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## Submission on the next Victorian HIV Strategy

We cannot afford to lose hard-won gains against HIV

21 October 2020

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### Thorne Harbour Health

Thorne Harbour Health is one of Australia's largest community-controlled health service providers for people living with HIV, and the lesbian, gay, bisexual, trans and gender diverse, and intersex (LGBTI) communities. Thorne Harbour Health primarily services Victoria and South Australia, but also leads national projects. Thorne Harbour Health works to protect and promote the health and human rights of LGBTI people and all people living with HIV.

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# 1. Introduction

Thorne Harbour Health welcomes the opportunity to contribute to the next Victorian HIV Strategy. Now is a critical juncture in the HIV response, and we cannot afford to lose decades of hard-won gains. It is essential that current levels of investment in Victoria's HIV response not just be maintained, but increased.

No action plan accompanied the current *Victorian HIV Strategy 2017-2020*. Ensuring that an action plan accompanies the next strategy will be fundamental to the effective implementation of actions intended to help Victoria end stigma and discrimination associated with HIV and meet the 95-95-95 targets, that is, 95% of all people living with HIV knowing their status, being on treatment, and having an undetectable viral load.

The HIV targets are a cascade, with undetectable viral load dependent on treatment, and treatment dependent on diagnosis. Victoria does exceptionally well at treatment retention and care; however, Victoria must do better at identifying people living with HIV who are not aware of their status. This is especially pressing for those from migrant and culturally and linguistically diverse communities who are less likely to get tested. Key to this will be boosting testing capacity and reducing barriers to testing, which can be achieved through mobile testing, targeted health promotion and peer navigation workers to increase service use.

## 2. Summary of recommendations

### Priority outcomes

1. Bring forward the 95-95-95 targets to 2025 and set 99-99-99 targets for 2030.
2. Add a priority outcome relating to quality of life for people living with HIV.

### New opportunities

3. Review clinical guidelines to increase the rates of HIV testing for perceived low-risk patients that present with a potentially HIV-related illness.

### Reducing stigma and discrimination

4. Expand and increase awareness of undetectable viral load among key affected populations with a Victorian health promotion campaign.
5. Fund research for a comprehensive intervention that seeks to reduce stigma.
6. Promote awareness of the experiences of stigma and discrimination by people living with HIV with disability.
7. Fund research into the experiences of stigma and discrimination by people living with HIV with disability.

### Reducing HIV transmission

8. Remove barriers to equitable PrEP access so that all Victorian residents, temporary visa holders, and those ineligible for Medicare who are at high risk of HIV can access PrEP, and the Victorian Government's goal of eliminating HIV can be achieved.
9. Do not implement real-time HIV surveillance without engaging Victoria's HIV sector and meaningfully involving people living with HIV in the design and governing principles for how such a program would be implemented.
10. Invest in general practitioner and nurse practitioner education about PrEP and PEP.

### Improving access to HIV testing

11. Boost the capacity of community-controlled LGBTI sexual health / HIV testing services.
12. Boost outreach testing for priority populations, including gay and bisexual men and trans and gender diverse people, by investing in a mobile testing service. For example, a van for Victoria's community-controlled LGBTI sexual health / HIV testing service, PRONTO!.
13. Fund peer support and navigation workers to deliver peer-driven health promotion to at-risk communities and connect people with services.

14. Fund an online peer education campaign designed to increase uptake of home testing for HIV.
15. Have regular and up-to-date detailed reports reflecting the HIV notification data that are stratified by useful demographics upon which responsive health promotion campaigns and targeted activities can be implemented.

### **Improving access to HIV treatment**

16. Increase funding for home care services to keep people living with HIV living independently in the community for as long as possible.
17. Support positive self-management programs to build the capacity of people living with HIV to enhance their knowledge and skills to manage their HIV, general health and other challenges such as depression, loneliness, isolation and stigma.
18. Continue funding housing support for people living with HIV who need it.
19. Promote assistive technology so that people living with HIV in rural and regional areas can connect to online social and health supports, such as peer groups and telehealth appointments.
20. Promote innovative health care models for people living with HIV that streamline health care and improve patient outcomes, such as receiving medication by post, attending some appointments via telehealth, or visiting a GP in person with a specialist engaged through telehealth.
21. Subsidise co-payments for HIV treatments to improve treatment uptake and retention, and enable Victoria to meet and maintain the Victorian HIV Strategy cascade target for treatment uptake.
22. Invest in roles that create employment pathways for nurse practitioners.
23. Encourage the use of nurse practitioners in services by prioritising funding to services investing in the development of, and working with, this under-utilised workforce.

### **Research to improve the HIV response**

24. Research service access barriers in culturally and linguistically diverse and migrant communities, including the intersection with LGBTI communities.

### **Investing in the HIV response**

25. Increase investment in Victoria's HIV response. In particular, significant investment is required to boost testing capacity, including mobile outreach testing. This will improve diagnosis rates to ensure Victoria meets the cascade target for people living with HIV knowing their status, and only then will they be on treatment and onward transmission reduced.

## 3. Priority outcomes

### 3.1. More ambitious targets

The current priority outcomes for 2030 are as follows:

- The proportion of all people with HIV who are diagnosed will be 95 per cent.
- The proportion of all people living with HIV who are accessing appropriate treatment will be 95 per cent.
- The proportion of people living with HIV with an undetectable viral load will be 95 per cent.
- The proportion of people experiencing and reporting HIV-related stigma and discrimination will be 0 per cent.

In terms of meeting these priority outcomes, fast-track cities data states that in Victoria 89% of people living with HIV are diagnosed, 87% are on appropriate treatment, and 84% are undetectable.<sup>1</sup> Percentages for the cascade are higher as they represent a proportion of the previous target and not the population as a whole. In Victoria 89% of people living with HIV are diagnosed, 98% of those diagnosed are on treatment, and 96% of those on treatment are undetectable.<sup>2</sup>

A recent study showed that the overall cascade in Victoria and New South Wales is 90-90-95.<sup>3</sup> Controlling for the migrant population, the cascade among permanent residents is 94-90-96.<sup>4</sup> This indicates where resources need to be prioritised, but it also shows how close some cohorts are to achieving the targets already. In light of this, as well as the fact that the virtual elimination of HIV will not occur before the 95-95-95 targets are achieved, the next HIV strategy should be more ambitious, and bring the year for meeting the cascade targets forward to 2025, and set 99-99-99 targets for 2030.

#### **Recommendation 1**

Bring forward the 95-95-95 targets to 2025 and set 99-99-99 targets for 2030.

### 3.2. Adding a quality of life priority outcome

Victoria's HIV strategy needs to consider what should occur beyond testing and treatment. Currently, the 95-95-95 cascade concentrates efforts on three targets, which are important, but only partially represent the HIV continuum-of-care. The WHO's *Global Health Sector Strategy on HIV* (2016-2021) recognises the importance of person-centred care for those on

<sup>1</sup> International Association of Providers of AIDS Care, Global Health Portal, (Website, 2020) <<https://www.fast-trackcities.org/cities/victoria>>

<sup>2</sup> Ibid

<sup>3</sup> Tafireyi Marukutira et al, 'Gaps in the HIV Diagnosis and Care Cascade for Migrants in Australia, 2013–2017: A Cross-Sectional Study' (2020) 17(3) *PLoS Medicine* e1003044 2

<sup>4</sup> Ibid 3

lifelong antiretroviral treatments.<sup>5</sup> A priority outcome that measures the quality of life of people living with HIV should be added to the target cascade. This would recognise challenges such as poor mental health, financial stress, comorbidities with age and experiences of stigma and discrimination,<sup>6</sup> and it would be in keeping with a person-centred approach to public health.

Humanising the priority outcomes, by linking them to a quality of life indicator, would acknowledge and foreground the challenges experienced by people living with HIV. For example, while recognising the statistical limitations of measuring 'perceptions', significant work has been undertaken to develop a quality of life indicator in Victoria, PozQoL.<sup>7</sup> Adding a quality of life indicator as a priority outcome would provide a goal that the government and stakeholders can work towards, expanding the current paradigm beyond an endpoint of viral suppression.<sup>8</sup>

### **Recommendation 2**

Add a priority outcome relating to quality of life for people living with HIV.

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<sup>5</sup> World Health Organisation, 'Global health sector strategy on HIV, 2016-2021' (Report, June 2016) <<http://apps.who.int/iris/bitstream/10665/246178/1/WHO-HIV-2016.05-eng.pdf?ua=1>>

<sup>6</sup> Alec Miners et al, 'Health-Related Quality-of-Life of People with HIV in the Era of Combination Antiretroviral Treatment: A Cross-Sectional Comparison with the General Population' (2014) 1(1) *The Lancet HIV* e32

<sup>7</sup> PozQoL, Valuing quality of life among people with HIV, (Website, 2020) <<http://www.pozqol.org.au/>>

<sup>8</sup> Jeffrey Lazarus et al, 'Beyond Viral Suppression of HIV—the New Quality of Life Frontier' (2016) 14(1) *BMC Medicine* 1

## 4. New opportunities

### 4.1. Normalising HIV screening in perceived low-risk populations

Approximately 30% of HIV diagnoses in Australia occur at a late-stage.<sup>9</sup> This means less effective medical treatment, higher health care costs, and an increased risk of transmission. Older age, female gender and heterosexuality are associated with a late diagnosis.<sup>10</sup> Health professionals may not identify these cohorts, who are considered low-risk, as in need of HIV testing. This can be due to heteronormative assumptions and a lack of HIV education, perceptions of stigma and fear of causing offense. This can be compounded when a patient is from a culturally or linguistically diverse background.<sup>11</sup>

Health professionals need tools to manage these situations. A recent study suggests that clinical guidelines for screening HIV when a potentially HIV-related disease is presented, are lacking and should be improved.<sup>12</sup>

#### **Recommendation 3**

Review clinical guidelines to increase the rates of HIV testing for perceived low-risk patients that present with a potentially HIV-related illness.

<sup>9</sup> Kirby Institute, *HIV, viral hepatitis and sexually transmissible infections in Australia* (Report, 2018) <[https://kirby.unsw.edu.au/sites/default/files/kirby/report/KI\\_Annual-Surveillance-Report-2018.pdf](https://kirby.unsw.edu.au/sites/default/files/kirby/report/KI_Annual-Surveillance-Report-2018.pdf)> 15

<sup>10</sup> Trent Yarwood and Darren B Russell, 'HIV: Almost Gone, but Still Forgotten' (2020) 50(3) *Internal Medicine Journal* 269

<sup>11</sup> Tafireyi Marukutira et al, 'Gaps in the HIV Diagnosis and Care Cascade for Migrants in Australia, 2013–2017: A Cross-Sectional Study' (2020) 17(3) *PLoS Medicine* e1003044 2

<sup>12</sup> Yi Dan Lin et al, 'Review of HIV Testing Recommendations in Australian Specialty Guidelines for HIV Indicator Conditions: A Missed Opportunity for Recommending Testing?' (2020) 50(3) *Internal Medicine Journal* 293

## 5. Reducing stigma and discrimination

### 5.1. Sharing the undetectable viral load message

While the Undetectable = Untransmittable (U=U) health promotion campaign sought to educate about the effectively zero risk of sexual transmission between a person with HIV receiving regular treatment with a sustained undetectable viral load and a HIV-negative person, a recent Australian survey suggests more awareness-raising and education is needed. Less than half of the survey respondents, who were people living with HIV, were confident in undetectable viral load as a prevention strategy.<sup>13</sup> Efforts should be bolstered to increase awareness and understanding of undetectable viral load as a prevention strategy.

#### **Recommendation 4**

Expand and increase awareness of undetectable viral load with a Victorian health promotion campaign.

### 5.2. Addressing research gaps to tackle HIV stigma

Educational campaigns by themselves, while necessary for awareness-raising, have not been shown to decrease stigma.<sup>14</sup> Indeed, there is little evidence of effective strategies for reducing stigma, with most reporting increased knowledge of HIV as the main positive effect.<sup>15</sup> While there is extensive literature on the adverse health effects of stigma, a recent paper found no peer-reviewed Australian studies that have tested a stigma reducing intervention for HIV.<sup>16</sup> Going forward, this gap in research needs to be addressed. This research should contain the following components:

- Study both individual (lack of knowledge, stereotypes and prejudices) and structural factors (laws, health care regulations, socio-economic indicators and cultural norms);
- Investigate a variety of settings, including health care and peer support programs, where data collection can be more meaningful;
- Use an intersectional lens for understanding how multiple identities (LGBTI, ethnicity etc.) and behaviours (substance use, occupations etc.) interact with stigma;
- Be co-designed with people living with HIV in the formation, development and implementation stages of the intervention; and
- Link to a measurable quality of life indicator, such as PozQoL.<sup>17</sup>

<sup>13</sup> Ben Huntingdon et al, 'Belief, Covariates, and Impact of the "Undetectable= Untransmittable" Message Among People Living with HIV in Australia' (2020) 34(5) *AIDS Patient Care and STDs* 205

<sup>14</sup> Marija Pantelic et al, "'Management of a Spoiled Identity": Systematic Review of Interventions to Address Self-Stigma among People Living with and Affected by HIV' (2019) 4(2) *BMJ Global Health* e001285

<sup>15</sup> Mak, Winnie et al, 'Meta-Analysis and Systematic Review of Studies on the Effectiveness of HIV Stigma Reduction Programs' (2017) 188 *Social Science & Medicine* 30

<sup>16</sup> Galit Zeluf Andersson et al, 'Stigma Reduction Interventions in People Living with HIV to Improve Health-Related Quality of Life' (2020) 7(2) *The Lancet HIV* e129

<sup>17</sup> Graham Brown et al, 'Development and Validation of PozQoL: A Scale to Assess Quality of Life of PLHIV' (2018) 18(1) *BMC Public Health* 527

As we move from the initial stage of identifying the effects to stigma, to the second stage of seeking to address it, an evidence-based understanding of methods to reduce stigma is required.

#### **Recommendation 5**

Fund research for a comprehensive intervention that seeks to reduce stigma.

### **5.3. Supporting people living with HIV and disability**

It is essential to recognise the compounding stigma experienced by people living with HIV and disability, who often lack visibility in health care settings and indeed society as a whole. Education strategies that raise awareness among non-disabled members of LGBTI communities of the barriers and compounding stigma experienced by people living with HIV and disability should be developed to foster social inclusion and support.

There is a significant lack of research on the impact of co-occurring stigmas.<sup>18</sup> Research in the area of being a person who lives with HIV and disability is needed to promote awareness and an understanding of the particular health and wellbeing constraints and ultimately, to create strategies that address these issues.

#### **Recommendation 6**

Promote awareness of the experiences of stigma and discrimination by people living with HIV with disability.

#### **Recommendation 7**

Fund research into experiences of stigma and discrimination by people living with HIV with disability.

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<sup>18</sup> Fatimah Jackson-Best and Nancy Edwards, 'Stigma and Intersectionality: A Systematic Review of Systematic Reviews across HIV/AIDS, Mental Illness, and Physical Disability' (2018) 18(1) *BMC Public Health* 919

## 6. Reducing HIV transmission

### 6.1. A responsive and equitable PrEP strategy

HIV will never be eliminated so long as barriers to accessing PrEP remain. Barriers include: culturally and linguistically diverse backgrounds, a younger age, a lower level of education and being less engaged with LGBTI communities.<sup>19</sup>

Investing in Victoria's sexual health infrastructure would improve PrEP uptake through increased service use. Clients that would benefit from PrEP would receive information about it, and clients already on PrEP would be better able to organise the three-monthly check-ups required to continue using PrEP effectively as a prevention strategy. However, there remain other barriers to accessing PrEP in Victoria. Financial barriers limit uptake of PrEP<sup>20</sup> and must be removed to ensure widespread PrEP uptake and to successfully maintain downward pressure on HIV transmission.

In responding to the increase in HIV notifications amongst mobile and migrant populations, Alfred Health introduced the PrEPMe service.<sup>21</sup> This includes free STI testing, even for those without a Medicare card, and PrEP can also be provided for free by applying for a coupon.

#### **Recommendation 8**

Remove barriers to equitable PrEP access so that all Victorian residents, temporary visa holders, and those ineligible for Medicare who are at high risk of HIV can access PrEP, and the Victorian Government's goal of eliminating HIV can be achieved.

### 6.2. Real-time HIV surveillance

Epidemiological typing applied to infectious diseases provides critical information on the emergence and spread of pathogens, and can inform public health responses.<sup>22</sup>

In Australia, while molecular epidemiology is not widely used prospectively, it has been increasingly used overseas in public health responses to HIV.<sup>23</sup> In particular, it has been

<sup>19</sup> Mohamed A Hammoud et al, 'HIV Pre-Exposure Prophylaxis (PrEP) Uptake among Gay and Bisexual Men in Australia and Factors Associated with the Nonuse of PrEP among Eligible Men: Results from a Prospective Cohort Study' (2019) 81(3) *JAIDS Journal of Acquired Immune Deficiency Syndromes* e73

<sup>20</sup> Kathleen E Ryan et al, 'Trends in Human Immunodeficiency Virus and Sexually Transmitted Infection Testing Among Gay, Bisexual, and Other Men Who Have Sex With Men After Rapid Scale-up of Preexposure Prophylaxis in Victoria, Australia' (2020) 47(8) *Sexually Transmitted Diseases* 516

<sup>21</sup> PREPACCESSNOW, PrEP without Medicare (Website, 2020) <<https://www.pan.org.au/no-medicare>>

<sup>22</sup> Xiaoxu Han et al, 'Molecular Network-Based Intervention Brings Us Closer to Ending the HIV Pandemic' (2020) 14(1) *Frontiers of Medicine* 136

<sup>23</sup> Angie Pinto et al, 'HIV-1 Subtype Diversity, Transmitted Drug Resistance and Phylogenetics in Australia' (2018) 13(08) *Future Virology* 575; Shannan Rich et al, 'Employing Molecular Phylodynamic Methods to Identify and Forecast HIV Transmission Clusters in Public Health Settings: A Qualitative Study' (2020) 12(9) *Viruses* 921

used overseas to identify HIV transmission clusters and outbreaks. There are several potential public health benefits to this approach, including:

- Identifying wider risk networks that include individuals among whom HIV transmission could still be occurring;
- Identifying networks in which drug-resistant strains of HIV are being transmitted; and
- Ensuring all individuals in transmission clusters are linked to, or re-engaged with care.

However, phylogenetic research presents complex and distinct ethical, social, legal, and public health considerations.<sup>24</sup> It is vital to meaningfully involve people living with HIV in the design of HIV phylogenetic studies and the use of molecular epidemiology in contact tracing programs. The fundamental principle should be to protect health and rights, including the right to privacy, of individuals and groups. Specific issues which must be considered include:

- A risk-benefit analysis of conducting HIV molecular epidemiological research;
- Risk mitigation strategies to protect the rights of individuals and vulnerable groups;
- Legal issues relating to the use of HIV phylogenetic analysis, in particular in the context of HIV criminalisation;
- Community engagement, collaboration and communication;
- Consent and confidentiality; and
- Data security and privacy.

#### **Recommendation 9**

Do not implement real-time HIV surveillance without engaging Victoria's HIV sector and meaningfully involving people living with HIV in the design and governing principles for how such a program would be implemented.

### **6.3. Expand general practitioner and nurse practitioner education in prescribing PrEP**

In April 2018, the prescribing of PrEP was expanded to all general practitioners (GPs) and nurse practitioners (NPs). This presents opportunities as well as potential challenges. This expansion could increase the awareness and availability of PrEP, which is a critical goal of Victoria's HIV strategy. However, it requires GPs and NPs to have the skills and knowledge to prescribe PrEP appropriately. As HIV treatment has historically been limited to specialist

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<sup>24</sup> Mark Boyd et al. 'Sexual transmission of HIV and the law: an Australian medical consensus statement' 205(9) *Medical Journal of Australia*; Stephanie Johnson and Michael Parker, 'Ethical Challenges in Pathogen Sequencing: A Systematic Scoping Review' (2020) 5(119) *Welcome Open Research* 119; Tony Sandset 'The Ethical and Epistemological Pitfalls of Translating Phylogenetic HIV Testing: From Patient-Centered Care to Surveillance' (2020) 7(1) *Humanities and Social Sciences Communications* 1

doctors, internal frictions over authority, control and expertise may emerge in the mainstreaming of PrEP.<sup>25</sup>

Barriers from the GP and NP's perspective include perceived concerns about toxicity, STI risk compensation, drug-resistant strains of HIV and inexperience.<sup>26</sup> This can be further complicated by the requirement for them to assess a patient's risk of acquiring HIV as medium to high; requiring discussions about sexual history and the 'cultural competency' to do that in a way where the GP/NP does not express their personal values or judgements.<sup>27</sup> This creates a scenario in which discrimination or stigma may occur.

While more research is needed to understand the specific requirements of GPs in the mainstreaming of PrEP, numerous studies have pointed to the importance of training and education.<sup>28</sup> Education is particularly crucial as discontinuation of PrEP is associated with low-PrEP caseload GPs.<sup>29</sup> Thus, with the rapid expansion of PrEP, risk management strategies are required to address potential weaknesses in approach.

### **Recommendation 10**

Invest in general practitioner and nurse practitioner education about PrEP and PEP.

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<sup>25</sup> Martin Holt 'Gay Men's HIV Risk Reduction Practices: The Influence of Epistemic Communities in HIV Social and Behavioral Research' (2014) 26(3) *AIDS Education and Prevention* 214

<sup>26</sup> William Lane, Clare Heal and Jennifer Banks, 'HIV Pre-Exposure Prophylaxis: Knowledge and Attitudes among General Practitioners' (2019) 48(10) *Australian Journal of General Practice* 722

<sup>27</sup> Anthony Smith et al, 'Troubling the Non-Specialist Prescription of HIV Pre-Exposure Prophylaxis (PrEP): The Views of Australian HIV Experts' (2020) 29(1) *Health Sociology Review* 62

<sup>28</sup> Susie Hoffman et al, 'A Clinical Home for Preexposure Prophylaxis: Diverse Health Care Providers' Perspectives on the "Purview Paradox" (2016) 15(1) *Journal of the International Association of Providers of AIDS Care (JIAPAC)* 59; Sarah Calabrese et al, 'Considering Stigma in the Provision of HIV Pre-Exposure Prophylaxis: Reflections from Current Prescribers' (2019) 33(2) *AIDS Patient Care and STDs* 79

<sup>29</sup> Phillip Keen and Benjamin R Bavinton, 'Could Disparities in PrEP Uptake Limit the Public Health Benefit?' (2020) 5(9) *The Lancet Public Health* e467

## 7. Improving access to HIV testing

### 7.1. Invest in community-controlled LGBTI sexual health / HIV testing services

Fear and experiences of stigma and discrimination act as barriers to HIV testing. This is especially true for the priority populations, including gay and bisexual men and trans and gender diverse people, that Thorne Harbour Health services. In order to improve access to HIV testing, LGBTI communities need access to culturally appropriate and safe testing and treatment services across Victoria. LGBTI people trust community-controlled LGBTI sexual health services to be safe and affirming because they are operated by and for members of LGBTI communities. An example of such a service is PRONTO!, operated by Thorne Harbour Health.

Peer-led rapid HIV testing has become an integral feature of the national push to increase HIV testing. Since Victoria opened Australia's first peer-led rapid testing site in July 2013, PRONTO! has demonstrated that its peer-led model attracts a population that is at high risk for HIV and that test irregularly.<sup>30</sup> As of June 2020, PRONTO! has provided rapid HIV tests to 10,920 individuals.

In February 2016, PRONTO! expanded its services to include STI testing and the provision of PrEP to clients at risk of HIV. As of June 2020, 1667 individuals accessed PrEP through PRONTO! and over 5240 peer tested clients have undertaken gonorrhoea, syphilis and chlamydia testing. The service has delivered PrEP through a mix of general practitioners and nurse practitioners.

An independent review by the Burnet Institute found that clients rated the peer testing model highly and preferred it over clinical settings. Piloted outreach and out-posted peer testing at non-fixed sites in regional areas like Bendigo have also proved popular. This successful community-controlled LGBTI sexual health service should be funded to expand its service reach.

#### **Recommendation 11**

Boost the capacity of community-controlled LGBTI sexual health / HIV testing services.

<sup>30</sup> Ryan, Kathleen, 'Evaluation of PRONTO!, A Peer-Led Rapid Point-of-Care HIV Testing Service in Melbourne, Australia' (Thesis, 24 September 2018)  
<[https://bridges.monash.edu/articles/thesis/Evaluation\\_of\\_PRONTO\\_a\\_peer-led\\_rapid\\_point-of-care\\_HIV\\_testing\\_service\\_in\\_Melbourne\\_Australia/7121951](https://bridges.monash.edu/articles/thesis/Evaluation_of_PRONTO_a_peer-led_rapid_point-of-care_HIV_testing_service_in_Melbourne_Australia/7121951)>

## 7.2. Invest in community-controlled, mobile LGBTI sexual health / HIV testing services

Victoria needs mobile sexual health testing capacity to reach men who have sex with men in community spaces, including events, beats, and sex on premises venues. This could be achieved, for example, by providing ongoing funding for a testing van for PRONTO!, Victoria's only community-controlled LGBTI sexual health service. A mobile testing facility would have significantly fewer capital costs than a static site, would increase service reach and provide access to currently underserved populations.

Along with a vehicle for mobile testing, there is a need for point of care testing (POCT) equipment. A one-off capital expense, or funding for PRONTO! to lease and operate a POCT Gene XPert testing machine would increase the service's STI testing for chlamydia and gonorrhoea by 30–40% and result in approximately 1000 additional STI screens being undertaken by the service each year. This POCT equipment provides results within 90 minutes and would allow same-day STI treatment, which would reduce onward transmission rates significantly.

The PRONTO! service has been evaluated and found to be highly acceptable to the men who have sex with men community.<sup>31</sup> Peer POCT for STIs using The Gene XPert machine has been favourably evaluated in a comparable setting in QLD at the Rapid Peer Testing service.<sup>32</sup>

### **Recommendation 12**

Boost outreach testing for priority populations, including gay and bisexual men and trans and gender diverse people, by investing in a mobile testing service. For example, a van for Victoria's community-controlled LGBTI sexual health / HIV testing service, PRONTO!.

## 7.3. Culturally and linguistically diverse peer support and navigation

Recently arrived migrant communities experience barriers including upfront costs, the complexity of the health care system, a reliance on word of mouth to advertise services, a lack of trust in the privacy and confidentiality of services, and often low levels of health literacy. With increased HIV notifications amongst non-Australian born men who have sex with men, groups like Gay Asian and Proud provide a culturally responsive model for

<sup>31</sup> Ryan, Kathleen Elizabeth, 'Evaluation of PRONTO!, a peer-led rapid point-of-care HIV testing service in Melbourne, Australia' (Thesis, 2018) <[https://bridges.monash.edu/articles/Evaluation\\_of\\_PRONTO\\_a\\_peer-led\\_rapid\\_point-of-care\\_HIV\\_testing\\_service\\_in\\_Melbourne\\_Australia/7121951](https://bridges.monash.edu/articles/Evaluation_of_PRONTO_a_peer-led_rapid_point-of-care_HIV_testing_service_in_Melbourne_Australia/7121951)>

<sup>32</sup> Amy Mullens et al, 'Point-of-Care Testing (POCT) for HIV/STI Targeting MSM in Regional Australia at Community 'Beat Locations' (2019) 19(1) *BMC Health Services Research* 93; Sara Bell et al, 'Peer-Delivered Point-of-Care Testing for Chlamydia Trachomatis and Neisseria Gonorrhoeae within an Urban Community Setting: A Cross-Sectional Analysis' (2020) 17(4) *Sexual Health* 359

addressing these barriers including social connectedness, information, education and an opportunity for shared learning to take place, and are an example of how programs can be tailored to address the particular social and situational factors of certain cohorts. An expansion of these services is critical, as peer support has been shown to build health knowledge in culturally and linguistically diverse communities. Funding is needed to expand multicultural and LGBTI peer support and navigation networks.

#### **Recommendation 13**

Fund peer support and navigation workers to deliver peer-driven health promotion to at-risk communities and connect people with services.

### **7.4. Home testing for HIV**

There are many reasons people don't engage services to receive a HIV test, and during the COVID-19 pandemic the need for people to have a convenient and contactless means of testing is greater than ever. ACON in New South Wales recently launched the you[TEST] service,<sup>33</sup> which connects gay and bisexual men with a trained peer worker who provides them with information about different home testing options, and presumably about what to do in the event of a positive result, before mailing them a kit to perform home testing. Victorians would benefit from a similar online peer education resource that promotes home testing for HIV.

#### **Recommendation 14**

Fund an online peer education campaign designed to increase uptake of home testing for HIV.

### **7.5. Ensure a data-driven response to priority populations**

The response to HIV should be data-driven, with particular attention given to priority populations. If testing rates decrease among priority populations, or notifications increase beyond a certain threshold, this should act as a trigger for responsive health promotion campaigns and activities targeted to these populations that bolster existing health promotion - the aim being to increase testing and decrease notifications.

Timely quarterly reports that provide a breakdown of HIV cases by age, gender, mode of transmission, ethnicity of men who have sex with men, length of time in the country etc., are the best way to inform HIV services to be responsive to any new and emerging trends, and

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<sup>33</sup> ACON, YOU[TEST], (Website, 2020)  
<[https://www.aconhealth.org.au/new\\_at\\_home\\_hiv\\_testing\\_service\\_to\\_put\\_you\\_in\\_control\\_of\\_testing](https://www.aconhealth.org.au/new_at_home_hiv_testing_service_to_put_you_in_control_of_testing)>

to reorient our focus to particular cohorts that may be more at risk of HIV. For example, if we were to see an emerging trend of HIV notifications amongst Columbian-born men who have sex with men, then services such as Thorne Harbour Health could engage with particular multicultural groups in a more direct way around HIV prevention or the promotion of U=U messaging.

**Recommendation 15**

Have regular and up-to-date detailed reports reflecting the HIV notification data that are stratified by useful demographics upon which responsive health promotion campaigns and targeted activities can be implemented.

## 8. Improving access to HIV treatment

### 8.1. Home care and self-management programs

Almost half of HIV-positive people in Australia are over 50 years old.<sup>34</sup> As people living with HIV age, numerous cardiac, renal, metabolic and neurological comorbidities are becoming more apparent.<sup>35</sup> The Home Care Program at Thorne Harbour Health seeks to respond to this aging population and support people living with HIV to remain independent and engaged in the community, rather than in aged care.<sup>36</sup> The Home Care Program provides a combination of practical and social support to improve people's quality of life, is more cost-effective than institutional care, and works in Partnership with Bolton Clarke's HIV Nursing Program to provide an integrated service.

Self-management programs that build the knowledge and skills to manage the complicated mental and physical health needs of people living with HIV, regardless of age, have been shown to increase quality of life, self-efficacy and coping.<sup>37</sup> They can also be delivered successfully in an online environment.<sup>38</sup> Sustained support for these programs is an essential component for a comprehensive HIV strategy.

#### **Recommendation 16**

Increase funding for home care services to keep people living with HIV living independently in the community for as long as possible.

#### **Recommendation 17**

Support positive self-management programs to build the capacity of people living with HIV to enhance their knowledge and skills to manage their HIV, general health and other challenges such as depression, loneliness, isolation and stigma.

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<sup>34</sup> Kathy Petoumenos et al, 'Prevalence of Self-Reported Comorbidities in HIV Positive and HIV Negative Men Who Have Sex with Men over 55 Years—The Australian Positive & Peers Longevity Evaluation Study (APPLES)' (2017) 12(9) *PLoS One* e0184583

<sup>35</sup> Ibid

<sup>36</sup> Thorne Harbour Health, *Community Support* (Webpage, 2020) <<https://thorneharbour.org/lgbti-health/community-support/>>

<sup>37</sup> Habtamu Abera Areri, Amy Marshall and Gillian Harvey, 'Interventions to Improve Self-Management of Adults Living with HIV on Antiretroviral Therapy: A Systematic Review' (2020) 15(5) *PLoS One* e0232709

<sup>38</sup> Tanya Millard et al, 'The Positive Outlook Study: A Randomised Controlled Trial Evaluating Online Self-Management for HIV Positive Gay Men' (2016) 20(9) *AIDS and Behavior* 1907

## 8.2. Housing support

Housing Plus is a state-wide program operated by Thorne Harbour Health that supports Victorians living with HIV who are homeless or at risk of homelessness to seek appropriate and stable accommodation.

We know from the social determinants model of health that people's health depends on their basic needs such as housing being met; a fact emphasised by the story of James May, a Housing Plus client who shifted from rooming houses to transitional housing:

*It was the first time I'd had my own space since contracting HIV and I was astounded by the difference it made... I didn't have to hide my sexuality or my HIV status from anyone... I had the space and privacy to focus my energy on the physical and emotional challenges of living with the virus and adjusting to ART therapy.*

*For the first time I could stock the fridge and pay close attention to my nutrition... I could sleep soundly at night without the chaos of people coming and going in a rooming house. My health soared and it made me realise how essential a safe, comfortable home is – particularly when you're living with HIV.<sup>39</sup>*

Housing Plus streamlines client referrals to Thorne Harbour Health's mental health and other health and support services, which improves efficiencies and data integration between services. This emphasises the importance of community-controlled health service delivery and the integration of wraparound support services for people living with HIV.

### **Recommendation 18**

Continue funding housing support for people living with HIV who need it.

## 8.3. Support for people living with HIV in rural and regional areas

People living with HIV in rural and regional areas can experience loneliness, social isolation, and a lack of community engagement. The loss or lack of peer and friendship networks, coupled with an increased likelihood of loss of family networks, exacerbates social isolation and increases the likelihood and severity of mental health issues. There is also a heightened potential for people living with HIV in rural and regional areas to have lower incomes and experience poverty, the effects of aging with HIV alone with a lack of resources, and a lack of stable and affordable transport options.

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<sup>39</sup> Poslink, 'AHAG: Still providing housing, support and referral' (Newsletter, June 2011) <[https://livingpositivevictoria.org.au/wp-content/uploads/2016/12/Poslink\\_Issue\\_057.pdf](https://livingpositivevictoria.org.au/wp-content/uploads/2016/12/Poslink_Issue_057.pdf)> 14

This disadvantage is amplified by the stigma of living with HIV, and fear of attending local mainstream health services, in particular due to concerns about disclosing their HIV status in a smaller community and feared lack of confidentiality.

Additionally, regional health systems lack continuity where S100 prescribers are not present. S100 or other related HIV specialists come and go from regional areas and people living in smaller areas have to travel long distances for specialist treatment. This reduces continuity of care, as people living with HIV from rural and regional areas often 'split' their medical providers by travelling to major urban centres for HIV treatment. This lack of flexibility, when combined with other issues mentioned, amplifies health disparities for people living with HIV.

#### **Recommendation 19**

Promote assistive technology so that people living with HIV in rural and regional areas can connect to online social and health supports, such as peer groups and telehealth appointments.

## **8.4. Specialist care**

People living with HIV have significantly increased risk of comorbidities such as diabetes, neuropathy, and heart disease.<sup>40</sup> People living with HIV with comorbidities require multidisciplinary care. This frequently happens with a person receiving shared care from their GP and a HIV specialist. Additionally, they have to visit other specialists if they have other health complications related to comorbidities. At the Alfred Hospital, the Department of Infectious Diseases runs a regular multidisciplinary clinic in the infectious diseases outpatient clinic, where specialists from several fields attend the clinic to support patients with complex comorbidities.

Another less common means of managing patients with comorbidities is for the GP to refer the patients to private specialists in the community setting. Further layers of complexity occur for people living with HIV who have comorbidities and who also have mental health or substance use disorders, or who are homeless or who choose to disengage with care. This makes coordination and optimisation of their care challenging. Such patients are best supported through a multidisciplinary complex care program as occurs at The Alfred hospital.

The COVID-19 pandemic necessitates the innovation of health care models. For people living with HIV, receiving medication by post, attending some appointments being by telehealth, or visiting a GP in person with a specialist engaged through telehealth, present opportunities to streamline health care and improve patient outcomes. Thus presenting an

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<sup>40</sup> Kathy Petoumenos et al, 'Prevalence of self-reported comorbidities in HIV positive and HIV negative men who have sex with men over 55 years: The Australian Positive & Peers Longevity Evaluation Study (APPLES)' (2017) 12(9) *PLoS ONE* e0184583; Jack Edward Heron et al, 'The Prevalence and Risk of Non-Infectious Comorbidities in HIV-Infected and Non-HIV Infected Men Attending General Practice in Australia' (2019) 14(10) *PLoS ONE* e0223224

opportunity for an online expansion of a multidisciplinary complex care model, to reach as many people living with HIV as possible.

#### **Recommendation 20**

Promote innovative health care models for people living with HIV that streamline health care and improve patient outcomes, such as receiving medication by post, attending some appointments via telehealth, or visiting a GP in person with a specialist engaged through telehealth.

### **8.5. Antiretroviral medication**

People living with HIV can have the burden of multiple co-payments per month to address numerous health issues.<sup>41</sup> Financial stress and socioeconomic status are associated with reduced HIV treatment adherence.<sup>42</sup> Recognising the importance of ensuring people with HIV remain on treatment, the New South Wales Government began subsidising co-payments for all S100 drugs to make them freely available, including HIV treatments, in 2015.<sup>43</sup> This measure has assisted the most vulnerable people living with HIV to access and adhere to treatment and should be implemented in Victoria.

#### **Recommendation 21**

Subsidise co-payments for HIV treatments to improve treatment uptake and retention, and enable Victoria to meet and maintain the Victorian HIV Strategy cascade target for treatment uptake.

### **8.6. Nurse practitioners**

Having skilled nurse practitioners (NPs) in high caseload HIV services means that they can manage the high number of patients presenting for routine STI testing and PrEP. At the same time, general practitioners can focus on complex HIV management. Additional clinical support in the practice ensures that HIV positive patients are able to access appointments and care readily.

NPs can work independently within the scope of their training, visit regional communities, and provide services in settings where people aren't comfortable seeing their regular GP for

<sup>41</sup> Krista Siefried et al, 'Socioeconomic Factors Explain Suboptimal Adherence to Antiretroviral Therapy among HIV-Infected Australian Adults with Viral Suppression' (2017) 12(4) PLoS ONE e0174613

<sup>42</sup> John McAllister et al, 'Financial Stress Is Associated with Reduced Treatment Adherence in HIV- infected Adults in a Resource- rich Setting' (2013) 14(2) *HIV Medicine* 120; Krista Siefried et al, 'Socioeconomic Factors Explain Suboptimal Adherence to Antiretroviral Therapy among HIV-Infected Australian Adults with Viral Suppression' (2017) 12(4) *PLoS ONE* e0174613

<sup>43</sup> New South Wales Government, *Co-payments for Section 100* (Webpage, 4 November 2019) <<https://www.health.nsw.gov.au/pharmaceutical/s100copay/Pages/default.aspx>>

testing and treatment because of fear of stigma and discrimination. They are a cost-effective workforce option, and their ability to claim Medicare Benefits Schedule (MBS) items helps offset employment costs. NPs can also work independently as subcontractors within services on an income share basis.

Unfortunately, the lack of potential employment opportunities and career pathways can be a deterrent for nurses considering this training. This can result from several factors, including:

- Some GPs not trusting NPs to do the work;
- To our knowledge, a lack of existing employment models and research that demonstrate the effectiveness of NP models in sexual health care to encourage health services to utilise this model;
- MBS rates being half what GPs are paid for the same work. Also, sexual health NPs cannot currently bill mental health or chronic disease management items; and
- The uncertainty of employability once the training is complete.

#### **Recommendation 22**

Invest in roles that create employment pathways for nurse practitioners.

#### **Recommendation 23**

Encourage the use of nurse practitioners in services by prioritising funding to services investing in the development of, and working with, this under-utilised workforce.

## 9. Research to improve the HIV response

### 9.1. Research into underserved priority populations

To improve HIV diagnosis and care cascades, it is essential to understand where certain communities are underserved. For example, in Victoria and NSW, migrant men who have sex with men had a cascade of 84-83-93, compared with 96-92-96 for non-migrants.<sup>44</sup> Understanding the drivers of these disparities is critical in making incremental steps towards the elimination of HIV. For instance, despite having access to ART, migrants are less likely to initiate early treatment.<sup>45</sup> They also experience barriers, including migration status, sociocultural factors, financial constraints, and stigma.<sup>46</sup>

Addressing these unique circumstances requires a sustained, coordinated and integrated approach to both identifying needs and then ensuring commensurate services. This builds upon previous recommendations targeting health care providers that the migrant community access, increasing health provider awareness and education and seeking to address the underlying factors, such as stigma.

#### **Recommendation 24**

Research service access barriers in culturally and linguistically diverse and migrant communities, including the intersection with LGBTI communities.

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<sup>44</sup> Tafireyi Marukutira et al, 'Gaps in the HIV Diagnosis and Care Cascade for Migrants in Australia, 2013–2017: A Cross-Sectional Study' (2020) 17(3) *PLoS Medicine* e1003044 2

<sup>45</sup> Praveena Gunaratnam et al, 'People Born in Non–Main English Speaking Countries Are Less Likely to Start HIV Treatment Early in Australia: A National Cohort Analysis, 2014–15' (2018) 77(3) *JAIDS Journal of Acquired Immune Deficiency Syndromes* e31

<sup>46</sup> Josephine Agu et al, 'Migrant Sexual Health Help-Seeking and Experiences of Stigmatization and Discrimination in Perth, Western Australia: Exploring Barriers and Enablers' (2016) 13(5) *International Journal Of Environmental Research And Public Health* 485

## 10. Investing in the HIV response

### 10.1. We cannot afford not to maintain investment in the HIV response

Under fiscal constraints, it is tempting to find short term cost savings in a range of areas that would not typically be considered for funding cuts. If these fiscal constraints occur during a recession, reduced government spending can result in a prolonged economic downturn - the only way out of a recession is to spend one's way out. Irrespective of the broader economic situation, it is always unwise to cut funding of essential health and support services, because this funding represents an investment that saves the government money in the long term.

Every person living with HIV should be supported to remain on treatment. Every case of HIV detected before someone can transmit HIV to another person saves a lifetime of costs associated with antiretroviral treatment and medical care. People whose health is well managed and who have the social and service supports to ensure it remains that way, are more productive members of society. There is no circumstance in which cutting funding for HIV and wraparound support services is sensible or acceptable.

#### **Recommendation 25**

Increase investment in Victoria's HIV response. In particular, significant investment is required to boost testing capacity, including mobile outreach testing and peer navigation. This will improve diagnosis rates to ensure Victoria meets the cascade target for people living with HIV knowing their status, and only then will they be on treatment and onward transmission reduced.