbeing and on health outcomes for people with HIV.

Discriminatory or unfair treatment increases the negative impact on the health status of people with HIV and can reduce access to care. Stigma and discrimination have been correlated with poor access to health care and risk behaviour [17].

People from affected communities require protection from multiple forms of discrimination [18]; not only those associated with fears of contagion, but also a range of other social phobias related to sexuality, drug use, or being a sex worker or person in a custodial setting [19].

In relation to sex workers, it is important to ensure that legislation, police practices and models of regulatory oversight support health promotion so that sex workers can implement safer sex practices and the industry can provide a more supporting environment for HIV prevention and health promotion.

All partners in Australia's HIV response have a responsibility to work toward ensuring that the response to HIV is based on human rights. Discrimination, unfair treatment and social burdens increase the negative impact of health status and can reduce access to care.

There is an ongoing need for Australian governments to:

- continue to review and work towards removing barriers to access to HIV prevention, management, care and support
- promote and protect the human rights of people with HIV and people among affected communities
- break down the stigma and discrimination associated with HIV.

Programs should be promoted that address advocacy and empowerment of priority populations to access HIV prevention, treatment, care and support in community, education, workplace, healthcare and legal settings. Approaches include awareness-raising initiatives, education and training programs, supporting advocacy and empowerment, improving access to effective complaint systems, and promoting research.

Support must also be provided to healthcare professionals, such as those at the frontline of HIV diagnosis and treatment, to ensure they are well informed about legal issues, including their own legal obligations, and can provide optimal information and support to patients.

Implementation of this Strategy rests within the health system. However, many of the barriers to access and equal treatment of affected individuals and communities fall outside the responsibility of the health system. For example, criminalisation impacts on priority populations through perpetuating isolation and marginalisation and limiting their ability to seek information, support and health care. It is important that the health sector enters into a respectful dialogue with other sectors to discuss impacts of wider decisions on the health of priority groups.

## 7.6 Surveillance, Research and Evaluation

### Priority Actions

- Address critical data gaps for priority populations, including incident measures and information on risk behaviours.
- Explore improved and innovative approaches to measuring testing rates among priority populations, antiretroviral treatment rates and quality of life indicators among people with HIV.
- Enhance evaluation and implementation research to support evidence-based and evidence-building policy and program development.
- Undertake research across the relevant disciplines – including social, behavioural, epidemiological, clinical and basic research – to inform the delivery of the Strategy.
- Evaluate health promotion, testing, treatment, care, support and education and awareness programs and activities to ensure they are effective.
- Explore options for assessing the impact of stigma, discrimination, legislation and regulation on barriers to equal access to health care.

The United Nations Declaration and the World Health Organization's *Global Health Sector Strategy on HIV/AIDS 2011–15* [20] both highlight the critical importance of 'knowing' the HIV epidemic to ensure an effective response. High quality surveillance, monitoring, research and evaluation inform our knowledge of our epidemic and the most effective response in the Australian context.

### 7.6.1 Surveillance and Monitoring

The objectives of HIV surveillance in Australia are to continuously monitor the extent, characteristics and distribution of HIV infection, risk behaviours, quality of life of people with HIV, and HIV-related morbidity and mortality in order to provide timely evidence to assist with planning of appropriate public health strategies and to evaluate policies and services.

Surveillance programs need to adapt and evolve to accommodate innovation and advances in the scientific and health technology areas, such as advances in treatment and the implementation of rapid HIV testing.

Comprehensive behavioural surveillance encompassing risk behaviours, prevention practices, testing routines, treatment uptake, and health needs and service use with gay and other men who have sex with men, must be maintained. There would be benefit in extending behavioural surveillance to other priority populations to better inform policy and programs addressing emerging prevention, testing, treatment, care and support needs.

A number of gaps and limitations in the indicators available to monitor implementation of the Strategy and progress against the targets have been identified. The *National BBV and STI Surveillance and Monitoring Plan* will be regularly reviewed, and strengthened as appropriate, to address these.

While the data quality and method currently used to estimate population HIV incidence is relatively high, there are gaps in our ability to systematically measure the incidence of HIV in some priority population groups.

Indicator reporting on sexual risk behaviours requires consideration of a more expanded range of risk reduction practices. Research is likely to be available to inform development of this indicator during the life of this Strategy.

Opportunities to strengthen surveillance of the extent and patterns of HIV testing in priority populations will be explored.

Surveillance measures of the uptake and patterns of treatment use, the adequacy of HIV treatment, and antiretroviral drug resistance across populations will be considered and strengthened.

While this Strategy includes an indicator to report against quality of life for people living with HIV, it is acknowledged that the current indicator is not the best measure. Further work should consider international surveillance tools, and the development of an appropriate indicator which can be applied across all the national strategies.

An important gap is the ability to monitor the health impact of stigma, discrimination, and legal and human rights on priority populations. Options need to be explored to develop an indicator related to removing barriers to equal care that informs activities and strategies in a meaningful way. We need to make a focused effort during the life of this Strategy to make headway on this important issue.

### 7.6.2 Research and Evaluation

The implementation of this Strategy is predicated on comprehensive and efficient data collection on epidemiological, behavioural and social changes over time among priority populations to provide evidence for program development and adjustment. Research plays a critical role in providing much of the evidence base to inform policy and for designing, monitoring and evaluating programs at all levels. It is important to create opportunities to promote and sustain interaction and collaboration between researchers, participants in research and the users of research.

Maintaining a strong research program that informs and responds to strategic priorities will ensure that policy and programs continue to be supported by a strong evidence base. Social, behavioural, epidemiological, clinical and evaluative research will continue to inform health promotion, treatment, care and support.

It is important that research is undertaken in partnership with community-based organisations and a partnership approach is taken to identify research priorities. The translational mechanisms by which research can inform policy and practice, and vice versa, are strengthened through continued collaboration across disciplines. Social, behavioural and biomedical research should be well connected, including in relation to emerging issues in the changing landscape of prevention and treatment. A culture of continuous improvement needs to underpin program and service development, including strong formative and evaluation research.

Monitoring and evaluating the implementation of the priority actions, and the supporting indicators and Implementation and Evaluation Plan, will ensure that we are progressing towards, and remain focused on, reaching the targets outlined in this Strategy.

Systematic evaluation of activities and programs should also focus on aligning outcomes with identified priority actions. The interrelationship between priority actions and associated programs should be monitored and linkages enhanced where appropriate.

A significant number of activities and programs have been undertaken in previous strategies and by state and territory, professional and community organisations, and research centres across all six priority action areas. The opportunities for scaling up these activities and programs to a national level should be evaluated and explored.

# Acknowledgements

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# Appendix: Priority Populations

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
People living with HIV	<ul style="list-style-type: none"> <li>An estimated 25 708 people were living with diagnosed HIV in Australia in 2012.<sup>1</sup></li> <li>Critical role to play in ensuring appropriate and effective HIV prevention, treatment, care and support.</li> <li>May have specific education, care and support needs.</li> </ul>	<ul style="list-style-type: none"> <li>Late diagnosis of infection.</li> <li>Barriers to accessing treatment, care and support, including cost of treatments.</li> <li>Stigma and discrimination, including in healthcare settings.</li> <li>Limited information and support surrounding the benefits of initiating and maintaining treatment while safeguarding individual's informed choice.</li> <li>Need for better engagement with specific subgroups.</li> </ul>	<ul style="list-style-type: none"> <li>People with HIV are a diverse group, requiring tailored responses. These groups include: <ul style="list-style-type: none"> <li>people with low income, including people who receive income support</li> <li>people who are ineligible for subsidised health care and medicines, including HIV treatment</li> <li>people with specific needs (e.g. migrants from high HIV prevalence countries, people with mental health issues, people who are incarcerated)</li> <li>people in serodiscordant relationships, including people wanting to conceive</li> <li>Sexually adventurous gay men with HIV.</li> </ul> </li> </ul>

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
Gay men and other men who have sex with men	<ul style="list-style-type: none"> <li>■ Population group most affected by HIV in Australia, with highest prevalence and risk; 64 per cent of all new HIV diagnoses are in gay men between 2008 and 2012.<sup>2</sup></li> <li>■ HIV transmission among gay men in Australia has been increasing nationally since 1999, with differing trends across states and territories.</li> <li>■ Unprotected anal intercourse between men remains the most important risk factor and has been increasing since the introduction of effective antiretroviral treatments.<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>■ Legal inequality and stigma and discrimination related to sexuality</li> <li>■ Marginalisation (e.g. migrant men, men with disabilities).</li> <li>■ Potential HIV-status divide.</li> <li>■ Community-driven engagement.</li> <li>■ Convenient and culturally appropriate HIV/STI testing.</li> <li>■ Limited information regarding context of new HIV infections.</li> <li>■ Limited information on the benefits of frequent testing, early diagnosis and initiating of early ART.</li> </ul>	<ul style="list-style-type: none"> <li>■ Men who use condoms inconsistently, including with casual partners.</li> <li>■ Men under 25 years of age (increasing new diagnoses and unprotected anal intercourse; lower rates of HIV/STI testing and exposure to prevention).<sup>4</sup></li> <li>■ Sexually adventurous men.</li> <li>■ HIV-positive gay men and men in serodiscordant relationships.</li> <li>■ Aboriginal and Torres Strait Islander gay men and sisters.</li> <li>■ Men who have never tested for HIV, have not tested within recommended timeframe or test irregularly.</li> <li>■ Older gay and bisexual men.</li> </ul>

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
Aboriginal and Torres Strait Islander people	<ul style="list-style-type: none"> <li>■ Potential for widespread HIV transmission, due to geographical, cultural and social circumstances eg:                             <ul style="list-style-type: none"> <li>– high mobility</li> <li>– lower health literacy</li> <li>– shame</li> <li>– underlying poor health status</li> <li>– sustained high prevalence of STI in many remote and very remote communities</li> <li>– higher rates of injecting drug use and sharing injecting and other equipment (16 per cent of HIV cases attributed to injecting drug use compared with 2 per cent in non-Indigenous Australians)<sup>6</sup></li> <li>– over representation in prisons and custodial settings.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Access to culturally appropriate services, including primary healthcare services for many communities.</li> <li>■ Language and cultural issues, including family and community relationships</li> <li>■ Systemic discrimination.</li> </ul>	<ul style="list-style-type: none"> <li>■ Gay men and other men who have sex with men</li> <li>■ People who inject drugs.</li> <li>■ Aboriginal and Torres Strait Islander people and communities in urban areas.</li> <li>■ People in contact with migrants from high prevalence countries.</li> </ul>

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
People from high HIV prevalence countries and their partners	<ul style="list-style-type: none"> <li>High prevalence (people from high prevalence countries of origin) and high risk associated with added barriers to effective HIV response.<sup>6</sup></li> <li>HIV risk is also increased among partners of people from high prevalence countries.</li> </ul>	<ul style="list-style-type: none"> <li>Language, cultural and gender issues.</li> <li>Low health literacy and perception of risk.</li> <li>Limited health-seeking behaviour.</li> <li>Lack of familiarity with health system and services.</li> <li>Previous negative experiences of healthcare.</li> <li>Issues relating to privacy and confidentiality (e.g. use of interpreters)</li> <li>Financial barriers.</li> <li>Refugees and asylum seekers may have experienced significant trauma or violence.</li> </ul>	<ul style="list-style-type: none"> <li>Women, due to contribution of heterosexual transmission, particularly those from South-East Asia, Sub-Saharan Africa and other regions with high HIV prevalence.</li> <li>Gay men and other men who have sex with men</li> <li>People who inject drugs.</li> </ul>
Travellers and mobile workers	<ul style="list-style-type: none"> <li>High risk associated with some travellers who engage in higher risk behaviours while travelling or who are exposed to greater HIV prevalence.</li> </ul>	<ul style="list-style-type: none"> <li>Healthcare affordability.</li> <li>Healthcare accessibility.</li> <li>Lack of information directly targeted to some groups (e.g. travel campaigns).</li> </ul>	<ul style="list-style-type: none"> <li>People who engage in unsafe sex while travelling.</li> <li>Fly-in-fly-out workers who travel to high-prevalence countries and the communities they have contact with e.g. remote areas of Western Australia and Queensland.</li> <li>Gay men and other men who have sex with men who travel to a high prevalence country.</li> </ul>

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
Sex workers	<ul style="list-style-type: none"> <li>Sex workers are at occupational risk for HIV, associated with high number of sexual encounters.</li> <li>Continued prevention efforts among sex workers ensure that rates of HIV among Australian sex workers remain among the lowest in the world.</li> </ul>	<ul style="list-style-type: none"> <li>Legal and regulatory frameworks, including criminalisation, licensing, registration and mandatory HIV testing.</li> <li>Lack of consistent and effective anti-discrimination protections.</li> </ul>	<ul style="list-style-type: none"> <li>Street-based sex workers.</li> <li>Aboriginal and Torres Strait Islander sex workers.</li> <li>Sex workers who inject drugs.</li> <li>Migrant and culturally and linguistically diverse sex workers.</li> <li>Transpeople sex workers.</li> <li>Male sex workers.</li> <li>Sex workers with HIV.</li> </ul>
People who inject drugs	<ul style="list-style-type: none"> <li>HIV prevalence is currently low because of effective harm reduction, including needle and syringe programs (NSPs) and opioid substitution treatment, and this needs to be maintained.</li> <li>Rates of HIV are sensitive to changes in the availability of injecting equipment.</li> </ul>	<ul style="list-style-type: none"> <li>Criminalisation of drug use.</li> <li>Access to injecting equipment.</li> <li>Accessibility of NSPs.</li> </ul>	<ul style="list-style-type: none"> <li>Aboriginal and Torres Strait Islander people who inject drugs (19 per cent of drug injecting population versus 3 per cent of non–drug-injecting population).<sup>7</sup></li> <li>Gay men and other men who have sex with men and inject drugs.</li> <li>People in custodial settings who inject drugs.</li> </ul>

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
People in custodial settings	<ul style="list-style-type: none"> <li>■ Risk is high as a result of:               <ul style="list-style-type: none"> <li>– injecting drug use and equipment re-use and sharing</li> <li>– unsafe tattooing</li> <li>– unprotected sex (including sexual assault)</li> <li>– overrepresentation of priority population groups (e.g. people who inject drugs and Aboriginal and Torres Strait Islander people).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Ensuring right to health.</li> <li>■ Institutionalisation issues relating to surveillance, punishment and violence.</li> <li>■ Continuity of access to HIV treatment and opioid substitution treatment.</li> <li>■ Access to prevention equipment, including sterile injecting and tattooing equipment and condoms (lack of access to condoms in all states and territories except New South Wales).</li> </ul>	<ul style="list-style-type: none"> <li>■ Incarcerated people with HIV.</li> <li>■ People who inject drugs in custodial settings.</li> <li>■ Aboriginal and Torres Strait Islander people.</li> <li>■ People with mental health issues.</li> <li>■ People with cognitive disabilities.</li> <li>■ People who are functionally illiterate.</li> <li>■ Gay men, other men who have sex with men, transpeople.</li> </ul>

# Notes to the Appendix

- 1 Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013. The Kirby Institute, the University of New South Wales, Sydney, NSW
- 2 Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013. The Kirby Institute, the University of New South Wales, Sydney, NSW
- 3 De Wit, Mao, Holt, & Treloar (2013). HIV/AIDS, hepatitis and sexually transmissible infections in Australia – Annual report of trends in behaviour 2013. Sydney: Centre for Social Research in Health, The University of New South Wales.
- 4 De Wit et al. (2013) HIV/AIDS, hepatitis and sexually transmissible infections in Australia: Annual report of trends in behaviour 2013. Centre for Social Research in Health.
- 5 The Kirby Institute. *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013*. The Kirby Institute, the University of New South Wales, Sydney, NSW
- 6 European Centre for Disease Prevention and Control (2013). Responses to HIV and migration in western industrialised countries: current challenges, promising practices, future directions. ECDC, Stockholm.
- 7 The Kirby Institute. National Blood-borne Virus and Sexually Transmissible Infections Surveillance and Monitoring Report, 2011. The Kirby Institute, the University of New South Wales, Sydney, NSW, p.62







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All information in this publication is correct as at July 2014