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**Toward 2020: Is Australia on track
to meet its targets?**

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AFAO is the national federation for the HIV community response, providing leadership, coordination and support to the Australian policy, advocacy and health promotion response to HIV/AIDS. Internationally, AFAO contributes to the development of effective policy and programmatic responses to HIV/AIDS at the global level, particularly in the Asia Pacific region.

AFAO's aims are to:

- Advocate on behalf of its members at the federal level, thereby providing the HIV community with a national voice;
- Stop the transmission of HIV by educating the community about HIV/AIDS, especially those whose behaviour may place them at high risk;
- Assist its members to provide material, emotional and social support to people living with HIV;
- Develop and formulate policy on HIV issues;
- Collect and disseminate information for its members;
- Represent its members at national and international forums; and
- Promote medical, scientific and social research into HIV and its effects.

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This edition of *HIV Australia* looks at the impact of target-setting on Australia's policy response to HIV. Contributors examine the target-driven commitments and strategies steering us toward 2020 with the aim of virtually eliminating HIV transmission in Australia.

Articles consider the benefits and limitations of national and global targets, asking whether such goals are aspirational or achievable. While ambitious targets are reigniting political will, an over-reliance on these metrics, combined with a lack of resources, may be setting us up to fail if the targets are not met.

Many articles examine the impact of key policy issues on communities affected by HIV, highlighting achievements and unmet challenges. Whose needs are being addressed by the current policy framework and who is being left behind?

A key question is how do we gauge improvements in the Australian legal and policy environment, and reductions in discrimination and stigma? Australia's focus on human rights and law reform – in particular, on decriminalisation and harm minimisation – have been hallmarks of our HIV response to date. How can we measure our achievements, or lack of them, in these important areas?

***HIV Australia* online includes additional content not published in the printed edition. Read more of *HIV Australia* at www.afao.org.au**

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Target-setting: Australia and the global context

A note from the editors

The Seventh National HIV Strategy

Since the launch of the first government response to HIV in 1989, successive national HIV strategies have guided Australia's partnership response in the areas of HIV prevention, treatment, care and human rights.

Australia's Seventh National HIV Strategy builds on these aims by including, for the first time, a set of specific targets as a key step towards the elimination of transmission of HIV in Australia.

The targets outlined in the Seventh National HIV Strategy are to¹:

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

UNAIDS global targets

In 2014, UNAIDS announced ambitious new global targets which aim to strengthen previous commitments outlined in the 2011 UN Political Declaration on HIV/AIDS. With these 'Fast-Track' targets, UNAIDS aims to end the HIV epidemic by 2030.

By 2020, the UNAIDS goals are that²:

- 90 percent of people living with HIV will know their HIV status
- 90 percent of people diagnosed with HIV will receive antiretroviral treatment
- 90 percent of people on treatment will have suppressed viral loads.

In order to meet the '90-90-90' targets, the UNAIDS Fast-Track strategy says action during the next five years is crucial.

UNAIDS estimates that by June 2014, around 13.6 million people had access to antiretroviral therapy, a huge step forward but still a long way off from 90-90-90.³ Other targets include reducing the annual number of new HIV infections by more than 75% – to 500,000 in 2020 – and achieving zero discrimination. The Fast-Track report highlights how critical investment is to achieving these targets.⁴

But is 90-90-90 really achievable by 2020 in Australia?

Despite the need for political will being expressed in Australia's key strategic documents, our coordinated partnership response is in danger of being stymied by a still unannounced tender process and persistent funding uncertainty.

Despite having more tools than ever before in our HIV prevention arsenal, we are seeing increasing rates of HIV diagnoses among men who have sex with men, both in Australia and in other countries with high antiretroviral coverage.⁵

In correspondence published recently in *The Lancet*, three leading Australian researchers warned that available evidence suggests a 90% reduction in HIV globally, in a climate where a cure or vaccine for HIV is still a long way off, may well not be achievable – even by 2030.⁶ They caution against an over-reliance on targets as a measure of success:

*'As successive years fail to align with ambitious HIV transmission targets, campaigns and programmes that may be successfully reducing transmission could be jeopardised if their measure of success is a substantial decline in new cases of HIV.'*⁷

US-based advocacy organisation AVAC's 'Prevention on the Line' report calls for a 'sharper and bolder' set of global HIV prevention targets tailored to specific interventions in areas including vaccine and cure research, pre-exposure prophylaxis (PrEP), combination prevention, harm reduction, treatment as prevention and human rights.⁸

AVAC argues that while targets are vitally important because they galvanise action, they can only be achieved if they are

supported by political will and adequate resources. The AVAC report stresses the need for more immediate short-term goals, saying that we can't risk waiting five years to make sure we are on track to ending HIV.

Key recommendations of the AVAC report are to⁹:

- Align high-impact strategies with human rights and realities
- Invest in an oral PrEP-driven paradigm shift
- Demand short-term results on the path to long-term goals.

But does the seeming impossibility of hitting 90-90-90 by 2020 mean that we should abandon ambition? As many articles in this edition of *HIV Australia* argue, the focus on targets, whether they are achievable or aspirational, is driving effective programmatic and policy development. It is essential that we continue to shape these targets and indicators such that they address ongoing policy issues in Australia, especially in the important areas of criminal law reform and stigma and discrimination, to ensure the needs of communities most affected are not left behind.

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Communities, policies and the enabling environment

By Ian Muchamore

The Seventh National HIV Strategy has laid out a set of bold goals and targets to turn around the tide of rising infections and bring the HIV epidemic in Australia to an end. The ambition to virtually eliminate HIV transmission by 2020 is underpinned by multiple targets built on UNAIDS goals, which include increasing HIV treatment uptake by people with HIV to 90 percent.

The adoption of high-level policy goals and targets has promoted a much-needed deep and frank discussion between policy makers, clinicians, researchers and communities. Key agenda items include what works, what doesn't, what do we need to do differently and how do we do it?

Whether all of the national goals and targets are as SMART (specific, measurable, achievable, relevant and time-bound) as they might be is debatable. However, this vision and rhetoric has (for the most part) been enthusiastically embraced and accepted by those directly affected by the epidemic – especially by people living with HIV.

The focus of much of this engagement and excitement has been built around new and reshaped biomedical treatment and prevention tools, supported by an impressive body of research studies and evidence.

The case for grasping and implementing these options in a combination prevention approach is also interdependent upon addressing longstanding system challenges – hard issues that are often bundled into the catchall idea of 'the enabling environment'.

Long-established structures and agencies in the health and community sector are under pressure to innovate and evolve. Challenges include building community engagement and developing effective messaging and communication. New models of service delivery will require coordination and fresh thinking about what our partnerships look like.

Naming and addressing HIV stigma is central to the successful implementation across all these innovations. Anti-stigma efforts are required within and beyond directly affected communities, within specialist and general health services and beyond the policy domains of government health departments.

Getting anywhere near a 50% reduction in the number of HIV transmissions by 2020 will require Australia to shift gear and speed up introduction of new technologies.

Rapid and home HIV testing options are considered key innovations which will support higher HIV testing rates. More regular and better targeted testing among affected communities is essential

to reducing the number of people living with HIV who are as yet undiagnosed. Minimising the time between infection and treatment will also have a prevention benefit.

After lengthy expert and community dialogue, treatment as prevention (TaSP) is now accepted as a vital component of the response. A major step up will be needed in the proportion of people with HIV who are on treatment and with viral suppression, if envisaged reductions in community viral load are to deliver the prevention dividends.

Pre-exposure prophylaxis (PrEP) is the latest development in the field of biomedical HIV prevention. The merits of PrEP as an effective prevention tool for individuals from populations at high risk are clear. How PrEP can be made more accessible and affordable is less clear, as is the potential impact on the epidemic following wider availability and targeted uptake of PrEP.

Understanding the impact of bold target setting, and demonstrating the potential of a combination prevention approach using real world results require us to move beyond the controlled and closely monitored environments of trials and studies.

At the same time, we also need to tackle the tough aspects of the enabling environment. Actions and objectives

expressed in the national blood borne virus strategies, such as 'eliminate stigma and discrimination' and 'addressing legal barriers', generally fail the SMART test. These concepts are hard to grasp, define and measure, and the underlying steps to reach them can be contestable.

Australia is one of about 190 countries that have passed motions and political declarations in the United Nations that commit us to the Greater Involvement of People Living with HIV/AIDS (GIPA). These principles of inclusion – more recently refined as 'meaningful involvement' (MIPA) – were first proposed in 1994 and have been supported for over 20 years.

UNAIDS policies specifically recommend that all governments adopt such participation and involvement principles in their HIV strategies and that they also ensure they measure and evaluate their success in meeting best and inclusive practices.

The latest National HIV Strategy specifically acknowledges that the meaningful involvement of people living with HIV is essential across both programs and policies. Despite the best intentions of governments, health professionals, researchers and community bodies, an occasional reminder is warranted so that the principle is consistently implemented. Meaningful community involvement matters – it means a better and stronger response.

Assessment tools and best practice guidelines such as *Renewing Our Voice*, the HIV Code for NGOs¹, should surely be part of the evidence and indicators we use to ensure that the high-level commitments to meaningful involvement of people living with HIV are not just rhetoric.

Examples of failure to consider the importance and value of meaningful involvement of people living with HIV in program development and delivery remain too common. However, we need to celebrate those cases where we have learnt from our experiences and reshaped best practice.

In November 2013, a tertiary health service used by many HIV-positive people in Victoria announced major changes to the delivery of its HIV health and care services, commencing with immediate



Addressing the enabling environment requires community advocacy, partnership and political leadership. Pictured: Martin Foley MP, Victoria's first ever Minister for Equality, together with ENUF supporters at the ChillOut Street Parade, Daylesford, Victoria, March 2015.

effect. Meaningful engagement of people living with HIV was completely lacking in the proposal and, unsurprisingly, the lack of such involvement prompted rather negative community sentiment. Ultimately, the proposal was withdrawn and a set of fresh proposals is now being prepared with the involvement of a community advisory committee which includes five people living with HIV from diverse backgrounds, as well as clinicians and service managers. This group is chaired by the CEO of the health service and will hopefully be an example that demonstrates best practice in working collaboratively. The outcome should be more patient-centred health services to better meet the needs of HIV-positive people.

In December 2014, a new state government was elected in Victoria with a platform and mandate to develop a fresh HIV action plan, deliver additional sector resources and bring in key commitments made during AIDS 2014.

Community advocacy and partnership has put HIV criminalisation in the spotlight. In July 2014 the AIDS 2014 pre-conference, *Beyond Blame: Challenging HIV Criminalisation* highlighted local and global examples of the stigma and discrimination resulting from unjust criminal laws that impede the public health response.²

A local advocacy partnership to reform how HIV exposure and transmission is treated in criminal law has been led by Living Positive Victoria and the Victorian AIDS Council. The clear message is that HIV should be treated as a public

health issue, not a criminal matter. Broad community support and a coalition of organisations and experts have gathered behind the Repeal Section 19A campaign, and both major political parties have accepted there is a clear case for reform. The upcoming challenge will be to see this taken to the Victorian Parliament in the coming months, where we hope to see the repeal of this discriminatory law. This could send a powerful anti-stigma message to the wider community.

Specific actions such as law reform advocacy designed to enhance the enabling environment are generally not made explicit in national and state strategies. Addressing such complex issues requires political leadership and commitment beyond the health sector, with the support of champions and advocacy from multiple sectors. The response and involvement of people living with HIV – those most directly affected – is essential for agenda-setting and for initiating innovative actions which are likely to make the UNAIDS targets achievable.

References

- 1 *Renewing our voice – Code of Good Practice for NGOs responding to HIV/AIDS* is available at: <http://www.who.int/3by5/partners/NGOcode/en/>
- 2 For further information on the *Beyond Blame* pre-conference see: <http://www.hivjustice.net/feature/feature-beyond-blame-challenging-hiv-criminalisation/>

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Measuring HIV-based discrimination and human rights abuses: why bother?¹

By **Sally Cameron**

There is no shortage of HIV policy documents outlining the ‘centrality’ of human rights to an effective HIV response, including the United Nations’ (UN) *2011 Political Declaration on HIV and AIDS*², UNAIDS’ 2011–2015 strategy, ‘Getting to Zero’³ and the 2012 Global Commission on HIV and the Law report⁴.

Domestically, Australia’s National HIV Strategy names eliminating ‘the negative impact of stigma, discrimination, and legal and human rights issues on people’s health’ as one of six objectives.⁵ Further, it outlines four priority actions⁶:

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

For the most part, the articulated actions identify work that needs to be done to improve Australia’s HIV response, although they are weakened by anomalous moments of restraint, particularly the oddly constructed third action to ‘work towards addressing’ legal barriers. Surely if stigma and discrimination is to be ‘eliminated’ in community and health care settings, then legal barriers to evidence based strategies can at least be ‘addressed’.

Despite the many articulations of a commitment to human rights, progress is notoriously slow. This is due in part to the absence of specific tangible goals and associated measurement of their success.

Such is the case with Australia’s National HIV Strategy. Unlike the other five objectives outlined in the National HIV Strategy, the objective on human rights lacks an ‘indicator’. That gap has not gone unnoticed, with the National Strategy acknowledging that ‘the lack of a nationally agreed indicator for measuring progress in reducing the health impact of stigma, discrimination and legal and human rights [is] an important gap’⁷. It calls for ‘a focused effort during the life of this Strategy to make headway on this important issue’⁸. A ‘focused effort’ sounds promising. ‘Make headway’, less so.

Australian indicators measuring progress against Strategy priority actions are yet to be developed – an issue that requires urgent attention before the next National Strategy rolls around.

The lack of human rights, stigma and discrimination indicators in the Strategy undermines advocacy ... and progress. Just what is it we’re trying to achieve? Are things really that bad? And how can we know whether things are improving? Without indicators, success cannot be ‘demonstrated’ but neither can failure, so there is no political urgency to fund programs or campaigns, or to generate the collective intellectual effort to come up with a plan ... a really good plan. Political will to address human rights abuses, stigma and discrimination is lost amongst

the urgency to meet highly ambitious targets on testing and treatment (which, as we know, rely on a human rights-based ‘enabling environment’).

Measuring discrimination

A common assertion is that human rights are difficult to measure. While it may be difficult, it is certainly not impossible. For example, UNAIDS Guidance Note on prosecutions for cases of HIV non-disclosure, HIV exposure and transmission⁹ clearly states that criminal laws should only be applied to cases of intentional transmission, i.e. where a person knows his or her HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit it. It also states that laws applied in these rare occasions should be general and not HIV specific. What is needed then is a commitment to monitor and report the number of prosecutions each year exceeding those limits. Is that really so complicated? No. But agreeing to count and report on such prosecutions would imply that they are problematic and that therefore, something needs to be done to stop such prosecutions from proceeding: an assertion no government agency has been willing to make.

Using its limited resources, GNP+ (The Global Network of People living with HIV) makes considerable effort to collect international information on HIV prosecution laws and cases through its Global Criminalisation Scan¹⁰, but without a formal UN requirement for countries to collect such data, the Scan remains limited. Some effort is made by

Australian non-government organisations (NGOs) to keep a tally of Australian cases but no formal collection of data is recorded or reported.

As with ‘criminalisation’, reporting on HIV-related stigma and discrimination is stymied by lack of political will, the absence of formal reporting mechanisms, and a lack of consensus on what such mechanisms should look like. HIV policy makers remain concerned about the feasibility of measuring HIV-related stigma and discrimination in a ‘meaningful way’. Granted there are methodological tensions: should measurements be quantitative (‘how many?’) or qualitative (‘what was it like?’)? Do we count the number of acts of discrimination or provide a scale to estimate the severity of the discrimination? Should we count the number of times people act in a discriminatory way or the perception of persons who believe they’ve been discriminated against? Are samples (no matter how large) really representative? And how do we factor in notions of

resilience: a discriminatory action that is hurtful or harmful to one person may be something another person is able to brush off.

There are in fact numerous examples of stigma and discrimination indicators that have been used in previous research. Notable among them is the People Living with HIV Stigma Index (PLHIV Stigma Index) which aims to measure stigma and discrimination experienced by people living with HIV in national settings. One of the strengths of the PLHIV Stigma Index has been the scale of its rollout. It has now been translated into 54 languages, and recorded the experiences of some 50,000 PLHIV in more than 50 countries (although not Australia). Its ‘reach’ has not only forced the issue onto the agenda of recalcitrant governments around the globe, but has facilitated regional comparison (see Figures 1 and 2): the point of which is not to embarrass individual governments (they are only representative samples after all) but to ensure stigma and discrimination make it onto the agenda of regional and international meetings and strategy development.

Data driven commentary on discrimination in Australia has largely relied on the findings of the HIV Futures survey. Conducted every two to three years since 1997, it routinely attracts more than 1000 responses from people living with HIV all over Australia. The survey has a broad focus, but also includes questions on discrimination and the environment in which that discrimination occurred. Although not often used in this way, the staying power of the HIV Futures survey allows consideration of progress since the previous survey, but also over a long period (Figure 3).

In 2011, the National Association of People Living With HIV Australia (NAPWHA) took a different tack, developing a detailed, peer-based social research survey to assess HIV-related stigma in Australia. The *HIV Stigma Audit Community Report* provided detailed information on the experiences and effects of stigma on the lives of almost 700 people with HIV in Australia. The Stigma Audit used scales to estimate the severity of stigma, impact on self-esteem, degrees of resilience and centrality of HIV and community attachment (Figure 4).

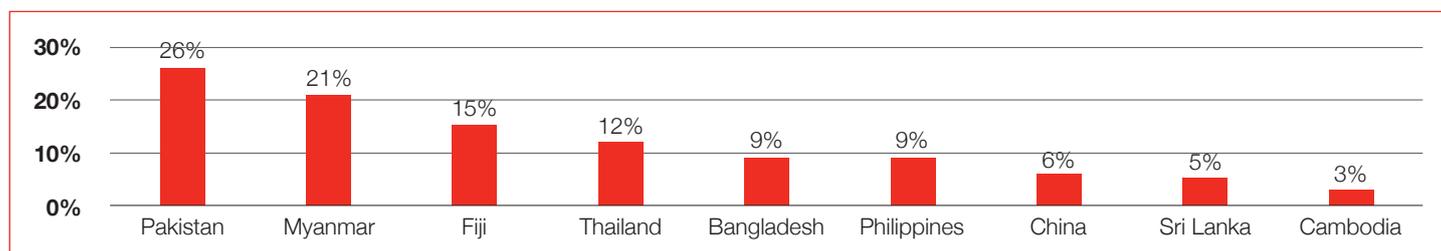


Figure 1: Excluded from family activities (previous 12 months)¹¹

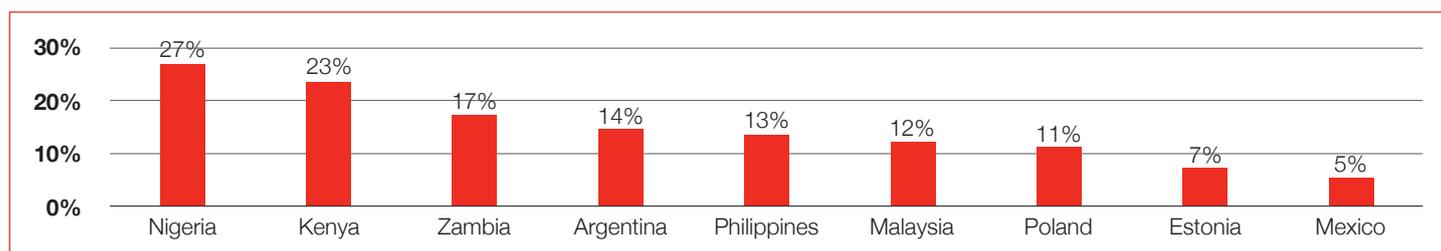


Figure 2: Refused employment or work opportunity because of HIV-positive status (previous 12 months)¹²

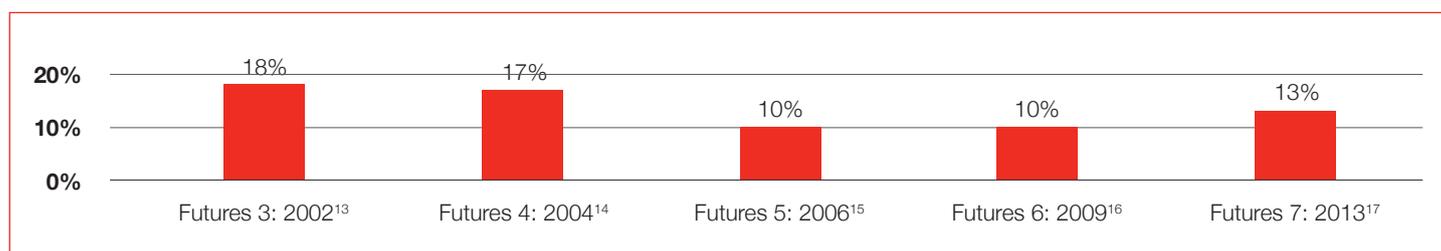


Figure 3: Received less favourable treatment at a medical service as a result of HIV (last two years)

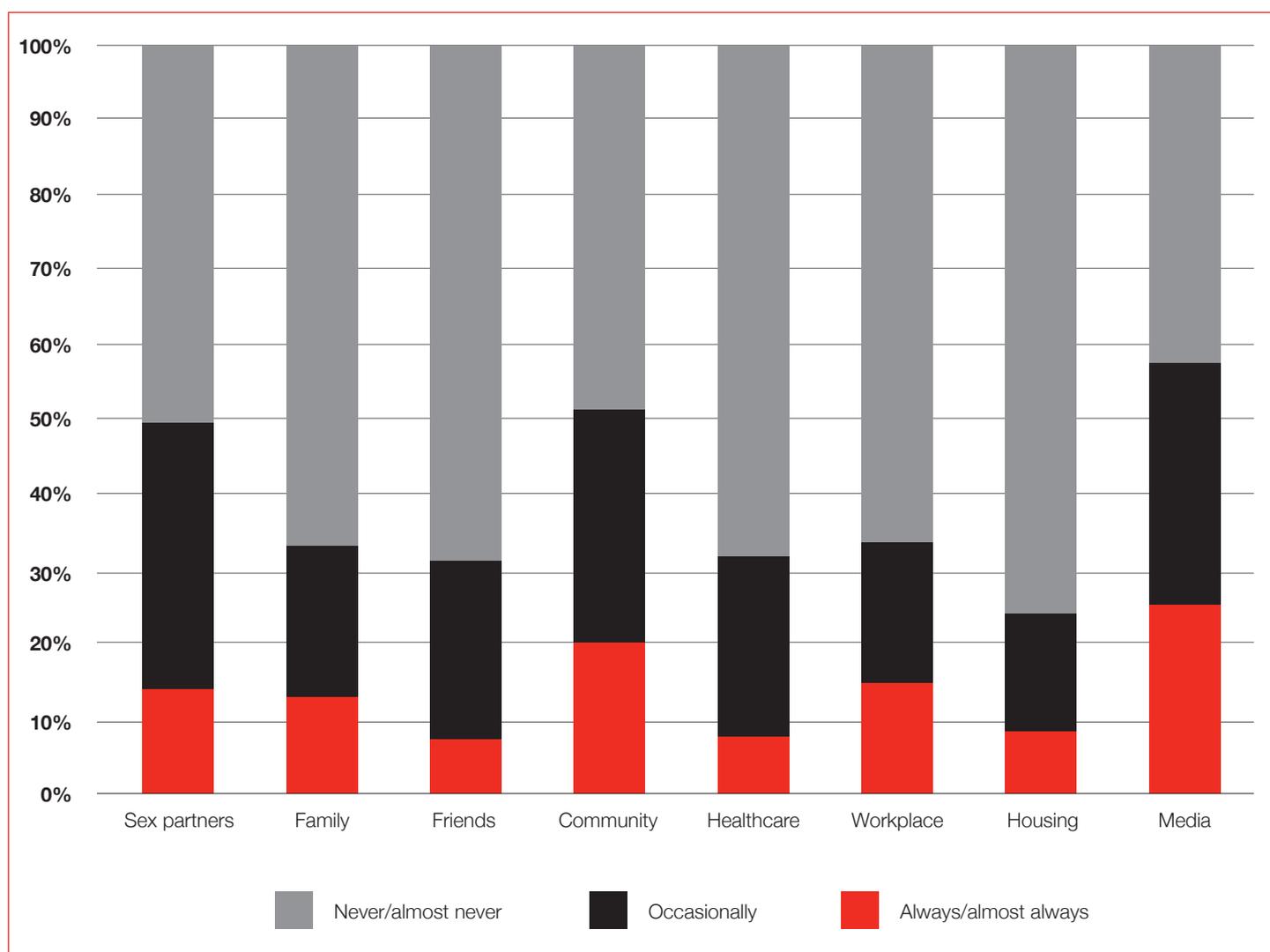


Figure 4: Feeling blamed¹⁸

That design should allow future use of the stigma audit methodology to show, not only changes in frequency, but also changes in degrees of stigma.

The importance of the Stigma Audit has been recognised in the Seventh National HIV Strategy, which notes the findings ‘will inform further efforts to both address and monitor the impact of stigma and discrimination over the life of this Strategy’¹⁹.

Development of international indicators

To be fair, Australia’s recent half-hearted efforts to ‘eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people’s health’²⁰, and our ambivalence towards human rights indicators do not rate particularly poorly by international standards. Official indicators to measure human rights abuses, stigma and discrimination, are generally lacking from international and state-based HIV strategies and we are without

a best-practice model from a comparable setting. That absence of standardised global discrimination indicators has been officially recognised as a barrier to the scale-up of human rights interventions.²¹ Fortunately, that may be about to change.

In February 2015, UNAIDS circulated a ‘Zero Discrimination Target: By 2020, everyone everywhere lives a life free from HIV-related discrimination’ a draft document which represents the culmination of at least six years work. (See Table 1, overleaf.) It outlines clear programmatic targets for 2020 and a second set of targets for 2030, as well as suggested indicators to measure them. Not only can discrimination indicators be named, some of them are already being collected. These indicators have the potential to enable consistent measurement of stigma and discrimination and the effectiveness of strategies to address them. But to be frank, their greatest impact may be in making the simple point that HIV-related stigma and discrimination

undermine HIV prevention, care and support, and governments need to do something about it.

The way forward

Across Australia, anti-discrimination laws make it unlawful to discriminate against any person with HIV or any person thought to have HIV. That is not enough. We know that people living with HIV in Australia continue to experience stigma and discrimination. At least 54% of those surveyed for HIV Futures 7 reported discrimination²², the most common forum being the healthcare sector. People continue to be prosecuted for failing to disclose their HIV status before sex, including cases where HIV was not transmitted. As an HIV sector, we do not scrutinise the number or nature of HIV-related complaints to anti-discrimination agencies around Australia. Learnings from legal casework is not effectively interfaced in our broad policy work.

Table 1: Summary of ‘Zero Discrimination Target: By 2020, everyone everywhere lives a life free from HIV-related discrimination’ (UNAIDS draft document, 17 February 2015).

Target by 2020	Examples of possible indicators
<p>1. Zero new HIV-related discriminatory laws and 50% of countries repeal existing laws No new HIV-related discriminatory laws, regulations and policies are passed, and 50% of countries that have such laws, regulations and policies repeal them.</p>	<ul style="list-style-type: none"> ■ Percentage of countries with overly broad criminalisation laws and number of new cases of overly broad HIV criminalisation prosecutions (Global Criminalisation Scan) ■ Percentage of countries with laws, regulations or policies that present obstacles to effective HIV prevention, treatment and care and support for key populations and women (National Commitments and Policy Instrument) ■ Percentage of countries with age-specific restrictions to HIV services (National Commitments and Policy Instrument) ■ Percentage of countries reporting that non-discrimination laws or regulations exist for people living with HIV, other key populations, and women (National Commitments and Policy Instrument) ■ Existence of laws and regulations that guarantee all women and adolescents informed choices regarding their sexual and reproductive health and rights regardless of marital status (National Commitments and Policy Instrument).
<p>2. <10% experience discrimination, harassment or violence Less than 10% of people living with HIV, key populations, women, girls and other affected populations experience discrimination, harassment or violence, including because of gender, gender-identity, sexual orientation, drug use, sex work, or age.</p>	<ul style="list-style-type: none"> ■ Percentage of people living with HIV reporting discrimination in community settings (PLHIV Stigma Index) ■ Percentage of people living with HIV reporting denial of health services, employment or education (PLHIV Stigma Index) ■ Percentage of HIV-related discriminatory attitudes towards people living with HIV by general population (Demographic and Health Survey, Global AIDS Response Progress Reporting) ■ Percentage of women who have a final say regarding their own health care at the household level ■ Percentage of key populations reporting stigmatising and discriminatory attitudes (Integrated Biological and Behavioural Surveillance) ■ Percentage of key populations who report physical violence in the last 12 months because someone believed they are members of key population groups (Integrated Biological and Behavioural Surveillance) ■ Percentage of key populations reporting physical violence identifying the police as the perpetrator(s) (Integrated Biological and Behavioural Surveillance) ■ Percentage of girls aged 15–19 years who report experiencing forced sexual intercourse or any other forced sexual acts, by age at first incident of violence (Demographic and Health Survey and Demographic and Health Surveys) ■ Percentage of countries reporting that the country has a policy, law or regulation to reduce violence against women (National Commitments and Policies Instrument, World Bank database).
<p>3. Zero denial of health services and zero discrimination in healthcare No one experiences denial of health services and sexual and reproductive health and rights, or discrimination in healthcare settings because of HIV status, gender, gender-identity, sexual orientation, drug use, sex work, age or any other grounds.</p>	<ul style="list-style-type: none"> ■ Percentage of people living with HIV, disaggregated by sex and gender identity, reporting denial of health services (PLHIV Stigma Index) ■ Percentage of healthcare staff reporting observed discrimination, discriminatory attitudes, drivers and manifestations of stigma (surveys in healthcare staff) ■ Percentage of key populations citing stigma as reason for not seeking HIV treatment and care (Integrated Biological and Behavioural Surveillance) ■ Percentage of women reporting ever being coerced into being sterilised by a healthcare professional since diagnosed as HIV-positive (PLHIV Stigma Index) OR No of cases and countries reporting forced or coerced sterilization against women living with HIV (International Community of Women Living with HIV) ■ Number of cases reported, investigated and adjudicated for by a legal authority on issues of discrimination, coercion and violence within the health system, disaggregated by sex, age, economic status and place of residence of the victim and other characteristics relevant to each country (through Sustainable Development Goal).
<p>4. 90% have access to justice 90% of people living with HIV, key populations and other affected populations who report experiencing discrimination have access to justice and can challenge rights violations.</p>	<ul style="list-style-type: none"> ■ Percentage of people living with HIV who sought redress where their rights were violated (PLHIV Stigma Index) ■ Percentage of countries reporting training programmes on HIV, human rights, gender equality and violence prevention and response for the judiciary ■ Percentage of countries where procedures or systems have been put in place to protect and respect the confidentiality in HIV-related cases ■ Percentage countries that fund access to justice services for people living with or affected by HIV.
<p>5. 90% of women control own sexual and reproductive health and rights (SRHR) 90% of women including adolescent girls, young women and women living with HIV can protect themselves from HIV through exercising their right to choose when and who to marry; when and with whom to have sex; how many children to have and how to protect themselves and live free of violence related to their HIV status.</p>	<ul style="list-style-type: none"> ■ Percentage of women and girls who make decisions about their own sexual and reproductive health by age, location, income, disability and other characteristics relevant to each country (Demographic and Health Survey composite). ■ Percentage of women (including women living with HIV) with unmet family planning needs (Demographic and Health Survey) ■ Percentage of women that have experienced physical or sexual violence from a male intimate partner in the past 12 months (Global AIDS Response Progress Reporting, Demographic and Health Survey).

The proposed global discrimination targets are less about facilitating nuanced academic measurement and analysis of HIV-related stigma and more about providing an advocacy tool: a blunt tool, but a tool nonetheless to add to our current poor arsenal of anecdotal versions of grassroots agencies' experiences, the odd conference paper and first person quotes.

Stigma and discrimination continue because of a failure to recognise the problem is systemic. Without specific strategies, and indicators to measure the success of those strategies, human rights will remain the poor relation of testing and treatment. The issue requires urgent action by the Commonwealth: leadership on the issue and the development of a mechanism with the political clout to deliver a set of indicators applicable to the Australian HIV epidemic.

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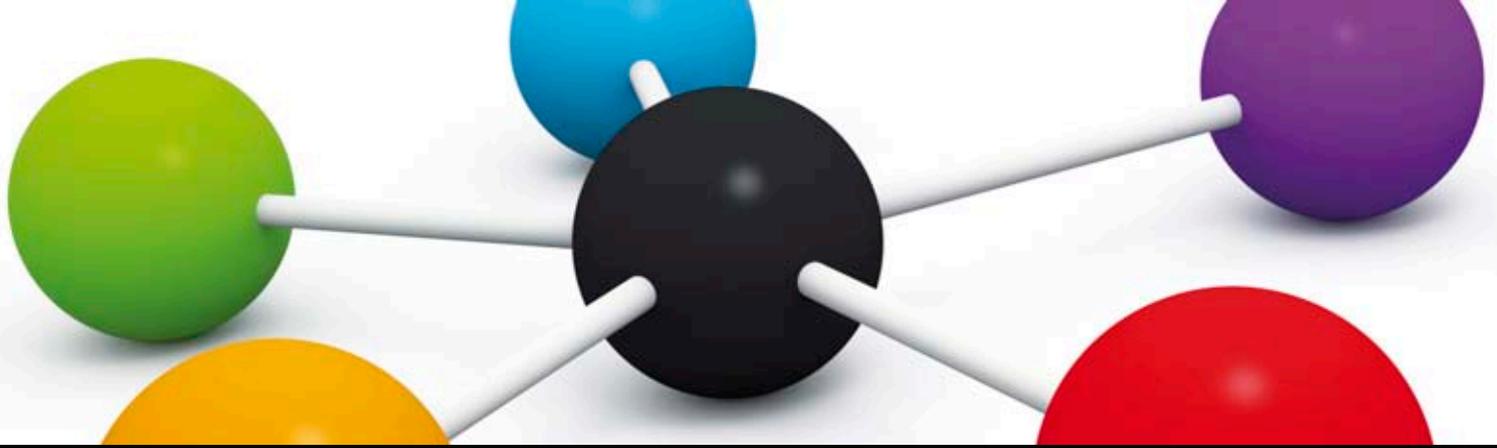


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Beyond combination prevention: understanding community-based prevention as a complex system

By Daniel Reeders and Graham Brown

What is combination prevention?

In a series on HIV prevention for *The Lancet* in 2008, Coates and colleagues describe combination prevention as behavioural, biomedical and structural approaches that are ‘combined strategically to address local epidemics’.¹

The concept originated as an analogy to highly active antiretroviral therapy. Instead of prevention ‘monotherapy’, it proposes to combine ‘potentially synergistic prevention activities’.² Coates et al., argue that behavioural interventions are ‘insufficient when used by themselves to produce substantial and lasting reductions in HIV transmission’.³ They suggest a multi-level approach is required that engages with individuals, couples, groups, networks, and communities, and integrates the behavioural, biomedical and structural aspects of prevention and treatment.

Put simply, the idea of combination prevention involves using a range of approaches simultaneously, at both the individual and higher levels, to respond to the needs of specific populations and address different modes of HIV transmission.

The discourse on combination prevention remains relatively vague about what strategy should guide the integration of programs in a combination prevention approach.^{4,5,6,7,8} The mere *addition* of complementary interventions is unlikely to achieve the bold targets that have been set for the global HIV response, even in a hypothetical scenario where they were perfectly integrated and coordinated.

Table 1: Features of combination prevention from UNAIDS guidance

- tailoring to national and local needs and conditions
- focus on the *mix* of programmatic and policy actions
- addressing both immediate risk and underlying vulnerability
- planned and managed to operate synergistically and consistently on multiple levels and over an adequate period of time
- requires and benefits from enhanced partnership and coordination
- includes mechanisms for learning and capacity building
- flexibility to permit continual adaptation to the changing environment

Source: UNAIDS⁹

These targets include the UNAIDS ‘90-90-90’ treatment goals (90% diagnosed, 90% on treatment, 90% achieving viral suppression) set out to be achieved by 2020.^{10,11}

The treatment goals are premised on the claim that the global epidemic is nearing a ‘tipping point’, a concept drawn from the science of complex systems and popularised by Malcolm Gladwell.¹² In a real world scenario, we know that ‘more is different’ – the components of a combination *can* interact synergistically, but with unexpected consequences.¹³ So it is surprising that the discourse on combination prevention has drawn so little on the science of complex systems to help understand these dynamics. Only *The Lancet* paper by Piot and colleagues mentions potentially relevant ideas such as complex adaptive systems and agent-based modelling.¹⁴

A recent scoping study by Graham Brown and colleagues suggests that most research on HIV prevention in developed countries has looked at one intervention

at a time, in isolation from both their potential interactions with other programs and the community and socio-political context of their implementation.¹⁵

New forms of research and approaches to policy making and strategy may be necessary to reach the full potential of combination prevention. This article will briefly review the findings of the scoping study and discuss what kind of research is needed to support planning and policy making for a genuinely systemic approach to HIV prevention. It will conclude by describing the work being done by the What Works and Why (W3) project to articulate the ‘system logic’ of peer and community based programs in HIV and hepatitis C prevention in Australia.

Findings from the scoping review

The scoping study looked at peer reviewed articles and grey literature (e.g., community published monographs and conference papers) from developed countries that were published between

2006 and 2013. The different kinds of intervention were categorised according to the framework used in *The Lancet* series¹⁶ and the September 2010 UNAIDS discussion paper on combination prevention¹⁷. The framework focuses on the level of social relationship or organisation that are targeted by HIV prevention interventions: from individuals and couples, groups and networks, to community and society. The scoping study reviewed papers for evidence and possible quality indicators for policy makers and program planners seeking guidance on how programs that work on different levels can be combined. The full findings have been published as a research monograph¹⁸ and this section will summarise its three main themes.

1) **An overwhelming focus on individual behaviour change**

The vast majority of studies reviewed were found to focus on formal, structured programs, underpinned by theories drawn from social psychology and health behavioural models, assessing short-term (up to 12 months) impacts on individuals.

2) **Evaluation of isolated effects rather than interactions**

The published literature was dominated by controlled trials using individually or group-randomised, or matched-case or quasi-experimental designs, where program activities stick closely to a standard protocol. These studies sought to measure the effect attributable to each intervention or program on its own, excluding effects attributable to interactions with other programs and the local community and socio-political context.

3) **Limited evidence on how to adapt programs to changing circumstances or to implement them in new contexts**

Developed countries like Australia have existing and often relatively well established and integrated programs for HIV prevention. Many of the included papers reflected the assumption that the interventions being tested would be implemented for the first time; few presented evidence on how to go about adapting existing programs to maintain or improve their effectiveness within the continually changing social and

scientific context of prevention. Few offered ‘program theories’^{19,20} that identify what mechanisms produce outcomes in context²¹ and offer guidance on what *functions* need to be preserved when interventions are adapted for new settings²².

What kind of research is needed?

Achieving ‘systemic prevention’ calls for a different approach to research. Rather than seeking to measure standalone effects for interventions in isolation from each other and abstracted from their context, research should help answer the policy-maker’s question: *what works, for whom, under what circumstances, and why?*²³ This question is about directing investment to where it can have the greatest impact. The answers are ‘complex’ in the sense of being *layered*²⁴ with knowledge about the activities, the context and target audience, not just average effect sizes.

Research is also required that informs a *strategy of combination* among programs that target and work on different levels. Understanding communities as complex adaptive systems^{25,26} enables research to identify local patterns of interaction and adaptation that create levels and emergent effects that are relevant to HIV prevention strategy. Such understandings may help identify ‘leverage points’ where investment in activities may be multiplied by the system into larger, more sustainable outcomes.²⁷

New methods are needed that focus on interactions between programs and between programs and context and their effects.²⁸ Systems science provides an expanded vocabulary for describing these interactions in terms of their behaviour over time, which might display delayed effects, feedback loops and more complex attributes like non-linearity and emergence.²⁹

For example, a multi-level, community-wide campaign may have delayed effects and if policy makers only looked at surveillance data, the situation might appear unchanged or even worse, even though the intervention was working as intended.

Non-linearity is reflected in the idea of ‘synergy’, where combinations have exponential rather than additive effects. Meeting the UNAIDS targets *depends* on this, but there is a lack of research and evidence on strategies to achieve it. Synergies can also occur in causal pathways

that produce risk and vulnerability, and these can also be subject to delayed effects: this is reflected in the popular idea of ‘tipping points’ that only become apparent when it’s too late to intervene in them.

The UNAIDS guidance on combination prevention calls for research to spell out and evaluate multi-step causal pathways between distal influences and risk behaviour.³⁰ What gets overlooked is that these ‘pathways’ are *predictions*. The more complicated these predictions are, the more likely they will turn out to be irrelevant or wrong, due to the rapid pace of change in the social environment around the program. Research can contribute here by describing and theorising ‘mechanisms’ – accounts of the ways in which program activities engage with social processes to produce outcomes of interest.³¹

Finally, programs generate knowledge as they adapt both to developments in prevention science and continual changes in their environment and communities. The knowledge they produce is strategically valuable, because rapidly changing environments impact on all prevention initiatives, but changes may take some time to appear in research findings. However, funding and evaluation arrangements can stifle the flexibility required for peer and community based programs to continually refine their effectiveness in changing circumstances.

Researchers can partner with community-based organisations and programs to develop new ways to strengthen, package and share this knowledge within the sector. This shifts the role of researchers from conducting independent evaluations to facilitation and strengthening of existing knowledge practices. The next section briefly describes work being done in the W3 project to explore this approach with peer-based programs.

Increasing knowledge sharing among peer based programs

The ‘Understanding What Works and Why’ (W3) project was funded for 2014–16 by the Commonwealth Department of Health to develop a monitoring, evaluation and learning framework for peer and community based programs in HIV and hepatitis C. In contrast with the majority of published literature reviewed in the scoping study (see above), the contribution of peer and community

based programs to the Australian HIV response is characterised by three things:

- flows of knowledge developed from peer insights enable programs to engage with, influence, and adapt to their constantly changing community and policy environments
- constant interaction with other programs – for instance, the way a needle and syringe program is a crucial referral node in a network of related clinical and social services
- influence across *multiple* levels – knowledge from one-on-one and small group work is frequently captured and used in the development of health promotion resources and messages for policy advice and participation.

The project aims to map out and theorise the ‘system logic’ of peer and community based programs. This has generated insights into how these programs interact across different levels and interfaces within their target communities and broader prevention systems. So far, the project has identified four key functions that any peer and community based program needs to fulfil in order to be effective in the medium term and sustainable in the long term. These functions are: Engagement, Adaptation, Influence and Alignment. The next year of the project involves working with partners to identify program-specific indicators of quality and effectiveness for each of the four key functions.

System mapping allowed the identification of different ‘scopes’ within the prevention system, based on kinds of knowledge generated by program activities. For instance, the *scope* (or ‘knowable horizons’) of health promotion differs greatly from that of counselling and clinical practice, which are more focused on individuals; it is also far removed from the clinical outcomes aggregated in epidemiological surveillance. Partnering between disciplines therefore involves *translation* between perspectives.³² This must be done well in order to genuinely integrate the contribution of behavioural, biomedical and structural approaches in a prevention system.

Conclusion

Reading the guidance on combination prevention together with the goals that have been set nationally and internationally for prevention, it should

be clear that simply adding prevention approaches together is not going to be sufficient. Research needs to engage with complex systems theories and methods in order to support policy makers and practitioners to create genuine prevention systems that engage the capacities of affected communities on multiple levels of adaptation and agency.

The W3 project blog can be visited online at: <http://www.w3project.org.au>

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Unlocking the medicine cabinet

By **Kathy Petoumenos** and **Aaron Cogle**

Your Medicare card is one of the most important cards in your wallet. Medicare is the only way people in Australia can access subsidised medications through the Pharmaceutical Benefits Scheme. For people living with HIV (PLHIV), a Medicare card is the key to the medicine cabinet. Without this little piece of inauspicious green plastic, the cost of treating HIV, alongside many other conditions, is beyond the reach of the average person.

However, some people living in Australia are denied what most of us take for granted. Temporary residents, students, people on business and employer-sponsored work visas, for instance, are not eligible for a Medicare card. HIV-positive people in these circumstances cannot access subsidised antiretroviral treatment (ART) through the Medicare system.

Without access to effective HIV treatment, health outcomes for these individuals are further complicated and compromised across the country,

and the risk of onward transmission of HIV is increased. It also puts increasing pressures on individual doctors and health professionals across public and private clinical settings about how to respond to these individual cases. This is at odds with the efforts of all governments and community partners to virtually eliminate HIV transmission in Australia by 2020.

For the first time, targets have been included in the National HIV Strategy by which we can measure our success and promote accountability. However, by their nature, targets represent only narrow aspects of what are in reality complex systems. This representative deficit has the potential to distort priorities and preference 'measured improvements' over 'actual improvements'. Our challenge is to ensure that the way we implement the Strategy recognises the diversity and breadth of the entire PLHIV population in Australia, regardless of visa status.

Sexual transmission remains the primary mode of HIV infection in Australia,

and the main focus for eliminating new cases of HIV. The current National HIV Strategy rightly targets priority populations such as people living with HIV, gay men and other men who have sex with men, people from HIV prevalence countries and their partners, sex workers, people who inject drugs, and people in custodial settings for the purpose of containing and eliminating HIV in Australia.

But how can key objectives of the Strategy be attained – such as increasing treatment uptake by people living with HIV to 90% and increasing the proportion of people on treatments with undetectable viral load (UVL) – when there are still HIV-positive people living in Australia who are being denied subsidised ART for their health maintenance?

The extent of this inequity and the potential impact on Australia is not fully understood. It is not known, for instance, precisely how many HIV-positive temporary residents there are in Australia

(although, according to estimates, there are around 450 HIV-positive patients who are Medicare ineligible in Australia at any one time¹). Which is why, in November 2011 – in collaboration with the Kirby Institute – the National Association of People with HIV Australia (NAPWHA) initiated ATRAS: the Australian HIV Observational Database Temporary Residents Access Study. ATRAS was established with the objective to systematically collect information on HIV-positive temporary residents ineligible for ART via Medicare.

Many HIV-positive people who are ineligible for Medicare are unable to afford the full price of antiretrovirals (cost estimates of first-line regimen such as Atripla come in at around \$12,438 per year²). People in these circumstances are therefore required to access treatment from a variety of sources including ordering from overseas, compassionate access, or by participating in clinical trials.

This is not ideal, as participation in trials and other access schemes is limited (particularly for people from culturally and linguistically diverse backgrounds). Also, ordering drugs from overseas can be risky – supplies can be delayed and interrupted.

As well, treatment options can be limited or unavailable in generic form, leaving patients to settle for combinations which are not ideal for their individual needs, or which today we would consider harsher or less effective drug options than the best standard of care an Australian patient can expect. In recognition of these issues, creating access to optimal treatment for this population was another important objective of ATRAS.

With this aim in mind, NAPWHA engaged all seven pharmaceutical companies with registered ART in Australia (AbbVie, MSD, Boehringer-Ingelheim, ViiV Healthcare, Gilead Sciences, Bristol Meyers Squibb and Janssen Pharmaceuticals) to commit to providing free treatment to HIV-positive temporary residents for the duration of the study (up to four years).

Between November 2011 and July 2012, 180 participants were recruited from clinical sites participating in the Australian HIV Observational Database (AHOD) commenced in 1999 and is a collaboration of 28 currently active tertiary referral centres, sexual health clinics and specialist

general practices throughout most states and territories of Australia). For inclusion into ATRAS patients had to be in both clinical and financial need.

It is unclear how representative patients recruited to ATRAS are of the entire HIV temporary resident population, but the study is a predominately male cohort (74%) with an average age for both men and women of 35 years. Almost half of the patients were from Asia/South East Asia (46%), a further 19% from sub-Saharan Africa, with the remaining from South America, the South Pacific, Europe and North America. Student and working visas proved to be the most common (35% and 34% respectively) followed by bridging visa (14%), spousal (13%) and other (13%).

The main mode of reported HIV exposure among men was through homosexual sex (66%), followed by heterosexual transmission (23%). Among women, the majority reported heterosexual contact (85%). Less than 2% of ATRAS participants reported injecting drug use as a mode of HIV exposure.

At entry, only 63% of participants were on ART and less than half (47%) of the entire 180 had UVL. After one year of follow-up, however – where all participants were receiving effective and uninterrupted ART – 88% had UVL, with CD4 cell count increases on average of 123 cells/ml.

After two years, the proportion with a UVL had increased to 96%, with CD4 cell counts up to an average of 185 cells/ml. These immunological and virological improvements clearly highlight the importance of supplying ART to this population in need.

In April 2015, the AHOD investigators, in collaboration with the ATRAS reference group, will be releasing two years of follow-up data. The data focuses on long-term outcomes of patients, including changes in their Medicare eligibility status. It also includes updated estimates of the current number of HIV-positive patients who are ineligible for Medicare in Australia, while living here legally as temporary residents.

By November 2015, it is estimated that 61 of the 180 ATRAS patients will still be Medicare ineligible and therefore will not have access to an ongoing supply of ART. As there will no longer be this study, or any other type of national scheme in place, alternative arrangements are required.

Without a clear policy in place – one that is not only applicable to people living with HIV, but also to others, such as those living with hepatitis C, or other chronic illnesses – the situation presents an obvious deficit in current public health policy. Such a deficit will compromise the National HIV Strategy's overarching goal of virtually eliminating HIV by 2020.

The ATRAS report provides convincing evidence to justify providing antiretroviral treatment to all temporary residents living with HIV, based not only on patient health outcomes but also public health objectives – mathematical modelling demonstrates that providing treatment to people in such circumstances will avert a median of 80 new infections over six years.

In Australia, our response to HIV is guided by major national strategies focused on the control and elimination of communicable disease at the population level. We cannot ignore vulnerable groups at risk, and clinicians should not be left to try and manage these issues alone. Let's get behind a truly national response to HIV, one which addresses the needs of all Australian residents, however temporary they may be. These people cannot be left behind.

The full ATRAS report will be available on the NAPWHA website from April 2015.³

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Impetus for change? The importance of targets and regulatory reform to ending HIV

By **Karen Price** and **Nicolas Parkhill**

Five years out, targets that have been set for 2020 are looming larger in the consciousness of HIV policy makers, advocates, community educators and health workers. Drawing on experience in NSW, it is reasonable to suggest that setting targets has the capacity to energise and revitalise the response to HIV, but only if those targets are accompanied by supportive environments and technological advancement. This article explores some of the benefits of setting targets, and also some of the limitations that are hindering progress.

Setting targets is a way for jurisdictions to prioritise what matters within its health system.¹ Increasing healthcare costs mean that there is greater pressure on health organisations to be as efficient and effective as possible, and accountability is increasing in these fiscally constrained times.

The 2011 National Health Reform Agreement signed off by the Council of Australian Governments (COAG) was the most notable use of targets to drive performance in recent years.² These reforms introduced public accountability and reporting of performance in an unprecedented manner. While robust arguments can be posited to suggest the success or otherwise of these reforms, one thing is irrefutable: targets, data collection and public reporting had an influence on the health system, focusing attention of administrators and health professionals alike.

Around this time, the world was learning of emerging evidence of the role that

treatment could play in preventing new cases of HIV. The results from the HIV Prevention Trials Network's HPTN052 study demonstrated a 96% reduction in HIV transmission in serodiscordant heterosexual couples.³ This 'game-changing' finding coincided with the arrival of a new state government in NSW, a government which – after 16 years in opposition – challenged the dominant markers of 'success' in containing HIV; low and stable rates were not enough – they wanted to see reduction.⁴

The confluence of new scientific evidence, a new and bold government, and a willing sector saw NSW embrace an HIV Strategy that sought to capitalise on new understandings about the relationship between HIV treatment and HIV prevention – 'Treatment as Prevention' – to drive dramatic change.

*The NSW HIV Strategy 2012 – 2015: A New Era*⁵, includes the following targets:

- reduce the transmission of HIV among gay and other homosexually active men by 60% by 2015, and by 80% by 2020
- reduce the average time between HIV infection and diagnosis from 4.5 years to 1.5 years by 2020
- increase to 90% the proportion of people living with HIV on antiretroviral treatment, by 2020.

The NSW Government further illustrated its serious commitment to these strategic targets by taking the strong step of incorporating targets into the performance expectations of the public health system and relevant non-government organisations (NGOs), with performance targets for chief executives of the Local Health Districts (LHDs) directly linked to the Strategy. This has driven enormous change, particularly in the area of HIV testing.

The impetus for change saw a number of important developments.

Firstly, the target driven approach necessitated a change to data collection – and, importantly, more frequent data releases. A government setting bold targets wants to know how the system is tracking on delivering on those goals. In the space of a year, HIV data went from an annual collection of data, reported well after the surveillance period ended, to quarterly data, issued weeks after the close of the quarter. This timely feedback to the system has been invaluable, as has the growth in the sophistication and depth of data analysis.

Secondly, to its credit, the NSW Government heard the voices of community advocates who mounted a convincing argument that the overly cautious regulatory environment was holding back progress in NSW (and

indeed Australia), and preventing the rollout of community rapid test services. HIV rapid tests have been approved for use in community settings in comparable overseas countries for quite some time but in Australia, protracted Therapeutic Goods Administration (TGA) application and approval processes have undermined efforts to rollout community testing across Australian jurisdictions.

It was clear to all that to achieve the bold targets in the Strategy, more gay men needed to know their status and that for this to be possible, HIV testing needed to be faster and more convenient. The regulatory environment was moving too slowly, so the NSW Government funded a trial, run by the Kirby Institute using the TGA research concessions. This meant that Local Health Districts and community partners could provide rapid HIV testing services in NSW for the first time.

Thirdly, use of new technology under the Kirby trial has allowed for development of more flexible and attractive service delivery models. Over the course of the last 18 months, ACON has undertaken a process of service realignment and worked with our clinical partners to establish a network of HIV and sexually transmissible infections (STI) screening services in community-based settings across NSW. Initially with one site, there are now four sites operating – including a permanent shop-front service on Oxford Street, Sydney’s iconic ‘gay strip’.⁶ Models in regional NSW involving peers, and ‘pop up’ testing sites have been trialled on World AIDS Day and at community events such as Tropical Fruits in Lismore.

Central to the seismic change to policy and services settings, has been ACON’s reconceptualisation of how it delivers peer-led, community-driven education

programs, with recognition that a more sophisticated, longer-term dialogue with gay men is required. One of the many outputs of this dialogue has been the development of ACON’s multi-award winning campaign platform – Ending HIV. Successive evaluation reports of the campaign have demonstrated a significant shift in community understanding, attitudes and behaviours when it comes to safe sex, testing and treatment – and crucially, regarding treatment as prevention science.

The planning and execution of these campaign phases have built upon each other, using modalities including social media, online platforms, physical spaces, community outreach, and population-wide high impact activations. Key words for the NSW HIV sector are scale-up, innovation and advocacy. In a relatively short space of time, the HIV testing landscape has changed markedly, and the results have been dramatic, with significant increases in testing among gay men and other men who have sex with men sustained across these years⁷, and testing rates almost doubling from 2011 to 2014 across five Local Health Districts.

Targets, tools and regulatory reform

Despite such strong commitment from government and the sector, legislation and regulatory policy can create public health ‘road blocks’ – particularly when it comes to the early adoption of new technologies at scale.

While it would be reasonable to suggest that stronger scientific evidence and experience are producing broader-based support for ‘new ways of doing business’, there remains no real access in Australia to key innovations such as home testing kits and pre-exposure prophylaxis (PrEP). The access that has been achieved to date has been largely granted through policy ‘workarounds’ by way of research trials. These are useful in the short-term but programming on this basis is, of course, unsustainable. This situation effectively means that those working hard to achieve the promise indicated by the research, and backed by government strategy, are potentially being held fully accountable for outcomes for which we only have half the tools. Regulatory barriers have created vulnerabilities and a situation that is

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difficult to imagine in comparable areas of public health.

Australia remains well behind comparable countries on HIV rapid testing:

- To date only one HIV rapid test has been approved by the TGA for use in non-clinical community settings (the Alere Determine Antigen/Antibody test).
- Issues including regulatory delays and lack of clarity regarding sensitivity criteria mean that manufacturers are not rushing to lodge TGA applications for HIV rapid tests. As yet, there have been no applications for approval of an HIV rapid test device for self-use/home use and it is unclear whether any manufacturers intend to lodge an application in the near future.
- No rapid test has been listed on the Medicare Benefits Schedule and none is under consideration by the Medical Services Advisory Committee.

There is also a lag in responding to growing community awareness and demand for PrEP in Australia, fuelled by demonstration projects underway in NSW and Victoria, and overwhelmingly positive interim announcements made by the PROUD (UK) and IPERGAY (France) PrEP trials (full results of which are anticipated later in 2015).^{8,9}

While it is understood that Gilead are likely to be applying to the TGA to have Truvada licensed as PrEP, the staged application process means that even if an application is lodged soon, a decision is unlikely to be made until mid-2016 at best. Pending TGA approval of Truvada as PrEP, Australian HIV specialists may prescribe Truvada as PrEP off-label.

National guidelines have been developed by ASHM (the Australasian Society for HIV Medicine) for clinicians prescribing PrEP. Once the TGA has approved Truvada as PrEP, enhancing PrEP access will depend on Pharmaceutical Benefit Scheme (PBS) approval, but access is likely to remain severely limited given the likelihood that PBS eligibility criteria will be very narrow. Glaciers have been known to move faster In the meantime, people are purchasing Truvada and other HIV antiretrovirals for use as PrEP from overseas via the internet, or over the counter during travel, and there is limited

information available regarding dosage and timing.

The determination of gay men to take control of their sexual health by finding ways to get around regulatory blockages is of no surprise to ACON – gay men have been the key actors in HIV prevention for three decades. It is entirely understandable that men want to take advantage of new ways of preventing HIV transmission – it is very much in keeping with gay men's full commitment and participation in HIV prevention over almost 30 years.

What has compounded this frustrating situation is conflicting advice from the TGA as to whether there are legal restrictions in place that limit or stop community and other public health bodies advising people about how to access new evidence-based and effective biomedical prevention technologies. The situation is beyond sense in that we were given to understand that any health organisation that had the audacity to assist its community members to look after their health by providing them with contemporary information on choosing the safest products and using them safely could potentially be penalised for doing so. We have recently been advised that in fact we are free to provide such information – this is great but it is extremely frustrating that we were previously advised otherwise.

Conclusion: are targets enough?

The experience in NSW suggests that setting targets has been very helpful. The fact that those targets were embedded into the reporting arrangements across the sector was essential to giving them real effect. The bold strategic direction, coupled with strong performance targets, data collection and public accountability for results has raised the profile and given priority to HIV, which remains a chronic and incurable disease that elevates the risk of cancer, cardiovascular disease, and diabetes.

However, setting targets can only achieve so much. Change in a range of other areas – including data collection and feedback, technology, service delivery models and community education and awareness must all play a role. Without community mobilisation – in recognition that significant reductions in HIV transmission are possible – no change will

occur, regardless of how bold the target or startling the science.

Advocacy has always been at the core of achievements in HIV over three decades. While the achievements in NSW over the past two years provide real cause for optimism, there are serious concerns that the counterproductive effect of the slow, expensive and hostile regulatory environment in Australia will circumvent public health, jurisdictional leadership and individual capacity. 2020 is looming large, and our community deserves a more supportive regulatory environment as it continues to fight HIV.

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Infection or detection? Mediating the message of increased testing

By Andrew Burry

It seems logical to say that if you increase the rate of HIV testing within a target community, you will be hoping to see an increase in diagnoses among that population. The aim of testing is to identify infection and without an increase you may well conclude that your testing program is misdirected or otherwise unsuccessful. But how do you respond when there is a significant rise in HIV notifications and the media conclude that the safe sex message has been lost? How can you show this is due to increased detection and not infection?

In 2014, Western Australia recorded a total of 139 new diagnoses. This represented an overall increase of 16% compared to 2013, and was driven almost entirely by a 27% increase among gay and other homosexually active men (GHAM). Significantly, the 2014 result was double the rate of 2009 and the highest annual total since 1991.

On 24 January 2015, *The West Australian* reported the increase under a headline: 'HIV rise points to safe sex decline', and quoted health authorities as being worried that the safe sex message has fallen off the radar in WA. The rise (among gay men) was labelled as alarming. Interviewed for the same article, the WA AIDS Council had a different take on the latest epidemiology: we said it would have been much more alarming if there hadn't been a rise, given the significant investment that has gone into testing over recent years.

As we have come to expect, our view of the situation was inadequately reported and readers were once again left with an impression of irresponsible gay men discarding their condoms with an air of 'complacency'.

In arriving at a position that differs somewhat from the more commonly reported view, we were not indulging in a process of wishful thinking. Far from it, as, in fact, the available evidence provides strong support for our view.

The evidence

The first significant indicator is the notification data itself.

As Figure 1 shows, there is a very clear rising trend of rising HIV notifications among gay men and other homosexually active men while all other categories are trending downwards or stable. During the five years prior to 2010, the notifications for this group of men were relatively stable, at around 35–40 in each year. So what happened in 2010/11 to trigger such a significant and ongoing increase in diagnoses among this category?

In July 2010, we opened M Clinic for business. M Clinic is a sexual health screening service specifically (and only) for gay and other homosexually active men. It operates five full days per week and includes two evening sessions for those unable to make appointments during normal business hours. The clinic offers a full suite of tests for HIV and sexually transmissible infections (STIs), including hepatitis, and provides treatment for all infections diagnosed, with the exception of HIV.

The testing offered by M Clinic is entirely additional to the testing services already available in Perth, and so the immediate impact was a dramatic increase in specialist testing availability. Not only has the clinic operated at capacity from day one, it was necessary to relocate to a larger premises within 18 months of opening. M Clinic now has 3,300 clients.

The other sexual health clinics continue to report that they are operating at full capacity, so the conclusion has to be that since the advent of M Clinic there are now more GHAM testing, and testing more often.

There is further evidence for this.

Although Figure 2 only includes data through to the end of 2013, it shows the trend of male testing over a five-year period. In 2010 (when M Clinic opened), the testing rate per 1,000 men was 40; this rate rose steadily until, by 2013, the rate was 50 – an increase of 25%.

Over the same period, the rate of positive test results (as measured per 1,000 tests conducted) stayed constant at 1.5. So what does this mean? If you test more men and increase diagnosis numbers at the same rate of positivity, wouldn't this suggest that the prevalence of undiagnosed existing HIV is declining – or alternatively, that the additional tests are being targeted where they are not needed?

One observation over the last year is the increase in the number of homosexually active men diagnosed in general practice. As Figure 3 (overleaf) demonstrates, the proportion of total diagnoses in general practice has remained constant at just over one third. However, when general practitioner (GP) data is further examined as shown in Figure 4 (overleaf), something interesting emerges.

Of significance here is the change in the reason for an HIV test. In absolute numbers, those presenting with symptoms suggestive of HIV where a positive diagnosis was subsequently made was the same in both years (10). The big changes are in the positive diagnoses where the patient reported risk behaviour with an HIV-positive person (a fivefold increase) and as a result of STI screening (a threefold increase).

Whilst we have long been encouraging GPs to proactively encourage their patients to consider sexual health screening, we have no evidence that they have been doing so. The two categories of HIV notification increase are thus seen as resulting from patient initiation or requests. Why would so many more GHAM be requesting tests from their existing or new GP? One possible explanation is onward referral from M Clinic. The popularity of the clinic

means that increasingly it is impossible to offer appointments when a client wants one. In such circumstances, those clients are strongly encouraged to try another sexual health service or general practice rather than wait until they can be seen at M Clinic.

It is acknowledged that the GP data covers only two years and further work needs to be done here, but it nonetheless provides fairly strong circumstantial evidence in support of believing that detection rather than infection is driving recent epidemiology.

Implications for health promotion

If the rise in HIV notifications among gay and other homosexually active men is a result of increased testing rates, can we conclude that there has not been a decline in safe sex? No!

A rise in risk behaviour – even a significant one – is completely compatible with a conclusion that rising notifications are resulting from increased testing. In reality, the increase in the effectiveness of modern treatments and greater ease of adherence together with the increased proportion of diagnosed HIV-positive men on treatment who are maintaining an undetectable viral load means that it has never been ‘harder’ to acquire HIV. Even if the number of men living with HIV continued to grow, community infectivity can still be declining. Even if the number of serodiscordant sexual interactions was increasing, new infections/transmission could still decline.

Increased testing rates that result in new diagnoses reduces the level of undiagnosed HIV amongst the GHAM population. This leads to less undiagnosed and infectious HIV in the community and a declining acquisition/transmission risk overall.

Moreover, the more GHAM that know their HIV status (as at their last test), the more accurate status disclosure is, if made. This then results in improved effectiveness of other risk reduction strategies, including serosorting and strategic positioning.

However, an increase in risk behaviour undermines the benefits that increased testing offers, and if the increase in risk behaviour was extreme, this could entirely negate the positive effects of increased testing. There is no suggestion that efforts

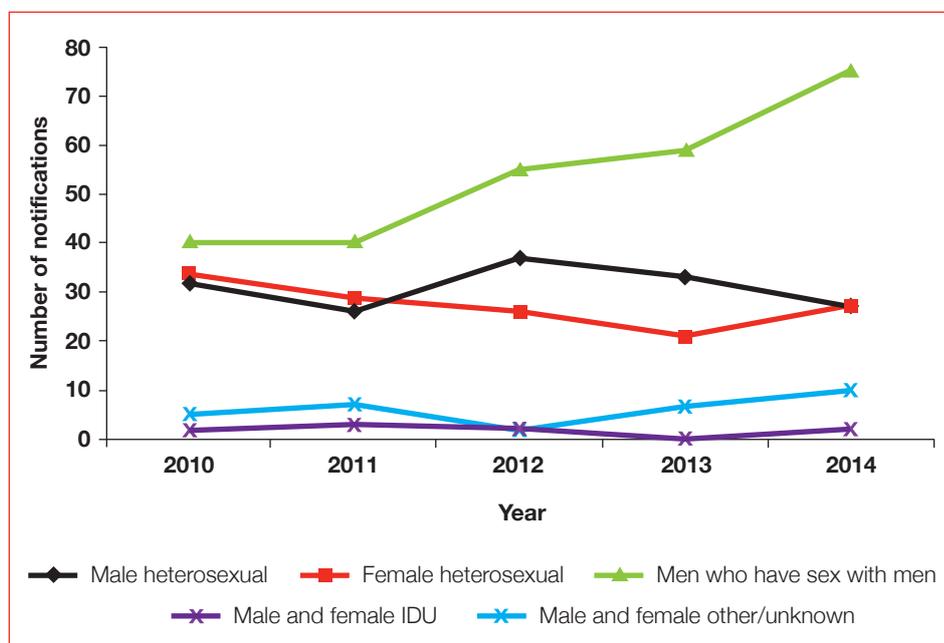


Figure 1: HIV notifications by mode of transmission. Source: WA Communicable Diseases Control Directorate published epidemiology report.¹

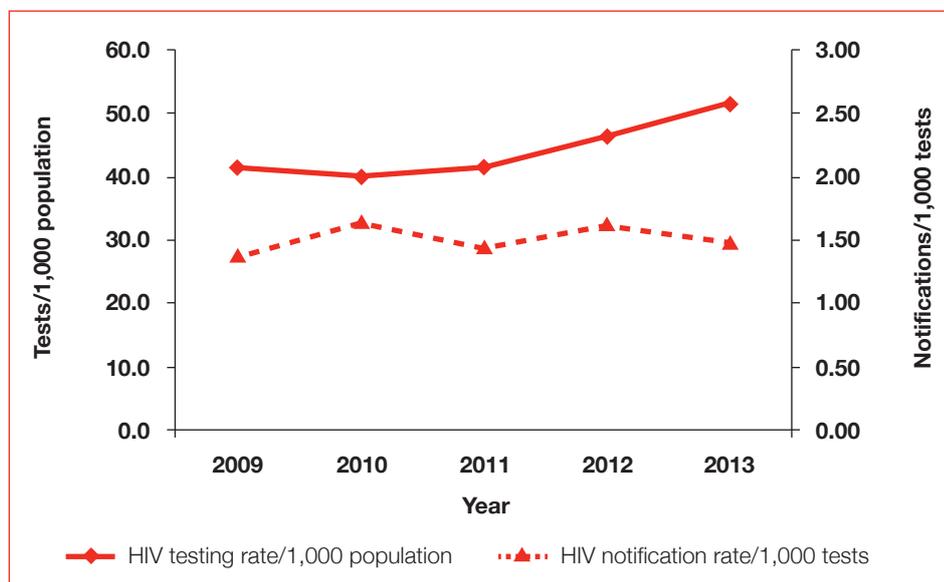


Figure 2: HIV notifications by mode of transmission. Source: WA Communicable Diseases Control Directorate published epidemiology report.²

to promote safer and better-informed sexual behavioural choices can be relaxed.

What is important is that there seems to be very clear evidence both from within WA, as well as nationally and internationally, that of all the behavioural changes we ask GHAM to consider, increasing testing and frequency of testing is the most likely to occur.

It is also clear that peer-based testing, particularly in community settings, is effective in achieving increased testing rates. This leads to an additional advantage of providing (in the case of Perth) 7–8,000 risk conversations that may well encourage other better-informed choices.

And so ...

It is not unusual for there to be differences of opinion between those that comprise the partnership response to HIV in WA or in Australia generally. A range of perspectives is surely one of the points of partnerships. One thing we are all agreed upon, though, is our commitment to a variety of targets in the Seventh National HIV Strategy and the United Nations 2011 Political Declaration. Principally, we are all dedicated to the notion of substantially ending HIV by 2020.

As a community organisation rather than a scientific one, the WA AIDS Council perhaps has a luxury of greater freedom in

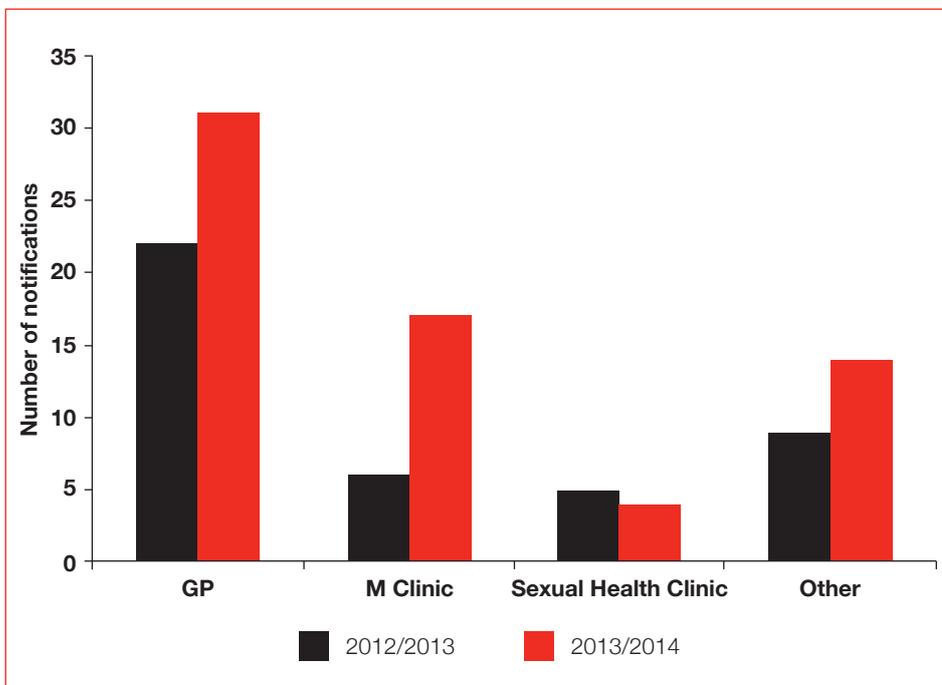


Figure 3: HIV notifications among men who have sex with men (MSM) by clinic of diagnosis, October to September period Source: WA Communicable Diseases Control Directorate published epidemiology report.³

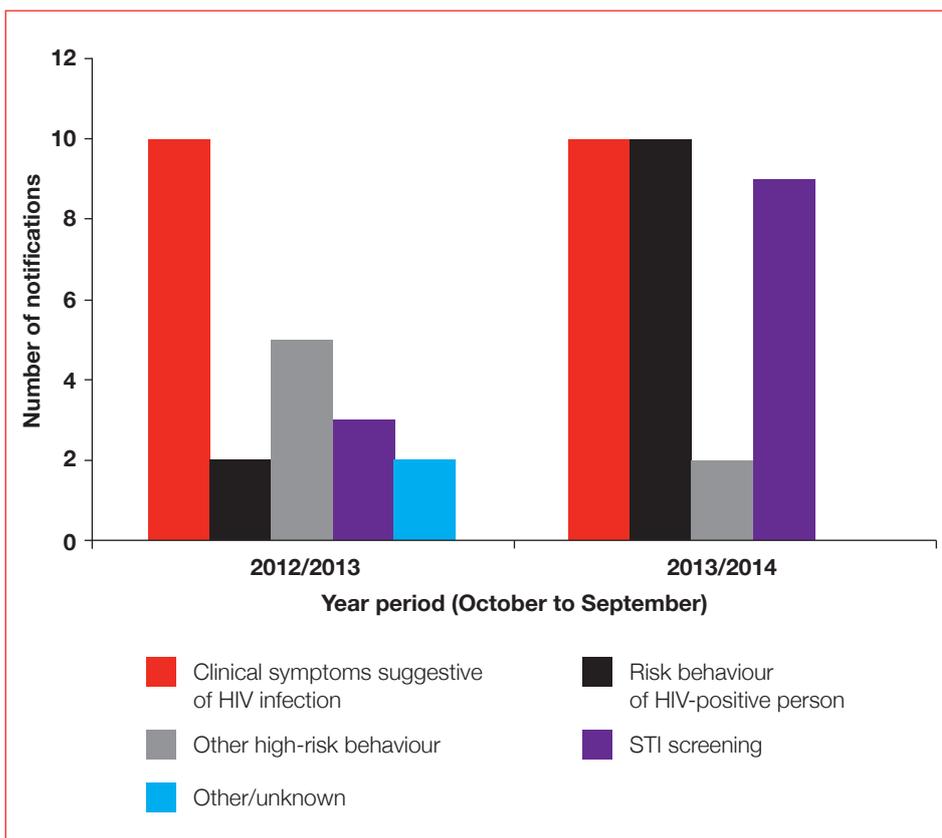


Figure 4: HIV notifications among MSM by reason for HIV test – GP. Source: WA Communicable Diseases Control Directorate published epidemiology report.⁴

interpreting and acting on the evidence it sees. The Council also has the benefit of sourcing information, evidence and other insights from a richer variety of sources. For example, we have almost 8,000 direct and individual face-to-face interactions with GHAM each year and can claim a better understanding of the current living experiences of GHAM in our jurisdiction and beyond.

Our view of the immediate challenge may seem simplistic. As long as we diagnose at a faster rate than new infections occur, we will reduce prevalence, increase the proportion of those with HIV on effective treatments and sooner or later we will see epidemiology reflecting falling rates of new HIV diagnoses.

We asked homosexually active men to step up and get tested or get tested more often and they have responded. The increase in diagnoses is an encouraging sign. It would be unfortunate, to say the least, to ‘blame’ these same men for HIV data that may be politically difficult and then to accuse this community of being complacent.

Nobody can now doubt the impact of peer-based sexual health services for GHAM. They require some investment; indeed, M Clinic absorbs \$750,000 each year, excluding the costs of pathology and treatment.

But our four years’ experience in WA should encourage other jurisdictions to recognise the importance of further increasing investment in peer-based testing programs in support of achieving our 2020 targets.

Some may believe that the jury is still out, but we think the verdict is in. It’s detection not infection in Western Australia.

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Australian women and the 90-90-90 targets: what does the data tell us?

By **Jennifer Power**

The latest National HIV Strategy includes, for the first time, numeric targets for reducing the rate of HIV transmissions in Australia. Based on the United Nations (UN) 2011 Political Declaration on HIV/AIDS, the targets aim to position Australia to achieve the UN objectives of 90% of people living with HIV being diagnosed, 90% of HIV-positive people receiving antiretroviral (ARV) treatment and 90% of people having an undetectable viral load – the 90-90-90 targets.

Achieving 90-90-90 will require a broad focus on the social experience of living with HIV/AIDS as much as it will on prevention and testing. Improving rates of care and treatment is more achievable in an environment where people living with HIV feel safe to disclose their HIV status. Issues that may affect this, such as poverty, discrimination and geography, become part of a mix of relevant issues.

Australia's National HIV Strategy reflects this, specifically identifying the

importance of quality health care and the creation of an 'enabling environment' in which stigma and discrimination are acknowledged as potential barriers to testing, care and treatment.

However, within the Strategy there is virtually no focus on women living with HIV – particularly women who sit outside target groups (sex workers, women from high prevalence countries, travellers, Indigenous women). This is not surprising given women have always been a minority within the total population of people living with HIV in Australia. The 2014 National Surveillance data indicates that around 13% of new HIV diagnoses in 2013 were among women. Overall, 10% of Australian people living with HIV are women.

But ten percent is not an insubstantial figure – a perspective that can be lost within public health statistics. Efforts to achieve 90-90-90 will need to be designed with some reflection on the discrete needs and experiences of these women.

Women in research

There is limited research on women living with HIV in Australia. In part this is because it is difficult to attract funding for research with women, given it is likely to have less impact on the trajectory of the HIV epidemic as a whole—smaller numbers, smaller impact. Women's stories tend to become a sub-plot, buried understandingly in the Australian context within the central narrative of the lives of HIV-positive gay men. HIV Futures, one of the larger studies of people living with HIV (PLHIV) in Australia has, however, always had some representation of women.

HIV Futures is an ongoing, cross-sectional study of people living with HIV in Australia. The study has been run every two to three years by the Australian Research Centre in Sex, Health and Society, based at La Trobe University in Melbourne. The first version of the study was conducted in 1997 and the most recent (HIV Futures 7) in 2012.

Data collected through HIV Futures has played an important role in guiding policy, community and health service responses for people living with HIV in Australia and includes indicators for the National HIV Strategy.

There were 1,058 responses to HIV Futures 7¹ from HIV-positive people living across Australia. Of these, 70 responses (7%) were from women. This is a smaller number than would be ideal (something we hope to address in 2015, with HIV Futures 8), but 70 women is still sufficient to offer some insight into the social world of women living with HIV.

A picture of women living with HIV in Australia

So, what is it like to be a woman living with HIV in Australia?

Of the 70 women who completed the HIV Futures 7 survey, the majority were born in Australia or New Zealand (72%) and spoke English at home (84%). Just one woman reported that she was an Indigenous Australian. Of those born outside of Australia, the largest group were from African countries including Botswana, Ethiopia, Kenya, Malawi, Rwanda and Zimbabwe. There were two women born in South East Asia and a small number from Europe.

Participants included women from all states and territories of Australia. Fifty percent lived in a capital city or inner suburban areas, while 30% lived in a regional or rural area.

The average age of women was 45, although ages ranged from 25 through to

76. Some had been living with HIV for up to 30 years, whilst others had tested positive only several months previously.

The majority of women had contracted HIV through sex with men (75%), while 12% has contracted the virus through injecting drug use. Thirty-five percent had contracted HIV overseas.

Half the women (50%) had received their positive diagnosis at their first-ever HIV test. Many were tested because their partner or ex-partner had tested positive.

Family

The majority of women (85%) identified as heterosexual and 50% were in a regular relationship or married at the time of the survey. There were 12 women (17%) who were in an ongoing relationship with a known HIV-positive partner.

The majority of women who responded to the survey (71%) were parents. This included 33 women (47%) who were living with dependent children, 10 of whom were single parents (14%). Motherhood was significant to many women, with 64% indicating that it was important or essential to their self-identity. Four women reported that they had at least one child who was also HIV-positive.

The impact of HIV on women's lives

It is difficult to quantify the impact of HIV on any individual's life and no research findings will ever tell the complete story. But there is always some indication.

There were stories of loss within the lives of some women who responded to

HIV Futures 7. Two women had lost a child to HIV/AIDS, while eight had lost a partner to HIV/AIDS.

Almost half the women surveyed (48%) had been diagnosed with a mental illness at some point in their life. This included 40% who had been diagnosed with depression. At the time of the survey, 25% were taking medication for a mental health condition. While it is likely that mental health problems were not directly related to HIV for many of these women, these are higher than average rates of mental illness.

Many women surveyed reported that HIV had affected their sexual and intimate relationships. For some, this was related anxiety about disclosing their status to potential partners whilst others reported that HIV had a negative impact upon their sexual pleasure or desire. Indeed, there were 24 women (34%) who reported that they stopped having sex due to their HIV status. Despite this, a number of women reported that being diagnosed with HIV had helped them form more satisfying relationships (32%).

On another optimistic note, the majority of women responding to HIV Futures 7 did not regard HIV as having greatly affected their career or capacity to work. However, this was not the case for everyone. Forty percent of women surveyed reported that being diagnosed with HIV had negatively affected their career path, with 12% indicating that contracting HIV ended their career. Related to this, money was a source of stress for many women: 35% were reliant on a pension or social security as their main source of income; and around 68% reported they had difficulty managing costs of living such as paying for utilities. Some women had also experienced discrimination at work following breaches of confidentiality regarding their HIV status.

Treatment, care and information

While the majority of women surveyed (81%) were currently taking ARV treatment, the number was below the 90% target. Fourteen percent had previously taken ARVs and stopped, while less than 10% had never commenced treatment (although, of these, 85% said they would consider using antiretroviral drugs in the future). Seventy-one percent reported that

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Data collected through HIV Futures has played an important role in guiding policy, community and health service responses for people living with HIV in Australia and includes indicators for the National HIV Strategy.

their viral load was undetectable at their most recent test; again, well below the 90% target.

Of the women who had stopped taking ARVs, the most common reasons cited were difficulties taking the medication due to side effects and/or a recommendation by their doctor. One woman noted she stopped for the first trimester of her pregnancy, while one other had wanted to see how she would go without medication.

Most women indicated that they were satisfied with the process through which their ARVs were prescribed and prescriptions were filled, although around 21% mentioned that they found it difficult and inconvenient to fill prescriptions at specialist locations and were keen for this to become accessible through local pharmacies. Only a small number of women reported that the cost of ARV medication was difficult to manage.

Looking forward

While the findings presented here offer a useful picture of women living with HIV in Australia, it is worth noting some important gaps. Indigenous women are clearly under-represented in the HIV Futures sample as are migrant women and

those who do not speak English as their first language.

That said, these findings do sketch some patterns that are worth noting. Many of the women surveyed did not consider themselves to be at risk of contracting HIV prior to their diagnosis. Sitting outside affected communities, Australian women are less likely to be seeing GPs with a high HIV caseload and less likely to consider testing. Anecdotal reports from young women recently diagnosed in Australia have suggested that HIV is not on the radar for women or their doctors when they first become ill.

The findings of HIV Futures 7 point to several issues that are likely to affect the care and treatment of many women living with HIV and these will be explored further in HIV Futures 8. Mental health stands out as an area of concern. Whether or not there is a direct relationship between HIV and issues such as depression or anxiety, these findings certainly indicate a need to support mental health and wellbeing in women living with HIV. From a public health perspective, positive wellbeing is associated with better physical health and greater capacity to engage in healthcare systems and self-care.

With indications that treatment rates and viral loads among women are below target levels, it is important that women are considered in efforts to achieve 90-90-90. The success of these endeavours will require a comprehensive understanding of the way that women with HIV access care and treatment within the contexts of their lives.

Data collection for HIV Futures 8 will begin mid-2015. There will be a dedicated focus within this survey on collecting information about the lives of Australian women living with HIV. For more information please contact jennifer.power@latrobe.edu.au.

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How can we set targets without the evidence? Achieving recognition for all women living with HIV in Australia

By **Alison Boughey, Autumn Pierce** and **Michelle Wesley**

On the first day of the 20th International AIDS Conference in Melbourne in July 2014, the Council of Australian Governments (COAG) Health Council released the *AIDS 2014 Legacy Statement*, a statement agreed to by all of Australia's Health Ministers pledging to work towards the virtual elimination of HIV transmission in Australia by the end of 2020. The *Seventh National HIV Strategy 2014–2017* outlines how Australia intends to meet this ambitious target. It identifies eight priority populations to which Australia's HIV response will be targeted in order to maximise its impact and sustainability.¹

While women are a subgroup of seven of these eight priority populations named in the Strategy, they are not identified as a priority population in their own right. This makes planning and implementing a tailored, targeted response to women challenging. The absence of women as a distinct priority group on the national

HIV agenda will hinder efforts to achieve an AIDS-free generation at a time of unprecedented opportunity.

Although the National HIV Strategy is developed in response to the latest data about HIV in Australia, the methods of data collection that inform key publications dealing with the epidemiology of HIV in Australia do not include an accurate representation of women's experiences of living with HIV in this country.

Take, for example, the HIV Futures Survey – Australia's national survey about health, treatments, work and the financial situation of people living with HIV. The Futures survey is highly regarded as one of the most comprehensive pictures of life with HIV in Australia; however, when looking at the most recent survey data (HIV Futures Seven, 2013), the sample size of HIV-positive women who participated does not reflect the percentage of women living with HIV

in Australia. Out of the 1058 survey participants in HIV Futures Seven, only 6.7 percent were women², whereas the percentage of women with HIV within Australia's overall population of people with HIV is estimated to be around 10 percent³. Clearly, a more targeted recruiting approach is required to increase the number of women respondents and improve the applicability of the findings.

It is also essential that gender-segregated analysis and reporting of the data is undertaken. In Futures Seven, aside from the demographic summary, reported data is only segregated by gender in the sections relating to relationships and children. An absence of analysis around the gender-related disparities in the HIV experience that extend beyond sexual and reproductive issues has significant consequences for organisations supporting women with HIV. Further evidence to inform an understanding of the non-sexual, social aspects of the lives of women

with HIV would be extremely helpful. This could be derived by including questions regarding the influence of personal characteristics and cultural context on respondents' sense of identity, sources of social support and gaps in the availability of current support.

The Kirby Institute 2014 Annual HIV Surveillance Report does provide useful gender-specific data relating to women and HIV transmission via heterosexual contact, however again, the data presented in the body of the report are focused on priority populations, as per the National Strategy. This means that women are only mentioned if they are also members of a priority population, such as sex workers, people who inject drugs and/or members of Aboriginal or Torres Strait Islander communities. The absence of 'women' as a subcategory in surveillance reports, and the limited capacity of surveillance data in general to provide contextual details about the lives and needs of women living with HIV, means that these reports offer little to meaningfully inform service provision for women.

The fact that these two highly-regarded publications are key documents referred to by policy makers in developing the country's HIV response may go some way to explaining why the needs of women are not being prioritised as a part of Australia's HIV response. A priority population should be defined not only by the raw numbers of people affected, but by the service delivery challenges the population presents. From the limited data that we do have, we know that women have an entirely different experience of living with HIV than men and face unique barriers to prevention and treatment. Known differences in modes of transmission, biological susceptibility, geographical accessibility, socioeconomic status, testing patterns, service use, health seeking behaviours, perceptions of risk and attitudes towards treatment all provide a robust starting point for service provision, but more sound, reliable information is desperately needed to inform strategic decision making.^{4,5}

On an international scale, women and girls are the number one priority in the response to HIV. In 2010, Michel Sidibé, Executive Director of UNAIDS reported on progress to date and said, 'This epidemic unfortunately remains an

epidemic of women.'⁶ More recently, in her address at the 2014 AIDS Conference in Melbourne in July 2014, Dr Lydia Mungherera said, 'I think the face of the pandemic is a female face.'⁷

The epidemiology of the virus differs in every country, but some of the same factors that put women at risk in Uganda or Cambodia are putting women at risk in Australia. The difference is that in international settings, resources have been allocated to identify gender-related disparities as a result of biological, structural and cultural factors and have been more fully integrated into the international HIV response.

More detailed data collection, analysis and reporting would assist organisations supporting women with HIV, such as Positive Women Victoria, to improve service delivery and efficacy and provide a stronger foundation for evidence-based advocacy. Data that accurately supports the legitimacy of women to claim priority population status would also go some way to helping combat the social stigmatisation experienced by many women.

For many women, stigma associated with their HIV status is experienced differently to the stigma men experience and yet is not often differentiated from that of men. Women must cope with what Reidpath and Chan referred to as 'layers' of stigma or multi-dimensional stigma.⁸ In addition to having a feared, contagious disease, women are also frequently ascribed the label of 'character deviance'. Their perceived role as vectors of disease to their unborn children adds another layer of vulnerability and judgement. The complex networks of relationships in women's lives and the structures which shape them must be considered when developing policies and services in the Australian context.

Optimistically, promising changes are underway. For the first time, the HIV Futures team, which is scheduled to commence data collection for the Futures 8 survey in the second half of 2015, has designed a parallel data-collection approach targeted at women. This will enable examination of issues specific to women with HIV and, it is hoped, produce gender-segregated HIV data that will allow services to more appropriately target their offerings to women's needs. Positive Women Victoria, as the only community-based organisation specifically

funded to support women living with HIV in Australia, will continue to support the efforts of researchers who endeavour to accurately capture the experiences of women living with HIV.

In addition, Positive Women is currently providing input into the work being undertaken by Victoria's Department of Health and Human Services to support the development of key strategic priorities and actions that will enable Victoria to achieve the Legacy Statement goals. Importantly, we will also be working towards the recognition of women as a priority population in the next National HIV Strategy. This is essential to create an enabling environment where women of all backgrounds, cultures, ages and experiences feel confident about accessing HIV testing, prevention and treatment services.

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Human rights, race and sexuality in the Pacific: regarding others as ourselves

By **Michael Kirby**

On 31 October 2014, at the University of Fiji, the Hon. Michael Kirby AC CMG, gave the Sir Moti Tikaram Memorial Lecture of 2014, entitled 'Human Rights, Race and Sexuality in the Pacific – Regarding Others as Ourselves'. This lecture, excerpts of which follow below, honours Sir Moti Tikaram's legacy of fighting against discrimination based on race and ethnicity in Fiji, and reflects on current discrimination against lesbian, gay, bisexual transgender and intersex (LGBTI) people across the region.

Conceiving the other: sexuality

It is usually easy to conceive the other, in terms of people who are different from oneself. People of different skin colour will often be immediately identifiable. They stand out. And this can cause discrimination. Sir Moti Tikaram experienced this in his lifetime. But he lived long enough to see the global struggle against racial discrimination: the end of 'White Australia' in the Australian Commonwealth¹; and the overthrow of apartheid in South Africa with the creation of the new constitution promising equal justice to people of all races. He also saw the same issues played out in his own country, Fiji. By his work and example, he contributed to a resolution of those issues, conformably with universal human rights.

It is normally difficult for a person to disguise their sex or gender. Features of their physiognomy, body shape, size and vocal and other characteristics tend to mark the difference. Interestingly, according to evidence, many transgender people, even those who wish to undergo gender reassignment surgery, assert that cosmetic surgery designed to soften facial features can be as important as any surgery altering the genital organs. Dress and physical presentation can also make sexual differences stand out or fade away. Such people are all too often regarded as 'other'. A deep atavistic animosity sometimes gives rise to stigma and discrimination against those 'others'.

In five international bodies, in recent times, I have witnessed and contributed to the attempt to terminate stereotypes, this

time on the basis of sexual orientation and gender identity:

■ In the International Commission of Jurists (ICJ), in 1988, I proposed a number of new human rights topics. They included deprivation of human rights on the grounds of HIV status and also on the grounds of sexual orientation. Most of my proposals were readily accepted by my colleagues. However, one of them, relating to sexual orientation, was contested. A distinguished African colleague declared that there were no cases of homosexual people in his country. Any who existed were regarded as 'deviants', deserving the full force of the criminal law. I argued against this attitude. Eventually, my view prevailed. Sexual orientation was adopted as a program objective of the ICJ.

■ In 2009, I delivered a plenary address to a conference of the Commonwealth Lawyers' Association (CLA) held in Hong Kong.² This conference was followed by a strong recommendation by the CLA, calling for the removal of punitive laws addressed to men who have sex with men in 42 countries of the Commonwealth which retain such laws. That was quoted by the judges in the Naz Foundation case in 2009 in India, declaring the anti-gay criminal law unconstitutional.

■ Between 2010–11, I served on an Eminent Persons Group (EPG) of the Commonwealth of Nations. The EPG addressed future challenges faced by the Commonwealth. Among the challenges were the rights of people living with, or exposed to, HIV/AIDS and the rights of sexual minorities, discriminated against by reason of their sexual orientation or gender identity. In its report of October 2011, the EPG recommended that:

*'Heads of Government should take steps to encourage the repeal of discriminatory laws that impede the effective response of Commonwealth countries to the HIV/AIDS epidemic, and to commit to programmes of education that would help a process of repeal of such laws.'*³

HIV/AIDS was identified as an urgent Commonwealth priority. Centres of the epidemic exist in Africa, Asia and the Caribbean where

there are many Commonwealth nations. Removal of the criminal laws against Commonwealth citizens who are members of the LGBTI minority was strongly recommended by the unanimous voice of the EPG.⁴ The EPG took a pragmatic stance:

*'Repeal of such laws facilitates the outreach to individuals and groups at heightened risk of infection.'*⁵

■ Between 2010–12, I served on the United Nations Development Programme (UNDP) Global Commission on HIV and the Law. In the report of that Commission, *HIV and the Law: Risks, Rights & Health*⁶, recommendations were made unanimously by the Commissioners. Strong proposals were made to all countries concerned to repeal all laws that criminalise consensual sex between adults of the same-sex and/or laws that punish homosexual identity.⁷ The recommendations called for anti-discrimination laws and for the promotion of measures to prevent violence, particularly against men who have sex with men. Further recommendations were made towards reform of the law on transgender people (TG). An affirmation of the identity and privacy of TG was emphasised.⁸ The UNDP Commission called for removal of all laws that punish cross dressing and ensuring that people should be able to have their affirmed gender recognised in identification documents.

■ Finally, in 2013–14, I participated in the deliberations of the Council of the Human Rights Institute (HRI) of the International Bar Association (IBA) on this topic. The IBA recognised, and asserted, the support of lawyers worldwide for the removal of criminal laws against LGBTI people, by reason of their sexual orientation. It called for these laws to be changed.⁹

I recount these activities not to boast. But to show that a lot is now happening on many fronts.

Sexuality in the Pacific

Unfortunately, in many countries of our world, including in the Pacific region, the advances in the legal rights of LGBTI people in the past decade have often been disappointing.

If regard is had to the position of LGBTI rights in Pacific countries, the position now reached is that eight out of 14 nations still criminalise same-sex sexual activity; 12 out of 14 do not have any anti-discrimination laws that include sexual orientation and gender identity as protected grounds; and 14 out of 14 provide no recognition to the personal relationships of same-sex couples. Yet, in the past 10 years, five of the 14 states of the Pacific have decriminalised same-sex sexual activities (Fiji, Marshall Islands, Niue, Palau and Vanuatu).

In the case of Fiji, the country's sodomy law was declared unconstitutional under the then *Fiji Constitution* in the decision in *McCoskar v The State*.¹⁰ Then, by the Constitution of Fiji of 2013, discrimination (relevantly) on the basis of 'sexual orientation, gender identity and gender expression' was prohibited.

Fiji has provided an example sorely needed in the Pacific region, because of the failure of other Pacific nations to take the recommended course of action. Its President gives a lead at home and at international conferences. However, Fiji too needs to do more in terms of anti-discrimination law, relationship recognition and reform of the colonial laws on sex work.¹¹

There is some good news appearing on the horizon concerning the repeal of criminal laws against LGBTI people in the Pacific. [In] the Cook Islands, a new amended *Crimes Act* has been prepared, although not yet enacted. This deletes all explicit criminal prohibitions against same-sex sexual activity.

Additionally, the new *Criminal Code* 2014 of Palau, which entered into force on 23 July 2014, decriminalised adult, private, same-sex sexual activity. In Samoa, the *Crimes Act* 2013 criminalises 'sodomy'. The previous *Crimes Ordinance* 1961 (Samoa) also criminalised 'indecent between males'. The latter provision was removed by the *Crimes Act* 2013 (Samoa) which entered into force on 1 August 2013. The same statute of 2013 also removed the previous offence of a 'male impersonating a woman'.

Save for these changes, the moves in the directions urged by the EPG and UNDP have been almost non-existent in the Pacific. Papua New Guinea still operates

under the *Criminal Code* 1974 (PNG), a gift of Australia in colonial times, which imposes sanctions on 'sexual penetration against the order of nature' and 'indecent practices between males'. Attempts by Dame Carol Kidu, Commissioner of the UNDP Commission, to gain support for decriminalisation in PNG fell on deaf ears during her service as a member of the PNG Legislature.

The urgency of securing reform arises out of the fact that funding for the Pacific struggle against HIV and for treatment of those infected has evaporated or certainly diminished. Some citizens were (and in some places still are) highly stigmatised: transgender people, sex workers and men who have sex with men. It is likely that many of them, with legal help, may seek to harness human rights provisions in their national constitutions that mandate that all citizens are equal.¹²

The same is true of Solomon Islands. The penal law of Solomon Islands criminalises 'buggery' and 'indecent practices between persons of the same-sex'. There are no relevant anti-discrimination laws.

We now know that sexual orientation and transgender status are not 'lifestyles', wilfully adopted by minorities to challenge divine and local law. They are inbuilt features of human beings (and other mammalian species). Therefore, imposition of criminal punishments and withdrawal of protection from discrimination, constitute irrational and unscientific responses to the characteristics of the persons concerned. LGBTI people search for love, support and companionship as much as heterosexual people do. The evidence of today's world suggests that LGBTI people will not die out or go away. They will increase in vigour and insistence and will continue to gather supporters from the broader community because of the irrationality and unkindness of this type of law and its effect on the peace and wellbeing of good citizens and on their communities, particularly as they struggle against blood borne diseases, especially HIV and the cruel disease of hatred.

Sir Moti's instruction and example

Sir Moti Tikaram did not grapple expressly (so as far as I am aware) with the issues of diversity presented by sexual

orientation and gender diversity. But he did show us the way by his lifelong opposition to racial discrimination and inequality.

I feel the same obligation to raise my voice in respect of hostility and discrimination on the ground of sexual orientation as well as transgender and intersex identity and status.

Eventually, human beings will build a world that removes from the minds of human societies the medieval hobgoblin and unscientific presuppositions that have caused such hatred, pain and violence to sexual minorities. We need leaders like Sir Moti to shine the light on the way forward. And that way forward will invoke the Golden Rule that is a feature of all of the world's great religions. To do unto others as we would wish them to do unto ourselves.¹³ Sir Moti Tikaram lived by the Golden Rule. So should we. So should our countries. So should our laws. We should all be advocates for this principle. It lies behind the universal rules of human rights and the international law that sustains those rules.

If Sir Moti Tikaram were with us today, I believe that he would endorse these sentiments. And he would say to those in doubt: I am doing and saying this for your benefit. So that you will inherit a world that is free of unjust hostility, discrimination and violence. That is the world that we must build everywhere. And particularly in the beautiful region of our planet that bears the marvellous proclamation and commitment: 'Pacific'.

The full text of this lecture will be published in the *University of Fiji Law Journal* (forthcoming, 2015).

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The Hon Michael Kirby AC CMG retired from the High Court of Australia on 2 February 2009 as Australia's longest serving judge. Since judicial retirement, his current achievements include being a member of the Eminent Persons Group which is investigating the future of the Commonwealth of Nations, and appointment to the UNDP Global Commission of HIV and the Law.



Imagining an Australia with PrEP

By **Heath Paynter**

As awareness about HIV pre-exposure prophylaxis (PrEP) grows in Australia, the US experience with PrEP, where it has been approved since July 2012, offers some useful insights.¹ Using that experience as a starting point, this article will consider the major issues associated with PrEP and raise questions that Australia might need to consider. The data around PrEP's effectiveness in preventing HIV will not be reviewed here, other than to say that the science is clear: if an individual takes Truvada daily, they are not at risk of acquiring HIV.^{2,3,4,5}

PrEP and moral panic

The debate on PrEP in the United States has often been cast in black and white terms, and what is missing in much of the early commentary is a coherent defence of PrEP.

Since its approval by the US Food and Drug Administration (FDA) in July 2012, uptake of PrEP among men who have sex with men (MSM) in the US has been slow.⁶ The initial public discourse centred around fears that it would displace condom use. This commentary largely focused on promiscuity and condomless sex and overlooked the complex ways in which people have sex and manage risk.

In 2013, when the Centers for Disease Control and Prevention (CDC) announced that condomless sex among men who have sex with men had increased 20 percent between 2005 to 2011⁷, a report in *The New York Times* said that this figure was spurring HIV fears and 'heightening concerns among health officials worldwide'⁸. In *The New Yorker*, columnist Michael Specter wrote, 'If unprotected anal sex is rising among gay men ... the rates of HIV infection will surely follow.'⁹

Around the same time, Michael Weinstein, the head of the AIDS Healthcare Foundation¹⁰ said PrEP 'shows just how disposable we consider the lives of gay men'¹¹ and that PrEP was 'a plot by Gilead to force young people onto unnecessary medication.'¹² Weinstein has also sought to cast PrEP as 'a party drug'.¹³

The public comments in the US about PrEP have shaped perceptions of this HIV prevention strategy. In so doing, prospective recipients of PrEP have been judged through the lens of deviancy, recalcitrance and otherness, rather than being appreciated as individuals who are making a decision to improve their sexual health, wellbeing and reduce their risk of acquiring a chronic illness and, by extension, their reliance on the public health system.

US endorsement of PrEP

It took almost two years for the CDC to release clinical guidelines on, and by implication, endorse PrEP.¹⁴ This was followed by a joint letter from 66 HIV/AIDS organisations in the USA supporting the CDC's endorsement.¹⁵ By mid-2014, as awareness of PrEP in the US increased, New York Governor Andrew Cuomo endorsed PrEP as part of a project called The Campaign to End AIDS (C2EA), targeting individuals at high risk of HIV.¹⁶ This incorporated PrEP into a three-pronged plan to end the AIDS epidemic in New York State.

Similarly, in San Francisco PrEP is part of Getting to Zero, a plan which aims to reduce HIV infections in San Francisco by 90 percent by 2020.¹⁷ These strategies seem to be having some impact, with evidence that PrEP use in the US is increasing, although uptake is still not as widespread as many advocates had hoped.^{18,19}

Accessibility

Given PrEP's effectiveness as an HIV risk reduction strategy, affordability is critical if PrEP is to reach the individuals who stand to benefit the most from it.

In promoting PrEP, advocates should not just focus on the costs of the medication, which in Australia is \$800 per month, but rather consider the preventative health benefits that PrEP offers.

In the US, the Affordable Care Act potentially creates a new framework for coordinating the delivery of prevention services. In the context of PrEP, individual patients sign up for regular testing, which includes counselling around PrEP use and opportunities for addressing mental health issues, alcohol and other drug issues, sexually transmissible infections (STI) screenings, and other ancillary services to be addressed through primary care. For those with medical insurance, the insurer will cover the cost of Truvada. The amount of the co-payment covered by the insurer depends on the level and type of cover.

PrEP in the US involves regular medical consultations providing people who belong to low socio-economic communities with a high prevalence of HIV the opportunity for routine medical screening and linkages to healthcare services they might not otherwise have. PrEP is often considered through the template of the cost of Truvada alone, and not as a tool that provides individuals at high risk of HIV with access to healthcare settings, medical testing and counselling that people who belong to low socio-economic communities would not otherwise have.

Given the preventative benefits PrEP offers, we need to consider whether there is an ethical imperative to extend the benefits of antiretroviral treatment to HIV-negative people in equal measure

to the way it is extended to HIV-positive people. Guidelines on PrEP have been developed by the Australasian Society for HIV Medicine (ASHM) for clinicians who may be consulted regarding PrEP. Pending TGA approval, this is for off-label use or for imported medications, and has been informed by guidelines developed for PrEP demonstration projects in Victoria, New South Wales and Queensland.²⁰

If PrEP were to be approved in Australia, one of the challenges for physicians and policy analysts will be ensuring that PrEP reaches individuals and populations who can benefit most from it.

In the US 'racial disparities in clinical judgment and prescription practices related to HIV treatment have been well documented ... The limited specificity of existing guidelines [for PrEP] potentially heightens the risk of discriminatory prescription practices occurring as they have with prescribing antiretroviral treatment [for positive people], thus posing a potential barrier to access [for high risk individuals from low socio-economic backgrounds.]²¹ Despite evidence of 'high interest' identified among men who have sex with men (MSM) involved in a recent US PrEP demonstration project²², researchers noted that there was low uptake among black MSM and transgender women, saying that 'additional strategies to increase community awareness of PrEP and engage these populations in PrEP programs are urgently needed.'²³

Ensuring PrEP reaches African Americans and people of colour at high risk of HIV appears to be an ongoing challenge in the US. In January 2014, the NYC Department of Health released guidelines for prescribing PrEP.²⁴ While these guidelines are more specific and highlight population groups who should be offered PrEP, they do not address the potential for racial discrimination amongst prescribers in the US. Nor do they address the fact that the people most at risk of HIV are also unlikely to be linked to health care services and, more critically, have medical insurance.

If non-specific guidelines are adopted in Australia the concern is how do we reach individuals at high risk of HIV beyond those already linked to sexual health services? For instance, recently arrived migrants from countries with a high prevalence of HIV who are less likely to

frequent sexual health clinics and have fewer specialist health services, or others who because of their circumstances are at risk of HIV?

Reshaping the prevention narrative

In the US, PrEP guidelines identify 'men who have sex with men who engage in unprotected anal intercourse' as candidates for PrEP.²⁵ Because of its effectiveness at blocking HIV, PrEP potentially permits sexual behaviours that traditional public health norms and HIV prevention strategies have rejected or considered less effective than condoms. At this level, PrEP has the potential to reshape HIV prevention norms and, in turn, herald a more dynamic approach to HIV prevention, both practically and morally.

Historically, condoms have been the first-line strategy for reducing the risk of HIV transmission. In contrast, condomless sex, or barebacking, has been stigmatised and condemned as an action that endangers. The real challenge with PrEP is challenging attitudes towards condomless sex.

For PrEP to reach individuals who can most benefit from it, safe sex needs to be understood, in the words of one commentator, 'as a dynamic practice that takes different forms in different historical and cultural contexts.'^{26,27} Condomless sex has always been a part of the gay sex narrative, however, in the past the tools available to attenuate the risks of acquiring HIV through barebacking were limited to 'serosorting', 'strategic positioning' 'undetectable viral load', and 'PEP' (post-exposure prophylaxis) in the event of accidental exposure. PrEP augments these existing strategies by allowing individuals to manage risk prospectively, regardless of condom use.

Stigma and shame

If PrEP is to reshape HIV prevention, the gay community needs to welcome PrEP as a strategy that supports the health and wellbeing of certain individuals, and not as a strategy that is reserved for individuals who are seen as shirking their responsibility to use socially acceptable prevention strategies like condoms. One of the interesting areas of commentary about PrEP in the US has been around the issue of stigma and PrEP, or more specifically the trope, 'Truvada whores'.²⁸ I am referring here to stigma not from outside

the gay community, but from within: gay-on-gay shaming. Stigma of the kind Dan Savage fuelled when he said of gay men and PrEP, 'The guys these sensible health care folks are trying to reach are not sensible. They are self-identified idiots who can only be saved by a vaccine'.²⁹

This sentiment casts PrEP as the last resort prevention strategy offered to those who are considered *non-compliant* with socially accepted prevention strategies, like condom use. It stops a wider interrogation of a new and highly effective risk reduction method that for certain people could provide considerable health benefits, and a wider discussion about safe sex and gay men's sexual behaviours.

PrEP and the Australian context: where to from here?

To capitalise on the opportunities presented by this new HIV prevention paradigm, general practitioners (GPs) need to provide an available and safe space for individuals to talk candidly about their sexual risk so that their candidacy for PrEP can be objectively evaluated. As discussed, physician subjectivity may preclude certain people from being granted PrEP, but this depends on the individual making it to a consultation in the first place.

To encourage individuals to discuss their readiness for PrEP we need to consider how we can focus the PrEP narrative on sexual health and wellbeing rather than on a narrative that codifies a PrEP recipient as a recalcitrant or an individual in need of special care. If the narrative focuses on the benefits of PrEP, individuals will be more likely to enter into a conversation with their GP about the possibilities of PrEP. A narrative that casts PrEP as lacking in credibility, and the potential recipients as bad will lead to non-engagement and disinterest amongst those who can benefit from PrEP, a situation that, it would appear, characterises the US context thus far.

PrEP is not going to end the epidemic alone, and the cost effectiveness of this HIV prevention strategy is still to be properly understood, but for those individuals who might be prescribed PrEP its impact in terms of reducing the risk of HIV and the anxiety associated with being at risk of HIV is considerable.

If in Australia we can empower the community to recognise PrEP as an additional measure in the suite of prevention tools available to specific individuals who are unable to consistently use condoms, the hope is that those who can benefit most from PrEP will get access to it.

So what do I imagine happening in Australia?

I imagine AIDS organisations and Positive organisations supporting the availability of PrEP to individuals who want to avoid HIV acquisition. The approval of PrEP needs to be accompanied by a framework that supports GPs and the community to understand PrEP. This should include guidelines for GPs that support the availability of PrEP to individuals and minority groups with a high prevalence of HIV who might not be connected to primary care.

Community organisations should be resourced to provide health promotion that engages the community and raises awareness about PrEP. This could be through community fora and/or the provision of PrEP education workers. Studies will also be needed to interpret the data generated by demonstration projects underway in some states³⁰, and additional research to monitor community attitudes, knowledge and expectations of PrEP. This should also include research to arm prescribers with knowledge about minority and disadvantaged communities with a high prevalence of HIV who could benefit from PrEP.

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Drug policy and criminalisation: more harm than good

By **Ele Morrison**

As a young volunteer in a drop-in centre for drug users in Yunnan Province, China, I was advised that above all I was there to 'do no harm'. It was some of the best advice I have ever been given.

Harm reduction is, as the name implies, an approach that is meant to reduce harms associated with using drugs. It realistically recognises that punishing people for drug use, drug dealing and drug trafficking will never be able to stop illicit drug use completely. Instead, it includes the provision of injecting equipment and opiate substitution programs like methadone with the main aim of reducing transmission of blood borne viruses such as HIV and hepatitis C.

Harm reduction services have been provided in Australia for almost thirty years and are still one of the most effective health programs ever put in place. In Australia alone, tens of thousands of hepatitis C and HIV transmissions have been prevented since the services were first rolled out. As well as saving lives, harm reduction is also cost effective: for every one dollar spent on needle and syringe programs, twenty-seven dollars is saved in health care costs.¹

The same harm reduction models are now used all over the world. Most countries with a recognised population of people who use drugs (PUD) have some sort of harm reduction program, often funded by donors like the Australian Aid program. Harm reduction has been successful in every country it has been established, even when it is small in scale.

And yet, criminalisation continues to be our primary response to drug use – even in Australia, a proud exporter of harm reduction expertise. Two-thirds of the funding for responses to drugs in Australia is given to law enforcement, and most of the drugs that were illicit in 1986 are still deemed illicit (only marijuana has been decriminalised in some states²). In many countries, the situation is worse. Some countries with harm reduction services rely entirely on international donors to fund them, while they are more than happy to put money into policing, prisons and, in several Asian countries, compulsory drug detention centres.

Incarceration, and fear of incarceration, are some of the most significant harms that come from using illicit drugs. People who are afraid of being arrested are less likely to

access health and harm reduction services and report stigma and discrimination when they do access these services.³ There are many consequences of this. People who use drugs in Australia access health services less than other sectors of the community, are more likely to access health services only when their health issue has become an emergency, and have unacceptably high rates of sharing and reuse of injecting equipment. In 2013, approximately 24% of people participating in a national NSP survey reported re-using needles and syringes and approximately 16% reported using a syringe that had been used by someone else – figures that are likely to be under-reported.⁴

Incarceration has a significant impact on the health of the people imprisoned. Since 1999, at least ten countries and sixty prisons in Europe, Central Asia and Iran, have implemented a range of models of providing injecting equipment to inmates.⁵ They have found these programs to be overwhelmingly positive. There have been no cases of prisoners using injecting equipment to threaten guards and there have been reduced transmission rates of HIV and hepatitis C within the prisons.⁶

Evidence from ten studies in prisons with needle and syringe exchange in fact shows improved safety for prison staff related to injecting equipment.⁷

In Australia, as in other prisons around the world where injecting equipment isn't supplied, prisoners still inject drugs, they just don't have new and clean equipment with which to do it. This makes sharing of injecting equipment common by necessity, and consistently Australian and international studies report higher levels of exposure of hepatitis C, hepatitis B and HIV among prisoners.⁸

While the prevalence of HIV and hepatitis C in Australian custodial settings is low, it is higher than in the community as a whole. For this reason people in custodial settings are identified as a priority population in Australia's National HIV Strategy, Sexually Transmissible Infections Strategy and Hepatitis C Strategy. However, despite this recognition of drug use in prisons as a priority issue for blood borne virus prevention and despite Australia's reputation as a 'world leader' in harm reduction, there is still no needle syringe program or needle exchange in a prison in Australia.

In 2008, the Alexander Maconochie Centre was opened in the ACT. It was promoted as Australia's first 'human rights prison' with the idea that rehabilitation, rather than punishment, would be the focus. Included were plans to establish Australia's first prison-based needle exchange, in line with the United Nations charter stating a prisoner's right to receive the same standard of health care they receive in the community.

The ACT government has been in full support of the establishment of a needle exchange inside the prison. Katy Gallagher, the former ACT Health Minister and Chief Minister, championed its implementation in the lead up to the 2012 election, saying: "There are some significant implementation decisions to be sorted out, but I'm not here to warm a seat. I've been working on this for years and now is the right time to take the next step."⁹

However, prison-based needle exchange has been an extremely contentious topic in Australia for many years, with prison staff and the Community and Public Sector Union representing them strongly

opposing the introduction of an NSP on the basis they compromise staff safety. The ACT union secretary stated in 2014 that the ACT prison would be 'flooded' with drug equipment¹⁰, while the union's deputy national president said the scheme would increase the risk to staff and inmates, facilitate the spread of blood borne viruses and significantly undermine rehabilitation efforts¹¹.

In 2015, even with full government support, funding and supportive legislation, there is still no needle exchange program being officially run in the Alexander Maconochie Centre. There is certainly a needle and syringe program operating within the prison, it's just an extremely dangerous one.

The opposition of prison staff around Australia to the idea of needle exchanges in prisons is symptomatic of the most important effect of criminalisation. That is, making some drugs illegal turns the people who use them into 'criminals'. People who use illicit drugs are therefore stigmatised for that behaviour alone. It doesn't matter if the person engages in no other criminal behaviour, has a good job, and in all ways is a 'normal', 'decent' member of the community, and it doesn't matter to others how criminalisation affects the lives of the people who use those drugs; their use of that substance robs them of the implied rights, trust and respect that are afforded other people.

There are no laws or policies to protect people who use drugs from poor treatment or discrimination on the basis of their real or perceived drug use. This lack of legal protections, combined with issues such as poverty, homelessness, unemployment, and lack of education, to name a few, can create layers of disadvantage. Criminalisation itself leads to effects such as:

- automatically creating a 'criminal class' of people who use or who have used drugs
- creating a black market of artificially inflated prices for substances so that people take great risks to obtain them or to obtain the money to buy them
- bringing people into contact with the criminal justice system
- creating social exclusion, driving people away from family, community, and social services
- leading to poverty and homelessness

- leading to people being dishonest when accessing services for fear of the reaction admitting to drug use might bring, leading in turn to substandard care and support
- reducing access to health services including harm reduction services
- allowing poor and inhumane treatment to go unnoticed and unreported.

People with a history of drug use sometimes internalise the stigma that is directed at them, believing themselves to be deserving of the poor treatment they receive when seeking support or even in everyday life. They sometimes try to appear like 'normal people', that is, not like 'typical junkies' so that they can access the services they need.¹² This process, however, does not always work. Even then, people with a history of drug use are unwilling to report cases of discrimination, and their attempts to 'manage their image' is seen as yet another example of the inherent dishonesty of people who use drugs.¹³

All of these factors work together to compound the marginalisation experienced by those who are unable to hide their drug use, and those who are seeking support. At the same time, many people tend to view people who use drugs as deserving of discrimination. In fact, research commissioned by the Australian Injecting and Illicit Drug Users League (AIVL) found that people in the general community believed that discrimination against people who use drugs was a good thing, because it would help them to stop using drugs.¹⁴

The evidence shows that people who use drugs are far less likely to use health services than other people in the community. They commonly experience discrimination in health services, and are then even more likely to stay away from these services. Fear of punishment drives people underground, while support and lack of judgment have benefits that reach into every aspect of people's lives.

The only country so far brave enough to decriminalise all drugs is Portugal. When that experiment first began, Portugal had rising levels of injecting drug use and some of the highest prevalence of HIV among people who inject drugs in Europe. In more than ten years of decriminalisation, HIV transmissions have

STOP THE EXECUTIONS!



AIVL campaign poster protesting the use of the death penalty for drug offenses in Indonesia. A vigil was held in Canberra on 18 February, 2015. Illustration by John Carey.

reduced dramatically, incarceration rates have reduced dramatically, and people who were initially strongly opposed to decriminalisation have become supporters. More and more major organisations and more and more people with a range of experience are beginning to ask why more countries aren't rejecting the failed war on drugs and trying their own experiments with drug policy. Australia, once a leader in harm reduction, has fallen behind by staying still. At a time when one of our closest neighbours, Indonesia, is showing no mercy to people convicted of drug crimes, shouldn't we be showing the world we are again brave enough to follow the evidence to somewhere new?

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Timothy Moore, 1964–2014

By **Tim Leach** and **Lou McCallum**

Timothy Moore was the author of many of Australia's best policy responses to the challenge of reducing HIV-related and other harms associated with drug use. His work reflected his deep commitment to HIV responses rooted in the human rights of people affected by the virus, particularly people who inject drugs. It was evidence-based (he was a scientist in a former life). It was grounded in community, being based on the experiences and advice of countless drug users and their representatives, particularly AIVL (the Australian Injecting and Illicit Drug Users League). It was creative and ground breaking. He could make complex issues seem simple.

As AFAO Policy Analyst from 1995 to 2002, Timothy made an incredibly important contribution to AFAO's work. And he did so at a critical time. While governments had begun by then to understand that involving gay men and HIV-positive people in the response might actually strengthen public health outcomes, there remained trenchant opposition to the involvement of people who inject drugs. Timothy responded with facts, reason and an enduring calm.

Timothy was part of a close-knit AFAO policy team that included Alan Brotherton, Susie McLean, Chris Ward and the late Geoffrey Fysh. It was quite the team. It provided critically important leadership for AFAO members across the country, and its work continues to be reflected in many contemporary policy responses, not just those of AFAO but of governments, agencies and other stakeholders across the sector. Timothy represented AFAO on the National Expert Advisory Committee on Illicit Drugs, which drafted the National Illicit Drug Action Plan (2000). His work was recognised beyond Australia and in 2000 he presented a paper at the International Conference on the Reduction of Drug Related Harm, entitled 'The centrality of drug users in a harm reduction response'.

Timothy's efforts extended beyond drugs policy. He undertook important



Photo: Udani Salgado, courtesy of VACCHO.

policy work in relation to research and government health funding; few people could track health spending through complex inter-governmental funding processes like Timothy – he was forensic. He co-wrote (with Gary Lee) AFAO's 1998 *National Indigenous Gay and Transgender Project Sexual Health Strategy*. This was the first strategy of its kind and helped lay the foundations for a decade of subsequent policy responses to the HIV and related needs of Indigenous gay men and sisters. His commitment to the health and other rights of Aboriginal and Torres Strait Islanders was apparent then and it is no surprise he went on to pursue these rights through a decade-long role with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

Timothy also worked as a Drug Policy Project Officer at Redfern Legal Centre from 1998–2002, and assisted in the development of *Really Positive*, an important series of resources for people who inject drugs developed by NUA (NSW Users and AIDS Association) and AIVL.

Timothy died in December 2014. He is fondly remembered by his colleagues. We are reminded of his impressive body of work. We remember that he was a really lovely man.

Tim Leach was Deputy Director of AFAO 1996–2001. Lou McCallum was Executive Director of AFAO from 1996–1998.

Decriminalisation of sex work: the evidence is in

By Jules Kim, Scarlet Alliance, Australian Sex Workers Association

Sex workers have been advocating for decades for the full decriminalisation of sex work and now it seems we have very persuasive evidence from *The Lancet* series on HIV and sex workers (www.thelancet.com/series/hiv-and-sex-workers).¹ Launched at AIDS 2014, the series examined the enablers and barriers to preventing and treating HIV infection in high, middle and low income countries with varying rates of HIV among sex workers. The findings were consistent across all settings. Researchers found that the ‘decriminalisation of sex work would have the greatest effect on the course of HIV epidemics across all settings, averting 33–46% of HIV infections in the next decade’².

The evidence clearly suggests that in order for biomedical prevention approaches to be successful, removal of structural barriers – including law reform and addressing stigma – remain critical. Without the support of enabling environments, through the full decriminalisation of sex work, barriers will remain far too substantial for biomedical prevention alone to succeed.

The Lancet makes the important distinction between decriminalisation of sex work and what is often referred to as the legalisation (or licensing) of sex work.³ Decriminalisation of sex work applies to laws that criminalise consensual sex and related activities, including laws criminalising sex work; buying, soliciting, or procuring; brothel-keeping and

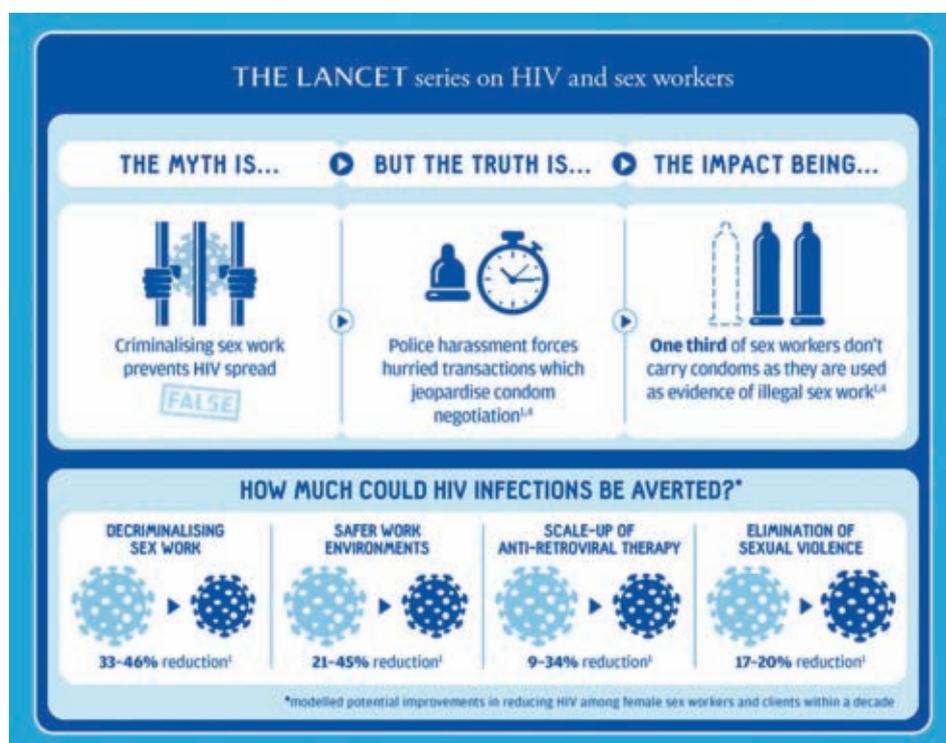


Figure 1: Excerpt from an infographic drawn from *The Lancet* series on HIV and sex workers.⁴

management of sex work; and vagrancy, loitering, and public nuisance that are also used to target sex workers or clients. In some countries it also applies to laws that criminalise same-sex consensual sex and laws that criminalise what is termed as ‘the impersonation of another sex’⁵.

The objective of legalisation is containment and control (and often surveillance) of sex work/ers, whereas the objective of decriminalisation is to uphold human rights and the occupational health and safety of sex workers. Under

decriminalisation criminal laws still apply to sex work, as they would to any other person or business. However, decriminalisation means that sex work is no longer seen as a crime but as work, and therefore, is subject to industrial regulatory mechanisms.

In the Australian context under a decriminalised system, sex industry businesses are treated like any other business. They are subject to existing regulatory mechanisms, such as: local council planning; zoning controls;

workers compensation requirements; occupational health and safety standards; and industrial rights obligations. Decriminalisation does not mean no regulation. Decriminalisation means whole of government regulation. Importantly, police are not involved as regulators at any level unless there is a breach of law. Decriminalisation supports the development and enforcement of occupational health and safety standards, access to industrial rights protections, and allows sex workers to organise for better working conditions.

Researchers Shannon, Strathdee, et al., conducted a systematic review of available epidemiological data on HIV and female sex work.⁶ They reviewed the role of structural determinants, i.e. contextual factors that reduce or increase the potential of HIV risk in HIV epidemics among female sex workers. They reviewed 3,214 relevant studies published in the last six years (2008–2013) on HIV (or HIV/STI) prevalence/ incidence or condom use outcomes in relation to female sex work.

The researchers found that: ‘macro-structural factors increasingly play a central role in HIV epidemic structures among female sex workers’ operating in recurring pathways with other structural, behavioural and biological factors.⁷

‘Our review and modelling emphasise that macro-structural changes (eg, decriminalisation of sex work; and addressing of migration and stigma), and work environment features (eg, reductions or elimination of violence, police harassment, and implementation of supportive venue-based policies and practices) that they engender, are crucial to stem HIV epidemics in sex workers and clients,’ the researchers said.⁸

To assess the population-level impact of key structural drivers, ‘deterministic transmission dynamic models’ were used by the researchers to simulate the course of HIV epidemics and potential HIV infections averted through structural changes in female sex work in three settings (encompassing high, middle and low income countries and differing rates of HIV).⁹ The research modelled potential improvements in reducing HIV within a decade through: the elimination of violence, safer work environments, sex worker organising and improved ART

coverage. Results of the meta-analysis determined that, ‘decriminalisation of sex work could have the largest impact on the course of HIV epidemics across all three settings, averting 33–46% of incident HIV infections over next decade among female sex workers and clients’¹⁰.

In South India, the researchers observed that behavioural HIV prevention efforts such as peer-led outreach, sex worker collectivisation, drop-in spaces, access to clinics and sex worker advocacy to local government, as well as structural and sex worker-led efforts on policy, police and stakeholder engagement and training, had already resulted in substantial impact on both macro-structural and work environment determinants of HIV, thus the research modelling showed only modest impact from further sex worker empowerment-centred responses (grouped in Figure 2 as ‘SW collectivization’).¹¹

Likewise, structural and sex worker led efforts had already resulted in large scale reductions in violence, thus the research modelling showed that elimination of physical violence and cessation of condom confiscation by police would only result in a further 6% reduction of HIV over the next decade; however, decriminalisation of sex work would avert up to 46% of HIV infections among female sex workers and clients over the next decade through its immediate and sustained effect on violence, policing, safer work environments, and condom use.¹² As in other settings, researchers observed that scale and reach would only be feasible alongside legislative reform.

In Canada (Figure 3), the researchers found access to safer work environments could avert 34% of HIV infections among female sex workers and clients – but they also found that this would only be feasible alongside legislative reform. However, decriminalisation of sex work, through immediate and sustained impacts on violence, police harassment and safer work environments, and condom use could avert 39% of HIV infections among female sex workers and clients over the next decade.¹³ The researchers note that the potential impact of decriminalising sex work on rates of HIV could be further enhanced by the increased access to HIV prevention and treatment. The percentages posited in the modeling of the impact of decriminalisation do not take this likely increased impact into account.¹⁴

The findings confirm the need for law reform and community-led interventions, to reduce HIV and promote human rights for sex workers globally. There has been a lot of emphasis on biomedical interventions and calls for population level antiretroviral treatment (ART) to end HIV. The World Health Organization’s guidelines recommend a scale-up of ART to end the HIV epidemic.

However the research has found that scale-up of ART alone will avert HIV infection by 9–34% in contrast to the 33–46% reduction achieved by decriminalising sex work alone.¹⁵ This research demonstrates that to be effective ART must occur in tandem with structural change and sex worker-led efforts. In order to achieve an effective HIV response, there is a critical need for structural change, (i.e., decriminalisation of sex work, elimination of violence, police harassment, safer work environments). *The Lancet* and other research supports that decriminalising sex work would also have immediate impacts on eliminating violence, police harassment and creating safer work environments.

Over 100 sex workers from 30 countries attending the AIDS 2014 Sex Worker Pre-conference agree. This is clearly articulated in the sex worker consensus statement on biomedical developments: ‘Current and existing implementations of biomedical approaches are doomed to fail because they don’t take into account discriminatory legal frameworks that create barriers for sex workers. Legal barriers for sex workers are still so significant that unless we resolve those issues first, through the full decriminalisation of sex work, test and treat or treatment as prevention are abstract concepts that have no meaning for sex workers but will divert resources away from approaches that we know work’¹⁶.

In fact, one of the main outcomes from the AIDS 2014 conference was the unanimous, united call for decriminalisation of sex work. Encouragingly, AIDS 2014 saw members of parliament from the region committing to rights-based reform to tackle HIV/AIDS in their countries. Papua New Guinean Health Minister, Michael Malabag, committed to introducing legislation to decriminalise sex work as a key reform to tackling HIV in his

Bellary, India:

Potential HIV Infections Averted through Structural Change

THE LANCET

Fraction of new HIV infections averted among FSWs and clients over ten years

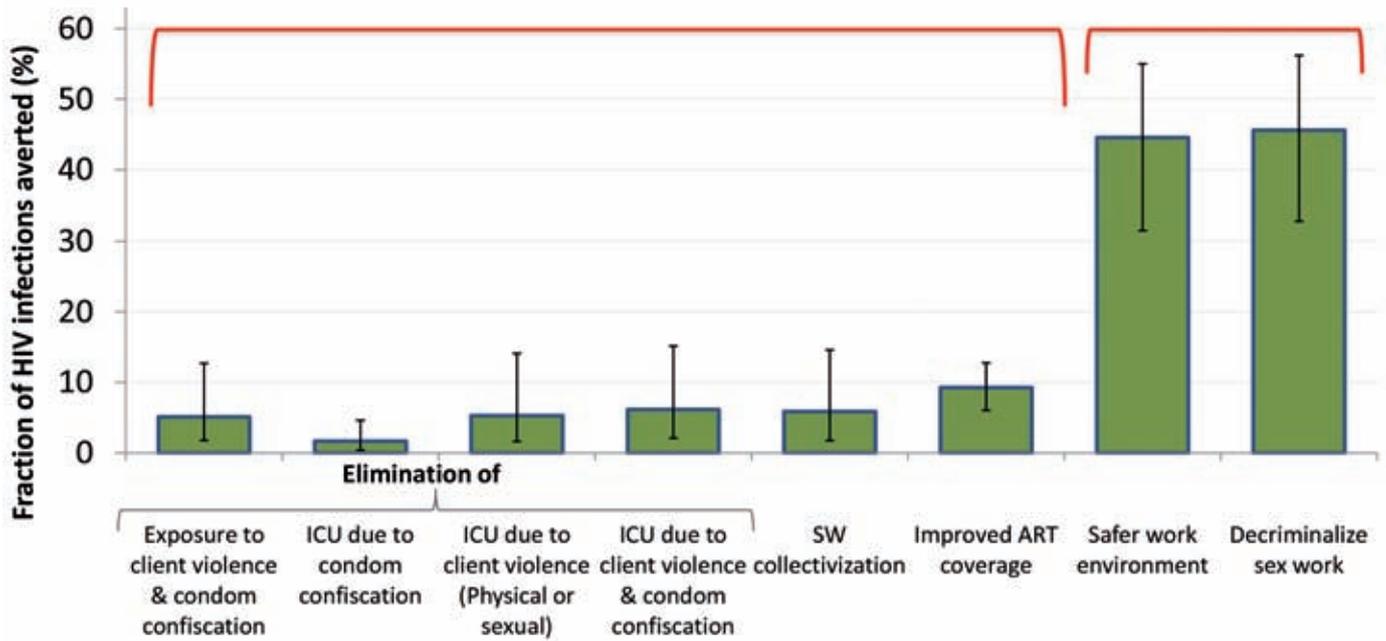


Figure 2: Bellary, India – potential HIV infections averted through structural change.¹⁷

Vancouver, Canada:

Potential HIV Infections Averted through Structural Change

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Fraction of new HIV infections averted among FSWs and clients over ten years

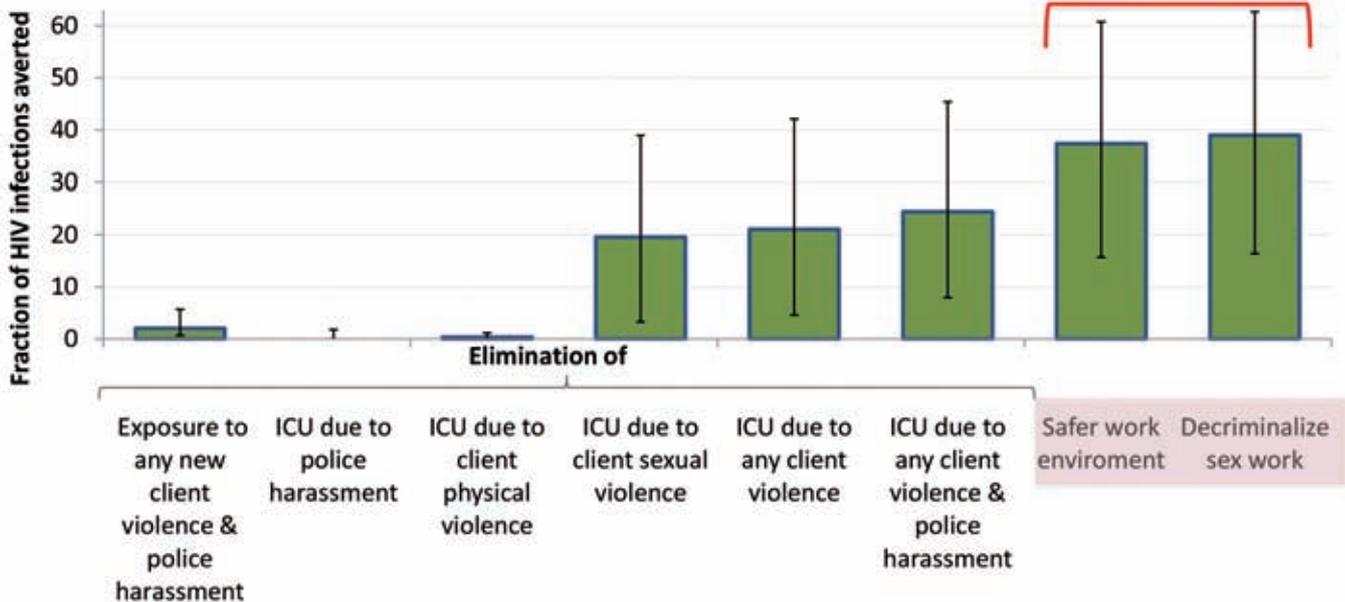


Figure 3: Vancouver, Canada – potential HIV infections averted through structural change.¹⁸

nation. Other MPs from the Asia-Pacific region, such as Fiji, Nepal and Indonesia also committed to dialogue with sex workers. 'I will bring in the legislation. We must remove the stigma. We are all equal,' Papua New Guinea Health Minister Malabag told the audience of civil society representatives, academics, parliamentarians and activists at AIDS 2014.¹⁹ Nepal MP Rajeev Shah told the audience that: 'We are Members of Parliament but we don't know everything. MPs must listen and work with civil society to bring about rights-based changes to end HIV/AIDS'²⁰.

In their Lancet series article, *An action agenda on sex workers and HIV*, Professor Chris Beyrer (Professor of Epidemiology, International Health, and Health, Behaviour, and Society at the Johns Hopkins University Bloomberg School of Public Health and President of the International AIDS Society) and Michel Sidibé (UNAIDS Executive Director) along with a number of experts, including sex worker Anna-Louise CRAIGO, are united in their call for decriminalisation of sex work: 'Legal environments, policies and police practices continue to challenge sex workers' abilities to protect themselves, their families, and their sexual partners from HIV ... To address HIV in sex workers will need structural and policy reform'²¹.

They are clear in the manifold impact of decriminalisation on HIV prevention, treatment and support as well as the substantial cost savings that would be achieved if sex work was decriminalised. They also outline other potential benefits and cost savings that would result from the decriminalisation of sex work. 'In addition to HIV prevention, other societal benefits could include raised access to police protection, improved occupational health and safety in sex work, and the redirection of law enforcement and criminal justice expenditures towards health and social services'²². They call on governments to, 'Decriminalise sex work, decriminalisation can improve the risk environment. Advance evidence-based policies, and practices in partnership with sex worker-led organisations'²³.

The Lancet clearly demonstrates the evidence of the need for and the many benefits of decriminalisation. Sex workers and sex worker activists have been calling for decriminalisation for many years for our rights, health and safety. The

evidence from NSW, where sex work was decriminalised in 1995, has been compelling and held up worldwide as an example. The UNAIDS, UNFPA and UNDP report *Sex Work and the Law in the Asia Pacific* states: 'Evidence from the jurisdictions in the region that have decriminalized sex work (New Zealand and New South Wales) indicates that the approach of defining sex work as legitimate labour empowers sex workers, increases their access to HIV and sexual health services and is associated with very high condom use rates'²⁴.

The 'positive public health and human rights outcomes' achieved in NSW are well documented^{25,26,27,28}, yet sex workers in NSW still have to fight to maintain decriminalisation. Globally and within the region, there has been a noticeable shift towards the recognition of the essential need for the decriminalisation of sex work. It is vital to effectively addressing HIV and a number of influential supporters, including politicians, policy makers and international bodies have spoken publicly in support of decriminalisation of sex work. There is an urgent need for action as Australia risks falling behind, where we have previously led the way.

There is irrefutable support and evidence for decriminalisation of sex work, our workplaces and our clients. In order to achieve this now, sex workers require the support from stakeholders in the HIV response and leadership from government and policy makers, in advocating for what is necessary to advancing HIV prevention, treatment and care in Australia.

For further information on *The Lancet* series on HIV and sex workers, see Scarlet Alliance's summary available at: <http://bit.ly/1MSGOKh>

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HIV and the law in Victoria: the competing demands of public health and criminal justice

By **Heath Paynter**

Introduction

Despite a public health approach forming the basis of Australia's response to HIV, other approaches have been used to respond to the epidemic, including use of the criminal justice system. This article considers a Victorian law that specifically criminalises the intentional transmission of HIV in Victoria, Section 19A of the *Crimes Act 1958*. In fact, Victoria is the only state in Australia that has an HIV-specific law criminalising the intentional transmission of HIV. That law highlights a tension between addressing HIV through public health initiatives aimed at empowering communities, and punitive criminal justice measures.

This article argues that the criminal justice approach not only conflicts with a public health approach, it also undermines public health measures that seek to reduce the incidence of HIV, and reduce HIV-related

stigma. Prosecutorial guidelines are needed to ensure that people who place others at risk of HIV are generally dealt with under the public health system rather than the justice system.

The law

Section 19A of the *Crimes Act 1958* (Vic) (the Act) provides that:

A person who, without lawful excuse, intentionally causes another person to be infected with a very serious disease is guilty of an indictable offence.

Subsection 2 of the Act defines very serious disease to be HIV. The provision carries a maximum term of imprisonment of 25 years.

The rationale for the law

Section 19A came into operation in 1993¹ after a number of robberies and assaults in Melbourne took place where threats

involving blood-filled syringes were made against the victims. The law was introduced to address the fear of acquiring HIV from a blood-filled syringe.

Section 19A presumes that death will be the end point to prove criminal harm as a consequence of a deliberate, intentional act. The severity of the law, which includes a maximum penalty of 25 years' imprisonment (one level down from murder), reflects the context of HIV/AIDS in 1993. This was a time when effective medications were only in development, and people diagnosed with HIV generally became very sick and died within a few years.² The justification for the law's harsh penalty lay in the associated inevitability of HIV morbidity and mortality, before the availability of effective treatment.

The law was also framed in this particular way because at the time, criminal law in

Victoria could not adequately address a situation where an individual's death was assumed to be inevitable but was suspended. As the law stood, a person could not be prosecuted for murder until the victim died. In the case of HIV, this could be a number of years after transmission. Section 19A was introduced to address a scenario where an offender convicted of intentionally transmitting HIV would otherwise be subject to a non-fatal assault charge. As the then Attorney General, Jan Wade, explained³:

'Modern medical science tells us that injecting another person with HIV will almost inevitably cause the death of the victim. It also tells us that there will be in almost all cases a delay of some years before the victim dies of AIDS or an AIDS-related illness ... the fact that some years will pass before the victim will die, means it is more likely that the offender will be charged with attempted murder, and that is totally unsatisfactory.'

Whatever the merits of the rationale for introducing section 19A in 1993, its focus on death and dying as an inevitable result of an HIV diagnosis is now outdated and exaggerates the harm associated with an HIV diagnosis. The law is now without any factual rationale: an anachronism that feeds community misunderstandings regarding HIV transmission and fuels HIV-related stigma.

The use of the law

Despite section 19A being devised to address instances of HIV transmission

risk through injection during an assault, no prosecutions for its originally intended purpose have ever been attempted.⁴ Section 19A has only been successfully applied in a single case involving transmission through sex.⁵ The conviction was subsequently overturned.⁶ While the 'over-use' of section 19A is not a major issue, its general use is. In practice, police and prosecutors use it to bargain with individuals, the outcome being that the accused is often coerced into complying with a lesser charge, such as causing injury recklessly or negligently, to avoid having to defend a charge under section 19A. We don't know the number of times this has occurred, but given Victoria has the highest number of legal cases involving HIV in Australia, there appears to be a culture of section 19A being used to plea bargain with individuals who are deemed to be putting others at risk of acquiring HIV.

All cases involving HIV exposure attract considerable media attention. Often only the most salacious evidence is reported and, invariably, the accused is presented as dangerous and the claimant as innocent, thus engendering fear in the community. This outcome perpetuates the idea that people living with HIV are inherently dangerous and put the community at risk of harm.

This leaves defence counsel, police and prosecutors to negotiate media coverage that may lead to a miscarriage of justice. The court may also find it impossible to empanel jury members not affected by

the media commentary. If the charges are dropped or the accused is acquitted, the accused still has to manage the reputational damage incurred by the media coverage.

The public health approach to managing people who place others at risk of HIV

Concurrent with Victoria's section 19A and the criminalisation of intentional transmission of HIV are the *Guidelines for the management of people living with HIV who put others at risk*⁷, first established in Victoria in 1989. This framework, which operates slightly differently in each state and territory, is overseen by the health department in each jurisdiction, supported by a committee of representatives from affected communities, government officials and health professionals. The Guidelines incorporate a thorough process for assessing individuals deemed to be putting others at risk.⁸ If needed, the Chief Health Officer can order that an individual's activities be restricted or that they undergo particular activities, like counselling. These orders are binding and act like court orders, and consequently the individual can also appeal such orders before a judge.

The model encourages engagement with individuals in a way that is intended to be consultative and compassionate, rather than combative and litigious as in criminal justice system. It is rehabilitative and based on public health objectives. It acknowledges HIV as a preventable condition, and that education and awareness are needed to inform the community about safe sex and safe injecting. An individual's right to privacy and confidentiality is also recognised with an emphasis on consultation in a way that least restricts the rights of the individual.

The public health management guidelines do not rule out use of criminal laws in cases of allegedly deliberate transmission of HIV. The Chief Health Officer has the power to enforce orders against individuals but where an individual, after ongoing consultation and support, continues to put others at risk, the Chief Health Officer can refer the individual to the police – at which time the individual can be dealt with through the criminal justice system. Referral to police only occurs after all avenues of rehabilitation have been exhausted, although this can happen at

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any stage if the public health approach is deemed to be ineffective.

Removing section 19A would not mean that people considered to have deliberately transmitted HIV could not be charged with a criminal offence; it would leave alleged cases of HIV transmission in Victoria to be dealt with through general criminal provisions in the Act – as is the case in other jurisdictions. These provisions of the *Crimes Act 1958* (Vic)⁹ are:

- section 16: Causing serious injury intentionally
- section 17: Causing serious injury recklessly
- section 22: Conduct endangering life
- section 23: Conduct endangering persons.

The co-existence of Victoria's section 19A and the public health approach for dealing with individuals who are considered to be putting others at risk of HIV clearly exposes the tension between addressing HIV as a public health issue and addressing HIV as a criminal issue.

HIV-specific criminal laws stigmatise HIV in a way that conflicts with public health messages. Overseas studies in similar jurisdictions have shown that the public perceives an association between health officials and the police, and that this deters people living with HIV from accessing health services and seeking information about safer sexual practices.¹⁰ These studies confirm the degree to which stigma acts as a barrier to disclosing HIV status and also its impact upon engagement with services targeting sexual health.

Prosecutorial guidelines

There is a need for prosecutorial guidelines to be developed to better inform police and prosecutors at the frontline of

responding to allegations of alleged transmission of HIV. Such guidelines might look at:

- the historical context of HIV legislation, including the applicability of general criminal laws to cases of alleged HIV transmission
- scientific and medical developments in HIV treatment, including treatment as prevention
- prevention strategies developed by the community to reduce HIV transmission
- prevention strategies used by people living with HIV to prevent HIV transmission
- the context of the alleged transmission.

Importantly, the guidelines would inform legal practitioners and the judiciary of the public health model, and provide guidance for referral.

Conclusion

The repeal of section 19A will not protect people with HIV from being arbitrarily and unjustly exposed to the criminal justice system, or from negative attitudes towards HIV and sexual diversity from police and prosecutors. However, its repeal will eliminate the stigma caused by having a specific law in place that casts people with HIV as dangerous and harmful vectors of a deadly disease.

The recently elected Victorian Government has a mandate to repeal section 19A and introduce prosecutorial guidelines. It is important that the Government consult with community organisations, like the Victorian AIDS Council (VAC) and Living Positive Victoria, in implementing these reforms. Of particular importance is the need to

develop prosecutorial guidelines to ensure that due consideration is given to dealing with people assessed as placing others at risk of HIV under the public health system rather than under the criminal law.

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The logo for HIV Australia, featuring the word "HIV" in large, bold, red capital letters above the word "AUSTRALIA" in smaller, bold, red capital letters, all set against a black rectangular background.

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The critical role of community mobilisation in meeting targets

By **James Gray** and **Brent Mackie**

Introduction

Within New South Wales, the adoption of bold targets has been considered a critical force for recent change in the HIV response. Establishing clear HIV targets has provided important opportunities to refocus HIV prevention and treatment work. Engendering support and engagement in response to the targets has played a critical role in much of work to achieve those goals and targets. Community mobilisation strategies utilised across HIV prevention and education efforts allow gay men to actively participate, engage with and lead changes in safe behaviour, testing and the early uptake of HIV antiretroviral therapies.

Understanding the motivations gay men have when considering their sexual

health and developing ways to engage with these motivations, requires a deep understanding of gay men's sexual culture and a willingness to engage with that culture in an open and direct dialogue. It is by utilising that dialogue to mobilise community and respond to targets that peer-based community organisations have demonstrated leadership.

Indeed, harnessing gay men's motivations and building a collective sense of a community movement towards achieving the HIV targets such as increasing HIV testing, has been a key component of the success of the much of the recent work.

Through social engagement and communication strategies that ensure regard is had to the sexual, cultural and community motivations of gay men (both

HIV-positive and negative) in program development, peer-based community organisations have effectively mobilised men to continue to think and act directly in response to the HIV goals and targets.

ACON has sought to mobilise the community in a range of ways, from engaging with HIV prevention messages through to actively becoming rapid HIV peer testers, both in community-based settings or in an outreach capacity. This includes engaging community in peer education programs and ensuring that the latest developments in HIV prevention technologies are widely understood. It also involves supporting community to actively question and debate the implications of new HIV prevention strategies and their role in preventing new HIV infections.

Outlined below are three examples of successful community mobilisation initiatives that show how a deep understanding of gay community culture can refocus the work of HIV health promotion programs.

Test More and a[TEST]

A key goal of the current NSW HIV Strategy is to both significantly increase the number and frequency of gay men being tested for HIV.¹ The Test More campaign and a[TEST] are two crucial, complementary areas of focus in NSW aiming to increase access to, and uptake of, HIV and sexual health testing.

The highly successful Test More campaign was an integrated part the Ending HIV communication platform, launched by ACON in 2013, and subsequently adopted by the NSW Ministry of Health and by HIV organisations across Australia. Test More focuses on the frequency of testing and the availability of rapid HIV testing in NSW.

By mobilising gay men and by updating their knowledge about access to testing, leveraging off access to new rapid HIV tests, it became possible to offer fast, confidential and effective HIV testing to gay men in community settings. Test More provides gay men with tools to facilitate rapid testing, such as online tools that identify the nearest providers that specialise in sexual health for gay men, and reminder services. The campaign also destigmatises testing by having these messages and services in a wide range of locations, including public spaces.

The Test More campaign aims to build community norms around regular HIV testing that may be easily accessed through community settings. Working in parallel with the Test More campaign, the a[TEST] services also aim to increase HIV testing, by mobilising the community to engage with peer-based rapid HIV testing services.

In an effective demonstration of community mobilisation, a[TEST] uses trained peer workers who are gay community members, to provide rapid HIV tests to other gay men in a non-clinical setting. Under clinical supervision peers obtain informed consent for the test and discuss any risk factors, then perform the test and give the result.

The success of these two programs can be seen through, firstly, the high numbers of gay men using the service that had never previously had an HIV test, and secondly, the willingness of gay men to return for regular testing; and positive client satisfaction results for the service. The success of both Test More and the a[TEST] service demonstrates the critical role of community mobilisation in developing effective responses to HIV targets.

Community mobilisation, campaigns and social media

In February 2013, ACON launched the Ending HIV campaign, the first large-scale campaign to embody the NSW HIV Strategy and to mobilise the gay community around ending the HIV epidemic by the end of the decade.

I'm In (phase one of Ending HIV) focused on engaging gay men in NSW to help end HIV transmission and took a historical approach to the idea of creating a movement. This initial campaign phase laid the groundwork for the campaign by introducing the Ending HIV equation to the community: [TEST MORE] + [TREAT EARLY] + [STAY SAFE] = ENDING HIV. This communication platform has provided ACON with a multi-stage communication plan, allowing us to engage in a longer-term, more detailed conversation with our community.

I'm On (Ending HIV phase two) focused on reinforcing the importance of condom use and was launched in September 2013, while Easy As (phase three) was launched in February 2014, promoting rapid HIV testing and the impetus to test more. The fourth phase of the campaign, Treat Early, was launched at Mardi Gras 2015 and focused on the health and transmission benefits of having an undetectable viral load. In addition to these main phases there have also been reruns of the I'm On campaign, with the latest featuring the high profile giant condom covering the obelisk in Hyde Park, Sydney.

Each phase of the campaign has been evaluated, with a sample size in excess of 500 guys being surveyed after each execution, with the evaluation of Treat Early currently in progress. Each phase evaluated exceptionally well across a range of key indicators: recall, persuasiveness, and engagement.

The campaign evaluation survey also tracks the attitudes and intentions to behaviour of NSW gay men. The survey shows how gay men view HIV prevention, testing and treatment, adding weight to the argument that mobilising and focusing the community around the goals of HIV strategies and building community awareness and engagement is having an encouraging impact. For example, the evaluation survey asked gay men whether they agree or disagree with the statement, 'HIV treatments significantly reduce the risk of passing on HIV'; in February 2013, just 33% of gay men surveyed agreed, but by April 2014 that number had risen to 64%, an overall increase of 31%.

Furthermore, the survey asked gay men if they agree with the statement, 'early HIV treatment is better for your health and can help protect your sex partners'; in February 2013, 74% of men agreed, by April 2014, 91% of men agreed with the statement, an increase of 17%.

Importantly, the survey also asked men if they agree that 'everything has changed, we can now dramatically reduce HIV transmission'; in February 2013, 48% of men agreed, by April 2014, 67% of men agreed with the statement, an increase of 19%.

The ACON campaign evaluation survey points to changing community attitudes and readiness to take on new information. The survey also shows engagement with strategy objectives, including by mobilising the community around new prevention technologies, increasing access to rapid testing and engaging gay men with HIV prevention programs that effectively utilise peer-led responses.

Community mobilisation and new technologies

The ACON position statements², released in mid-2014 to coincide with the Melbourne AIDS 2014 conference, outlined new understanding of what is safe sex, pre-exposure prophylaxis (PrEP), the importance of treating HIV early and home-based testing. The statements further outlined that gay men should have access to the full range of proven prevention technologies in order to reduce HIV transmission and ultimately meet the HIV prevention targets.



ACON volunteers pose with I'm On campaign collateral.

In order for gay men to effectively engage with and utilise these new technologies and strategies, community mobilisation is critical.

There is much talk of PrEP in the gay community and ACON, like other peer-based organisations, has embarked on the process of informing, educating and mobilising the community. This process has included successful PrEP community forums which have highlighted both the interest in as well as the complexities for gay men of utilising PrEP in prevention. Importantly, these forums have engaged the community in discussing and coming to an understanding of what PrEP is, and how it contributes to the suite of prevention strategies available to gay men.

While PrEP is not going to be the prevention option used by all gay men, those who will benefit from it need to be involved in the advocacy processes to help guarantee its availability. Community mobilisation is essential to the effective uptake of innovative new prevention strategies, and ultimately their effective contribution to achieving targets.

Likewise the complexities of treatment as prevention – i.e., reducing to undetectable viral load so as to significantly reduce the risk of onward transmission of HIV infection in sex without condoms – is both an important strategy in HIV prevention and one that will require significant community engagement and mobilisation. ACON is both embarking on a major social marketing campaign regarding treatment as prevention, and also a community engagement strategy that includes talking directly to the community through community forums and meetings to build community support.

Critical to the successful impact of these new prevention strategies and technologies will be community mobilisation, led by peer-based organisations engaging gay men.

Conclusion

The gay community in NSW is demonstrating they are listening to HIV prevention messages and are willing to act in order to end the HIV epidemic. Unprecedented HIV testing rates and

earlier HIV diagnoses are signs of success on the long road to ending HIV. Gay men are willing to act in the public and community's health interest and increasingly want to be in control of their health – including through the timely access to new technology. It is essential that community not only is brought along with these new messages, strategies and technologies but are mobilised to engage with them in order to achieve those targets.

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HIV and mobility in Australia: road map for action

By **Gemma Crawford**¹, **Roanna Lobo**² and **Graham Brown**³

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HIV epidemics throughout their history have been influenced by international mobility, changing as a result of globalisation, rapid urbanisation and mass mobility. In the last decade, the issue has been growing in profile in Australia due to increasing HIV diagnoses related to international mobility. Australia has been one of a number of high income countries experiencing a disproportionate number of new HIV diagnoses among people from high prevalence regions, particularly from sub Saharan Africa and South East Asia.

While the majority of HIV diagnoses in Australia are among Australian residents, and primarily amongst gay men, in some jurisdictions such as Western Australia, HIV among internationally mobile communities comprises more than 50% of new diagnoses. Similar diversifying epidemics related to increased mobility between high and low prevalence countries have been identified across North America and Europe (see Figure 1, overleaf).

Australia has used a combination of strategies to respond to HIV with a focus on prevention. These include:

- mobilising communities most impacted by HIV
- encouraging individuals in priority groups to reduce risk behaviour, undergo regular HIV testing and start and maintain treatment
- changing government laws and modifying policies to ensure that a human rights approach underpinned the Australian HIV response and that other strategies could be implemented, and

- undertaking appropriate surveillance, research and evaluation to guide and inform responses.

However, the relationship between HIV and mobility is complex and the causal links between HIV and the experiences of people travelling to and from regions of high HIV prevalence are not well understood. Overlaid are issues of stigma, racism and marginalisation as well as historical contexts such as colonisation, evolving economic and migration policies, and labour mobility. These complexities have resulted in an emphasis on short-term, small-scale projects and research studies, both in Australia and elsewhere.

The *Seventh National HIV Strategy 2014–2017*¹ identifies people from high prevalence countries and their partners, and travellers and mobile workers as priority populations (see Figure 2, overleaf), but provides little guidance as to priority action. Much of Australia's policy response to HIV and mobility has been relegated to the 'needs attention' category but with no harmonised policy and program response. Without an integrated response across government, community, health services and research there will be little progress in this emerging priority for the Australian HIV epidemic.

The *HIV and Mobility in Australia: Road Map for Action*² has been developed to move the discussion from rhetoric to comprehensive and coordinated action.

The Road Map is an outcome of a partnership between the Collaboration for Evidence, Research and Impact in

Public Health (CERIPH) (formerly the Western Australian Centre for Health Promotion Research) and the Australian Research Centre in Sex, Health and Society (ARCSHS), with support from the Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN) and funding from the Commonwealth Department of Health.

The Road Map proposes a way forward for the Australian HIV partnership and is informed by:

- the *Seventh National HIV Strategy 2014–2017*
- frameworks and approaches successfully used in Australia
- frameworks and approaches used with mobile populations and migrants in similar countries
- relevant research from Australia and overseas, and
- consultation with key community, policy and research stakeholders.

The Road Map outlines ten principles and over 70 strategies across five action areas to support a strategic approach to HIV management for mobile populations and migrants in Australia (see breakout boxes 'Ten principles for a strategic approach to HIV and mobility' and 'Five areas for action', right).

Next steps

HIV has always been, and still is, a condition related to population movement and mobility. Despite this, many governments and regions have been slow to understand the impact

HIV and mobility in Australia ... maybe not so unique?

Overseas Acquired HIV

In countries with similar epidemics to Australia (concentrated epidemics rather than generalised epidemics), there has been a similar phenomenon observed, as shown in Figure 2. 28-43



Figure 1

HIV and mobility: what are we talking about?

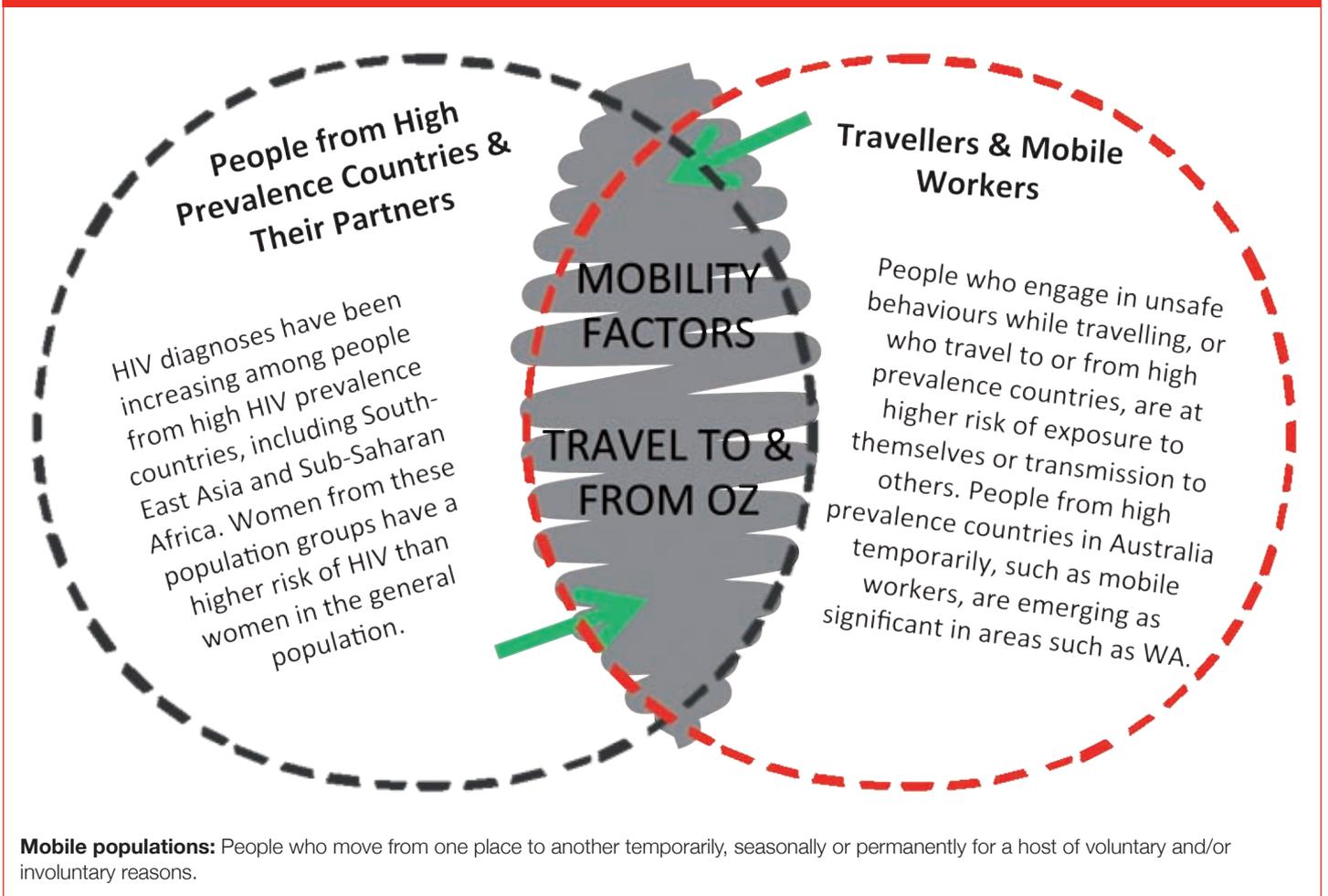


Figure 2

of mobility on local HIV epidemics and local responses. However, some governments and regions have developed strategies and approaches in response to the increase in HIV infections related to mobile populations that are starting to pay dividends. The Road Map has drawn on these experiences, and the work to date in Australia, and applied them to the emerging Australian context.

The Road Map is intended to generate discussion and action among key stakeholders including community organisations, health services, research institutions, government bodies and policy makers and provides a way forward to respond to these emerging challenges with courage, creativity and commitment.

Subsequent to the launch of the Road Map on World AIDS Day 2014, the Western Australian Department of Health has provided funds to support a Coalition for HIV and Mobility Issues. The coalition will comprise policy, community, health service and research members to progress action towards the recommendations of the Road Map (contact siren@curtin.edu.au for further details).

Read the *HIV and Mobility: Road Map for Action* report (<http://siren.org.au/hivandmobility> or www.latrobe.edu.au/arcshs/publications), share it with others, talk about it.

Join the **Coalition for HIV and Mobility Issues** to progress action on advocacy, research, policy and practice. Please email expressions of interest to SIREN at siren@curtin.edu.au

Get involved in discussion via twitter **#HIVMobile**.

Look for opportunities to partner with others to explore the issues.

Keep HIV and Mobility on the agenda.

This work would not have been possible without input from a number of people. Thanks to those who provided direct input in to the report. Thanks also to authors Trish Langdon, Gemma Crawford, Roanna Lobo, and Graham Brown.

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Ten principles for a strategic approach to HIV and mobility

- Incorporate a human rights approach – stigma and discrimination directed at mobile populations and migrants must be reduced
- Reduce all barriers to testing and access to treatment
- Pay attention to the confluence between HIV and mobility
- Move beyond ‘narrow protectionist policies’
- Commit resources to improve migrant health
- Continue to develop links and cooperative partnerships with affected communities locally and internationally
- Participate in and contribute to global health governance
- Create closer cooperation between Australia and the HIV policy, public health, treatment and support sectors in countries of origin and destination for Australian mobile populations and migrants
- Acknowledge that mobile population and migrants need more than information (even if it is translated). Specialist services as well as generalised services need to be provided
- Know your epidemic(s) – continue surveillance and monitoring and develop evaluation strategies in conjunction with migrant populations.

Five areas for action

The Road Map identifies over 70 strategies with proposed primary responsibilities and suggested timeframes. Some key themes are highlighted below.

- **International Leadership and Global Health Governance**
For example – Australia is well placed to participate in and contribute to international dialogue on cross border HIV responses, providing policy leadership to minimise rates of HIV as a result of mobility in the Pacific region and to ensure that Australia’s own policies are consistent with this outcome
- **Commonwealth and State leadership**
For example – ensuring the Australian HIV response enables an effective response to migrants and mobile populations that experience increased vulnerability to HIV acquisition or transmission, within a human rights framework. This includes providing strong leadership in relation to building overall community support and consensus to prioritisation of health services related to mobile populations and migrants and coherent legal and policy responses to mobile populations and migration.
- **Community mobilisation**
For example – supporting partnerships between migrant groups, other community groups and the HIV sector to advocate for change and improvements in health and other service delivery; encouraging leadership and peer advocacy within migrant and mobile populations and increase participation in the HIV response; and improving mobile population and migrant community awareness, health literacy, knowledge, attitudes and risk reduction behaviours around HIV in the context of living in Australia
- **Development of services for mobile or migrant people and groups**
For example – increase the uptake of sexual health testing, treatment, education and referral amongst migrants and mobile populations with an emphasis on early detection and treatment and supporting the health and wellbeing of migrants and other mobile people living with HIV. This will require improved understanding of the cultural and structural impacts of services on mobile populations and migrants, decreased discriminative attitudes towards migrants and other mobile people with HIV, and increased health literacy of migrants and mobile population.
- **Surveillance, research and evaluation**
For example – invest in high quality research to inform the strategic and policy response to mobile populations and migrants such as: standardised surveillance for sub populations; evaluation of interventions for migrants and mobile populations, including universal access to treatment; social research on migrant healthcare seeking behaviours, HIV knowledge and attitudes, and experiences of migrants living with HIV; analysis of barriers to uptake, maintenance and effectiveness of treatment; role and feasibility of treatment as prevention in migrant populations; and investigation of impacts of legislation on migrant health and access to HIV treatment.

The Bottom Line: HPV, gay men and anal cancer

By **Ben Wilcock**

Human papillomavirus (HPV) is the most common sexually transmitted infection (STI). Most sexually active people come into contact with it at some time in their lives. HPV causes common warts, genital warts and a range of cancers, including cancers of the anus, cervix, penis, vagina, vulva, and the neck and throat.

Gay men (and particularly HIV-positive gay men) are at a greater risk of developing some HPV-related cancers, compared to the general population. Other people at an increased risk of anal cancer include women with previous anal or genital HPV disease, organ transplant recipients and HIV-positive women and men (that are not men who have sex with men [MSM]). MSM are about 20 times more likely than heterosexual men to develop anal cancer, and HIV-positive MSM are even more likely (up to 100 times more than the general community). Gay men over 35 and HIV-positive gay men are at greater risk of cell changes progressing to anal cancer. Anal cancer is one of the most common cancers for people living with HIV.

There are vaccines available to protect against acquiring HPV, including the two strains of HPV that cause the most anal cancers. The most commonly used vaccine also protects against two main strains that cause anal and genital warts. The vaccine is most effective if given prior to exposure to HPV. However, some research has shown that even if someone has had prior HPV exposure, they may still derive some benefit from vaccination. If someone has already been exposed to one or more of the HPV strains against which the vaccine is targeted, they may still potentially benefit from the vaccine by protection against other strains which they have not yet been exposed to. In people with evidence of prior infection of the vaccine strains, vaccination can possibly help protect from reacquisition or recurrence of infections of these strains that could lead to warts and other cell changes, including cancer.

**HPV & ANAL
CANCER**

WHAT DO I NEED TO KNOW?

HOW CAN I PROTECT MYSELF?

TALK TO YOUR
DOCTOR ABOUT
VACCINATION FOR
HPV AND HOW YOU
CAN GET CHECKED
FOR ANAL CANCER.

FOR MORE INFO,
CHECK OUT:
THEBOTTOMLINE.ORG.AU

**THE
BOTTOM
LINE**

GAY MEN, HPV &
ANAL CANCER

AFAO Australian Federation
of AIDS Organisations

napwha national association of
people with HIV australia

There are currently no widely accepted clinical guidelines for doctors on anal screening. At the moment, there is insufficient understanding of how anal cancer progresses from the early stages, which lesions are most likely to develop, and which treatments are most effective. Research projects are being conducted in Australia now to see what these guidelines

might be. Information on these research projects are detailed with this article.

Although there are not yet widely accepted clinical guidelines for anal screening, many clinicians believe early detection through anal screening is the right approach. What is clear is that there are advantages in people knowing that they have early signs of anal changes –

which may or may not progress – and to ask their doctor to keep monitoring for changes in the anus. This is particularly the case for gay men over 35 and HIV-positive gay men. Early detection greatly increases the chances of survival.

Until screening guidelines are determined asking your doctor for digital anal-rectal examinations (DAREs) can be an important way to detect for early signs of anal cancer. DAREs involve the doctor inserting a lubricated finger into the anus to check for changes. As this is a relatively new field, it may be best for people to go to a doctor that sees a lot of gay men or a sexual health clinic to speak to them about getting a DARE. Information for clinicians on the training to perform DAREs are detailed in the breakout boxes (right).

In response to gay men (and particularly HIV-positive gay men) at greater risk of developing anal cancer, the Australian Federation of AIDS Organisations (AFAO) has recently launched The Bottom Line, a new nation-wide campaign for gay men and other men who have sex with men on HPV and anal cancer.

The campaign has been designed to increase gay men's knowledge in relation to HPV, the impact of HPV and related cancers, screening procedures for anal cancer, and vaccinations available to reduce the risk of HPV infection and related cancers.

The Bottom Line is based around a website (www.thebottomline.org.au) and is supported by a range of materials including posters, a booklet on understanding anal cancer screening results, a booklet for men diagnosed with anal cancer, and a range of advertisements.

Ben Wilcock is a Health Promotion Officer at AFAO.

Pictured, above right: Web banner promoting the website component of the Bottom Line campaign. Below right: two printed booklets *Information for men diagnosed with anal cancer* and *Understanding anal cancer screening results*. Opposite: The Bottom Line campaign poster. The printed booklets and posters are available from AIDS Councils in each state and territory. The booklets can also be downloaded at thebottomline.org.au

Research projects in Australia on anal cancer screening

A trial in Sydney called SPANC (Study of the Prevention of Anal Cancer) is tracking the prevalence of anal HPV infection and related anal disease in a cohort of gay men. The aim of the study is to provide gay men with guidelines about screening for anal cancer. Men who have sex with men who are 35 and older, living in and around Sydney and who have never been diagnosed with anal cancer are encouraged to join the study. For more information or to register your interest visit www.spanc.org.au or call 1800 4 SPANC (1800 4 77262).

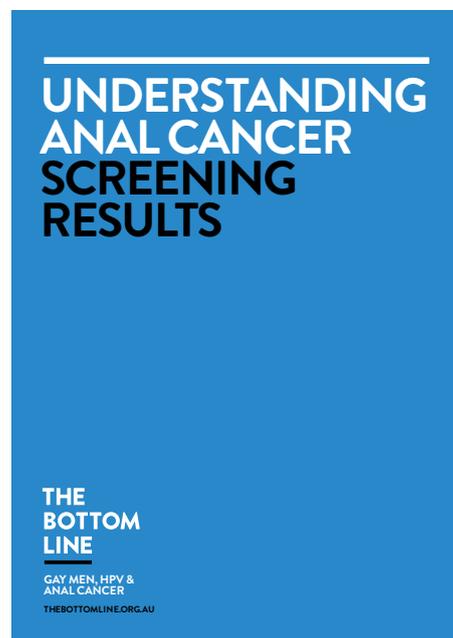
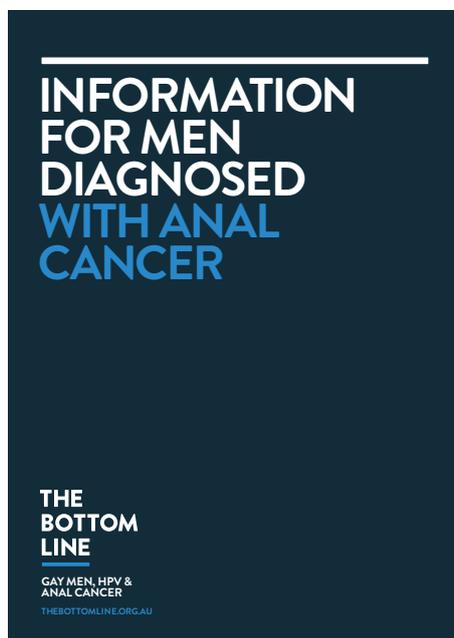
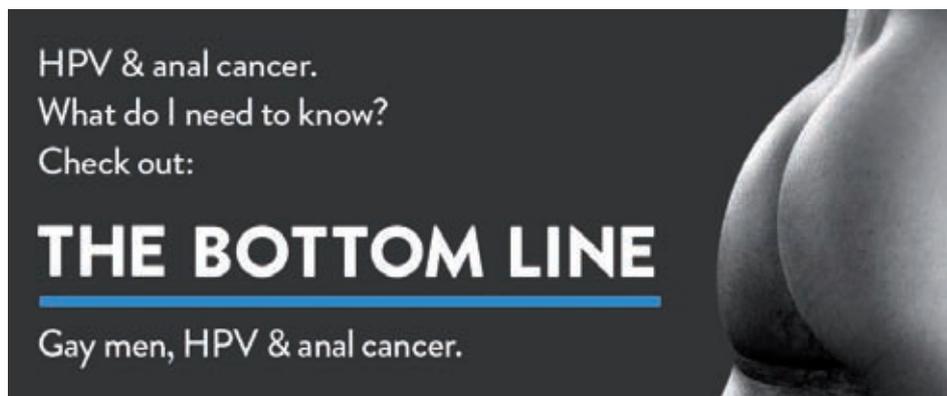
A trial in Melbourne, the Anal Cancer Examination Study (ACES), is currently looking at the usefulness of having annual digital anal-rectal examinations (DAREs) done by a doctor for the detection of early stages of anal cancer. Men who are 35 years or over with HIV and who have sex with men can participate. For more information or to register your interest, visit www.anal.org.au, email anal@mshc.org.au, or call 1800 082 820.

Information for clinicians

There are some training requirements for doctors to ensure digital anal-rectal examinations (DAREs) are performed correctly.

ASHM (Australasian Society for HIV Medicine) has produced a webinar for HIV prescriber clinicians about anal cancer and HIV. It gives background information and epidemiology of anal cancer and what we know about screening and treatment. It also provides information about the latest developments in terms of screening, considerations of who to screen and when, advice on how to screen and a video demonstrating how to perform a DARE. Although this webinar is designed primarily for HIV prescribers, it is a very useful tool for all clinicians. For clinicians interested in this webinar, the video can be accessed online as part of the ASHM Live webinar series at: <http://vimeo.com/ashm/live/video/109082973>

For clinicians looking for further resources, one of the studies into anal cancer in Australia has developed a website for clinicians. It provides a range of useful resources relating to anal cancer for clinicians, including video tutorials. This includes the video on how to perform a Digital Anal Rectal Examination (DARE). The link to this website is: www.anal.org.au/clinician





REGIONAL FEATURE: The United Nations hosts Asia Pacific Governments and Civil Society: a regional HIV and AIDS response and the post-2015 development agenda

By James Malar

'[T]he most effective way of preventing the spread of HIV is to protect the human rights of the persons at risk. These are the vulnerable and marginalised members of our society.'

— The President of Fiji, Hon. Ratu Epeli Nailatikau¹

Introduction

Between 28–30 January 2015, the Asia-Pacific Intergovernmental Meeting (IGM) on HIV and AIDS took place in Bangkok, Thailand. The President of Fiji, Hon. Ratu Epeli Nailatikau, chaired the gathering of over 30 countries that included China, India, Iran, Russia, Japan and Australia.

The IGM is a periodic, inclusive review of national efforts and progress in commitments made by governments to HIV prevention, treatment, care and support under the *2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*. The United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) coordinated the IGM in Bangkok, providing an opportunity for governments and civil society from across Asia and the Pacific to evaluate progress

to date and agree on a shared roadmap to guide the region's future response to HIV and AIDS.

'Don't leave communities behind': civil society's message to the IGM

While it is widely accepted that the effectiveness of the response in Australia has been a product of community and government working in partnership, civil society presence on the official delegations was a rarity, with most countries apart from Australia failing to afford this standing to civil society representatives.

The Australian Federation of AIDS Organisations (AFAO) was actively involved in meeting preparations, including articulating the civil society advocacy agenda, and in the meeting

proper. AFAO Executive Director Rob Lake was a member of the Official Australian Delegation and AFAO International Program staff also attended, holding civil society observer status at formal proceedings.

The sentiments of the Hon. Ratu Epeli Nailatikau (shared above) were reaffirmed by Civil Society in a statement read by Naro Ao from APN+ (the Asia Pacific Network of People Living with HIV/AIDS), when she called for a community and people-centred response to HIV:

*'We call on decision makers to scale-up rights-based, community-led and gender-responsive HIV treatment, care and support interventions.'*²

Civil society representatives including AFAO expressed grave concerns that, despite major advances in HIV treatment, over 1,000 people are infected with HIV every day in the Asia-Pacific region, with the majority of these among men who have sex with men, transgender people, sex workers and people who inject drugs. Across all these affected communities, young people are disproportionately affected.

At the meeting, the new 90-90-90 global treatment targets were also discussed, with civil society calling for more community-based HIV services. Although the epidemic in the region is concentrated among key populations, less than 8% of overall AIDS spending is dedicated to HIV prevention among these populations.³

While community representatives understand that community-based prevention, testing and treatment works, many governments in the Asia-Pacific region continue to ignore this evidence.

In a statement presented by Mr. Liu Yan, a Core Working Group Member of Youth Voices Count, governments were urged not to 'leave communities behind':

*'Ending AIDS is impossible if governments continue to commit to Universal Access, without committing to decriminalise sex work, homosexuality, transmission of HIV, drug use; or creating laws to recognise the rights of young people and transgender people. We are here today to remind governments that ending AIDS is only possible with a holistic approach that truly leaves no one behind.'*⁴

But above all, the urgency of the required HIV response was particularly powerfully articulated by Joleen Matele from the Pacific Sexual Diversity Network, who said:

*'Ending HIV is no longer a dream. It is now an achievable reality. By the end of this three-day meeting, 2,877 people from our region will have been newly infected. Let's make this IGM count. Let's do our job. Let's bring the number to zero. Don't leave communities behind.'*⁵

Rob Lake furthered calls for evidence-based community centred responses that address legal and policy barriers to effective HIV prevention, testing, treatment, care, and support. He noted that Australian Government funded programs, including those implemented by community organisations AFAO, APCOM (Asia-Pacific Coalition for Male Sexual Health), and APCASO (Asia Pacific Council of AIDS Service Organisations), are based on 30 years of evidence from Australia and across the region: 'DFAT funded programs, including AFAO's work in the region, are effective because they work with the most vulnerable populations. They have provided value and impact for Australia's aid investment,' Rob Lake said during the meeting.

What did the IGM achieve?

There were two key IGM achievements: a review of the regional HIV response; regional agreement on a future direction; and the launch of several key civil society initiatives, including the reports:

- *The Right(s) Evidence: Sex Work, Violence and HIV in Asia – A Multi-Country Qualitative Study*⁶, which examines the impact of violence against male, female and transgender sex workers on their human rights and HIV risk.
- John Godwin's 2013 report, *Young people and the law in Asia and the Pacific*⁷.

The IGM also provided a forum for discussion on key challenges, innovations and opportunities in the regional HIV response. Financial sustainability of national and regional responses and the need for regional cooperation were featured discussions as part of the regional review. These discussions particularly focused on the need to continue

addressing legal and policy barriers to accessing services for key populations at a higher risk of HIV and persons living with HIV. The legal and policy barriers include discrimination in health care, education, insurance, travel and employment, as well as the affordability and accessibility of life-saving medicine and diagnostics.

A vital component of the meeting was reaching agreement on a shared agenda and direction for Asia and the Pacific's future HIV response. Governments were able to come to an agreement (The Road Map), featuring a commitment to ending the AIDS epidemic in the region by 2030. The Road Map calls for increased collaboration between government ministries, including health, justice, public security, police and drug control, in genuine partnership with civil society and key affected populations.

The Road Map also articulates the ongoing commitments and priorities of governments in the region for the HIV response as we move toward the conclusion of the Millennium Development Goals (MDGs) timeframe. The new iteration of these goals, the 2015 Sustainable Development Goals (SDGs)⁸, will be formalised in September 2015, and are a key mechanism in shaping development priorities for the coming years.

The original MDGs were quite targeted and specific. The MDGs number eight in total, including goal number 6, which focuses on HIV. In contrast the SDGs represent a comprehensive and integrated set of global priorities for inclusive, equitable and sustainable development. Proposed goal 3.3 aims to end the AIDS epidemic, along with other communicable diseases, by 2030.⁹

In addition to proposed goal 3.3, proposed goals 3.7–3.8 aim to ensure universal access to sexual and reproductive health care services and 'safe, effective, quality and affordable essential medicines and vaccines for all'; proposed goal 5 focuses on achieving gender equality for women and girls; and proposed goals 10.2–10.3 aim to eliminate discriminatory laws, policies and practices.¹⁰

For an effective response to HIV, it is vital that HIV remains prominent on the international development agenda. The SDGs reduce the international focus on

HIV. It no longer features in a stand-alone development goal and this shift in focus is compounded by the expanding number of key development priorities in the SDGs. The ongoing challenge for governments and civil society will be to ensure we do not lose focus on achieving the goal of ending the HIV epidemic by 2030.

Civil society advocacy tools

The AFAO International team, in partnership with APCASO, produced advocacy materials for the IGM and undertook a capacity building-mentoring program for the 50 Asia and Pacific community participants who are part of the Australia Awards Fellowships (AAF) Mentoring Program.

The first civil society advocacy tool produced for the IGM was a briefing paper, 'HIV Investment Matters', examining the HIV commitments that have been made by Governments in Asia and the Pacific. This briefing paper highlights that although the gap between targets and investments remains vast, it is not insurmountable provided there is sufficient political will and action to breach the gap. The briefing serves as an important reminder to governments in Asia and the Pacific of their explicit commitments to sustained and strategic HIV investments. The briefing paper is available at: <http://bit.ly/1x6CftH>

The second advocacy product captured the Vietnam experience in reforming health insurance laws and processes to ensure access to antiretrovirals for people with HIV. In the context of declining international donor contributions to HIV in the region, especially to countries like Vietnam where economic development is occurring at a rapid rate, the need to secure domestic solutions to domestic HIV

challenges is paramount. The case study is available at: <http://bit.ly/1ALQqkd>

The third key activity by civil society in association with the IGM was the delivery of a mentoring module by AFAO Executive Director Rob Lake and APCASO Executive Director RD Marte to AAF fellows who attended the AIDS 2014 conference in Melbourne. This module introduced the participants to the IGM. It provided background to the meeting, as well as explaining the meetings processes and the importance of the IGM in the global development agenda. Effort was made to also share with participants some methods by which they could ensure their involvement in future regional meetings on behalf of their communities.

Where to from here?

Ending HIV by 2030 is a key commitment of governments from across the region. In the context of the emerging post 2015 development agenda, meetings such as the IGM carry additional weight, and provide an opportunity to highlight key advocacy messages. The need to ensure implementation of the right interventions, for the right communities in the right locations, and to address the legal and policy barriers that impede these interventions, were key messages from the meeting. Equally, the need for governments to allocate domestic financing to their HIV responses was delivered with resounding clarity from civil society and the majority of the governments in attendance.

Attendance at the meeting proper, and production of advocacy materials reminding governments of their existing commitments and the success stories they can look to replicate, were key features of AFAO's involvement and influence in the

IGM. The Road Map guiding the future response, the advocacy tools that were released by civil society over the course of the meeting, and the clear messaging that was delivered to governments regarding their existing commitments and the challenges ahead, underscored the significance of the IGM for Australia and for the region.

An expanded version of this article is available in the online edition of *HIV Australia* at www.afafo.org.au

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- 10 ibid.

James Malar is the Engagement and Communications Advisor at AFAO International Program in Bangkok.

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Male Sex Work and Society

Editors Victor Minichiello and John Scott. **Published by** Harrington Park Press

Reviewed by **Cameron Cox**

Male Sex Work and Society is 500 pages with 17 essays and research pieces presented in four sections: historical, marketing of male sex work, current social and cultural issues and seven case studies of social and cultural variations between different countries.

The editors state their intention to examine ‘how male sex work has been understood, both historically and cross-culturally’ and in doing so attempt ‘to move away from “scientific” understandings of male sex work that have painted sex workers and their clients as at-risk and/or pathological populations’

The collection is prefaced by a swathe of glowing reviews, nearly all of these by academics. But as a sex worker, I cannot agree that the collection completely moves away from pathologising us. Much of the work included in the collection is problematic in many ways and on many levels.

While recognising there is a huge range and diversity of male sex work, most of the works in the collection fail to capture the dynamics of this range or understand it in full. Male sex workers are presented through a series of static studies of segments of our work, many of which include broad and often sweeping statements that imply conclusions well beyond what was studied.

The editors specifically recognise that male sex work changes quickly and has done so recently, especially with the uptake of the internet by male sex workers and their clients. However, many of the studies included in the collection are already dated and no longer relevant.

The editors and contributors appear to be travellers in a foreign land whose language they do not speak and customs they only partially understand. They are all certainly experienced sexual health and public health researchers who have published a range of work on sex work and the sex industry. However, flaws attributable to the lack of consultation with male sex workers themselves in the research projects and

the editing of the collection are glaringly obvious if you are yourself a sex worker. As I read this work and evaluated the research, its interpretation, and conclusions, my reaction on almost each page was: ‘Maybe yes, but’. In almost every case I could see something that had been overlooked or to an extent misread. Sometimes it was just one or two minor things, but often a fairly major factor.

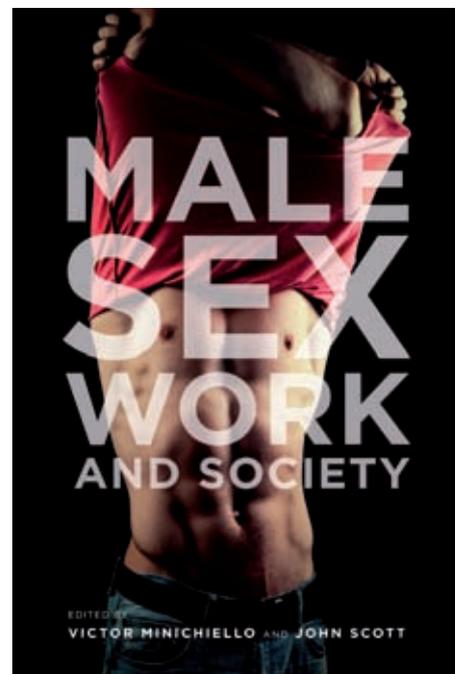
This was also the leading reaction of many of my colleagues who read various parts of the work. Few ended up reading it in full, even though its publication had been eagerly awaited. Maybe that in itself forms a sort of peer review.

Most importantly, from both a rights and health perspective, the editors and the authors do not seem to understand the concept of decriminalisation in a sex work context. The terms ‘decriminalisation’ and ‘legalisation’ are often used interchangeably, despite their distinct meanings. In one place there is even a reference to the need to regulate sex work in decriminalised settings.

The editors seem more interested in male sex work research than they do in male sex workers. They repeatedly stress the need for more research and in their conclusion they fall back on the vector of disease argument that they explicitly rejected earlier in the work.

Statements such as: ‘Existing HIV prevention programs succeed in changing behavior only in highly motivated individuals. The AIDS epidemic is moving relentlessly into its next phase (Parsons & Bimbi, 2007) and intervention approaches are now urgently needed for men who intentionally engage in unsafe commercial sex’ (p. 466) are dated, and not supported by evidence.

Linking sex workers with deliberate HIV seroconversion, ‘a growth of subcultural sexual behaviors, such as HIV-negative individuals seeking out HIV-positive partners;’ (p. 466) is also not supported by evidence, and nor is the ‘urgent need for



studies that explore and explain individual MSWs’ motivations for offering and/ or practicing unsafe sex or being ambiguous about their intentions.’ (p.467).

The editors conclude with a call for more research in order that sex work might be better regulated for the benefit of the sex worker, their clients and public health. This is not a surprising conclusion for a book that misinterprets decriminalisation and its impacts, and ignores almost completely the sex worker rights movement and sex worker organisations – not to mention the perspective of male sex workers in these groups and movements.

One can only hope that the editors and a majority of the authors, like us, received free copies of *The Lancet’s* series on Sex Work and HIV when it was released at AIDS 2014 in July last year, and have now updated their thinking on sex work, male sex work and how sex work research might be better conducted.

Cameron Cox is Male Sex Worker Representative, Scarlet Alliance, Australian Sex Workers Association.

NO-ONE WITH AN UNDETECTABLE VIRAL LOAD, GAY OR HETEROSEXUAL, TRANSMITS HIV IN FIRST TWO YEARS OF PARTNER STUDY; FINAL RESULTS NOT DUE TILL 2017

By Gus Cairns

The second large study to look at whether people with HIV become non-infectious if they are on antiretroviral therapy (ART) has found no cases where someone with a viral load under 200 copies/ml transmitted HIV, either by anal or vaginal sex.

Statistical analysis shows that the maximum likely chance of transmission via anal sex from someone on successful HIV treatment was 1% a year for any anal sex and 4% for anal sex with ejaculation where the HIV-negative partner was receptive; but the true likelihood is probably much nearer to zero than this.

The previous study, HPTN 052, established in 2011 that the efficacy of antiretroviral therapy at reducing HIV transmission from the HIV-positive partner to the HIV-negative one was at least 96% in heterosexual couples, but had too few gay couples in it to establish if the same applied to gay men. The PARTNER study¹ was designed to remedy this gap in knowledge. The study has so far recruited 1110 serodiscordant couples – with nearly 40% of them gay male couples.

The PARTNER study requires couples to be having sex without condoms at least some of the time. The HIV-negative partner cannot be using post-exposure prophylaxis (PEP) or pre-exposure prophylaxis (PrEP) and the HIV-positive partner must be on ART, with the most recent viral load below 200 copies/ml. This is different from HPTN 052, which measured the efficacy of the HIV-positive partner starting therapy (versus partners who did not).

In total, 767 couples took part in this two-year interim analysis and there were a total of 894 couple-years of follow-up. Among the heterosexual couples, HIV serostatus was split evenly – in half the couples the man had HIV and in the other half, the woman.

The main news is that, to date, in PARTNER there have been no transmissions within couples from a partner with an undetectable viral load, in what was estimated as 16,400 occasions of sex among the gay men and 28,000 among the heterosexuals.

Although some of the HIV-negative partners became HIV-positive (exactly how many will be revealed in later analyses), genetic testing of the HIV revealed that in all cases the virus came from someone other than the main partner.

No HIV transmissions occurred despite quite high levels of sexually transmissible infections (STIs), especially among the gay couples. When the ‘Swiss Statement’ was released in 2008, it declared that people with an undetectable viral load did not transmit HIV, but made an exception of people with an STI: the PARTNER study may be telling us that STIs (in either the positive or negative partner) don’t increase the likelihood of HIV transmission if the positive partner is on ART and undetectable (though of course STI themselves can still be transmitted).

PARTNER is still recruiting gay male couples and, as noted above, its full results will not be out till 2017.

Adapted from [aidsmap.com](#)
Published: 4 March 2014.

Reference

- 1 Rodger, A. et al. (2014, March). *HIV transmission risk through condomless sex if HIV+ partner on suppressive ART: PARTNER study*. 21st Conference on Retroviruses and Opportunistic Infections (CROI 2014), Boston. Abstract 153LB.

STARTING HIV TREATMENT AT CD4 COUNT ABOVE 500 REDUCES THE RISK OF SERIOUS ILLNESS AND DEATH BY 44%, AFRICAN TEMPRANO TRIAL SHOWS

By Keith Alcorn

Starting HIV treatment at a CD4 cell count above 500 reduced the risk of serious illness including tuberculosis (TB), and death, by 44% when compared to starting treatment according to World Health Organization (WHO) guidelines,

results from the seven-year Temprano study show. The findings were presented at the 22nd Conference on Retroviruses and Opportunistic Infections (CROI 2015) in Seattle, USA.¹

Temprano was designed to test the safety and efficacy of early HIV treatment initiation compared to standard treatment initiation in a lower-income setting with a high prevalence of TB and bacterial infections. The study was conducted in Ivory Coast by the French AIDS research institute ANRS.

The results of Temprano will lend support to the view that CD4 criteria for starting treatment should be dropped, and that the threshold for starting treatment should shift from a CD4 count of 500 to whenever the patient is ready to start, at least in lower-income settings where tuberculosis and bacterial infections are major causes of illness in people living with HIV. The START study of early treatment initiation will provide information about the risks and benefits of early treatment in developed world settings, where TB and bacterial infections do not cause substantial morbidity in people living with HIV. Results of the START study are expected in late 2016 or early 2017.

Adapted from [aidsmap.com](#)
Published: 26 February 2015.

Reference

- 1 Danel, C. et al. (2015, February). *Early ART and IPT in HIV-infected African adults with high CD4 count (Temprano trial)*. 22nd Conference on Retroviruses and Opportunistic Infections (CROI 2015), Seattle. Abstract 115LB.

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● **May**

24–27

National Rural Health Conference

Darwin, Australia

<http://www.ruralhealth.org.au/13nrhc>

● **June**

18–20

Anwernekenhe 6 – National Aboriginal and Torres Strait Islander Community Conference on HIV Education, Prevention and Wellbeing

Alice Springs, Australia

<http://ana.org.au/news/anwernekenhe-6>

● **July**

17–18

The 7th International Workshop on HIV Pediatrics

Vancouver, Canada

<http://www.virology-education.com>

19–22

8th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention

Vancouver, Canada

<http://www.ias2015.org>

● **September**

13–16

World STI & HIV Congress

Brisbane, Australia

<http://www.worldsti2015.com>

16–18

Australasian HIV&AIDS Conference

Brisbane, Australia

<http://www.hivaidsconference.com.au>

● **October**

5–6

6th HIV & Aging Workshop 2015

Washington, DC, United States of America

<http://www.virology-education.com>

18–21

24th International Harm Reduction Conference 2015

Kuala Lumpur, Malaysia

<http://www.ihra.net/conference-2015>

● **November**

20–23

12th International Congress on AIDS in Asia and the Pacific (ICAAP12)

Dhaka, Bangladesh

<http://www.icaap2015.org>

22–27

International Conference on AIDS and STIs in Africa (ICASA) 2015

Tunis, Tunisia

<http://icasa2015tunisia.org>

● **December**

8–11

7th International Workshop on HIV Persistence, Reservoirs and Cure

Miami, USA

<http://www.hiv-persistence.com>

● **July 2016**

17–22

21th International AIDS Conference (AIDS 2016)

Durban, South Africa

<http://www.aids2016.org>

Diary

ENDING HIV

Everything has changed. Advances in HIV treatment offer improved health benefits and the potential to dramatically reduce the risk of HIV transmission among gay men by 2020 if we:

$$\left[\begin{array}{c} \text{TEST} \\ \text{MORE} \end{array} \right] + \left[\begin{array}{c} \text{TREAT} \\ \text{EARLY} \end{array} \right] + \left[\begin{array}{c} \text{STAY} \\ \text{SAFE} \end{array} \right] = \left[\begin{array}{c} \text{ENDING} \\ \text{HIV} \end{array} \right]$$

Get tested at least twice a year. To decrease undiagnosed infections, to increase access to treatments, more of us need to know our HIV status earlier.

Poz guys - advances in HIV treatment offer improved health benefits and the potential to dramatically reduce the risk of passing on HIV.

By testing more often, by treating earlier and by continuing to stay safe, we can drive new infections among gay men down by 80% by 2020.



ENDINGHIV.ORG.AU