Australian Government
Department of Health and Ageing

SIXTH NATIONAL HIV STRATEGY 2010–2013

Sixth National HIV Strategy

2010–2013

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1. Background

This is the sixth national HIV strategy to be adopted in Australia. It builds on five previous strategies which guided Australia's response to HIV and AIDS between 1989 and 2009. It is also one of a suite of five strategies aiming to reduce the transmission of sexually transmissible infections (STIs) and blood borne viruses (BBVs), and the morbidity, mortality and personal and social impacts they cause. The relationship of the Sixth National HIV Strategy 2010–2013 (this strategy) to the other four strategies is detailed in section 1.2.

1.1 Roles and responsibilities of parties to this strategy

While governments are the formal parties to this document, a partnership approach has been central to the development of this strategy. This has included significant consultation with, and input from, community organisations, researchers, clinicians and health sector workforce organisations. A number of people who contributed are members, or representative members, of the advisory committees detailed further below.

The priority actions identified in this strategy will be progressed through a continuation of this partnership between governments and the community sector, representing people with the infections and their communities, researchers, clinicians and health sector workforce organisations.

Leadership is provided by the Australian Government which works through the Australian Health Ministers' Conference and its sub-committees to facilitate national policy formulation and coordination. The Blood Borne Virus and Sexually Transmissible Infections Sub-Committee of the Australian Population Health Development Principal Committee includes representatives of all governments as well as community based organisations. It provides expert advice to health ministers through the principal committee and the Australian Health Ministers' Advisory Council. The Australian Government further seeks advice from the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections.

These groups will work in the context of funding arrangements for the health system, reshaping existing policies and programs or extending them where possible. These funding arrangements are provided jointly by the Commonwealth and the states and territories under the National Healthcare Agreement, which is a Schedule to the Council of Australian Governments (COAG) Intergovernmental Agreement on Federal Financial Relations (which came into effect on 1 January 2009). Related national partnership agreements provide the broad basis for funding reform in the Australian health system. The partnerships relevant to these strategies include the Indigenous Early Childhood Development Partnership and the National Essential Vaccines Partnership.

The Australian Government also funds community and professional organisations, and program delivery organisations and research centres to engage with, and build a knowledge base for, communities affected by BBVs and STIs—to put effective responses in place. The involvement of these organisations and research centres helped develop the overall response to these health challenges.

1.2 Relationship to other strategies

This strategy is one of a suite of five strategies aiming to reduce the transmission of STIs and BBVs in Australia, and the morbidity, mortality and personal and social impacts they cause. The five strategies cover the period 2010 to 2013 and include the:

- Sixth National HIV Strategy (this strategy)
- National Hepatitis B Strategy
- Second National Sexually Transmissible Infections Strategy
- Third National Hepatitis C Strategy
- Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy.

While the first four strategies listed focus on individual infections, the last one focuses on the combined health impact these infections have on Aboriginal and Torres Strait Islander peoples in Australia. Despite their specific focus, each strategy shares common structural elements. This is designed to support a coordinated effort and pinpoint common concerns. The shared structural elements are:

- guiding principles (Chapter 4 in each strategy)
- priority populations (Chapter 5)
- similar priority action areas (Chapter 6)
- issues around surveillance, research and work force development (later chapters).

1.3 HIV in Australia

Australia's HIV response is recognised globally as a success. National prevalence is lower than in most other comparable high-income countries. Australian gay communities, sex workers and people who inject drugs mobilised early and effectively to the emergent crisis, providing care and support and educating each other through peer education and community based organisations about safe sex and injecting practices. Government and healthcare professionals demonstrated strong leadership in their engagement with affected communities and the epidemic in its early days. This leadership produced a level of policy innovation that Australia continues to benefit from, for example, in the implementation of needle and syringe programs (NSPs) that prevented a large-scale HIV epidemic among people who inject drugs.

At the end of 2008 an estimated 17 444 people were living with HIV infection in Australia, of whom 995 were diagnosed during 2008.[1] During this period around two-thirds of new infections occurred between men who have sex with men (69% in 2008). While the HIV epidemic in Australia remains concentrated it is now resurgent among gay men with increasing

numbers of new infections. There are also clear indications of smaller but significant epidemics emerging among Australians travelling and working in high prevalence countries, among some culturally and linguistically diverse (CALD) communities and among injecting drug users in some Aboriginal and Torres Strait Islander communities. This indicates that the national response has entered a challenging period. Strong leadership on HIV from government at all levels is required, especially as public interest in engagement in the domestic epidemic has waned. The long-standing success of Australia's HIV response among injecting drug users and sex workers also needs to be maintained.

The national response has been adjusted over the last decade to recognise the dramatic advances in HIV treatment since 1996. However, there remains no cure or effective vaccine for HIV on the horizon. It is important to recognise this reality in focusing on the need to reinvigorate prevention and to reinvest in a long-term, comprehensive response to HIV. This sixth national HIV strategy takes immediate steps to:

- strengthen the HIV partnership
- reinvigorate prevention as a cornerstone of the national response
- emphasise monitoring and accountability
- address key workforce development needs
- provide a renewed focus on law reform to ensure an enabling human rights-based environment for the response.

It is essential that a partnership approach be reflected in all jurisdictional and non-government agency planning, implementation, monitoring and evaluation and that lessons learned are shared.

Australia has endorsed the United Nations (UN) General Assembly Declaration of Commitment on HIV (2001) and the UN Political Declaration on HIV (2006) including commitments to universal access to HIV prevention, care, support and treatment.

Partnership between people living with HIV, affected communities, the healthcare professions, researchers and government at all levels is at the core of the national HIV response. A guiding principle of this strategy is the meaningful participation of people living with HIV and affected communities in development, implementation, monitoring and evaluation of programs and policies. Their participation is essential because it ensures that policies and programs:

- are effective
- are informed by the experiences of those with HIV and affected communities
- are responsive to need
- take into account the full range of personal and community effects of policy directions.

2. Goal

The goal of the Sixth National HIV Strategy 2010–2013 is to reduce the transmission of and morbidity and mortality caused by HIV and to minimise the personal and social impact of HIV.

3. Objectives and indicators

This section details objectives and indicators for use in monitoring progress under the strategy. Indicators are measurable targets that apply to the related objective.

The primary indicators are those that have been agreed under the National Healthcare Agreement. These have been specified and will be regularly reported on during the life of the agreement. Additional indicators have been included for the more specific objectives relevant to this strategy. Further work will be undertaken during the implementation phase to develop a surveillance and monitoring plan. This will include further work on specifications for the indicators, and development of an agreed process for reporting on them. In some circumstances further data development may also be needed.

GOAL	OBJECTIVE	INDICATOR[1]
To reduce the transmission of and morbidity and mortality caused by HIV and to minimise the personal and social impact of HIV.	Reduce the incidence of HIV	Incidence of HIV infection (National Healthcare Agreement Indicator)
	Reduce the risk behaviours associated with the transmission of HIV	Proportion of men who have engaged in unprotected anal intercourse with casual male partners in the previous six months (National Healthcare Agreement Indicator) Proportion of people who inject drugs who re-used another person's used needle and syringe in the previous month

GOAL	OBJECTIVE	INDICATOR(1)
To reduce the transmission of and morbidity and mortality caused by HIV and to minimise the personal and social impact of HIV.	Increase the proportion of people living with HIV on treatments with undetectable viral load	Proportion of people receiving antiretroviral treatment for HIV infection whose viral load is less than 400 copies/ml
	Decrease the number of people with undiagnosed HIV infection	Proportion of cases of newly diagnosed HIV infection that are a late HIV diagnosis (defined as newly diagnosed HIV infection with a CD4+ cell count of <200 cells/µl)
	Improve the quality of life of people living with HIV	Proportion of people with HIV who report their general health status and their general wellbeing to be excellent or good

(1) In areas with available data

4. Guiding principles

The guiding principles informing this strategy are drawn from Australia's efforts over time to respond to the challenges, threats and impacts of HIV, STIs and hepatitis C. Strategies addressing each of these diseases, including as they relate to Aboriginal and Torres Strait Islander peoples, seek to minimise their transmission and impacts on individuals and communities and establish directions based on their unique epidemiology, natural history and public health imperatives.

The guiding principles underpinning Australia's response to hepatitis B, hepatitis C, HIV and STIs, are:

- The transmission of HIV, STIs and hepatitis C can be prevented by adopting and maintaining protective behaviours. Vaccination is the most effective means of preventing the transmission of hepatitis B. Vaccination, education and prevention programs, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures. Individuals and communities have a mutual responsibility to prevent themselves and others from becoming infected.
- The Ottawa Charter for Health Promotion[2] provides the framework for effective HIV, STI and viral hepatitis health promotion action and facilitates the:
  - ~ active participation of affected communities and individuals, including peer education and community ownership, to increase their influence over the determinants of their health
  - ~ formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights as this protects those who are vulnerable or marginalised, promotes confidence in the system and secures support for initiatives.

- Harm reduction principles underpin effective measures to prevent transmission of HIV and viral hepatitis, including through the needle and syringe programs (NSPs) and drug treatment programs.
- People with HIV, STIs and viral hepatitis have a right to participate in the community without experience of stigma or discrimination, and have the same rights to comprehensive and appropriate healthcare as do other members of the community (including the right to the confidential and sensitive handling of their personal and medical information).
- An effective partnership of governments, affected communities, researchers and health professionals is to be characterised by consultation, cooperative effort, respectful discussion and action to achieve this strategy's goal. This includes:
  - ~ non-partisan support for the pragmatic social policy measures needed to control HIV, STIs and viral hepatitis
  - ~ recognition that those living with, and at risk of, infection are experts in their own experience and are therefore best placed to inform efforts that address their own education and support needs
  - ~ timely and quality research and surveillance to provide the necessary evidence base for action
  - ~ a skilled and supported workforce
  - ~ leadership from the Australian Government, but also the full cooperative efforts of all members of the partnership struck to implement this strategy's agreed directions and early adoption of a framework for monitoring and evaluation.

5. Priority populations

Communities most affected by HIV are often best placed to respond to its impacts. The importance of continued cooperation and participation of those living with and affected by HIV in shared efforts to prevent further transmission and to provide quality treatment, care and support to those living with HIV is acknowledged.

The priority population groups identified in this strategy are:

- people living with HIV
- gay men and other men who have sex with men
- Aboriginal and Torres Strait Islander peoples
- people from (or who travel to) high prevalence countries
- sex workers
- people in custodial settings
- people who inject drugs.

These priority population groups are not mutually exclusive. Members of one priority population may also be members of another or a range of other priority populations.

5.1 People living with HIV

People living with HIV are a priority for all action areas of this strategy. Their needs and human rights are central concerns of this strategy, which recognises that people living with HIV are a diverse group.

5.2 Gay men and other men who have sex with men

As a group, gay men have a much higher risk of acquiring HIV than other Australians. The highest priority is to address the resurgence of HIV transmission among gay men in Australia. Resurgent epidemics have occurred in several states and territories since 2000. In 2004 to 2008, the most frequently reported route of HIV transmission among new HIV diagnoses was sexual contact between men in non-Indigenous populations (67%) and Indigenous populations (54%). These increases in HIV transmissions were not uniform across the country.

Other men who have sex with men, such as bisexually and homosexually active men who do not identify as being gay, are part of this strategy's priority population.

5.3 Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander populations have rates of HIV similar to the general population. Although around half of new infections in this population are in homosexual men, and almost a third of diagnoses are reported among women, the proportion of infections in people who inject drugs continues to increase. The potential remains for an acceleration of the epidemic among Aboriginal and Torres Strait Islander communities, especially given:

- the geographical, cultural and social circumstances of these communities, including the high mobility between them, lower health literacy, and issues such as shame and underlying poor health status
- sustained high prevalence of viral and bacterial STIs in many remote and very remote communities
- the over-representation of Aboriginal and Torres Strait Islander men and women in prisons and juvenile detention

- limited access to culturally appropriate services, including primary healthcare services for many communities
- higher rates of injecting drug use and sharing of injecting and other equipment.

5.4 People from (or who travel to) high prevalence countries

The spread of HIV among people who are from, or who travel to, countries where there is a high prevalence of HIV, has been identified as an emerging epidemic. A small but steadily growing percentage of new HIV diagnoses relate to heterosexual contact. Many people in this group are from CALD backgrounds. Due to the high and growing levels of HIV associated with unsafe injecting practices within many countries in South Asia and South East Asia, there is also a need to better understand mobility patterns among people who inject drugs who are from or who travel to countries of high HIV prevalence in the region.

Priority CALD communities for targeted HIV prevention can be identified in several ways, including by examining evidence on:

- country of birth data in HIV surveillance
- immigration data and trends
- how recently people have arrived in a community
- the immigration trends of a community
- consultations held with community organisations and multicultural health services.

Women from South East Asia, sub-Saharan Africa and other regions with high HIV prevalence have special needs.

5.5 Sex workers

Despite the occupational risks, the incidence of HIV in sex workers in Australia is among the lowest in the world. This is largely because of the establishment of safe-sex as a norm, the availability of safe-sex equipment, and community-driven health promotion and peer-based interventions. However, the potential for an increase in HIV in sex work populations remains. Continuing support of prevention initiatives are therefore required to minimise transmission of HIV.

Sex workers are a priority population because of their significantly higher number of sexual encounters than other community members leading to an increased potential for transmission of HIV if safe practices are not adopted. Other contributing factors are relative youth, discrimination, mobility and migration, and barriers to control over the occupational health and safety conditions of their work and to health service access. High priority subpopulations require specifically tailored and targeted interventions. This includes transgender sex workers, street based sex workers, Aboriginal and Torres Strait Islander sex workers, CALD sex workers, sex workers who inject drugs, and male sex workers.

5.6 People in custodial settings

Overall, HIV prevalence within the inmate population is low. However, the high turnover of inmates, the frequency of risk practices such as unsafe injecting drug use, unsafe tattooing, unprotected sex (including through sexual assault), and an over-representation of priority populations (including Aboriginal and Torres Strait Islander peoples and people who inject drugs) heighten the risk of exposure to HIV during incarceration. This is evidenced by national surveillance figures showing increases in the rates of HIV infection among new prison entrants over the past three to four years.[3] Impediments to best-practice prevention and standards of care include lack of access to the means of prevention, limited skills and capacity to maintain protective practices, higher levels of co-infection

with HIV and hepatitis C, and background population health issues. The over-representation of people with an intellectual disability or people who are functionally illiterate poses particular challenges for HIV prevention education in custodial settings.

People in custodial settings, including young people in detention, are a priority group under this strategy because of the risk of an increase in HIV among people in correctional facilities and the increased risk of transmission by inmates on their return to the community. The physical and mental health needs of young people in custodial settings should also be taken into account when considering education and service provision in custodial settings.

5.7 People who inject drugs

HIV prevention among people who inject drugs has been highly successful in Australia. This success has been underpinned by the early introduction and maintenance of NSPs and the contribution of peer-based education and drug-user organisations in HIV prevention.

Despite this early success, however, injecting drug users are still a priority population because rates of HIV among this group are sensitive to even small adjustments in the availability of injecting equipment.

6. Priority areas for action

6.1 HIV prevention targeting priority communities and populations

It is recognised that individuals have a responsibility to prevent themselves and others from acquiring HIV infection and to prevent further transmission, and Australia's targeted HIV prevention and health promotion response should be improved in relation to this. To respond to rises in infections, prevention will be revitalised as the cornerstone of the national response. Targeted prevention is cost effective, and is cost saving to the national economy. Investment in HIV prevention shows higher returns than other comparable health promotion programs, including tobacco control and prevention of heart disease. An economic model measuring the impact of investment in HIV prevention in New South Wales, for example, projected that at least 44 500 infections had been avoided in the state through HIV prevention programs and that for every dollar spent, $13 was saved.[4]

Prevention will focus on populations experiencing resurgent epidemics. It will also strengthen efforts focused on populations in which the epidemic has largely to date been prevented (particularly sex workers, people who inject drugs and people in custodial settings) and guard against emerging epidemics (particularly in Aboriginal and Torres Strait Islander peoples who inject drugs and people from priority CALD backgrounds). International evidence on concentrated epidemics concludes that effective HIV prevention must be focused on communities and populations most at risk and most affected by HIV rather than be spread evenly throughout the population.[5] Targeted resourcing of the prevention response is highly efficient and critical to the success of the national response, but may need increased support to reach highly marginalised populations. Poorly targeted investment and disinvestment in prevention have led to a resurgence of HIV in some jurisdictions.[6]

With young people, the focus will be on those most at risk of HIV who fall within the priority groups identified earlier in this strategy. Universal programs for youth in the general population will be implemented through the Second National Sexually Transmitted Infections Strategy 2010–2013.

New complexities also need to be addressed, including changing community perceptions about HIV, the impacts of new therapies, increasingly diverse and diffuse gay communities, a growing and ageing population of people living with HIV and challenges in reaching particular populations where emerging or re-emerging epidemics may be a problem. A continued strong focus on gay men will be coupled with recognition of increasing diversity in the populations most at risk of HIV. It is important to ensure that a comprehensive package for HIV prevention is delivered to those most at risk. This includes:

- providing information and equipment to support safe sex and safe injecting practices
- building individual skills around HIV risk reduction strategies
- ensuring community development, social change and peer-based health promotion
- tackling STIs that act as a cofactor in HIV transmission
- working with mainstream services to address the health factors that compound HIV vulnerability such as alcohol and other drug use, depression and other mental health issues among people living with HIV and priority populations
- paying attention to the social determinants of health that affect HIV prevention efforts, including social marginalisation, access to health promotion and health services, and law and policy frameworks
- reducing HIV-related stigma and discrimination.

New technological developments should be considered for their relevance and value to the Australian HIV response. Areas of current interest include:

- communication and biomedical technologies relevant to specific prevention and health promotion interventions
- prevention agents such as microbicides and vaccines.

Over the life of this strategy the expertise and analysis available across these fields will be monitored to ensure a coordinated, considered and evidence-based approach to potential implementation.

The following populations are priorities for prevention. These populations are not mutually exclusive.

6.1.1 Gay men and other men who have sex with men

An upgraded prevention program focusing on gay men and other men who have sex with men should be conducted to address rises in new infections. The program will reflect a partnership approach and be led by affected communities.

It should be acknowledged that some gay men are at higher risk than others and, therefore, HIV prevention programs should include programs targeted toward specific groups of gay men. These include sexually adventurous or highly sexually active gay men living in major cities and men in HIV sero-discordant relationships.

Consistent condom use is the most effective way to prevent HIV transmission and acquisition, and is particularly important with casual partners. Social research indicates that the majority of gay men consistently use condoms with casual partners. However there is also evidence that gay men's engagement in risk practices is influenced by a complex range of factors including circumstance, partner, salience of HIV as a health threat and epidemiological virological evidence. Targeted prevention messages should

therefore take these factors into account and incorporate information on the evidence base for risk reduction strategies to promote informed decisions.

The effectiveness of peer-based responses to HIV has been clearly demonstrated in gay communities.[7] The challenge is to promote risk reduction and safe behaviour among gay men and other men who have sex with men in the broader context of the changing nature of gay communities. Programs implemented will therefore respond to the cultural diversity of gay men including Aboriginal and Torres Strait Islander gay men, transgender people, sistergirls, gay men from CALD backgrounds, male sex workers and men with cognitive, intellectual or psychiatric disability.

6.1.2 People living with HIV

Programs that support and affirm HIV-positive people as partners in HIV health promotion and prevention strategies are critical. HIV prevention interventions will focus on preventing transmission, as well as the health and prevention needs of HIV-positive individuals. Preventing transmission is a shared responsibility of all individuals, irrespective of HIV status. Sexual and reproductive rights, regardless of HIV status, must be recognised. Further analysis of the role of treatment in preventing transmission and close monitoring and evaluation of new perspectives on early anti-retroviral therapy as an element of prevention should be undertaken.

6.1.3 Aboriginal and Torres Strait Islander peoples

Some Aboriginal and Torres Strait Islander communities have very high rates of STIs, which amplify the likelihood of HIV transmission. There is potential for a rapid-spreading epidemic initiated by injecting and sustained by high rates of STIs as has occurred overseas among Indigenous peoples and injecting drug users.[8,9,10] The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013 places a high priority on harm reduction interventions to reduce

HIV and hepatitis C transmission associated with unsafe injecting drug use practices. Ensuring that a wide range of strategies to distribute sterile injecting equipment, including through NSPs, are available in Aboriginal and Torres Strait Islander communities is a priority. Bacterial STIs will be addressed through detection and treatment. This HIV strategy will complement those efforts. Both strategies seek to address the high levels of stigma associated with HIV and STIs, particularly in remote communities, which leads to fears of disclosure and heightened secrecy. Both strategies also seek to protect Aboriginal and Torres Strait Islander women from HIV.

Health promotion and harm reduction services can be difficult for Aboriginal and Torres Strait Islander populations to access. Strategies will be put in place to provide services that are accessible, culturally appropriate and which better meet their health needs. This includes support for retaining an appropriately trained clinical, prevention and health promotion workforce. Cultural awareness and sensitivity to Aboriginal and Torres Strait Islander practices and beliefs are required. So too is capacity development in sexual health promotion, community development, peer education, clinical care and research.

Cross-border issues with Papua New Guinea are a significant concern affecting Torres Strait Island communities. This issue has received increasing attention since 2007 and is addressed in the Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013. This HIV strategy acknowledges the heightened risk of HIV, STI and tuberculosis transmission associated with the movement and interaction of people between Australia and the Western Province of Papua New Guinea, and the importance of continued efforts to address the increased burden on health services and the need for improved coordination of public health programs.

6.1.4 *People who travel and priority culturally and linguistically diverse populations*

Australian residents who acquire HIV while travelling and working in countries or regions with high HIV prevalence are a diverse group that includes people holidaying, working overseas or visiting friends and relatives. This group also includes gay men and other men who have sex with men, people who inject drugs, sex workers who work while travelling, heterosexual travellers, expatriates and Australians from high prevalence countries returning to their country of origin for visits. More research on this priority population is required, to inform tailored health promotion interventions targeting specific groups travelling to particular countries.

There is also a need to target programs to travel-related prevention and to work with migrant and expatriate communities within Australia—including Papua New Guinea communities in far north Queensland—and people working and studying here and overseas. Opportunities also exist for collaboration between domestic and regional organisations working in the HIV area, as well as across portfolios with migrant and settlement services and through the Australian Agency for International Development and other development partners.

6.1.5 *People who inject drugs*

Ensuring a supportive and enabling environment to both maintain and expand access to harm reduction and peer-based services and programs will help prevent further increases in HIV infection rates among people who inject drugs. The identification, monitoring and resolution of problems in relation to the quality, coverage and accessibility of NSPs are therefore supported.

The need to improve access to primary heath care and to reduce the level of discrimination experienced by people who inject drugs as a result of stigma within the healthcare system is a priority. It is important to provide additional support for people who inject drugs who may have difficulty

adhering to complex HIV treatment regimens. These issues will be addressed through community education, training programs for healthcare workers and the development of supportive systems at local levels.

Workforce development will be supported to ensure that NSPs meet the needs of the diverse population groups requiring access to services.

6.1.6 People in custodial settings

In the correctional environment, there are often impediments to best practice BBV prevention. These problems are exacerbated by higher levels of co-infection with HIV and hepatitis C in this population. Effective HIV and other BBV prevention and health promotion requires a whole-of-government approach enlisting those concerned with juvenile detention centres as well as adult prisons.

Each state and territory has its own independent systems for police, courts, prisons and juvenile institutions. Health services are provided variously by health or justice jurisdictions and supplied directly, or contracted, by public and private custodial facilities. Australia's prison systems are relatively small and isolated from each other. This presents challenges for coordinating research and policy development, implementation, evaluation and education. However, these challenges have been overcome within the custodial environment to enable effective responses to a number of key public health issues including BBV and STI initiatives such as provision of condoms, access to bleach, provision of opioid pharmacotherapies, and the National Prison Entrants BBV & Risk Behaviour Survey.

Providing sterile injecting equipment in Australian prisons is controversial in some parts of the community, even though an increasing number of international jurisdictions have implemented this approach, or are actively contemplating doing so. To date there is no evidence of adverse outcomes associated with providing an NSP. A number of positive or beneficial outcomes have emerged from evaluated programs including: no documented increase in illicit or injecting drug use; significant reductions

in equipment reusing and sharing; no documented attacks or violence in prisons; no documented seroconversion for HIV or hepatitis; and acceptance by staff and prisoners. In view of the well documented return on investment and the effectiveness of Australian community-based NSPs, it is appropriate throughout the life of this strategy for state and territory governments to identify opportunities for trialling this approach in Australian custodial settings. This is also supported by the international evidence demonstrating the effectiveness of prison NSPs.

In addition, it is essential that the full range of BBV and STI prevention strategies be maintained in Australian custodial settings, including:

- increasing the provision of, and access to, bleach and disinfectants where no safer alternatives are provided for decontaminating spills, surfaces or equipment
- easily accessible education and counselling—including peer education and support on HIV and STIs, hepatitis B, hepatitis C and injecting drug use—as a fundamental health promotion technique to support risk reduction practices
- increasing access to drug treatment programs, including opioid pharmacotherapy programs which have reduced BBV transmission in custodial settings, as well as detoxification and drug rehabilitation programs.

Strategies should also be explored for developing and promoting Australian infection control standards for tattooing and body art to further reduce the risk of BBV transmission in custodial settings.

6.1.7 Sex workers

Ensuring sex workers are equipped to maintain safe sex practices, while adapting to a changing industry, requires complex education and community development approaches by sex worker organisations within the context of occupational health and safety in the sex industry. Support

for community-based sex worker organisations to provide peer education and outreach—particularly to those who work individually and to migrant and CALD sex workers—should continue to be provided. Innovative access, education and community development approaches are required to engage with this diverse and highly transient community, which includes males (gay-identified and otherwise), people from CALD backgrounds, people who inject drugs, Aboriginal and Torres Strait Islander peoples and street-based workers.

Implementation of Australia's National Training Project has provided important national support for and development opportunities to sex worker peer educators to extend and receive accreditation for their skills. Attention will continue to be given to the professional development needs of the sex work organisation workforce.

Priority actions in HIV prevention

- Use the expertise of community sector agencies within the partnership to develop and implement an expanded and comprehensive national program aimed at:
  - ~ reversing the resurgent epidemic among gay men through the use of national media, new communication technologies and other relevant approaches
  - ~ maintaining low rates of HIV among priority groups (sex workers and drug users) through the implementation of peer education and community led health promotion.
- Continue to invest in and monitor prevention programs for priority risk populations.
- Monitor research developments to inform policy and program development on new prevention technologies before introducing them to local populations.

- Continue with the professional development of the HIV prevention and health promotion workforce, including by investing in a new generation of peer education and prevention workers.
- Invest in evaluation and evidence-building approaches to support evidence-based and innovative policy and program decisions.

6.2 HIV diagnosis and testing

While Australia maintains a high level of testing for HIV continuing patterns of late diagnosis suggest there is still room for improvement. The principles of informed consent and confidentiality underpin high rates of voluntary testing, and these principles remain central to managing the epidemic nationwide. A coordinated, accessible and affordable HIV testing system allows for:

- access to treatment for those diagnosed with HIV to optimise therapeutic effects
- minimised sexual transmission through partner notification
- protection of the blood supply and of organ and tissue donation
- the prevention of transmission from a mother with HIV infection to foetus and newborn
- mapping the epidemic to aid the development of evidence-based public health interventions.

Priority will be given to assessing approaches to the implementation of rapid HIV testing for use in communities that have high HIV prevalence, drawing on evidence from comparable countries where rapid testing has been successfully introduced. While rapid techniques may present opportunities for better uptake of testing, they must meet Australia's established quality standards.

Improving access to, and the uptake of, testing is important to reduce late diagnosis of HIV. Targeted campaigns to promote HIV testing on its own, and in the context of the STI testing, is important. Emerging data suggests that newly diagnosed gay men have low rates of testing in the 12 months before infection and there is recognition that some gay men are reducing the frequency of testing due to inconvenience and lack of perceived benefit.

The National HIV Testing Policy recommends routine offering of HIV testing to pregnant women. The risk of transmission is now dramatically being reduced through control of HIV in the mother. As a result, the prevalence of HIV infection in the antenatal population remains very low.

Approximately a quarter of people living with HIV are diagnosed by a general practitioner (GP) who has not previously diagnosed HIV. This indicates the need for support for these general practitioners, linked to the testing process with attention to the need to facilitate shared care with experienced clinicians.[11]

Priority actions in HIV testing

- Increase the number of people in priority populations who voluntarily seek HIV testing and increase the rate of testing among people at higher risk of exposure to HIV infection to decrease the burden of undiagnosed HIV in the community.
- Promote HIV testing among gay men, including gay men from CALD backgrounds and other priority populations through targeted campaigns.

6.3 Treatment, health and wellbeing

There is increasing diversity among people living with HIV, with a growing population of newly diagnosed people whose health is relatively good,

alongside an ageing cohort of people who are living long term with HIV. The HIV-positive population in Australia is made up of a large proportion of people living with manageable HIV disease. Across the population are others facing a range of clinical complexities in their health management. Clinical management of HIV is now also focused on monitoring and treating other co-morbidities— both associated with HIV and other conditions occurring as the population is ageing.

An approach that is holistic and addresses prevention of illness and the maintenance of health and wellbeing is supported. Services should respond to the needs of people living with HIV in the mainstream health sectors and in the HIV-specific healthcare, services and peer support sector, including those delivered in community settings. This approach will contribute to an evidence building response to guide where HIV treatment and care is shared across sectors.

People living with HIV continue to face complex challenges to their health and wellbeing. The complexities of clinical disease for some HIV-positive people can involve drug toxicities, psychiatric illness, drug interactions and drug and alcohol dependency issues. In many communities, people living with HIV report social isolation and discrimination. They can face barriers to social participation and may experience difficulty in accessing healthcare and welfare services, housing, insurance, employment and education. People with HIV may also experience significant challenges in forming and maintaining relationships due to issues of disclosure, stigma and discrimination as well as inaccurate perceptions of health and wellbeing.

Managing HIV requires continuous medication with life-long therapy and high levels of clinical monitoring, which can be a substantial cost and time burden. Difficulties exist in providing support to adhere to treatment combinations. These can be related to access and disclosure issues, particularly in rural and remote communities where disclosure is a concern. Everyone in Australia should have access to high-quality HIV healthcare and appropriate treatments should they need it.

Health promotion activities will also respond to the specific needs of older gay men living with HIV, women with HIV, heterosexual people with HIV, Aboriginal and Torres Strait Islander communities, people who inject drugs and people from CALD communities.

6.3.1 Emerging issues

Ageing of the overall population of people living with HIV is giving rise to new challenges. Effects of ageing can be accelerated by HIV and the diseases of ageing can be made more complex by HIV treatments. Many who leave the workforce experience problems associated with living on a fixed retirement or pension income combined with the added costs of chronic illness.

People who have been living with HIV for a long time have different needs to those newly diagnosed, especially regarding management of therapies. Changes in the morbidity profile of HIV require a focus on the aged care system and on mental health and wellbeing. Serious non-acquired immunodeficiency syndrome morbidities (e.g. cardiovascular and renal disease, cancers) occur at increased rates in people living with HIV and cause an increasing proportion of morbidity and mortality. Co-morbidities demand adjustments to HIV clinical services and research.

Avenues for improving access for people living with HIV and determining the best practice models for service delivery across HIV specific and mainstream long-term support services, including aged care services require consideration and should be progressed in consultation with people living with HIV, through advocacy and workforce development initiatives in partnership with the relevant commonwealth, state and territory departments.

A range of health conditions can be prevented, their onset delayed and their management improved through early preventative and curative healthcare services delivered long-term in the community. It is important that people living with HIV be encouraged to participate in preventative

health promotion programs focusing on improved diet and nutrition, regular exercise, smoking cessation, reduced alcohol and other drug intake, and regular monitoring and screening. A positive health promotion and awareness framework conducted by mainstream organisations should be complemented and reinforced by targeted efforts offered by HIV community-based organisations.

Health promotion programs should encompass: treatment (including national guidelines on the prevention and treatment of co-infections and co-morbidities); side effect management; health maintenance including sexual health, effective STI testing and treatment; smoking cessation; reducing cardiac risk factors; vaccination for hepatitis B; education in relation to hepatitis C prevention, particularly for HIV-positive gay men and people who inject or have injected drugs; chronic disease self-management and strategies to address depression and anxiety; peer support; social connectedness; and workplace policies and occupational programming to support people living with HIV to remain in or re-enter the workforce.

While the number of children with HIV infection in Australia is small[12], the provision of adequate specialist paediatric services is important. Adolescents who have grown up living with HIV have specific care and support needs.

6.3.2 Treatment advances

With mortality declining and infections increasing, the number of people living with HIV in Australia will continue to grow. Improving the health of those living with the disease requires increasing the effectiveness of new treatments, improved targeting of treatments and increased availability of clinical information.

It is vital that people on HIV treatments maintain a high degree of adherence to their treatments. Social and clinical initiatives and measures to improve and retain adherence to treatment regimes will be developed, while ensuring continued prompt access to new treatments

through Australia's Highly Specialised Drugs Program, particularly for people experiencing treatment failure and longer-term toxicity impacts. New tools developed for better management of antiretroviral therapy, including genotypic tests to identify resistance to antiretroviral treatments and therapeutic drug monitoring, have the capacity to improve clinical outcomes for people with HIV and ensure that highly potent antiretroviral therapies are used in the most targeted and cost-effective ways.

6.3.3 Models of care

While increasing numbers of HIV-positive people are living longer and changes have occurred in the duration and type of care they require, both HIV specialised and generalist general practitioners continue to play a wide role in care, with the majority of people living with HIV seeing a Section100 GP for their HIV care. Increasingly, HIV can be managed as a chronic disease using a team-based interdisciplinary approach, including general practitioners, specialists, nurses, Aboriginal Health Workers, pharmacists and other primary care providers.

Models of care review and analysis should be further developed to address increased access to testing, shared care provision, and the needs of the ageing population of people living with HIV. This work will also focus on describing ways to avoid system barriers to care and loss of follow-up in specific populations.

A range of models will ensure that all people living with HIV have equitable access to primary care services with general HIV awareness combined with, or in addition to, specialist HIV general practice and tertiary care. Models will be promoted that address the need for patient-centred, coordinated and integrated care; self-management; continuum of care; and effective management of the acute—chronic interface with electronic records and other clinical management initiatives.

During the life of this strategy, implementation of the recommendations of the Models of Access and Clinical Service Delivery for HIV Positive People

Living in Australia should be considered a priority. It will also be important to identify links between this strategy and other health reform initiatives that can support the development of an integrated approach to HIV specialised care in parallel with chronic illness management approaches.

Exploration of dispensing options to make access to Section100 medications in the context of long-term care more optimal and efficient is increasingly important, and is being considered within a broader context through a separate Australian Government Department of Health and Ageing review.

Measures will include:

- supporting HIV-diagnosing GPs, linked to the testing process
- supporting mainstream services (particularly mental health, ageing, oral health and drug and alcohol services) to provide quality services to people living with HIV, particularly in partnership with HIV service agencies and primary healthcare teams
- addressing national counselling guidelines and standards of care for HIV positive women and their children, for use by GPs and specialists—including supporting appropriate choices regarding fertility, family planning and antiretroviral therapy during pregnancy and birth.

6.3.4 Aboriginal and Torres Strait Islander people

The strategy will ensure attention to the treatment, health and wellbeing needs of Indigenous people living with HIV, consistent with Australian Government commitments to closing the gaps in health outcomes and life expectancy between Aboriginal and Torres Strait Islander peoples and other Australians. Measures will include:

- development of culturally effective health promotion programs
- a focus on addressing stigma and social isolation, that responds to

the different support needs of Aboriginal and Torres Strait Islander people living in rural and remote communities or in urban settings

- HIV-positive peer support
- recognition of the importance of Aboriginal and Torres Strait Islander input and the role of community-based organisations in delivering support services and in advocating for improved HIV health services appropriate to Aboriginal and Torres Strait Islander communities.

6.3.5 Women

In general, there are lower rates of HIV infection among Australian women than men. This has resulted in lower levels of awareness among many women and healthcare professionals about potential risks for HIV transmission. Women are more likely to be diagnosed with HIV later in the course of infection. As a consequence, women who have partners from high prevalence countries may be at an increased risk of HIV transmission, and they are not always in a position to negotiate safer sex, or access education about testing and treatments.

HIV-positive women and children have specific care and support needs. Psychosocial issues and medical complications are important factors to quality of life for children. Access to appropriate services for women is a priority under this strategy. Aboriginal and Torres Strait Islander women, and women from priority CALD communities (such as from sub-Saharan Africa and South East Asia) have specific needs. Challenges that will also be addressed under this strategy include:

- decreasing the isolation experienced by HIV-positive women
- promoting opportunities for peer support
- increasing the visibility of HIV-positive women
- encouraging women who have HIV to be involved in developing and delivering HIV services, educational interventions and policy.

The availability of antiretroviral therapy has meant that many HIV-positive women can and do choose to have children. However, the treatment needs of HIV-positive women who are pregnant or considering pregnancy are complex, and all of them should be supported in making decisions on appropriate counselling, treatment and support in the ante, intra and post partum periods. It is essential that this support be provided in a timely manner, particularly when women are diagnosed during pregnancy.

6.3.6 People with HIV and hepatitis B and/or C co-infection

It is estimated that about 11% of HIV-positive people also have hepatitis C infection, 6% hepatitis B infection and 1% both hepatitis B and C infections. This group of people has poor health outcomes, when compared with people with HIV infection only. Co-infection with HIV and hepatitis B significantly increases mortality.

There is also strong evidence that controlling hepatitis C infection is an important factor in obtaining better clinical outcomes for people with HIV co-infection. The importance of ensuring that all people with HIV and hepatitis B and C co-infection have priority access to best practice treatment, as supported by current research, is recognised.

These people often face stigma and experience discrimination when accessing treatment and other health and social services and require targeted peer support. Communication between health and social service agencies will be essential to ensure that people do not fall through the cracks. This concern will need to be addressed in prevention as well as care and support areas during the implementation planning phase.

6.3.7 People living with HIV with high support needs

Some HIV-positive people may have high support needs that are ongoing, or occur over a short period. Situations that may lead to intensified support include:

- a new HIV diagnosis[13]
- a diagnosis of AIDS or serious HIV-related illness[14]
- persistent failure of antiretroviral therapy to suppress HIV or development of resistance to treatment[15,16]
- the development of major side effects such as peripheral neuropathy and body shape changes[17,18]
- diagnosis of a second, major illness such as advanced hepatitis C infection or a bleeding disorder[19,20,21,22]
- alcohol and other drug dependency issues (particularly with reference to a mental health co-morbidity)[23]
- HIV-related serious non-AIDS morbidities such as cardiovascular or renal disease or cancer[24,25]
- psychiatric, cognitive or intellectual disability that may or may not relate to HIV infection[26]
- social determinant issues such as homelessness and poverty.[27]

People who have high support needs are at greatest risk of disease progression and also, possibly, of onward transmission. Some are also at risk of being lost in follow up. Specialised and better coordinated services are needed to respond to their needs. Health and HIV agencies need to work closely in a team-based approach with alcohol and other drugs services as well as mental health and housing services to provide case management with a team-based approach linked to primary healthcare services that meet welfare and rehabilitation needs.

Complex needs require a comprehensive response from a range of service providers. In many cases, the most appropriate sector to provide case management is the HIV sector. People with complex needs may lack basic survival skills, for example, or be particularly susceptible to social isolation and not inclined to access health promotion or other services.

The appropriate management of people with HIV-related cognitive illness remains a particular challenge. While people with cognitive illness have priority care and support needs, community agencies often cannot provide the intensive levels of care required or the specialised, supported accommodation that is often necessary.

Priority actions in treatment, health and wellbeing

- Improving models of care by adapting chronic disease models to the HIV context and by promoting of implementation of the recommendations of the Final Report of the project Models of Access and Clinical Service Delivery for HIV Positive People Living in Australia, including through the reorientation of some existing services.
- As part of broader programs to reduce HIV related stigma and discrimination, integrating programs to build resilience and coping strategies for people living with HIV.
- Continuing investigation of new laboratory technologies with benefits for individual patients and/or applications that improve broader population surveillance and data collection.
- Ensuring health technology assessments that allow for the best utilisation of drugs to patient populations as well as diagnostic and screening tools for best practice in clinical management will be considered for their relevance to the Australian HIV response.
- Defining the social and economic cost-burden of care and support on HIV-positive people.
- Investigating the changing needs of a significant population of people living with HIV, on treatments, living longer and ageing with HIV.

6.4 Human rights, legislation and anti-discrimination

Taking a human rights approach to HIV means creating a supportive social and legal environment where rights are respected and protected and the equitable right to health is fulfilled. A commitment by governments to human rights is particularly important in seeking to establish the cooperation and trust of communities that are marginalised and disadvantaged and that may be subject to legal sanction. Australia's approach to HIV/AIDS has demonstrated the protection of human rights to be both compatible with and essential to the effective protection of public health.

Australia was a leader in the development of the 1996 International Guidelines on HIV/AIDS and Human Rights (consolidated in 2006). These were based in part on the recommendations for reform in the 1992 Final Report of the Legal Working Party on AIDS, which identified a range of legislative and regulatory measures that both supported or impeded HIV programs.

Areas for consideration include anti-discrimination laws; the application of criminal and public health law to HIV transmission and/or exposure offences[28]; the impact of drug control laws on efforts to prevent HIV; sex work law; and immigration law.

The effectiveness of the public health approach to HIV and implementation of the National Guidelines for the Management of People with HIV who place others at risk of infection will be monitored.

Also, consideration will be given to the impact of drug control laws on HIV prevention efforts, and opportunities to further harmonise these laws and policies with public health priorities.

In relation to sex workers, some data suggest that under a decriminalised and deregulated legislative framework sex workers would have increased control over their work and be able to achieve similar or better health outcomes without the expense and invasiveness of mandatory

screening.[29,30] The priority is to ensure that legislation, police practices and models of regulatory oversight support health promotion, so sex workers can implement safer sex practices and the industry can provide a more supportive environment for HIV prevention and health promotion.

Priority actions in human rights and anti-discrimination

- Identify and work to address the legal barriers to evidence-based prevention strategies across jurisdictions.
- Promote programs to challenge stigma and discrimination including education, compliance and measurement (such as attitude surveys), support for advocacy, and improved access to effective complaint systems.
- Closely monitor the implementation of the National Guidelines for the Management of People with HIV Who Place Others at Risk.

7. Surveillance

The objectives of HIV surveillance in Australia are to monitor the extent and characteristics of HIV infection to assist with planning public health strategies and informing governments and communities about:

- trends in HIV transmission and the profile of the epidemic
- behavioural, geographical and demographic factors associated with HIV transmission
- the numbers and demographic characteristics of people living with HIV
- morbidity and mortality due to HIV infection.

HIV surveillance provides information on the extent and characteristics of new diagnoses of infection. Greater attention is required in the analysis of surveillance data to assist in the planning and implementation of population-based health promotion programs and to plan for change in service delivery.

Work in this area will be undertaken with input from, and in collaboration with, the Australian Government together with state and territory health authorities, the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections, the National Centres in HIV research, and other research and community organisations in the sector. The National Centre in HIV Epidemiology and Clinical Research and the Communicable Diseases Network of Australia have a key role in national analyses and evaluation of surveillance data and public health programs under this strategy. Some jurisdictions do not have active surveillance systems that can provide good information about the dynamics of the spread of HIV. All jurisdictions are encouraged to carry out active surveillance of HIV diagnoses to inform policy and program planning and an understanding of the dynamics of the spread of the disease.

Over the life of this strategy the national HIV surveillance framework will be comprehensively reviewed to ensure that epidemic trends and population priorities are being consistently and appropriately measured and reported on at national and state and territory levels. Attention will be given to the unique epidemiology of HIV in each jurisdiction. The review will also consider the best evidence base for the mechanisms being used in the Australian context, how they are considered across the whole public health partnership approach, and legal or ethical implications requiring assessment. This will include surveillance of diagnoses and behaviours in emerging at-risk populations and improved approaches to measuring testing rates in priority populations.

Enhancing surveillance capacity to improve measures of HIV transmission, HIV sub-types, and patterns of treatments used and resistance across populations will be considered, including improving the efficiency and effectiveness of data transfer and retrieval, and database linkages and access.

Behavioural surveillance—including unsafe injecting and sexual behaviour such as unprotected anal intercourse—must be maintained to provide information on trends in risk behaviours. Refinements to behavioural surveillance are enouraged, including considering incorporation of blood tests in periodic surveys. Improved approaches to measuring testing rates among priority populations should be supported. Protocols should be established for wider availability of behavioural surveillance data, including a public access data set.

The ongoing development of national surveillance programs need to be linked to the expert advice provided through monitoring and evaluating innovation and advances in scientific and health technology areas.

Extended evaluation and secondary analyses of surveillance data are recommended, including elucidation of how behavioural trends influence epidemic trends. Mathematical modelling is one approach to be used for this and for estimating incidence and prevalence levels for BBVs and STIs.

Priority actions in surveillance

- HIV surveillance will be reviewed to ensure data is being collected which best informs targeted prevention with priority populations—including nationally consistent data on Indigenous status and ethnicity, data relating to sex workers, transgender persons, sexuality, injection drug use and location where transmission has occurred.
- New technologies will be assessed that help identify the proportion of HIV diagnoses that are newly acquired.
- Refinements to behavioural surveillance of unprotected anal intercourse will be supported to help determine trends in high risk behaviours.
- Improved approaches to measuring testing rates among priority populations will be supported.

8. Research

The implementation of this strategy requires comprehensive and efficient data collection of epidemiological, behavioural and social changes over time among the most at-risk populations to provide evidence for program development and adjustment.

Research plays a critical role in providing much of the strong evidence base needed to inform policy and to design, monitor and evaluate programs at all levels. It is therefore important that research remains focused on strategic priorities. Social research will also continue to inform health promotion, treatment, care and support.

Collaborative support for research will be based on the following principles:

- commitment to delivering strategic research through the infrastructure of the national centres in HIV research
- encouragement of enhanced collaboration between the national centres in HIV research and other relevant research institutions, to increase the dissemination of information between research areas
- requirement for more effective research practices and reduced duplication
- the requirement to build research capacity across jurisdictions to maximise the return on research investment
- the need for a competitive environment that encourages innovative ideas and research methodologies for the funding of investigator-initiated research.

The Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmitted Infections will develop mechanisms to promote these types of collaborative ventures. Consultation with stakeholders will inform research priorities. The Australian Government is committed to ensuring that the

strategic research conducted by national research centres remains relevant and addresses current needs and priorities. The partners to this strategy value research that occurs in partnership with community based organisations. A process to establish research priorities will be established by a consultative process in the following areas:

- social, behavioural and epidemiological research in prevention, diagnosis, treatment, care and support, including into effectiveness of interventions and drivers of the increasing rates of new infections
- clinical research on treatment and care
- program evaluation research
- cost-effectiveness studies to assess value for money to government and the community of HIV programs.

Priority actions in research

- Investigate the utility of rapid HIV testing for use in clinical and community settings in areas of high HIV prevalence, informed by experiences in comparable countries.
- Evaluate and further develop effective peer education and peer support programs for people living with HIV as their needs and experiences change.
- Establish more structured and formal consultative mechanisms to set the agenda for social, behavioural, evaluative, epidemiological, clinical and basic research.
- Create opportunities for increased interaction between and collaboration with researchers, participants in research and the users of research.

9. Workforce development

The importance of ensuring that the healthcare workforce involved in HIV is sustainable and supported to provide long-term care under nationally endorsed best practice models is recognised. Workforce issues also include addressing the fluctuating distribution of Section 100 prescribers (GP based and specialist) and their patient caseloads, the recruitment and retention difficulties for Section100 GP prescribers and clinicians with an interest in HIV, and the importance of ongoing training, support and financial resources for medical, nursing and certain allied health professionals. Professional development should address multidisciplinary team roles and effective case management. Training and skills development for staff of health and community services will improve service accessibility for Indigenous and CALD populations.

Investment or the reorientation of spending is required to build workforce capacity in ambulatory care, shared care and primary healthcare for the ageing population of people living with HIV. This includes in the non-government, community and voluntary sector. Training requirements of healthcare workers and other service providers will respond to the need to mainstream some services for people with HIV, the decline in skills for recognising, diagnosing and treating HIV within some health services, and the need to reduce discriminatory practices. Policy, service protocols and training will reinforce the need to adhere to privacy principles in electronic sharing of health and other client information.

The need to maintain HIV specialist treatment, care and support services in hospitals, sexual health services and high-case load general practice as well as mainstream services to make them more accessible and appropriate for people living with HIV is supported. Improved access to mainstream health services is important, as is maintaining designated HIV services and encouraging mainstream healthcare service providers to consider the specialist needs of people living with HIV. A small number of people with HIV are likely to present complex challenges for on-the-ground service providers.

The role of the community sector, including paid and unpaid workers in education prevention, support and advocacy, has served the Australian community well. Ongoing support of this sector is therefore essential to the strength of the partnership.

It is also important to ensure that HIV awareness and education to address stigma and discrimination is included in training programs for staff in all mainstream service agencies. It is also important that training of mental healthcare workers includes building awareness of the interactions between HIV and psychiatric medications, and understanding of the nature of HIV illnesses.

Priority actions in workforce development

- Strengthen training programs and continuing medical education in HIV for GPs, recognising the differing needs of GPs with low and high HIV caseloads.
- Facilitate the development of a primary healthcare team-based approach in collaboration with specialised services.
- Ensure high quality knowledge and skills in relation to HIV in government and non-government health and community services.
- Improve collaboration between mental health, clinical and welfare services to address the care and support needs of people living with HIV who have cognitive illness and drug and alcohol dependency issues
- Strengthen community agencies in the provision of education, prevention support and advocacy services to affected and infected communities.

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