



Australian Government

Ninth National HIV Strategy

2024-2030

Acknowledgment of Country

In the spirit of reconciliation, the Department of Health and Aged Care acknowledges the Traditional Custodians of the Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Special recognition

All partners responsible for drafting and agreeing to this Strategy are indebted to those people living with human immunodeficiency virus (HIV) who have shared their experience, as well as those who have been actively involved in HIV advocacy and research; as their valued input informs and advances our national response.

Minister's Foreword



Australia is committed to eliminating bloodborne viruses (BBV) and sexually transmissible infections (STI) as a public health challenge by 2030.

For some diseases, this means driving towards elimination. For others, it means treating and managing how they affect people's lives.

Most BBVs and STIs are curable or manageable. So our health system must ensure care reaches those who need it when they need it.

This Strategy sets a strong direction for our national goal of virtual elimination of HIV transmission by 2030. It is ambitious but achievable.

Australia is a global leader in the HIV response. We continue to have one of the lowest rates of HIV. This is a result of significant effort and progress under the Eighth National HIV Strategy 2018–2022.

Key achievements for Australia's HIV response include:

- free access to antiretroviral treatment (ART) through government-funded hospitals for people with HIV who do not have Medicare
- Australia becoming the fourth country to formally sign onto the Undetectable = Untransmittable (U=U) call to action
- the addition of long-acting injectable ART to the Pharmaceutical Benefits Scheme (PBS), as an alternative HIV treatment
- increased availability of rapid testing for HIV in Australia, including at pharmacies
- telehealth items for BBVs and sexual and reproductive health becoming permanent for any eligible practitioner, nationally.

In 2023, I established the HIV Taskforce to build on these achievements and identify future priorities. This included in the areas of prevention, testing, treatment, awareness, decriminalisation and partnership.

Through the partnership of people with lived experience, governments, community organisations, peak bodies and researchers, the HIV Taskforce Report was published in November 2023. Many of its recommendations are incorporated in the Ninth National HIV Strategy 2024–2030, which sets out how we will achieve our goal of elimination.

Under this Strategy, we aim to:

- reduce new and late diagnoses
- promote understanding and support for U=U
- implement and sustain models of service delivery and intervention.

We want to ensure everyone affected by or living with HIV can have healthy lives, free of stigma and discrimination.

Our goal is virtual elimination of HIV transmission in Australia. But that will not be the end of Australia's response to HIV. Beyond 2030, we will continue to pursue better health outcomes and maintain our reputation as a world leader in public health.

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Glossary

The following acronyms and terms have been used throughout this document.

AHPC	Australian Health Protection Committee
AIDS	acquired immunodeficiency syndrome
AIVL	Australian Injecting and Illicit Drug Users League
ART	antiretroviral therapy
BBV	bloodborne viruses
BBVSS	Blood Borne Viruses and Sexually Transmissible Infections Standing Committee
CDNA	Communicable Diseases Network Australia
GBMSM	gay, bisexual and other men who have sex with men
GPs	general practitioners
GCPS	GBQ+ Community Periodic Survey
HIV	human immunodeficiency virus
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NAPWHA	National Association of People with HIV Australia
NSP	needle and syringe program
PBS	Pharmaceutical Benefits Scheme
PEP	post-exposure prophylaxis
POCT	point of care testing
PrEP	pre-exposure prophylaxis
STI	sexually transmissible infection
TasP	Treatment as Prevention
UNAIDS	Joint United Nations Programme on HIV/AIDS
U=U	Undetectable = Untransmittable



Vision

HIV transmission is virtually eliminated in Australia.

Everyone has access to safe, affordable and effective HIV prevention, testing, treatment and care.

All people living with HIV live well, free from stigma and discrimination.



1. Introduction

Since the first cases of HIV and acquired immunodeficiency syndrome (AIDS), Australia has made a sustained, multi-partisan effort to respond to HIV. Australia has a national HIV prevalence lower than most comparable countries, and the response to HIV is regarded internationally as a world-leading model of best practice.

In the past five years, Australia has built on its success. More people living with HIV than ever before are connected to care and receiving HIV treatment. With continuing advances in science and medicine, Australia now has a suite of prevention, testing and treatment tools needed to end HIV transmission.

This Ninth National HIV Strategy 2024–2030 sets out a new vision in which Australia will lead the world in virtually eliminating HIV transmission. Virtual elimination will mean HIV is no longer a challenge to public health, equivalent to a 90% reduction in new diagnoses since 2010ⁱ.

Achieving this goal will require a strengthened scaled-up response and targeted investment across all jurisdictions. This Strategy continues to emphasise the importance of community-led and peer-based organisations in delivering education and interventions, and acknowledges the critical role of the workforce in driving Australia's response to HIV.

An elimination goal will not mean an end to Australia's HIV response. As Australia approaches and reaches virtual elimination, the response will shift to supporting people living with HIV to live healthy lives, free of stigma while maintaining elimination of transmission, as HIV will continue to have a presence in Australia due to its status as a global epidemic.

Australia is now one of only a few countries in the world for which the end of HIV transmission is a possibility. Through this Strategy, we establish a path to be the first country to virtually eliminate HIV transmission by 2030.

i See Health Equity Matters' Agenda 2025 Technical Paper on Science, Trends and Targets (<https://healthequitymatters.org.au/our-work/agenda-2025/>).

1.1. Partnerships

Since the first national HIV Strategy in 1989, Australia's response has been underpinned by a partnership between people living with and affected by HIV, the Australian Government, state and territory governments, community organisations, workforce, researchers and clinicians. Each of these partners has a vital role in bringing about the virtual elimination of HIV transmission in Australia.

In 2023, the Minister for Health and Aged Care, the Hon Mark Butler MP, chaired the HIV Taskforce, which was comprised of representatives from the HIV sector who were tasked with determining priorities for Australia's HIV response. This Strategy reflects the outlook and recommendations of the HIV Taskforce [1].

The Australian and state and territory governments acknowledge the significant contribution of people living with HIV, the national community, peak organisations and other organisations representing priority populations, all HIV-related workforces, and the research sector over the course of previous HIV strategies.

The following peak organisation members of the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS) have played and continue to play a critical role in the success of Australia's response to HIV: Health Equity Matters; the National Association of People with HIV Australia (NAPWHA); the Australian Injecting and Illicit Drug Users League (AIVL); Scarlet Alliance, Australian Sex Workers Association; the National Aboriginal Community Controlled Health Organisation (NACCHO); and ASHM Health.

This strong foundation and the commitment and work of all partners, both national and local, means that Australia remains well placed to build on the successes of the Eighth National HIV Strategy 2018–2022, realise positive outcomes for all priority populations and achieve the goal of virtually eliminating HIV transmission domestically. This Strategy will be in place from 2024 to 2030.

2. Guiding Principles

The guiding principles of this Strategy set a framework for a high-quality, evidence-based and equitable response to HIV. These are drawn from Australia's efforts over time to respond to HIV.

Principle 1: The centrality and meaningful/greater involvement of people living with and affected by HIV

The centrality of people living with HIV in accordance with the meaningful/greater involvement of people living with and affected by HIV (known as MIPA/GIPA - Greater and Meaningful Involvement of People Living with HIV/AIDS principle) and their meaningful participation along with other priority populations is essential to developing, implementing, monitoring and evaluating effective programs and policies.

This has been critical to the success of Australia's HIV response. This participation ensures programs are more relevant, effective and acceptable to people living with HIV and priority populations, are responsive to need, and take account of the effects of policy directions.

Principle 2: Human rights

The full realisation of human rights is a fundamental element to the HIV response in Australia.

People living with HIV and other priority populations have the right to participate fully in society without experiencing stigma and discrimination. They have the same rights to comprehensive and appropriate information, privacy and healthcare, as other members of the community, particularly the right to the confidential and sensitive handling of personal and medical information.

Principle 3: Access and equity

Health and community care in Australia should be accessible to all and based upon need.

The multiple dimensions of inequality, compounded by intersecting characteristics, should be addressed, whether related to gender, sexuality, drug use, occupations such as sex work, co-morbidities, socio-economic status, race, ethnicity, migration status, language, religion, culture or geographic location including custodial settings.

Special attention must be given to populations that experience multiple dimensions of inequality at disproportionate rates compared to the broader Australian community. Populations at higher risk of HIV are identified as priority populations and are discussed later in this Strategy. Notably, in alignment with the National Agreement on Closing the Gap, all Australian governments must develop meaningful partnerships with Aboriginal and Torres Strait Islander peoples that foster shared decision-making and self-determination over health outcomes.

Principle 4: The Australian HIV Partnership

Partnership is at the heart of Australia's response to HIV.

The partnership is a long-standing, uniquely Australian collaboration recognised by successive national strategies that dates from the earliest days of the HIV epidemic. It is a cooperative effort between community, government, health professionals and researchers. Achievement of the goals and targets in the national strategies requires that all the partners of the response must be enabled to effectively acquit their respective roles as equal stakeholders. It is based on a commitment to consultation and joint decision-making in all aspects of the response.

Principle 5: Health promotion

The Ottawa Charter for Health Promotion [2] is a global agreement signed at the First International Conference on Health Promotion, organised by the World Health Organization in 1986. The Charter provides the framework for effective action under this Strategy.

This Strategy facilitates the active participation of organisations, priority populations and individuals to increase their influence over the determinants of their health and the formulation and application of laws and public policies to support and encourage healthy behaviours and respect for human rights.

Health promotion programs for priority population groups are delivered by those communities, in partnership with governments, health professionals and researchers. Evaluation of these programs is an important tool often utilised, providing insights into the effectiveness and sustainability of the program.

Principle 6: Harm reduction

Grounded in justice and human rights, harm reduction aims to minimise the potential negative health, social and legal impacts of drug use through evidence-based policies, programs, practices and the involvement of priority populations. This includes strategies that aim to increase access to information and resources that allow people to reduce risk of HIV transmission, and decrease stigma and discrimination relating to HIV and drug use.

Practical harm reduction strategies include needle and syringe programs (NSPs), peer-based support and navigation programs, drug checking, take home naloxone programs, peer education about safer drug use practices and supervised drug consumption programs.

Principle 7: Effective HIV Prevention

The appropriate mix of evidence-based biomedical, behavioural and social measures within an enabling environment can reduce the transmission of HIV.

An overwhelming evidence base has confirmed that U=U (meaning Undetectable = Untransmittable) is scientifically accurate. Also referred to as 'treatment as prevention' (TasP), a person with an undetectable viral load cannot transmit

HIV through sexual activity, a concept which has fundamentally altered our understanding of HIV transmission.

In Australia, education programs combined with access to the means of prevention, such as condom distribution, pre-exposure prophylaxis (PrEP)/post exposure prophylaxis (PEP), NSPs and TasP/U=U, have proved to be highly effective [3].

Principle 8: Shared responsibility

The prevention of HIV transmission is a shared responsibility. Everyone has a responsibility to take measures to prevent HIV transmission regardless of their HIV status.

For people to make choices with autonomy, governments and community organisations must provide an environment that informs and reflects the current scientific and social landscape of HIV.

Principle 9: An enabling social, legal and policy environment

A supportive social, legal and policy environment enables individuals and communities to exercise control over their health.

The United Nations 2021 Political Declaration on HIV and AIDS [4] prioritises governments creating an enabling legal environment by reviewing and reforming restrictive legal and policy frameworks, including discriminatory laws and practices that criminalise priority populations and create barriers or reinforce stigma and discrimination.

This requires ongoing scrutiny of the impact of laws, policies and policing on priority populations, including in areas such as access to healthcare, mental health, drugs and alcohol, migration, welfare, housing, income support, insurance, work health and safety, human rights and criminal justice.

3. HIV in Australia

HIV in Australia

What is HIV?

HIV is a virus that impairs the body's immune system by reducing CD4⁺ cells, a type of blood cell that plays a key role in the immune system. AIDS is the late stage of HIV infection.

Routes of transmission

HIV is transmissible by sexual and blood-to-blood contact as well as from birth parent to child during pregnancy, childbirth or through breastfeeding (known as vertical transmission).

What health issues does HIV cause?

Without treatment, HIV damages the immune system which can lead to serious infections and cancers over time. Consequently, there is a need to sustain lifelong HIV treatment to prevent disease progression and development of AIDS-defining illnesses.

Stigma and discrimination associated with HIV can have significant impact on health outcomes and can lead to social isolation, poorer mental health, poorer access to testing and treatment, and overall poorer health outcomes.

How is HIV managed?

There is currently no cure for HIV. ART can suppress the virus to extremely low levels, which prevents disease progression and eliminates the risk of sexual transmission of HIV to other people [5].

New diagnoses

HIV diagnoses in Australiaⁱ nearly halved over 2014-2023, with **722 new HIV notifications** in 2023. Within this group, a higher proportion (58%) were born overseas than in Australia in 2023 [6].

The majority (63%) of these new HIV notifications continue to be among gay, bisexual and other men who have sex with men (GBMSM) [6].

Prevalence

In 2023, an estimated **30,010** people were living with HIV in Australia [6].

The self-reported prevalence of HIV among GBMSM in Australia was **7.1%** [7].

ⁱ A breakdown of notifications by jurisdiction is available at: www.data.kirby.unsw.edu.au/hiv.

Testing and care

Of the estimated 30,010 people with HIV in Australia in 2023 [6], **92%** were diagnosed;

- **97%** of those diagnosed were receiving ART
- **98%** of those receiving ART had reached viral suppression.

Prevention

Everyone has an important part to play in preventing HIV transmission. Prevention strategies include:

- Use of PrEP (daily or on-demand) and PEP (in an emergency)
- Use of condoms
- Viral suppression with an undetectable viral loadⁱ (TasP/U=U)
- Access to safe injecting equipment
- Widespread and regular testing for HIV infection
- Peer or community-led education and support.

PrEP is the use of ART medicine by an HIV-negative person to prevent them acquiring HIV. Most people using PrEP take a single pill each day over an extended period (for example, months or years), or as needed (called 'on demand' PrEP) prior to and after sex. Multiple forms of long-acting PrEP are currently being investigated in clinical trials.

PEP is the use of ART medicine by an HIV-negative person in the 72 hours after an HIV risk exposure to prevent seroconversionⁱⁱ.

Increasing HIV testing rates and having timely and frequent testing is critical to HIV prevention. Most HIV transmission in Australia is from a person who has not been diagnosed with HIV [8]. Regular HIV testing reduces the time between a person acquiring HIV and being diagnosed, and reduces the potential for further transmissions.

With the continuing advances to HIV treatment and prevention, it is expected that further innovations will become available over the course of this Strategy.

There is currently no vaccine or cure for HIV.

ⁱ Currently defined as a sustained viral load of less than 200 copies/mL.

ⁱⁱ Seroconversion is defined as a change from negative to positive specific immunoglobulin G (IgG) antibodies.

4. About this Strategy

This Strategy sets the direction to end HIV transmission in Australia. It builds on achievements and lessons learned from previous strategies.

It is one of five national strategies that, together, outline a framework for a high-quality and coordinated national response to BBVs and STIs in Australia.

These five strategies are:

- Fourth National Hepatitis B Strategy 2024–2030
- Sixth National Hepatitis C Strategy 2024–2030
- Ninth National HIV Strategy 2024–2030 (this Strategy)
- Fifth National Sexually Transmissible Infections Strategy 2024–2030
- Sixth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2024–2030.

The five national strategies are supported by the First National Bloodborne Viruses and Sexually Transmissible Infections Research Strategy 2021–2025.

This Strategy complements other jurisdictional, national and international policy documents that contribute to the HIV response and supports the achievement of existing commitments. These include:

- State and territory HIV strategies
- HIV Taskforce Report (2023) [1]
- Global health sector strategies on HIV, viral hepatitis, and sexually transmitted infections 2022-2030 (2021) [9]
- Global Progress Report on HIV, Viral Hepatitis and Sexually Transmitted Infections, 2021 [10]
- United Nations Political Declaration on HIV and AIDS: ending inequalities and getting on track to end AIDS by 2030 (2021) [4]
- Global AIDS Strategy 2021-2026 [3]
- National Drug Strategy 2017–2026 [11]
- National Agreement on Closing the Gap 2020 [12]
- National Preventative Health Strategy 2021-2030 [13]
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031 [14].

This Strategy also supports progress towards Sustainable Development Goal 3 ('Ensure healthy lives and promote well-being for all at all ages') of the United Nations 2030 Agenda for Sustainable Development [15].

This Strategy acknowledges that some states and territories have set or may set different targets to drive progress and that the goals and targets of this Strategy are intended to facilitate jurisdictional efforts. Wherever possible, jurisdictions are encouraged to match or exceed the targets of this Strategy.

5. Key Achievements

Australia has progressed towards meeting the goals and targets under the Eighth National HIV Strategy 2018–2022 [16].

The harm reduction HIV prevention strategies to minimise BBV transmission have been highly successful at sustaining a low HIV prevalence in some priority populations, particularly among people who inject drugs and sex workers.

Further, progression to AIDS is sufficiently rare in Australia that it is no longer a notifiable condition and has been eliminated as a public health challenge.

These outcomes represent achievements for the previous Strategy and reflect the impact the HIV sector has had in driving improvements in HIV prevention, testing and treatment.

5.1. Key achievements under the Eighth National HIV Strategy

Overall, HIV prevalence in Australia among the general population remains one of the lowest globally [17]. Australia continues to sustain the virtual elimination of vertical transmission, and maintain low rates of HIV transmission among sex workers and people who inject drugs. This has been achieved through peer education, harm reduction, high rates of NSPs and condom use. Australia has steadily increased treatment uptake by people diagnosed with HIV [6], and effectively maintained prevention programs for most priority populations [6].

Key achievements include:

- HIV notifications continue to decline. A **33% reduction** in HIV notifications was recorded between 2014 and 2023 [6]. The decline was driven by a decrease in notifications in Australian-born men with male-to-male sex as the exposure risk [6].
- Rates of HIV transmission are low in **Inner Sydney**, the former epicentre of the HIV epidemic in Australia [18].
- In 2023, HIV prevalence (the proportion of all people in Australia who are living with HIV) was **estimated to be 0.14%**, which is low compared with other high-income and Asia Pacific countries [6].
- Among people who inject drugs, harm reduction strategies to minimise BBV transmission have been **highly successful** at sustaining a low HIV prevalence nationally [6].
- Australia has **maintained low rates** of HIV infection among sex workers [6] and made positive progress in decriminalising sex work in Victoria, Northern Territory and Queensland.

- Australia exceeded the 2020 Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 care cascade targets [19]. In 2020, an estimated **91%** of people living with HIV had received a diagnosis. Of those diagnosed, **91%** were engaged in care, and of those, **97%** had a suppressed viral load [6].
- Implementation of a new program for people living with HIV who are ineligible for Medicare to **access their treatment free of charge** through government-funded hospital pharmacies, as part of the new Australian Government HIV treatment access scheme, commenced nationally on 1 July 2023.
- In May 2024, Australia became the 4th nation to formally sign onto the **multi-national U=U call to action**.
- In April 2022, **long-acting injectable ART** was added to the PBS, providing another HIV treatment option for people living with HIV where appropriate.
- **Rapid testing for HIV** commenced and is being used in Australia, and the Therapeutic Goods Administration regulations allow for sale of self-tests in pharmacies.
- From 2024, bloodborne viruses and sexual and reproductive **telehealth** Medicare Benefits Schedule (MBS) items were made permanent and include an exemption to the established clinical relationship criteria, meaning people can **access any eligible practitioner nationally**.
- Among gay and bisexual men attending sexual health clinics, the proportion who had a repeat HIV test within 13 months of a previous HIV test increased from **47%** in 2014 to **56%** in 2023. In this period, the proportion retested within 7 months of a previous HIV test increased from **37%** in 2014 to **46%** in 2023 [6].
- The proportion of female sex workers participating in the Australian Collaboration for Coordinated Enhanced Sentinel Surveillance of Sexually Transmissible Infections and Blood Borne Viruses network who were tested for HIV at least once in a year was **84%** in 2023 [6].
- In 2023, the number of people who had taken PrEP in the previous 12 months **increased from 6,432 to 45,244**. This follows declines in PrEP use in 2020 and 2021, coinciding with COVID-19 restrictions across Australia [20].
- According to the GBQ+ Community Periodic Survey (GCPS), the proportion of HIV-negative gay and bisexual men with casual partners who were regularly using at least one strategy (the use of any safe sex strategy, including condoms, PrEP or undetectable viral load) to protect themselves against acquiring HIV increased from **69%** in 2014 to **80%** in 2023 [20].

Progress against Eighth National HIV Strategy 2018 - 2022 targets

■ Not achieved

■ Partially achieved

■ Achieved



Increase the proportion of people living with HIV (in all priority populations) who are diagnosed to 95%

In 2023, an estimated **92%** of people living with HIV in Australia had received a diagnosis [6].



Increase the proportion of people diagnosed with HIV on treatment to 95%

In 2023, the estimated proportion of people diagnosed with HIV who were receiving care was **97%** and **97%** were on ART [6].



Increase the proportion of those on treatment with an undetectable viral load to 95%

In 2023, the proportion of people who were on ART with a suppressed (undetectable) viral load (<200 copies/mL) was **98%** [6].



Reduce the incidence of HIV transmissions in men who have sex with men

Between 2014 and 2023, there was a 43% decline in HIV notifications attributed to male-to-male sex [6].



Reduce the incidence of HIV transmission in other priority populations

In 2023, there were 24 HIV notifications among Aboriginal and Torres Strait Islander peoples, representing 3% of the total 722 notifications. Between 2014 and 2023, the total number of HIV notifications among Aboriginal and Torres Strait Islander peoples fluctuated [6].

Between 2014 and 2023, the number of HIV notifications among men born in Asia (Southeast Asia, Northeast Asia, Southern and Central Asia) fluctuated between 97 (in 2020) and 183 (in 2016), with 165 notifications in 2023 (36% of all notifications attributed to male-to-male sex) [6].

The number of HIV notifications among men born in countries other than Asia declined by 32% from 150 notifications in 2014 to 102 notifications in 2023 (22% of all notifications attributed to male-to-male sex) [6].



Sustain the virtual elimination of HIV among sex workers, among people who inject drugs, and from mother to child through the maintenance of effective prevention programs

In 2023, the HIV incidence rate was 0.0 per 100 person-years among female sex workers [6].

Australia continues to observe low rates of vertical transmission of HIV. For the period 2019–2023, the HIV transmission rate was 1.3%, compared to 21.8% in the period of 1994–1998. In 2023, there was one vertical transmission [6].

In 2023, 2% of exposures were attributed to injecting drug use [6].



Increase the proportion of eligible people who are on PrEP, in combination with STI prevention and testing, to 75%

As of 31 December 2023, 74,597 people had received PBS-subsidised PrEP at least once. Among participants of the GCPS, 42% were eligible for PrEP in 2023 (compared to 37% in 2018), and 69% of those reported using prescribed PrEP in the previous 6 months, an increase from 40% in 2018 [6].

Among gay and bisexual men attending sexual health clinics in the ACCESS Project, 53% had a repeat comprehensive STI screen (includes chlamydia and gonorrhoea testing on any anatomical site, and syphilis and HIV testing among HIV-negative men) within 13 months of a previous comprehensive STI screen in 2023, an increase from 40% in 2014 [6].

In a before and after study of GBMSM for a PrEP implementation project, STI rates were found to be high but stable among these men [21].



75% of people with HIV report good quality of life

According to the HIV Futures 10: Quality of Life Among People Living with HIV in Australia, 71.8% of the participants reported they had “good” quality of life and 50.5% reported their overall wellbeing (including physical, emotional and mental wellbeing) to be good or excellent in 2022 [22].



Reduce by 75% the reported experience of stigma among people with HIV, and expression of stigma, in relation to HIV status

Findings from the Stigma Indicators Monitoring Project showed that 37% of participants living with HIV reported experiences of stigma within the last 12 months in relation to their HIV [23].

Between 2018 and 2022, the proportion of people living with HIV who reported any negative treatment by health workers in the previous year decreased from 33% to 30% [23].

5.2. Areas where further effort is required

Achievement of several targets from the previous Strategy is to be celebrated and represents good progress towards our goal of ending HIV as a public health challenge in Australia. However, the limited progress against some of the targets highlights areas where more action needs to be taken, to ensure the virtual elimination of HIV transmission in Australia is achieved by 2030.

The proportion of late HIV diagnoses in Australia are significantly higher in overseas-born populations, particularly among people born in Oceania (58%), Southeast Asia (54%) and Sub-Saharan Africa (53%) [6]. There is a need for more culturally and linguistically appropriate models of health promotion and care, developed in consultation with relevant communities, and aimed at settings where these populations may visit soon after arriving in Australia.

Models of care must account for the unique historical, social and traditional context of our culturally and linguistically diverse communities; to facilitate testing, treatment and prevention [24]. An intersectional approach is needed, that addresses structural inequities such as racism, gender inequity, homophobia and geographical marginalisation. Cultural safety and meaningful involvement of priority populations is essential.

Male-to-male sex continues to be the major route of transmission for HIV risk exposure in Australia, accounting for 63% of HIV notifications in 2023 [6]. This highlights the need to continue or expand targeted ongoing education in this population to encourage HIV prevention strategies, including the use of PrEP, TasP/U=U, the use of condoms and routine testing.

Removing barriers to access existing medical advancements, like PrEP, ART and HIV self-tests, as well as relaxing limitations on their use, like easing monitoring requirements for people using PrEP, could improve usage rates [25]. Incentives may be required for manufacturers to bring new products to the Australian market.

Stigma is a major barrier to the successful implementation of preventive, diagnostic, treatment and care strategies for HIV [26]. Structural stigma, such as stigma that is embodied in laws and policies [27], is particularly difficult to unpick, but must be addressed due to its significant effect on health and wellbeing outcomes [28]. Increasing awareness and understanding of U=U among the general population can assist to address HIV stigma [29]. There is a need for more research into effective interventions to tackle stigma, and to inform collaborative efforts between government, policy makers, researchers, community-led organisations and healthcare workers [30].

The COVID-19 pandemic was an impediment to achieving aspects of the National BBVs and STIs Strategies, particularly the testing and treatment uptake in priority population communities [31]. PrEP prescriptions also declined during this time [32]. Now that COVID-19 restrictions have been removed, there is a need to redirect resources to counter the decline in testing in 2021 [6]. There is also the need to ensure that future actions contributing to the HIV response, are built to be resilient and withstand the effects of future pandemics or similar global disruptions.

The HIV response must continue to address primary prevention, including community education and peer interventions [30]; in conjunction with medical interventions, such as U=U, PrEP and PEP, NSPs and internal and external condom use.

The continued involvement of people living with HIV, including people from a broad section of priority populations, is required to improve rates of prevention, diagnosis, treatment and ongoing care. This could include tailored approaches for distinct priority populations, particularly for culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander peoples, due to barriers in accessing HIV treatment and lower rates on the care cascadesⁱ compared to other groups. Multicultural organisations and Aboriginal Community Controlled Health Organisations are key to improving awareness of HIV in these communities, be it through the design and delivery of culturally appropriate and safe health promotion programs, delivery of peer-based services or simply directing the community to existing resources from relevant HIV peak organisations.

The success of the National Strategies relies on building a strong evidence base to better inform Australia's responses and evaluate approaches. This includes the accurate and timely collection, analysis and use of data at every level, including patient testing and treatment, wellbeing and quality of life, and national program monitoring and evaluation. Additionally, the evidence should inform Australia's responses to further strengthen the workforce, partnerships and connections to priority populations [33].

The future direction of Australia's HIV response must consider and address areas where our previous efforts have not succeeded.






i The HIV care cascade is a tool for determining what proportion of a population knows their HIV status, is accessing treatment, and has a suppressed viral load.

6. Measuring Progress

Progress of this Strategy will be measured through the achievement of goals, targets and key areas for action.

- Key areas for action are the activities that need to be progressed as a priority of the national HIV response.
- Targets are the measurable outcomes that should be achieved through undertaking the key areas for action.
- Goals are the high-level intentions of this Strategy that can only be realised through the achievement of key areas for action and targets.

6.1. Goals

	Virtually eliminate HIV transmission in Australia by 2030 ⁱ .
	Sustain the virtual elimination of HIV transmission among people who inject drugs, among sex workers and by vertical transmission.
	Reduce morbidity related to HIV.
	Eliminate the negative impact of stigma, discrimination, policy, legal and human rights issues on people's health.
	Minimise the personal and social impact of HIV on health and wellbeing.

ⁱ Defined as a 90% reduction in HIV diagnoses in Australia by 2030 (compared to a 2010 baseline).

6.2. Targetsⁱ

01	Increase the proportion of people living with HIV (in all priority populations) who are diagnosed to 95% by 2025 and 98% by 2030 .
02	Sustain or increase the proportion of people diagnosed with HIV (in all priority populations) on treatment to 95% by 2025 and increase to 98% by 2030 .
03	Increase the commencement of treatment following diagnosis (in all priority populations) within 4 weeks to 90% by 2025 and 95% by 2030 .
04	Increase the proportion of those on treatment (in all priority populations) with an undetectable viral load to 98% by 2025 and more than 98% by 2030 .
05	Reduce the incidence of HIV transmissions in GBMSM by 90% by 2030 ⁱⁱ .
06	Reduce the incidence of new HIV transmissions in other priority populations by 90% by 2030 ⁱⁱⁱ .
07	Sustain or reduce the low rates of HIV transmission among sex workers and people who inject drugs and the virtual elimination of vertical transmission through the maintenance of effective prevention programs.
08	Increase the use of one or more forms of effective HIV prevention (e.g. condoms, PrEP, TasP/U=U) in people at risk of HIV infection to 90% by 2025 and 95% by 2030 .
09	95% of people living with HIV report good quality of life by 2030.
10	95% of people living with or affected by HIV report 'rarely' or 'never' experiencing stigma in healthcare.
11	95% of healthcare workers report 'never' or 'rarely' expressing stigma to people living with or affected by HIV.

i Indicators and associated data sources for each target are included in the Surveillance and Monitoring Plan.

ii Defined as a 90% reduction in HIV diagnoses in Australia by 2030 (compared to a 2010 baseline).

iii Baseline is 2010.

7. Priority Populations and Settings

While everyone in Australia is potentially at risk, HIV disproportionately impacts specific populations, and the impact can be compounded by social and structural inequities.

In Australia's response to HIV, it is important to prioritise populations that are most impacted and at continued risk, as well as emerging populations at elevated risk.

It is also important to note that people may identify as members of multiple priority populations, resulting in a diverse range of intersecting characteristics, experiences, challenges and risk factors unique to each person.

7.1. Priority populations for the Ninth National HIV Strategy

7.1.1 All people living with HIV

People living with HIV have a variety of health and social needs, lived experiences and diverse identities. Stigma impacts quality of life and health outcomes for all people living with HIV. For some people, HIV-related stigma will intersect with and heighten in relation to their memberships of specific subpopulations. Tailored health and social services are required to ensure people living with HIV reach a good quality of life while maintaining high treatment coverage.

Gay and bisexual men continue to shoulder the greatest burden of HIV in Australia. Gay and bisexual men living with HIV have forged a powerful sense of community over many decades, including through networks that offer peer support, and are inclusive of people who are newly diagnosed.

Aboriginal and Torres Strait Islander peoples living with HIV face additional social and structural barriers to HIV diagnosis and treatment. This includes heightened experiences of discrimination, racism, stigma and inaccessibility to culturally appropriate health services. There is a need for tailored, culturally inclusive and safe approaches that are peer-led and community-led to support Aboriginal and Torres Strait Islander peoples living with HIV.

Women living with HIV have specific health needs across their life span. Women are more likely to be overlooked for HIV testing opportunities, seek diagnosis only after their partner has received a positive diagnosis, be diagnosed in low caseload settings, and receive late diagnoses; an amalgamation of circumstances that can result in poorer overall outcomes. It is crucial that health professionals have guidance around identifying possible HIV transmission risks for women.

Heterosexual men living with HIV are a less visible population within the Australian response to HIV. Late diagnosis is a significant issue for this population [6]. Heterosexual men report high levels of stigma and often lack peer connection which can increase their health vulnerabilities.

People in older age groups are increasingly experiencing issues associated with living long term with HIV. The life expectancy of Australians living with HIV has been steadily increasing and is approaching that of the general population [34]. This has implications for the healthcare system and aged care services [34]. People living with HIV in older age groups are more likely to experience complex age-related co-morbidities and chronic illnesses, like cardiovascular disease. Lower quality of life is reported by this population, that is not related to the clinical co-morbidities associated with ageing, but attributable to stigma and isolation [35].

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 success of this Strategy.

7.1.2 Gay, bisexual and other men who have sex with men

GBMSM are the population most affected by HIV in Australia and comprise the majority of those who acquire HIV (63% of new notifications in 2023 [6]). Over more than four decades, gay and bisexual men have created a community response to HIV which is proactive, sex positive and health-seeking. This response is highly goal-oriented – to a future without HIV transmission – and grounded in community behavioural norms that support and reinforce positive behaviours. These norms are pivotal in guiding safe sexual practices and supporting health-seeking behaviour.

Bisexual men are a unique cohort within GBMSM that experience inequities when compared to gay men across HIV prevention and living with HIV. Bisexual men require catered strategies to adequately address their unique experiences and challenges due to separate attraction, identity and behavioural profiles to gay men. Addressing the needs of non-gay/bisexual-identifying men who have sex with men can be even harder, especially given there is limited statistical data available on this population.

7.1.3 People from culturally and linguistically diverse populations, and people born overseas

A broader perspective on HIV prevention and sexual health promotion is needed for all culturally and linguistically diverse communities and people born overseas.

There are larger gaps in the HIV diagnosis and care cascade among people born overseas and from culturally and linguistically diverse communities. They may experience high levels of stigmatisation, racism and discrimination which can prevent them from accessing healthcare, and in turn increase the risk of HIV transmission. They may also be more vulnerable to HIV due to myths and misconceptions around HIV transmission and illness, gender inequity and cultural sensitivities around talking about sex.

From 2019 to 2023, the proportion of late HIV diagnoses was higher among people born in Sub-Saharan Africa, Southeast Asia and Latin America or the Caribbean [6]. A recent report on this cohort highlights that there is confusion around whether HIV tests are included in all blood tests conducted in Australia, misconceptions that HIV is not a public health issue in Australia, and low levels of awareness on the

availability of effective treatments for HIV and prevention methods [36]. As Australia moves toward elimination, tailored initiatives must respond to the inaccurate understanding of HIV in Australia in these populations [37].

To address some of the gaps in HIV surveillance further, behavioural and prevention research, and cultural, language and gender issues must be addressed across all aspects of Australia's national HIV response.

7.1.4 Aboriginal and Torres Strait Islander peoples

The prevalence of HIV remains low among Aboriginal and Torres Strait Islander peoples and new notifications of HIV have steadily declined since 2016 [6], a credit to the strength and resilience of the Aboriginal and Torres Strait Islander peoples.

While prevalence of HIV remains low, social and structural barriers result in diagnosis and treatment inaccessibility for some in the Aboriginal and Torres Strait Islander population.

Detailed approaches for Aboriginal and Torres Strait Islander peoples are outlined in the National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2024-2030. Both this Strategy and the Aboriginal and Torres Strait Islander Strategy recognise that culture is the foundation for health and wellbeing, and that furthermore family, Elders and peers are seen as valuable sources of advice.

7.1.5 Sex workers

Despite maintaining low rates of HIV transmission, sex workers are a priority population due to the potential higher exposure risk associated with sex work and the need to sustain the effective response in this population. Continued peer education, high rates of condom use and other prevention efforts led by sex workers and their organisations ensure that HIV prevalence among Australian sex workers remains among the lowest in the world.

Sex workers experience barriers to accessing health services including high levels of stigma and discrimination [38] [39]. They also face a range of regulatory and legal issues including criminalisation, licensing, registration, mandatory testing and a lack of anti-discrimination protections in some jurisdictions.

These barriers create a complex system of impediments to evidence-based prevention, access to testing and healthcare services. This can result in increased risk of BBVs and STIs, loss of livelihood, and risk to personal and physical safety. Evidence definitively shows that decriminalisation of sex work is linked to the reduction of HIV risk and rates, improved access to health promotion and access to workplace health and safety [40] [41].

Tailored approaches that address the intersecting experiences of stigma and discrimination and the regulatory and legal barriers experienced by sex workers are required.

7.1.6 People who inject drugs

Australia's highly successful NSPs, coupled with services provided by peer-based harm reduction and drug user organisations and state and territory governments, have maintained low HIV infection rates among people who inject drugs. This population remains a priority population due to the enhanced risks of HIV transmission through injecting drug use.

Risks for people who inject drugs are exacerbated by stigma, discrimination and the criminalisation of drug use. Ensuring that this cohort receives appropriate care requires the provision of effective harm reduction responses directly targeting injecting drug users.

Between 2014 and 2023, the proportion of people who inject drugs attending NSPs and reporting receptive needle and syringe sharing in the last month, was between 16% and 19% [6].

Tailored approaches are needed for people who inject drugs with complex needs and/or from other priority populations, particularly Aboriginal and Torres Strait Islander peoples, GBMSM and people in custodial settings. People living with hepatitis C, experiencing mental illness or homelessness are also important subpopulations identified to be at a higher risk.

7.1.7 Trans and gender diverse people

Research on HIV prevalence among trans and gender diverse people in Australia is limited.

Between 2014 and 2023, there were 61 HIV notifications among people whose gender was reported as trans or gender diverse [6].

It is likely that this figure is an underrepresentation of the true number of trans and gender diverse people newly diagnosed with HIV [6]. The lack of accurate data and evidence-based understanding of the characteristics, including HIV prevalence and risk of trans and gender diverse people in Australia, presents a significant barrier in delivering appropriate programs and services to this population.

Some trans and gender diverse people are already part of existing priority populations, such as people living with HIV, sex workers and people who inject drugs, and they may share some of the same risk exposures of other priority populations. However, trans and gender diverse people also have specific sexual health needs and barriers to prevention, treatment and care [42].

Increased community engagement with trans and gender diverse people, alongside improved data and research, is needed to better understand how HIV impacts this population. The inclusion of trans and gender diverse people in the HIV response is a priority for all stakeholders.

Increased use of HIV prevention, testing and treatment will require improving the levels of literacy about gender diversity in the broader health workforce, as well as reducing the harmful stigma and transphobia faced by this population when accessing healthcare. Healthcare settings will require support to provide appropriate and sensitive sexual healthcare to trans and gender diverse people, especially in settings providing gender affirming care.

Within this population, tailored approaches are needed for Aboriginal and Torres Strait Islander people, as they have long recognised and accepted diverse concepts of gender, such as Sistergirls, Brotherboys and trans mob [43].

7.1.8 People in custodial settings and detention centres

People in custodial settings are at risk of HIV transmission through shared use of injecting equipment, unsafe tattooing, condomless sex and a lack of access to HIV prevention tools. The risk of transmission in the context of undiagnosed HIV or detectable viral load is significant given the nature of risk exposures in custodial settings.

Effective HIV prevention, testing and treatment for this population requires a strong, whole-of-government partnership involving those in juvenile detention centres, adult prisons and detention centres. This requires coordinated access to testing, treatment, care and harm reduction tools, such as opioid substitution therapy, NSPs and support, for people living with HIV in custody, and when transitioning from custodial to community settings, to improve health outcomes and minimise risk of disengagement from care. It also requires safe working environments for staff and safe environments for inmates.

7.2. Priority settings for the Ninth National HIV Strategy

The identified priority settings are the environments where priority populations live, work, seek help, socialise and have sex, such asⁱ:

- Regional, rural, remote and outer suburban areas of major cities, and geographic locations with high prevalence and/or incidence of HIV due to additional barriers to accessing prevention, testing and treatment
- Healthcare services used by priority populations, including:
 - Community and primary health services, such as public sexual health clinics and pharmacies
 - Aboriginal Community Controlled Health Organisations/Aboriginal Medical Services
 - Hospital settings including emergency departments
 - Settings providing gender affirming care.
- Aged care services for people living with HIV in home care or residential settings
- Custodial settings
- Other settings where support is provided to priority populations including peer-based services, NSPs, homelessness services, alcohol and other drug services and mental health services.

i Priority settings have been limited to clinical and custodial settings where interventions could be targeted.

8. Priorities

8.1. Prevention

Effective HIV prevention relies upon ready access to a range of prevention tools such as condoms, PrEP, PEP, TasP/U=U and sterile injecting equipment, together with an educated health workforce and strong enabling environment to support awareness, access and use. This needs to be combined with sustained, community-led education programs to improve health literacy and support priority populations.

Community-led programming, particularly for Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities and overseas-born populations, is critical to ensure that initiatives are appropriately targeted for different cultures, sexualities and genders, and tailored to local contexts.

Some populations are vulnerable to acquiring HIV due to a multitude of reasons, such as myths and misconceptions about HIV transmission, prevention and treatment, underestimation of risk, lack of knowledge about available health services and other sources of information, and HIV-related stigma and discrimination.

When promoting prevention, we must consider tailoring health promotion and education programs to the needs of subgroups, with increased efforts aimed at those subgroups with lower uptake of HIV prevention.

Prevention approaches that have worked well in Australia's response, including peer and community-led education for people living with HIV, GBMSM living in urban areas, sex workers and people who inject drugs, need to be strengthened and considered for other priority populations.

If taken as recommended, PrEP reduces the risk of acquiring HIV through sexual activity by 99% as a single preventative medication [44]. For Australia's HIV response to reap the full benefits of PrEP, it is essential to identify and address the remaining barriers to access, including for people not eligible for Medicare [45] and former PrEP users who do not resume use [46].

Relaxing the restrictions placed on people on a PrEP regime, such as extending prescription and monitoring cycles beyond 3 months and/or providing multiple pathology forms for repeat testing in an appointment, should be considered. Options for promoting, prescribing or supplying PrEP through pharmacists, registered nurses or peers should also be considered to widen access. The suitability of expanding innovative prescribing models nationally should be considered, such as the NSW Policy Directive which allows registered nurses working in NSW public sexual health clinics to supply and administer PrEP for 90 days or on demand [47].

New PrEP options, such as long-acting forms, also have the potential to further transform HIV prevention [46]. Targeted partnerships to deliver new HIV biomedical prevention options are critical.

Any activities aimed at increasing the use of PrEP must be accompanied by efforts to support the health workforce. Education and training suitable to the setting, plus ensuring capacity to respond to the demand for PrEP, are necessary.

PrEP is not the only prevention tool that has proved effective in Australia. For example, sex workers' consistently high condom use is a significant contributor to the low rates of HIV transmission in this population. Condom use also contributes to lowering rates of STI transmission among all populations. The ongoing use of NSPs by people who inject drugs has contributed significantly to the low transmission rates in this population (though this does not extend to custodial settings). All effective prevention strategies should be encouraged, with people able to make choices that suit their individual circumstances. Community or peer-based organisations can play a central role in delivering peer education on HIV prevention.

TasP/U=U also plays a fundamental role in reducing population-level HIV incidence [48]. Education for health professionals and priority populations should outline the benefits of TasP and the science of U=U in improving the health and wellbeing of people living with HIV. Raising awareness of the significance of having an undetectable viral load, particularly in HIV negative populations, may also assist in addressing HIV-related stigma, particularly in structures where it is systemically entrenched [49].

PEP is an important intervention for individuals who have potentially been exposed to HIV in both non-occupational and occupational settings. Strategies on making PEP more convenient to access should be explored.

In addition to these efforts, a vaccine for HIV must remain a goal of the Australian community. We must continue to support our researchers in this endeavour, of moving us closer to achieving a global community free from HIV.

Prevention efforts which deliver coverage at the population level are crucial, and something no single prevention tool alone can achieve. Combination prevention approaches which consider effectiveness, accessibility and personal preferences are critical to improving HIV prevention in Australia.

Key areas for action - Prevention

- 01** Develop or expand targeted, culturally appropriate, community-led prevention programs which improve HIV-related knowledge, promote the importance of prevention in priority populations and increase the demand for PrEP amongst groups who would benefit.
- 02** Promote and support the integration of current and emerging HIV prevention techniques into the health workforce, including building capacity for clinical settings with lower PrEP caseloads to engage in discussions about PrEP and TasP/U=U.
- 03** Promote HIV awareness and prevention tools such as PrEP, U=U, condoms and NSPs among populations that may not consider themselves to be at risk of HIV, such as Australian-born heterosexual men who travel to HIV high-prevalence countries, women and young people.
- 04** Investigate the barriers to resumption of PrEP use among former PrEP users.
- 05** Investigate more convenient and affordable access to PrEP, including:
 - Subsidising access to oral PrEP for individuals who meet PrEP eligibility criteria but are not eligible for Medicare;
 - Allowing pharmacists and registered nurses to prescribe or supply PrEP;
 - Investigating options to expand the role of peers in support of PrEP awareness, promotion and initiation;
 - Expanding the length of scripts and monitoring cycles for people on a PrEP regimen; and
 - Fast-tracking long-acting, injectable PrEP into the Australian market.
- 06** Develop an HIV communications strategy to shape long-term communication activities to 2030.
- 07** Challenge historic social and institutional stigma related to HIV by promoting evidence-based messages, including TasP/U=U.
- 08** Ensure the wide availability of sterile injecting equipment and education on safer injecting among people who inject drugs, including a focus on GBMSM, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse populations, people born overseas and people living in regional, rural and remote areas.
- 09** State and territory governments, supported by the Commonwealth, explore the implementation of NSPs and other harm reduction measures in prisons, to improve health outcomes and the safety of corrective services.

8.2. Testing

Free and anonymous HIV testing has been central to Australia's response to HIV. HIV testing must be convenient and accessible if Australia is to meet its goal of virtually eliminating HIV transmission.

The widest possible range of options for HIV testing should be available to suit different individuals, depending on their circumstances and preferences. Many global advances in testing technology have occurred in recent years, however the Australian market is not seeing the benefit of the full range of innovations.

HIV testing enables people to know their status and adopt behaviours that minimise transmission. It also supports early diagnosis and treatment commencement which is important in achieving a healthy and improved quality of life for people living with HIV.

Regular testing among GBMSM increased steadily over time prior to the disruption of the COVID-19 pandemic. The disruption to testing behaviours resulted in the proportion of people diagnosed late increasing since 2019, with 2020 having the highest proportion of late diagnoses in the last 10 years [50]. Late diagnoses decreased up to 2023, but still accounted for 37% of all notifications made in 2023 [6].

As late diagnoses notificationsⁱ are increasing across subgroups, HIV testing to identify people with undiagnosed HIV and provide treatment and support is vitally important. Some priority populations are overrepresented in late diagnosis data, including people born overseas, women and heterosexual people [6]. The proportion of late HIV diagnoses was higher among people who reported heterosexual sex as their HIV risk exposure. People who are diagnosed with HIV late are more likely to experience comorbidities and poorer outcomes [51].

One way to address the increase in late diagnoses is through opportunistic HIV testing. Most people who receive a late diagnosis have had prior interactions with the health system [52]. The Australasian STI Testing Guidelines recommend that all STI testing, including asymptomatic check-ups, should include HIV testing [53].

Further high-risk individuals, not limited to GBMSM, could be targeted when testing for other communicable and non-communicable diseases, allowing HIV testing to be normalised and easily integrated into existing practices. The United Kingdom allows for hospitals to implement opt-out testing, and consideration could be given to similar models in Australian hospitals in areas of high HIV prevalence [54].

Workforce development opportunities should be considered to encourage workers to identify and pursue opportunistic testing when delivering care.

HIV self-testing is safe, convenient and highly accurate, with recent programs showing they reach people who are infrequent testers, have never tested for HIV before or have recently arrived in Australia [55]. Similarly, point of care testing (POCT) provides rapid test results, though it occurs within a healthcare or community setting [56].

i Diagnosis after 4+ years.

Both forms of testing have the potential to transform testing rates in Australia, however neither form of testing should replace traditional pathology testing but be considered as tools in the mix that can be tailored to suit different needs.

Currently, the use of both HIV self-testing and POCT is limited, due in part to manufacturers not being invested in entering the market of a country with a smaller concentrated epidemic (when compared globally). Incentives to manufacturers that overcome the perceived barriers of supplying the Australian market should be considered.

In the meantime, Australia needs to support and scale up the existing range of testing options in new ways, such as rapid testing by community-led organisations, Medicare rebates for POCT in clinical settings, HIV self-test kits using different distribution modes and peer-led testing models. Efforts to expand testing coverage must also be supported by improved community education of the testing options available and the importance of frequent and regular testing.

Optimising and expanding HIV testing in Australia will facilitate people getting tested when and how they want.

Key areas for action - Testing

- 01** 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.
- 02** Expand access and promote POCT and HIV self-testing, including local and regional testing initiatives and peer models across all states and territories. This should include options that address barriers which reduce access to and availability of POCT and HIV self-tests.
- 03** Increase awareness of and access to a variety of HIV test options to ensure that people can get tested for HIV, no matter their circumstances.
- 04** Improve the knowledge and awareness of HIV transmission risk factors among population groups overrepresented in late diagnosis data to encourage regular testing.
- 05** Identify and implement incentives to encourage manufacturers to bring new testing technologies to the Australian market.
- 06** Improve the knowledge of health professionals on HIV testing, including opportunistic testing, asymptomatic testing and the investigation of non-specific symptoms without identifiable risk factors.

8.3. Treatment and care

Early uptake of HIV treatment after diagnosis leads to better long-term outcomes for people living with HIV. Testing options that support early diagnosis need to be linked to the provision of early treatment and care, preferably within 4 weeks.

As the landscape of HIV in Australia changes, there is increasing demand for services to be delivered by shared care models, involving primary health settings [57] and peer-led programs [58]. Those newly diagnosed should be connected to a peer navigator as soon as possible after diagnosis.

Current rules around prescribing highly specialised drugs, including ART, limit how much care can be provided in the primary care setting. Most people living with HIV need to visit a specialist or a general practitioner (GP) certified to prescribe ART under PBS Section 100.

Adoption of formal multidisciplinary shared care management models between primary healthcare and specialist services, and referrals to peer-led services, can help support high-quality service delivery. To further enhance the healthcare of people living with HIV, a reconsideration of the role of the primary care workforce to provide ongoing management and monitoring of their patients is needed.

Primary care practitioners interested in providing treatment and care to people living with HIV should be encouraged to consider further training and education on HIV, which is available through PBS Section 100 registration. Interested primary care practitioners should also seek education aimed at dismantling stigma, as health workforce-based stigma can cause people to delay or forgo seeking health services and treatment.

Placing patients at the centre of care is vital. People living with HIV have a unique knowledge of their own treatment and management, and need to be actively engaged as equal participants in the planning and delivery of their own care [59].

Rapid patient follow-up, strong coordination of care, peer navigation and support, and active case management are critical to support diagnoses and provision of appropriate treatment and ongoing care. This is true as new and novel types of treatment and care, such as long-acting injectable treatments, become available. As the types of treatment modalities offered evolve, patient support must follow.

Community-based peer support remains an essential part of the treatment journey. People connected with peer navigators are more likely to commence treatment sooner and remain adherent to treatment, engaged in care and have better health outcomes in the long term [60] [61]. Engagement with a peer navigator has also been shown to improve HIV health literacy, reduce self-stigma and foster peer and social connection, thereby creating a sense of belonging and reducing social isolation leading to improved health and wellbeing [62].

The use of technologies to better support person-centred care, including telehealth, should be promoted where relevant. New options for HIV treatment also need to be promoted to the sector. This will be especially important for people living with HIV who have multi-drug resistance and/or adherence difficulties.

In 2021, United Nations Member States adopted the Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030 [4]. The achievement of the targets of the Declaration relies on rapid, affordable and continued access to ART for all people living with HIV and their ongoing clinical management in community-based settings.

Australia can help ensure treatment is more readily available by removing restrictive conditions or costs to consumers on public health grounds. This will lead to early engagement in care, an area needing greater attention.

People in Australia who were born overseas are significantly less likely to commence ART within 6 months of HIV diagnosis than people born in Australia [63]. People in Australia who were born in Southeast Asia, Latin America and Sub-Saharan Africa have larger gaps in their HIV treatment and care cascades than their Australian-born counterparts [6].

More effort is also required to improve the treatment and care cascade for Aboriginal and Torres Strait Islander peoples, who typically commence treatment and achieve an undetectable viral load later than non-Indigenous Australians [64]. Models of culturally safe care need to facilitate improvements in the cascade with diagnosis and early referral to treatment services, retaining newly diagnosed patients in care, and maintaining (or re-establishing) links to services for people living with HIV.

Models of care should be practical for implementation within rural and remote areas, recognising that specialist visits may be limited, staff turnover may be high, and that nursing professionals and Aboriginal and Torres Strait Islander health workers, health professionals and community workers may be the primary care providers in an area.

People living with HIV can experience mental health challenges which have significant impact on their quality of life [65]. Trauma experienced by people living with HIV can be intersectional and complex, and act as a barrier to engaging in healthcare. Healthcare workers such as psychologists, social workers, case managers and allied health workers can play a significant role in the care provided to people living with HIV.

Older people living with HIV in Australia are likely to require special care and support, including access to high-quality aged care services, the management of comorbidities, assistance with treatment adherence, access to programs that reduce social isolation and other issues related to ageing [34].

HIV treatment continues to be a key component of Australia's response to HIV. Providing accessible, equitable, affordable, multidisciplinary, culturally safe treatment and care to people living with HIV will contribute greatly to eliminating HIV transmission in Australia.

Key areas for action - Treatment and care

- 01** Ensure people diagnosed with HIV are promptly linked to ongoing care and peer navigation where available.
- 02** Explore tailored, wrap-around support for those who may not be able to commence or sustain treatment.
- 03** Promote the use of technologies to drive person-centred care, including telehealth, where appropriate.
- 04** Propagate integrated models of treatment and care for people living with HIV.
- 05** Identify, implement and evaluate models of care that meet the needs of people living with HIV who are ageing and ensure quality of care across services.
- 06** Identify gaps and improve the HIV treatment and care cascade among temporary residents, permanent migrants to Australia and Aboriginal and Torres Strait Islander peoples, and ensure services provide culturally safe care.
- 07** Investigate options to reduce or remove PBS co-payments for HIV medication.

8.4. Stigma

HIV-related stigma continues to be a central part of the lives of many people living with HIV. Stigma is widely recognised as one of the most significant barriers to an effective HIV response [66]. It can deter people from testing for HIV and reduce willingness to disclose HIV status and engage in HIV treatment.

Stigma is also one of the best predictors of poorer outcomes, making its effect on quality of life significant [65]. It has significant impact on health outcomes, as well as relationships and employment prospects, and can lead to social isolation and mental health concerns.

Stigma is driven by a range of factors including outdated notions of HIV and misinformation about transmission. It can be compounded by intersecting characteristics including sexuality, gender, cultural background, racism, homophobia, perceived impacts on migrant status, disability, being a sex worker, a person who injects drugs, or a person in a custodial setting.

While attitudes to HIV have changed since the beginning of the epidemic, stigma continues to be reported by people living with HIV. Findings from the Stigma Indicators Monitoring Project showed that 37% of participants living with HIV in 2022 reported experiencing stigma within the last 12 months in relation to HIV, and 30% of participants living with HIV reported experiencing negative treatment by health workers [23].

There is a substantial body of knowledge about the prevalence and impact of HIV-related stigma, but there needs to be more consideration of its intersection with other types of stigma and innovative interventions that can reduce discrimination that arises due to stigma. This is especially relevant when looking at structural stigma and criminalisation.

HIV is often considered to be 'worse' than other communicable diseases, due to the lasting imprint of the homophobic and moralistic stigma associated with HIV when the virus emerged in our communities four decades ago. Unfortunately, this pejorative view continues to be reflected in our current legislative landscape along with inconsistent provisions across jurisdictions [67].

No criminal law in Australia directly criminalises HIV transmission or exposure, but various provisions under state and territory criminal acts and public health laws allow charges to be brought forward. Six Australian jurisdictions currently have mandatory disease testing laws which compel HIV testing in cases where emergency workers come into contact with a person's bodily fluids. Newly introduced consent laws can allow misrepresentation of HIV status to be criminalised as sex due to fraudulent inducementⁱ. These laws are in some instances unscientific and do not recognise U=U. Laws and policies based on unscientific principles stigmatise HIV and place Australia out of step with international practices.

i Wording varies between jurisdictions.

Further, the fear of prosecution can lead people to avoid conversations about HIV with sexual partners and health professionals, and delay or forgo HIV testing and treatment, all of which contributes to increased risk of HIV transmission. In 2021-22 data, 44% of people living with HIV did not disclose their HIV status to health workers in order to avoid negative treatment, 29% looked for alternative services, 26% delayed accessing healthcare and 16% did not attend a follow-up appointment in the previous year [23].

Increased efforts are needed to address stigma. While continuing to improve our support to people living with HIV and priority populations, it is important to understand that the solution is not to make those subjected to stigma also responsible for challenging and reforming it. This Strategy recognises that the source of stigma is the people, systems and laws that perpetrate it upon others. As such, efforts to combat stigma must be targeted there.

Efforts are also needed to increase the awareness of health professionals and community health workers, particularly those on the front line of HIV diagnosis, testing and treatment, in relation to stigma. This is an important part of training programs for specialists, primary healthcare and community-based service providers. This must be accompanied by a focus on policy, processes and health quality standards that address privacy and confidentiality, while providing non-discriminatory services and upholding diversity and consumer rights.

The design and delivery of anti-stigma interventions must meaningfully involve people living with HIV and other priority populations. This approach enables individuals and communities to draw on their lived experience to support the design, implementation and evaluation of HIV anti-stigma interventions [68].

HIV-related stigma is a harmful phenomena that greatly effects health and wellbeing. Reducing stigma in all its intersecting forms is essential.

Key areas for action - Stigma

- 01** Implement initiatives to reduce stigma, including education which incorporates messaging to counteract stigma.
- 02** Engage with research and surveillance partners to build evidence to better understand stigma and its effects, and develop interventions.
- 03** Utilise peer navigators and other support to help address stigma for people engaging with testing, diagnosis and treatment.
- 04** Increase awareness of the impact of HIV and intersectional stigma among healthcare providers and engage with workforce partners to build competency in all healthcare settings.
- 05** Disseminate the U=U message in justice, healthcare and education settings with supporting education.
- 06** Engage with state and territory partners to discuss the laws that indirectly perpetuate stigma and are incongruent with Australia's endorsement of the science of U=U.
- 07** Implement interventions that build resilience among people living with HIV, so individuals can better manage stigma when it does occur.

9. Enablers

9.1. Policy and legislation

The United Nations 2021 Political Declaration on HIV and AIDS [4] identifies the need to create an enabling environment by reviewing and reforming restrictive legal and policy frameworks. Australian governments need to continue to review and work towards removing barriers to HIV prevention, diagnosis and management; promoting and protecting the human rights of people living with HIV and priority populations; promoting quality of life; and breaking down HIV-related and intersectional stigma and discrimination.

Barriers that impact HIV prevention and access to HIV services in Australia include the following:

- The cost of services and treatments
- Challenges to service delivery in regional, rural and remote areas and in low HIV caseload primary care or health practices
- Lack of awareness about HIV, risk of transmission and available services
- HIV-related stigma, homophobia, transphobia, gender inequity, language barriers, lack of culturally appropriate health services, cultural stigma, racism and sensitivity about discussing sex and sexuality
- Real or perceived visa restrictions, including the perception that being diagnosed with HIV will affect current migration status
- Laws that negatively restrict sex work, drug use, peer distribution of injecting equipment and access to sterile injecting equipment in custodial settings
- Laws which mandate HIV testing and the taking of reasonable precautions
- Laws which criminalise misrepresentation of HIV status, exposure and transmission of HIV.

The removal of such barriers can increase the rates of testing and treatment, and contribute to a decrease in the incidence and prevalence of HIV. Approaches to addressing these barriers in Australia need to be informed by national and international evidence.

Improving the quality of life for people living with HIV starts with appropriate treatment and care but requires freedom from stigma and discrimination, as well as addressing the socio-economic factors that can be a barrier to good quality of life such as poverty, housing, financial security and social isolation.

The implementation of this Strategy primarily rests with members of Australia's HIV partnership. However, many of the barriers to access and equitable treatment of affected individuals and communities fall outside of the responsibility of the health system. Criminalisation impacts priority populations by driving isolation and marginalisation, and limiting individuals' ability to seek information, support and healthcare.

It is important that effective and meaningful dialogue is maintained across sectors and jurisdictions to support knowledge translation (for example, current HIV-related clinical evidence) and to understand the potential impacts of any wider decisions on the health of priority populations.

Australia has a strong, enabling environment, but key legal, regulatory, policy, social, cultural and economic barriers must be addressed.

Key areas for action - Policy and legislation

- 01** Review laws and policies that perpetuate stigma and discrimination and impact health-seeking among priority populations.
- 02** Review and address institutional, regulatory and system policies which create barriers to prevention, testing, treatment and care for people living with HIV and priority populations.
- 03** Explore ways to address real or perceived immigration issues for people living with HIV or people at high risk of acquiring HIV that result in low levels of prevention, testing and connections with health services and community.
- 04** Engage in dialogue with other government sectors to promote the use of evidence-based HIV-related science to improve policies affecting people living with HIV and priority populations.

9.2. Workforce

A strong multidisciplinary workforce of motivated and trained health professionals and peer workers is vital to delivering high-quality services.

Primary health services, including general practice, Aboriginal Community Controlled Health Organisations and Aboriginal Medical Services, are priority settings for the delivery of HIV prevention, testing and treatment services, in collaboration with PBS Section 100 prescribers and specialist care as necessary.

Sexual health clinics and community-led organisations play an important role in providing ongoing treatment and monitoring, and culturally safe services to priority populations and people who are not accessing mainstream primary health services. Other health services, including specialist, antenatal, alcohol and other drugs, mental health services, treatment programs and NSPs, are also important settings in the response to HIV.

Shared care models involving GPs, specialists, nursing professionals, Aboriginal and Torres Strait Islander health workers, community-based and peer workers, and other health workers, will assist in decreasing the burden on public sexual health services [69]. Less experienced diagnosing clinicians need strong links with specialist providers in providing culturally safe HIV diagnosis, and enabling treatment, ongoing care, and other support services in the community. These clinicians also need support to pro-actively engage priority populations in discussions about PrEP and TasP/U=U.

An enabling regulatory environment is necessary for the expansion of HIV care in primary healthcare settings [1]. Opportunities to expand scope of practice should be considered where appropriate, with registered nurse-led services being a particular focus, through the provision of education and professional development.

Lower rates of bulk-billing among GPs impacts the ability of people with limited financial means to access quality healthcare (including HIV testing), and PBS and MBS restrictions on prescribing limit the scope of registered nurse-led models of care. The sustainable delivery of appropriate care within primary healthcare requires a focus on addressing regulatory barriers to HIV management in these settings.

Evidence-based, culturally safe, responsive and accessible clinical guidelines and tools are essential to the provision of effective HIV prevention and care in Australia. Guidelines must be updated at regular intervals and coupled with education and training to build workforce capability. This is particularly important in supporting the management of patients with complex needs in community settings.

Specific culturally safe education, professional development and specialisation opportunities need to be available to support the development of essential knowledge and skills across the workforce [70]. Consideration should also be given to expanding how HIV is incorporated into tertiary curricula. Hybrid approaches of

online learning, web-based resources, and mobile applications, as well as face-to-face learning opportunities, should be tailored to specific workforce needs and locations. Workplaces also need to be culturally safe for the workers.

Comprehensive guidance for the workforce that supports professionals in providing advice to people, including on legal and policy issues in relation to HIV transmission and undetectable viral load, would better support people living with HIV, especially those populations with little knowledge of HIV, so they can make informed decisions about prevention and treatment adherence.

Anti-stigma and discrimination education, and education about HIV risk and the effectiveness of TasP/U=U, should be delivered to the healthcare workforce, as well as to the non-health government portfolios as part of a whole-of-government approach to the reduction of stigma. Police, prison and other custodial settings staff, and emergency services personnel require increased or improved education.

Community-led and peer-based organisations are critical for developing and implementing communication strategies and peer-to-peer programming to increase demand for, and access to prevention services, testing and treatment, and reducing ongoing stigma and discrimination. Peers employed in the community workforce need regular training and support from peers to ensure their work is informed by the most recent developments in HIV science and technology. Culturally sensitive health service delivery policies and systems are also required for stigma reduction among healthcare workers.

Issues in relation to recruitment and retention of staff need to be addressed, particularly in rural and remote areas to ensure that the required expertise and capacity exists in all areas. Innovative models adapted to local contexts can assist in addressing such challenges by utilising the skills of other appropriately trained health professionals. Appropriately trained peers could play a much larger role in prevention, testing and treatment of HIV.

Bilingual and/or bicultural healthcare workers who can act as trusted sources of health information can help overcome communication barriers and misconceptions of HIV among overseas-born or culturally and linguistically diverse populations. Resources should be tailored to deliver person-centred, stigma-free, evidence-based, culturally safe treatment and care, and if needed, interpreters should be made available.

The research workforce continues to be an essential enabler to the HIV response in Australia. A multi-disciplinary research workforce should be equipped to advance HIV science, improve clinical care, maintain the high quality of HIV surveillance data and contribute in-depth social research on prevention, care and treatment.

A strong and informed workforce is critical to Australia's HIV response. Supporting capacity and capability across the workforce will ensure priority populations receive high-quality and culturally safe care.

Key areas for action - Workforce

- 01** Develop knowledge and awareness of HIV across the multidisciplinary workforce to facilitate the delivery of culturally safe and appropriate services.
- 02** Continuously update and make accessible evidence-based clinical guidelines, tools and support for prevention, testing and management of HIV and related comorbidities.
- 03** Ensure access to PEP, PrEP, condoms, TasP/U=U and other prevention methods is supported by consistent, targeted and culturally safe information and messaging for health professionals.
- 04** Strengthen the inclusion of HIV information in undergraduate and post-graduate curricula for healthcare workers.
- 05** Explore innovative, multidisciplinary models of care for HIV prevention and management, particularly models for rural and remote areas, and areas experiencing workforce shortage.
- 06** Promote and support sustainable models of care within the health workforce, including primary care nursing, registered nurse prescribing, community pharmacies and peer workers to increase access to prevention, testing and treatment.
- 07** Develop culturally safe models and standards for HIV prevention and education with priority populations.
- 08** Deliver culturally safe training and professional development to expand and strengthen the capacity of the peer workforce.
- 09** Deliver evidence-based knowledge of HIV to government sectors outside of health.

9.3. Surveillance, research and evaluation

Australia's world class response to HIV has been informed by high-quality research, conducted in collaboration with people living with HIV, priority populations, governments and the health workforce.

Sustaining the collaborative research response between social, behavioural, epidemiological, clinical, legal and policy research is essential in developing a strong evidence base for managing and preventing HIV in the community, to identify disparities in the HIV response, evaluate interventions and programs, monitor HIV-related laws and policies, and pursue effective responses to stigma and discrimination.

This research identifies and examines key changes in the epidemiology and behaviours of priority populations, emerging issues and concerns, and influences on people's decisions about risk taking and seeking testing, care and treatment. It assists to understand the structural barriers and enablers affecting communities and inform targeted responses in priority populations and settings.

Partnerships between research institutes, clinicians, and community-led and peer-based organisations are valuable, as they are often the first to identify changes in behaviours, social interactions and demographics of priority populations [33]. As the epidemiology of HIV in Australia shifts, identification of trends and issues of concern among priority populations and their subgroups is vital, with particular emphasis on overseas-born and culturally and linguistically diverse GBMSM, non-gay/bisexual-identifying men who have sex with men, women, younger men, men living in outer suburban and regional, rural and remote areas, and trans and gender diverse people. These populations should be engaged as research partners in future endeavours, and research outcomes be communicated with them and the wider HIV sector.

Improvements in reporting Aboriginal and Torres Strait Islander status in clinical and pathology datasets and strengthened data linkage are needed to build our understanding of HIV in Aboriginal and Torres Strait Islander peoples.

As technological advances to surveillance emerge, such as digital health, artificial intelligence, big data, cluster-based surveillance, molecular epidemiology and phylogenetic analysis, significant consideration must be given to ethical, legal and privacy issues before they are safely implemented [71]. Novel methods supporting more rapid and efficient mechanisms of surveillance require development and assessment.

There is also a need to improve the timeliness and consistency of data collection across Australia to better support completeness and comparability. Potential areas for greater involvement of community-led and peer-based organisations in surveillance also need to be identified, given their strong knowledge of priority populations [72].

The National BBV and STI Surveillance and Monitoring Plan 2024–2030 will measure and monitor the implementation of this Strategy through the identification and development of indicators to measure progress towards achieving this Strategy’s targets. The evaluation of existing HIV activities and programs, and development of new ones, will aim to maximise their alignment with the priority areas for action set out in this Strategy.

It is vital that Australian research organisations and partnerships work to build a strong, high-quality evidence base for HIV.

Key areas for action - Surveillance, research and evaluation

- 01** Strengthen HIV surveillance, behavioural and prevention research to inform the implementation of this Strategy.
- 02** Measure and monitor the implementation of this Strategy.
- 03** Identify opportunities to improve the timeliness and consistency of data collection.
- 04** Improve surveillance of issues impacting on people living with HIV, including morbidity, stigma and discrimination, and quality of life measures.
- 05** Assess the impact of legislation, regulation and policies on access to healthcare, and identify other barriers to healthcare, including social determinants of health.
- 06** Support community organisations to undertake community-led research to identify early changes in behaviour that may warrant more formal research investigation.
- 07** Evaluate programs and activities to ensure a strong evidence base for future interventions that align to the priority areas of this Strategy.
- 08** Support research within Australia to find a cure for HIV as well as a vaccine to prevent HIV transmission.

10. Implementing this Strategy

01



Leadership, partnership and connections to community

The Australian Government will provide national leadership by working across portfolios and jurisdictions to achieve the goals of this Strategy. The Department of Health and Aged Care leads the coordination of the national response to HIV under this Strategy. However, the success of this Strategy is contingent on continuing the productive partnerships between Commonwealth, state and territory governments and partners, including peak bodies representing communities, health professionals and researchers.

National peak organisations remain at the forefront of the HIV response in Australia. Organisations including Health Equity Matters, NAPWHA, AIVL, Scarlet Alliance, NACCHO, and ASHM Health, and the relationship these organisations have with each other and their members, have a critical role to play in the implementation of this Strategy. Monitoring and evaluation of current and emerging trends will be essential in enabling decision-making and guiding existing partnerships to implement agreed directions. This requires investment and mobilisation of resources across all levels of government and ensuring resources are utilised by the sector to achieve maximum impact and desired outcomes.

02



Governance, reporting and evaluation

This Strategy is endorsed by Australia's Health Ministers and governed through relevant committees of the Health Chief Executives Forum. This includes BBVSS. BBVSS coordinates implementation efforts across jurisdictions and reports to the Australian Health Protection Committee (AHPC) on progress in the implementation of this Strategy. BBVSS and the Communicable Diseases Network Australia (CDNA) will jointly monitor progress towards the targets of this Strategy and identify emerging issues and opportunities for action.

03



Surveillance and monitoring plan

The Department will develop a National BBV and STI Surveillance and Monitoring Plan 2024–2030 which will inform and monitor progress on achieving the goals and targets of this Strategy and other Strategies, in alignment with United Nations 2021 Political Declaration on HIV and AIDS and international strategies. A subcommittee of CDNA is responsible for overseeing the surveillance and monitoring plan and reporting on progress to CDNA and BBVSS.

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