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A National Consensus Statement on the Future of Australia's HIV Response

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Acknowledgement of Country

We acknowledge the Traditional Owners of the Lands on which this report was produced, including the Gadigal people of the Eora nation, where Health Equity Matters and the National Association of People With HIV Australia are located. We also acknowledge the many other Lands that contributors to this report and the Australian HIV response work on. We pay respects to all Aboriginal and/or Torres Strait Islander people, recognise their connections to land, sea and community, and acknowledge that sovereignty was never ceded.

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Acronyms and Abbreviations

Acronyms	Definitions
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral therapy
CALD	Culturally and Linguistically Diverse
FIFO	Fly In-Fly Out
HIV	Human Immunodeficiency Virus
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, , Asexual +
GBMSM	Gay, Bisexual and other Men who have Sex with Men
NAPWHA	National Association of People With HIV Australia
PEP	Post-Exposure Prophylaxis
PWHIV	People With HIV
POCT	Point Of Care Test
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
STI	Sexually Transmissible Infection
TasP	Treatment as Prevention
U=U	Undetectable = Untransmittable
UNAIDS	Joint United Nations Programme on HIV/AIDS

Foreword

Mark Orr AM

President
Health Equity Matters

From the outset of the HIV pandemic, Australia's response has set a global standard for community-led public health initiatives. With multipartisan political backing, the communities most affected have taken a leading role, initially offering information and support to affected communities and People with HIV (PWHIV), and later providing strong advocacy for access to treatment and prevention strategies to reduce transmission. These strategies continue to form cornerstones of the public health response today as new technologies become accessible and interventions more widespread.

As a result of the hard work and dedication of everyone involved in the HIV response—an enduring partnership including researchers, medical professionals and affected communities—Australia has seen a substantial reduction in HIV transmission. Inner Sydney is on the cusp of becoming the first community in the world to achieve the virtual elimination of HIV transmission. This profound achievement demonstrates the viability and impact of our community-led approach, including access to Pre-Exposure Prophylaxis (PrEP) and treatment leading to viral suppression (Undetectable = Untransmittable). We now have a clear trajectory to virtual elimination nationwide and achieving the UNAIDS targets of 95:95:95, in which 95% of the people who are living with HIV know their status, 95% of the people who know that they are living with HIV are on lifesaving antiretroviral treatment, and 95% of people who are on treatment are virally suppressed.

Australia's HIV response has already proved highly effective at reducing transmission rates and improving the quality of life for those living with HIV. However, despite the significant achievements made to date, we are reaching a critical point in our journey towards virtual elimination. We must continue to stay focused. It is crucial that people with HIV and communities to whom prevention efforts are directed are at the forefront of our response until a cure is developed. We must continue to work together to improve the understanding of the impact of HIV transmission, fight stigma, and develop evidence-based, targeted interventions built on previous successes.

A national consensus statement on the future of Australia's HIV response aims to provide an authoritative outline of how virtual elimination of HIV transmission can be achieved and sustained, the barriers to progress, and what a future with minimal HIV transmission rates might look like. It seeks to guide policy development and funding decisions, foster collaboration among stakeholders and further engage affected communities. A diverse range of experts involved in Australia's response have contributed, representing the interests of the many individuals and communities impacted by HIV.

With a determined focus on leaving no one behind, our work is not yet complete. Long-term political commitment is needed, along with increased funding and ongoing community leadership. With this support, we can build on the successes of Australia's world-leading HIV response and continue our progress towards virtual elimination of HIV transmission in Australia, and beyond.

Scott Harlum

President
National Association of People With HIV Australia

Australia is a global leader in HIV prevention and care, setting a benchmark for a comprehensive approach to tackling the epidemic. From its outset, the Australian response was strongly community-led, with the most affected communities driving the movement, backed by consistent bipartisan political support. This combination enabled the effective dissemination of information and support to those living with HIV during the initial stages, and subsequently played a crucial role in influencing behaviours related to testing and transmission.

As part of the public health framework, community mobilisation around HIV remained instrumental, especially as new technologies emerged and intervention strategies expanded. The significant reduction in HIV transmission rates in Australia can be attributed to the diligent efforts of early leaders in research, healthcare, governance, and community advocacy. Thanks to them, the country is on track towards the virtual elimination of HIV transmission, with rates dropping below 90% since 2010 and approaching the UNAIDS 95-95-95 targets.

A national consensus provides a forum for reflecting on how Australia can sustain and further its achievements in the HIV response. It recognises that the perspectives and wellbeing of persons living with HIV must be at the forefront of the response even as the search for a cure persists. Furthermore, the historical complexities of treatment advancements need to be considered in any discussions about Australia's future HIV strategy.

To build upon past successes, stakeholders must work collaboratively to improve the understanding of HIV transmission and refine evidence-based interventions. The insights shared in this national consensus reflect the collective input of experts in the HIV sector and the diverse communities affected by the virus.

Australia's efforts have led to considerable progress in curbing HIV transmission and enhancing the quality of life for people with HIV. However, obstacles persist, particularly in the context of legal frameworks. The use of general criminal laws to address HIV transmission or exposure, as well as public health legislation that criminalises these acts, remains a contentious issue. Moreover, misinterpretations of transmission risks, such as through spitting, have resulted in problematic legislation. Additionally, immigration policies that discriminate based on HIV status disincentivise HIV testing among cohorts of people working or studying in Australia.

As the demographic at risk of HIV evolves, it is apparent that efforts and political resolve must continue to evolve alongside, striving not just for virtual elimination but also for maintenance and improvement of the gains. For the response to HIV in Australia to remain effective and forward-looking, systemic stigma needs to be addressed and dismantled.

Our work is not yet complete. Continued political dedication to allow it to adapt towards virtual elimination and beyond forms a critical part of the HIV response in Australia.

Introduction

Health Equity Matters and the National Association of People with HIV Australia (NAPWHA) have partnered to establish a national consensus statement on the future of Australia's HIV response. Australia is working towards achieving its target of virtual elimination of HIV transmission by 2030 – this will mark a historical milestone indicated by a 90% reduction in newly reported HIV transmission cases from a 2010 baseline[1].

The national consensus statement on the future of Australia's HIV response has worked with over 100 experts in the Australian HIV response to develop a set of statements that will inform the HIV response and support community, research and clinical priorities as Australia approaches and moves beyond virtual elimination of HIV transmission.

The diverse communities that worked together to enhance the HIV response have ensured Australia made progress toward UNAIDS Fast-Track targets by 2030: 95% of people with HIV are diagnosed, 95% of those people receive sustained Anti-Retroviral Therapy (ART), and 95% of people diagnosed achieve viral suppression*[2].Those communities where the prevalence of HIV is high, or whose members are at risk of HIV because of their identity, are defined by the Eighth National HIV Strategy (Please see page 19 of the Strategy). The HIV response in Australia is considered world-class in its achievements and commitment to reduce transmission and improve ART coverage and care for PWHIV. Empowered priority populations, with support and cooperation from medical and research groups, as well as multipartisan government support, have advocated for action on HIV since the beginning of the epidemic[3].

Continued national and jurisdictional support is critical as the HIV response approaches the next phase of the epidemic. Ensuring that Australia achieves and moves beyond virtual elimination requires dedication to evidence-based interventions, an increased understanding of transmission and risk factors, prioritising the care and wellbeing of PWHIV, and continued political advocacy.

With the launch of the Federal Government's HIV Taskforce Report[4] in November 2023, the path to virtual elimination of HIV transmission has become even clearer. Recommendations for activities and areas of priority have been identified in the HIV Taskforce Report to meet this goal. A national consensus reinforces this plan to achieve virtual elimination and provides a consensus on sustaining and moving beyond this target.

With a clarified pathway toward reduced HIV transmission rates, the Australian HIV response is now poised to continue to successfully progress toward its goal of achieving virtual elimination.

**Viral suppression is defined as <200 copies/mL*

Virtual Elimination

Virtual elimination of HIV transmission describes a measurable target for the progress towards minimal HIV transmission rates in Australia and is defined as a 90% reduction in HIV transmission rates from a 2010 baseline[1]. With reports of inner Sydney being the first locality in the world to approach virtual elimination[5], sights are now set on achieving this target nationally. Ensuring that all communities progress towards virtual elimination, despite progress being variable across different states and territories, will continue to be a central priority for the HIV response.

Achieving virtual elimination in Australia is a defined scenario in the future in which there are fewer than 91 new diagnoses a year[1]. At this juncture, the practices that have enabled this achievement will need to be balanced against emergent evidence of interventions and new norms to address the challenges of a changing epidemic.

This national consensus statement describes the activities and priorities that are important in the lead-up to the point of virtual elimination and what is required beyond this point – to sustain and build on the progress that has already been made. The statements in the report have considered various activities as well as the importance of continued evaluation of the relevance, impact and effectiveness of interventions as innovative public health measures are used once virtual elimination has been achieved. Community leadership and engagement must also form a critical part of designing policies, programs and activities relating to affected or at-risk populations.

People With HIV

Virtual elimination of HIV transmission goes beyond a measurable target – it should also consider the collective improvement and progress needed to empower PWHIV to live their lives to their full potential, free of discrimination to achieve the best health outcomes possible, as a central driver to reach and sustain this target.

The U=U message has been clear in highlighting the importance of high ART coverage and the role PWHIV play in efforts towards HIV transmission reduction[6]. Universal access to ART, retention in care, stigma-free healthcare and health promotion are key objectives of the response and need to be enhanced as new diagnoses decline. Preventative interventions need to continue to engage PWHIV to ensure these communities remain central to these efforts.

Ensuring a high quality of life for PWHIV has been shown to directly impact HIV transmission rates. The needs of PWHIV are diverse and organisations that represent the interests of PWHIV should continue to be at the centre of policy development, interventions, and collaborations. Ensuring PWHIV and their interests are central to the HIV response ensures HIV transmission will continue to decline and virtual elimination is achievable and then sustained.

Priority Populations and Priority Settings

As the epidemic continues to evolve, the HIV response needs to ensure all priority populations are visible and their needs are considered in all transmission-reduction activities.

Communities affected by HIV are highly diverse. This national consensus statement acknowledges the continuum of experiences and identities that inform the HIV response. The expert panel that contributed to this project was selected to ensure the voices of PWHIV and priority populations were represented.

Epidemiological research supports defining priority populations as an important starting point for directing further research and interventions[7]. It is essential to highlight who represents the priority population to

provide a voice and ensure that the HIV response is inclusive of the diversity of this population.

HIV in Australia continues to impact gay, bisexual and other men who have sex with men (GBMSM), with the majority of new diagnoses being among these people. The high rate of TasP amongst PWHIV and PrEP coverage amongst GBMSM, in combination with proven effective prevention tools including condom use, has led to excellent progress in reducing HIV transmissions among this population. Across the ten years to 2022, HIV notifications in Australia decreased by almost 50%.[8] Sustained investment in community-controlled jurisdictional HIV and national peak HIV organisations is essential to ensure declines in HIV transmission continue to occur in this priority population.

The risk of transmission and prevalence amongst Aboriginal and Torres Strait Islander communities remains disproportionately high[9], with rates increasing from 2.3 per 100,000 in 2021 to 3.2 per 100,000 in 2022[9]. Rates of other STIs, particularly syphilis, are also disproportionately high, and potentially impacting HIV transmission. The rate of PWID amongst First Nations communities also remains disproportionately high and may act as an effective mode of transmission. Improved access to effective prevention tools such as PrEP, treatment, needle and syringe programs, and appropriate testing is required to ensure diagnosis rates trend towards virtual elimination. Other health services supporting a shift toward decolonised healthcare models to address racism are also required.

Rate of Notification *(per 100,000 in 2022)*

3.2	2.2
Aboriginal and Torres Strait Islander peoples	Non-Aboriginal people

People from high-prevalence countries account for one-third of new cases and the intersectionality of sexuality, migration, healthcare, and socio-economic factors confound the risk experienced by parts of CALD communities. In addition, stigma and racism, particularly when experienced in healthcare, creates a significant barrier for newly settled Australians[10]. Ensuring healthcare is culturally appropriate and effective and conducted in the context of universal access to PrEP, testing and TasP has been established in several of the statements outlined in this report.

Definitive successes have been made in other priority populations such as the sex worker community, with high rates of condom use and peer-led education[11]. To continue to address the risk of transmission, a sustained focus on resourcing peer-led education and safe sex practices is required. Removal of structural barriers through addressing stigma and law reform, including the full decriminalisation of sex work, remains critical[12].

For the Care Cascade

93% of people with HIV were diagnosed by the end of 2022

95% of people with HIV received treatment

98% of people receiving treatment had an undetectable viral load[a]

The Partnership

There has been a long-standing partnership in the Australian HIV response that has placed community-controlled HIV organisations at the forefront of the epidemic[3]. In collaboration with clinical, research networks and government, community-controlled HIV organisations have led the coordination of critical achievements across the life course of Australia's HIV epidemic. By building trust over decades, and engaging community members in the design and implementation of interventions, community-controlled HIV organisations have provided a voice to priority populations and PWHIV.

Biomedical Technologies

The medical needs of priority populations are diverse and require a variety and combination of medical technologies to ensure no one is left behind.

The collective effect of PrEP and TasP/U=U for priority populations and PWHIV has demonstrated the potent effect of these technologies on reducing transmission rates, allowing the Australian response to turn its sights towards virtual elimination of HIV transmission – a world first. As HIV-related mortality rates decline a new phase of the response has evolved and emerged. For PWHIV, this phase has seen a shift from mortality reduction to improvement of quality-of-life metrics.

There is still a demand for new medical technologies across testing, prevention, and treatment, particularly as the response changes and activities to sustain new minimal transmission rates materialise.

Technical limitations in medical therapies for PWHIV and other priority populations mean the existing suite of treatment and prevention options does not meet the needs of all people. Continued advocacy is required to encourage pharmaceutical companies to manufacture new therapies that address the limitations of existing therapies. Simultaneously, advocacy to government and regulatory authorities is required to enable rapid access to these technologies in Australia. Collaboration between the pharmaceutical and medical technologies industries, researchers, clinicians and communities is essential to understand the role and feasibility of new technology as transmission rates progress towards zero.

a - Viral suppression is defined as <200 copies/mL

Scope

This report outlines the results from the project that aimed to build a national consensus on the priorities of the future of the Australian HIV response. More than 100 experts from community, clinical and research groups were surveyed to establish these priorities. The rigorous process ensured equitable representation of input, particularly from priority populations such as PWHIV and community and civil society organisations that represent their interests.

Use and Relevance

The Consensus Statement is a high-level national document that was informed by a diverse panel of HIV experts representing community, research and/or clinical interests in the HIV response. It can:

Assist in defining future organisational priorities and activities relating to the HIV response.

Continue to highlight the importance of community representation and engagement, particularly priority populations.

Continue to highlight the importance of cooperation between community, research, clinical and government bodies.

Inform areas of research interest, particularly those relating to the consensus report statements and themes.

Define types of interventions and/or areas of evidence deficiencies.

Identify areas of clinical practice to assist, enhance or service PWHIV and priority populations.

Allow for interpretation and translation of statements based on local community needs to identify and advocate for areas of need in the HIV response.

Highlight the need for sustained or increased financial resourcing, particularly for identified areas of need.

Assist and guide policy development

Where applicable, support approaches or interventions.

Guiding Principles

The national consensus statement on the future of Australia's HIV response has been developed in accordance with the following principles to ensure the project reflects the priorities of the Australian HIV response effectively and appropriately:

1. PWHIV are at the core of the Australian HIV response and their involvement is critical to reaching virtual elimination.
2. Meaningful and appropriate consultation with PWHIV is critical for the future of HIV in Australia.
3. People and priority populations are represented and consulted.
4. Experts from research, clinical, government and community groups form critical parts of the HIV response and ensure the response is based on best practice.
5. Procedural integrity and academic robustness should inform the design and development of the national consensus statement.
6. The consensus process is designed and developed in a manner that ensures the interests of priority populations and PWHIV are represented.

The Future Response of the HIV Epidemic in Australia

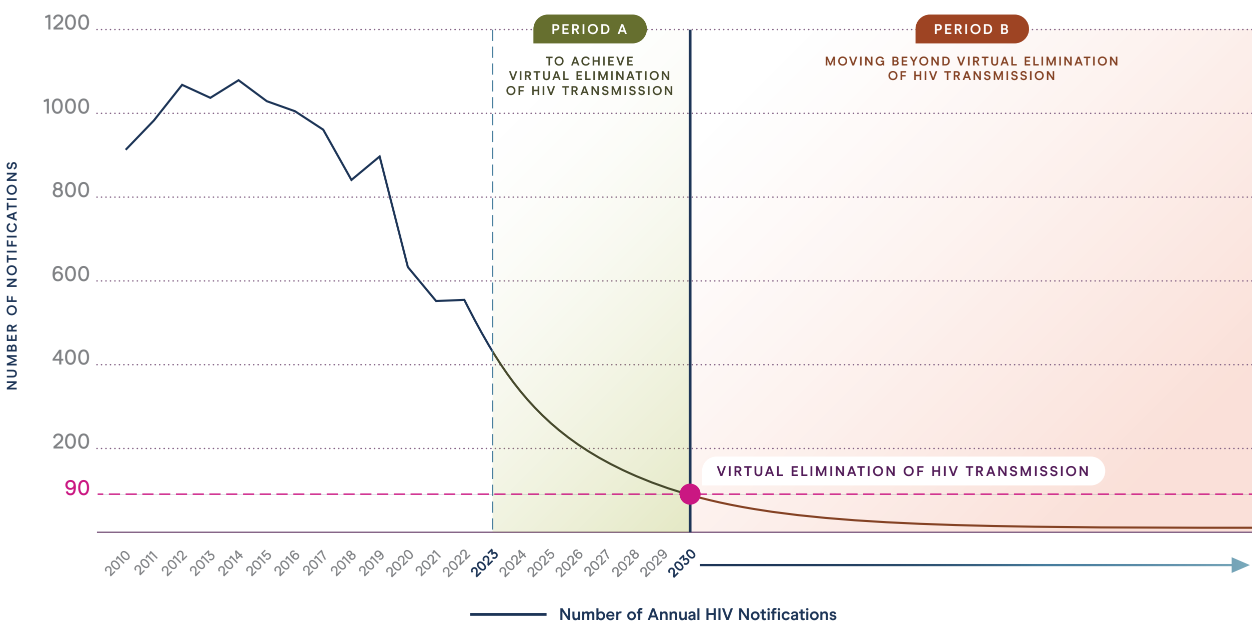


Figure 1 - *HIV diagnoses in Australia, actual (2010-2022) and projected (from 2023) Projects for Period A and B*

The Consensus Process

The project utilised a two-step process to establish a national consensus statement that ensured equitable representation across the community, research and clinical leaders of the Australian HIV response[3].

The project worked with field and methodological experts to ensure the process would provide a voice to the individuals who were being represented in this consensus statement and would be inclusive of key organisations that provide leadership and guidance to the HIV response.

The process is summarised in two parts:

Part 1
Creating draft statements with the Steering Committee

Part 2
Establishing consensus with experts using a Delphi Study

Part 1 - Creating draft statements with the Steering Committee

A steering committee was formed to guide the consultation process and collect expertise within sub-specialties of the HIV response. The steering committee was composed of:

- Two representatives from the national PWHIV peak organisation
- Two community-controlled HIV organisation representatives
- Four researchers from key research centres covering epidemiological, medical, and social areas of HIV research.
- One clinical peak organisational representative
- One Aboriginal and Torres Strait Islander clinical peak organisational representative
- One representative from the national HIV peak organisation

The steering committee was Chaired by Scientia Professor Andrew Grulich.

Two co-creation focus groups were held with the steering committee. The first focus group used an exploratory approach where a series of open-ended questions guided the committee in conversation around the progress of the response so far, deficiencies in the response and potential interventions or strategies that could be used to enhance the response's progress towards virtual elimination. Committee members were advised that opinions shared during the focus groups would be considered as their own professional and personal experiences.

The research team was led by A/Prof Jason Ong and included Dr Tiffany Phillips, Dr Phyllis Lau, Dr Reuben Kiggundu, Habib Taouk and Ben Wilcock. It conducted content and thematic analyses and elicited six distinct themes: Prevention, Testing, HIV-related Stigma, Community-Led Response, Research, and Treatment, Management and Care. Thirty-five corresponding unique statements were then drafted from the data collected and grouped under these themes.

The second focus group was then held to review the draft statements and the Steering Committee was asked to clarify or elaborate on certain statements. The feedback received was analysed again to form the final iteration of draft statements.

Part 2 - Establishing consensus with experts using a Delphi study

To ensure robust and equitable contribution across the diverse HIV response, the project utilised the Delphi methodology[13], which is an anonymous process whereby a panel of experts score the importance of the draft statements.

For the Delphi study, an 'expert' was defined as a leader in the HIV response who holds or has held a professional appointment within the response (that is, within a community, a clinical organisation or a research institute). Purposive and snowballing sampling methods were used to identify and invite relevant experts to participate in the panel. In October 2023, the expert panellists were emailed a link and invited to complete the first round of an online survey.They were asked to score the importance of draft statements on a scale of 1 to 4 (4=Strongly Agree, 3=Agree, 2=Disagree, 1=Strongly Disagree). The experts were asked to consider each statement according to two scenarios:

Scenario 1 **PERIOD A**

Achieving virtual elimination of HIV transmission

labelled **PERIOD A** in *Figure 1*. This period describes the current national response and its progress toward the goal of **virtual elimination of HIV transmission by 2030, defined by** a 90% reduction of diagnoses compared to a 2010 baseline. In Australia, this would mean annual new diagnoses are less than 91 cases per year. baseline. In Australia, this would mean annual new diagnoses are less than 91 cases per year.

Scenario 2 **PERIOD B**

Moving beyond virtual elimination of HIV transmission after it is achieved

labelled **PERIOD B** in *Figure 1*. This is the long tail of the HIV epidemic – beyond virtual elimination. This period describes a distant future where HIV transmission rates are below 91 cases every year. Delphi survey participants were asked to assume the following:

- There is still no HIV cure or vaccine.
- The response is now entering a phase that requires some activities to be modified whilst others are increased (a mix of suppression and control responses).
- Political interest is difficult to sustain, and there may be pressure to reduce resources devoted to the HIV response.
- The HIV response in this period aims to ensure HIV does not resurge.

Scores of 4 (Strongly Agree) and 3 (Agree) were combined to produce %agreement for each statement. Statements that reached the predetermined consensus threshold of 80% agreement across all experts were included as Consensus Statements. Statements that did not reach 80% agreement were rescored by the experts in the second round of the survey using the same process.

During the first round, some participants suggested new ideas for consideration. These were discussed by the research team, and six new draft statements were crafted and presented in the second round for rating using the same process. These additional draft statements all reached a consensus, hence there was no need for a third round.

a Purposive Sampling – *A technique whereby the experts are intentionally selected to the panel based on their expertise.*

b Snowball Sampling – *A technique whereby existing experts recruit and recommend other experts to the panel.*

Workflow Diagram

Part 1

Steering Committee is assembled

↓

Focus Groups with Steering Committee to generate input

↓

Thematic analysis of focus group results

↓

Draft Statements are formed and reviewed by the Steering Committee

↓

Part 2

Round 1: Expert panel rates draft statements based on the level of importance

← Expert Panel assembled

↓

Round 2: Statements with <80% consensus undergo re-scoring. Six new statements added

↓

Five failed statements are removed

↓

Final consensus statements formed

Demographics of the Expert Panelists

This national consensus statement has worked with the communities of the response to ensure that the statements reflect a true consensus on activities and priorities required to reach virtual elimination by 2030.

The project invited 164 experts to participate in the Delphi study; 106 accepted our invitation (response rate 64.6%) and participated in the first survey round of survey; 87 of whom (retention rate 82.1%) subsequently participated in the second round.

The table below summarises the characteristics of the participating experts.

Table 1 - *Demographic summary of expert panel*

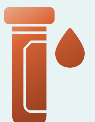
Number of experts surveyed:	Round 1 N=**106** n, %	Round 2 N=**89** n, %
Age Range		
20-30	6 (5.7)	6 (6.9)
31-50	43 (40.6)	35 (40.2)
51+	57 (53.8)	46 (52.9)
Aboriginal and Torres Strait Islander		
No	95 (89.6)	79 (90.8)
Aboriginal	9 (8.5)	6 (6.9)
Torres Strait Islander	0	0
Aboriginal and Torres Strait Islander	0	0
Prefer not to answer	2 (1.9)	2 (2.3)
Gender Identity		
Man or male	66 (62.3)	54 (62.1)
Woman or female	33 (31.1)	27 (31.0)
Non-binary	6 (5.7)	5 (5.8)
I use a term not listed above	1 (0.9)	1 (1.2)
Sexual Identity		
Straight (heterosexual)	42 (39.6)	36 (41.4)
Gay or lesbian	49 (46.2)	41 (47.1)
Bisexual	7 (6.6)	5 (5.8)
I use a term not listed above	5 (4.7)	3 (3.5)
Prefer not to answer	3 (2.8)	2 (2.3)
HIV Status		
Not living with HIV	88 (83.0)	72 (82.8)
Living with HIV	15 (14.1)	13 (14.9)
Prefer not to answer	3 (2.8)	2 (2.3)
Years Working in HIV Sector		
1-10 Years	33 (31.1)	28 (32.2)
11-20 Years	34 (32.1)	27 (31.0)
21+ Years	39 (36.8)	32 (36.8)
Organisation Jurisdiction**		
National	37 (34.9)	30 (34.5)
Victoria	21 (19.8)	19 (21.8)
New South Wales	15 (14.2)	12 (13.8)
Queensland	14 (13.2)	10 (11.5)
Western Australia	12 (11.3)	10 (11.5)
Tasmania	5 (4.7)	4 (4.6)
Northern Territory	4 (3.8)	4 (4.6)
Australian Capital Territory	4 (3.8)	4 (4.6)
South Australia	2 (1.9)	2 (2.3)
Type of Work**		
Community	56 (52.8)	45 (51.7)
Research	42 (39.6)	35 (40.2)
Clinical	36 (34.0)	28 (32.2)

**Participants could tick all that apply*

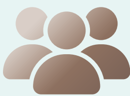
Themes of the Consensus Statements

Prevention

Testing


Treatment, Management and Care

Stigma and Discrimination Reduction


Community-Led Response

HIV Research

Final Consensus Statements and their scores

Theme 1
Prevention of HIV Transmission

Consensus statements under this theme are listed in Table 2.

A combination of preventative practices have significantly helped to reduce the rate of HIV diagnoses[14]. The introduction of subsidised PrEP in 2018 substantially reduced HIV transmission but further efforts are required to ensure maximum coverage for priority populations.[15]

Preventative measures should sustain a combination approach.[14] This includes new technologies to overcome access barriers and contraindications to current PrEP medication, expanding availability to Medicare-ineligible people, continued support for needle-and-syringe programs and other harm-reduction efforts and education on other prevention technologies such as condoms.

TasP and Undetectable=Untransmittable messaging and the continued improvement of the quality of life of PWHIV are congruent parts of the preventative effort. PWHIV and civil society organisations that advocate for the recognition and importance of PWHIV rights within preventative education, particularly in the context of U=U education, are an inseparable part of the overall response.

The expert panel was also asked to rate separate statements on two different models of PrEP access in both rounds of the survey. Although they scored closely to the consensus threshold, neither statement achieved consensus (See Table 3). The first statement described PrEP access without the need for a doctor's script. The second described PrEP access through a community-led clinic.

Pre-Exposure Prophylaxis

Since subsidisation in April 2018, PrEP, TasP/U=U, condoms, and effective testing have led to significant declines in HIV notifications. However, these declines have not been evenly shared across all priority populations. This disparity needs to be a research priority if the response is to achieve virtual elimination. Without a focus on equitable access to PrEP for all people in Australia, we will struggle to capitalise on the population-wide benefits of further reducing rates of HIV transmission[16]. A systemic approach to liberalising PrEP access through nurse- and pharmacy-led supply and reaching people ineligible for Medicare is critical.

Fifty-nine percent of experts from a community background agreed with Statement A – Provision of PrEP without the need for a doctor's prescription (Table 3); p=0.015. Experts who indicated they were from a clinical background were less likely to agree with either statements A or B from Table 3. Eighty-seven per cent of clinicians from a clinical background did not agree with the importance of either statement A or B (p=0.002)compared to 61% of experts from a non-clinical background (p=0.005).

The varying consensus around the two models indicates a need for research into PrEP access models as well as community-initiated dialogue with clinical partners to discuss the benefits of PrEP demedicalisation.

59% of experts from a community background agreed with Statement A

Table 2
Consensus Statements on Prevention

1.	Prevention	% Agreement	
		Achieving	Moving Beyond
1.1	Sustain a combination approach to HIV prevention	99.1	97.2
1.2	Ensure biomedical HIV prevention methods are subsidised and readily accessible to those who need them, including visa holders who are Medicare ineligible.	97.2	96.2
1.3	Increase HIV and sexual health education to clinicians in primary care, focusing on prevention, treatment, and testing.	99.1	97.2
1.4	Sustain access to harm reduction measures, including needle and syringe programs.	97.2	97.2
1.5	Strengthen the capacity of publicly funded sexual health services to work with priority populations.	99.1	97.2
1.6	Ensure new and approved subsidised biomedical HIV prevention options are made available.	97.2	97.2

Table 3
Statements on PrEP that did not reach consensus

	Statements on PrEP that did not reach consensus	% Agreement	
		Achieving	Moving Beyond
A.	Provide pre-exposure prophylaxis (PrEP) without needing a doctor's prescription, for example through nurses and over-the-counter access through pharmacies.	78.2	75.6
B.	Empower community-led clinics to provide PrEP without a doctor's prescription.	79.5	79.5

Theme 2
HIV Testing

Consensus statements under this theme are listed in Table 4.

Innovative approaches to testing technologies improve interventions that address economic barriers, access issues, and stigma, both at the personal and population-wide level. High testing rates amongst priority populations empower these populations about their sexual health and are strongly linked to PrEP uptake and adherence[17]. Testing also impacts long-term health outcomes for PWHIV by increasing the rates of early diagnoses and minimising delayed initiation of ART.[18]

The Therapeutic Goods Administration (TGA) approval of novel testing approaches, such as self-testing or rapid point-of-care testing (POCT), is supported by the National HIV Testing Policy[19]. However, current and future testing models need to address policy and health system barriers that hinder increased testing. It is also essential to consider the unique needs of priority populations and determine how testing services can be tailored to meet these requirements.

Blood sample testing for HIV, while available and subsidised under Medicare, varies in accessibility across Australia. The rates of testing remain low among certain priority populations, such as Aboriginal and Torres Strait Islander communities, rural communities, and CALD groups. Importance should be placed on increasing testing coverage amongst these communities.

Despite the TGA approval, POCT and HIV self-testing are not subsidised through Medicare items. This is despite the robust evidence demonstrating the ability of these technologies to overcome access barriers experienced by GBMSM[20]. These tests also have the potential to service priority settings that do not have reliable access to conventional testing methods because of geographical barriers, a lack of testing clinics and healthcare-related stigma. Promoting self-test use needs to be accompanied by information on linkages to care and surveillance[21].

The expert panel was also asked to rate statements about real-time molecular epidemiology and opt-out testing models in both rounds of the survey. The responses demonstrated very strong support for these measures; however, neither statement achieved the threshold of 80% agreement to reach a consensus.

Testing Models of HIV

Molecular epidemiology and the use of phylogenetics is used to determine emerging sub-types of the virus. This has the potential to enhance public health responses as transmission rates reach new minimums, especially in transient populations and infections acquired overseas. Molecular epidemiology's ability to attribute certain viral sub-types with associated demographic and risk factors will inform the public health response with great specificity about the sub-type dynamics[22].

Legal and civil groups have raised concerns with the ethical use of this technology, particularly the fact that molecular epidemiology performed in a criminalised environment will expose PWHIV to criminalisation. Co-design of policy relating to this technology and close examination of its impact on HIV and PWHIV is critical.

When asked about the importance of batch testing for population surveillance (testing blood samples collected for other clinical purposes for HIV and returning a positive result to the patient), 50% of the expert panel indicated a strong disagreement with this statement.

To overcome barriers to testing, opt-out testing is now part of the National HIV Testing Policy[19], as an alternative to other models to improve testing uptake, when compared to opt-in models[23]. This allows HIV testing to be offered in high-prevalence settings or amongst priority populations such as CALD communities, where testing rates are low and/or late diagnosis rates are high and a patient-initiated testing model has not yielded comparative rates.

Forty percent of experts were from a research background and this group scored differently to the majority of other experts in relation to opt-out testing in primary care settings (Table 3 – Statement D). 86% and 84% of researchers did not agree with the importance of Statement D in either *achieving* or *moving beyond* virtual elimination, p=0.036 and p=009, respectively. The response needs to consider opt-out testing interventions that enable a transition from policy into clinical practice.

Table 4
Consensus Statements on Testing

2.	Testing	% Agreement	
		Achieving	Moving Beyond
2.1	Provide accessible and affordable HIV self-testing kits and tailored post-test support systems.	96.2	96.2
2.2	Increase the availability of new and innovative HIV testing technologies through improved government regulatory and approval processes.	96.2	94.3
2.3	Expand nurse-led HIV testing programs that are funded by Medicare rebates.	94.3	92.5
2.4	2.Improve obstetric HIV clinical protocols and support midwives in improving prenatal HIV testing.	90.6	89.6

Table 5
Statements on Testing that did not reach consensus

	Statements on PrEP that did not reach consensus	% Agreement	
		Achieving	Moving Beyond
C.	Use real-time molecular epidemiology to facilitate rapid responses to emerging HIV transmission networks.	79.5	79.5
D.	Use an opt-out HIV testing model in primary healthcare settings, particularly for priority populations (individuals are notified of a positive HIV result).	79.5	73.1

Theme 3
Treatment, Management and Care of PWHIV

Consensus statements under this theme are listed in Table 6.

The adoption of the U=U messaging in 2017 signalled a new era in the HIV response: one that focuses on reducing stigma and reinforcing PWHIV as critical leaders in the elimination of HIV transmission. In 2022, 95% of people diagnosed with HIV were receiving ART[9] – a steady increase from previous years.

The rates of ART coverage vary across different communities in Australia, being particularly low in visa holders. Equitable access to ART is necessary to ensure the response continues to make progress towards virtual elimination. Equitable access assumes ongoing linkage to care and support which ensures the healthcare needs of PWHIV can be monitored and addressed by medical specialists.

Achieving a good quality of life for PWHIV in Australia is crucial to preventing transmission now and particularly after virtual elimination. Improving quality of life metrics will ensure PWHIV are engaged in designing and implementing interventions that empower this demographic to take control of their health and wellbeing.

Laws around HIV criminalisation undermine public health measures to prevent HIV transmission and support PWHIV. These laws are based on inaccurate and outdated assumptions about HIV transmission. They frame PWHIV as harmful and dangerous are based on inaccurate and outdated assumptions around HIV transmission risk and deter priority populations from engaging with health and social services out of fear of prosecution. This situation negatively impacts the wellbeing of PWHIV[24]. State and territory departments of health and jurisdictional legislatures have a responsibility to work with PWHIV organisations to reform existing laws so that HIV remains a public health and not a criminal objective.

Table 6
Consensus Statements on Treatment, Management and Care

3.	Treatment, Management and Care	% Agreement	
		Achieving	Moving Beyond
3.1	Continue funding subsidised access to HIV treatments for all people with HIV, regardless of visa status.	100	100
3.2	Sustain workforce education to clinicians on HIV treatment options.	100	98.1
3.3	Increase workforce education to clinicians for culturally appropriate HIV care.	99.1	98.1
3.4	Ensure new and approved subsidised treatment options are made available.	99.1	99.1
3.5	Strengthen the management of each new diagnosis, including peer-led contact tracing, linkage to care and rapid initiation of HIV treatments.	97.2	97.2
3.6	Maintain retention in care and adherence to treatment.	99.1	99.1
3.7	Improve the quality of life for people with HIV*	96.6	95.4

**Introduced in Round 2 of scoring*

Theme 4
Stigma and Discrimination Reduction

Consensus statements under this theme are listed in Table 7.

Stigma and discrimination in healthcare are key issues in service accessibility and trust building. This is particularly relevant in the context of HIV, given the implications of HIV stigma on PWHIV. For communities such as Aboriginal and Torres Strait Islander Peoples or CALD people, emphasis on building trust and meaningful engagement of community leaders is required to build interventions that empower and enable communities to create culturally appropriate and safe services for their unique barriers to healthcare.

A deeper understanding of the impacts of stigma and discrimination and effective interventions are required. Furthermore, the evaluation of these interventions, associated aetiology, and psychosocial impacts has the potential to inform public health measures to reduce HIV transmission[25].

Research that focuses on stigma and discrimination should be considered in light of reduced HIV transmission and how this might change stigma experienced by different communities.

Legal Issues

The criminalisation of HIV across jurisdictions presents a barrier to reducing stigma and discrimination toward PWHIV. Scientific and medical evidence to disprove misconceptions about HIV[26] has supported limited legislative reforms to laws criminalising HIV.

HIV should be treated as a public health issue – not a criminal one. Laws that directly and indirectly criminalise HIV remain a major deterrent to healthcare access and enhance stigma and discrimination. The *HIV Taskforce* has made decriminalisation of HIV a priority[4], with a focus on jurisdictional law reform efforts and continued education of U=U messaging to combat misinformation. The expert panel has supported several statements in this project that support law reform that targets PWHIV and at-risk people and enhances public health education.

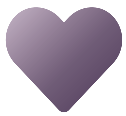


Table 7
Consensus Statements on Stigma and Discrimination

4.	Stigma and Discrimination	% Agreement	
		Achieving	Moving Beyond
4.1	Remove harmful legislation that criminalises HIV transmission.	96.2	96.2
4.2	Remove mandatory HIV testing laws.	88.7	87.7
4.3	Remove HIV as a barrier to visiting and migrating to Australia	93.4	94.3
4.4	Increase funding for age-appropriate sex-positive sexual health education that includes HIV prevention in schools	97.2	98.1
4.5	Increase sexual health education that includes HIV prevention in tertiary education institutions, including for international students.	95.3	96.2
4.6	Provide education and increase awareness in the general public on a contemporary understanding of HIV, including as a chronic and manageable disease, and U=U (Undetectable = Untransmittable).	93.4	95.3
4.7	Reduce HIV-related stigma in healthcare*	98.9	100
4.8	Research and support activities to understand and address stigma and discrimination, including racism and its impacts in healthcare*	95.4	93.1

**Introduced in Round 2 of scoring*

Theme 5
Community-Led Response to HIV

Consensus statements under this theme are listed in Table 8.

One of the reasons why Australia's HIV response is recognised as world-leading because of the role of community-controlled HIV and PWHIV organisations in leading the response. The leading role adopted by community-controlled organisations representing priority populations and PWHIV has been central to ensuring advocacy is led by communities.

Future activities and interventions need to be informed by the community-led approach of the Australian HIV response to sustain and strengthen partnerships across the clinical, research and political groups.

As HIV transmission rates continue to decline towards the point of virtual elimination, the HIV response must continue to place priority populations at the forefront of consultations with decision and empowerment practices. Co-design of research activities, public health interventions and programs, led by peers, has already demonstrated its ability to lead the integration of new practices and interventions in response to a changing epidemic.

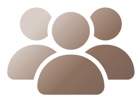


Table 8
Consensus Statement on Community-led Response

5.	Community-led Response	% Agreement	
		Achieving	Moving Beyond
5.1	Continue partnerships between communities, research, clinicians, and funding bodies to eliminate HIV transmission.	100	99.1
5.2	Co-design evidence-based strategies and interventions for HIV prevention, testing and treatment with priority populations; provide support to implement and evaluate these strategies.	99.1	97.2
5.3	Expand free and easily available community-based peer-led education, HIV testing and care services for priority populations	99.1	97.2
5.4	Empower priority populations to design interventions and strategies unique to the needs of their communities*	97.7	97.7
5.5	Sustain funding for community-led organisations*	100	96.6

Introduced in Round 2 of scoring

Theme 6
HIV Research

Consensus statements under this theme are listed in Table 9.

The Australian HIV response has a strong history of developing programming, activities and policy initiatives that are evidence based. To ensure the response continues to build on its progress, HIV research needs to be sustained and enhanced. HIV research, in its full breadth, connects the lived experience of HIV with evidence-based policy, advocacy and practice. HIV research involves a diverse range of experts that cover several fields, including social determinants of health, psychological and behavioural, epidemiological, socio-legal, political, economics, ethical, legal, and human rights sciences, translational science, clinical, and medical research.

Cooperation between these fields of research is imperative to form effective collaborations and enhance research efforts by meaningfully engaging community representatives to ensure gaps in knowledge and understanding are resolved.

Gaps in HIV research disproportionately affect certain priority populations. Data collection against pre-existing standards does little to provide deeper insights and an accurate understanding of HIV of emerging priority populations. Poor granulation in demographic data sets means the response is less informed about communities where HIV transmission is less understood.

The expert panel were asked to consider a scenario that did not include a cure for HIV, instead encouraging it to consider enhancing current technologies and interventions to maximise the reductions in HIV transmission across different priority populations. However, research relating to an HIV cure is still an important objective toward virtual elimination and the global research effort towards a cure will greatly impact PWHIV and priority populations. Given Australia's world-class HIV response, it is well positioned to contribute to this effort.

Data collection

Part of the progress towards virtual elimination has involved improvements to data collection. Surveillance programs such as ACCESS and jurisdictional reporting requirements have ensured more accurate reporting and the ability to improve understanding of transmission patterns and the social determinants that influence them. Accurately informing public health responses is a critical part of ensuring no harm is done to PWHIV or priority populations and maximises the impact of certain interventions.

There are deficiencies in data collection that limit the ability of epidemiologists to identify priority populations. CALD communities are highly diverse and reporting of data on the origins and identity of these communities is limited and has a direct impact on research accuracy, safety and inclusion[27]. This limits the ability of the data to represent and account for an undiagnosed or priority population. The effort to granulate data collection remains an important issue that requires addressing, especially with the shift in the demography of priority populations.

Table 9
Consensus Statement on HIV Research

6.	Research	% Agreement	
		Achieving	Moving Beyond
6.1	Sustain funding for research in HIV.	100	97.2
6.2	Ensure funding for research to improve identifying people with HIV who remain undiagnosed and those with late HIV diagnoses.	98.1	97.2
6.3	Maintain the engagement and involvement of the HIV community sector and the communities they represent as critical partners in HIV research.	98.1	99.1
6.4	Enable economic evaluations of HIV prevention and treatment methods to ensure strategies provide value for money.	90.6	91.5
6.5	Conduct research on the implementation of new prevention technologies.	97.2	95.3
6.6	Improve demographic data collection for priority populations to increase accuracy and enable effective responses*	97.7	95.6

**Introduced in Round 2 of scoring*

Conclusion

The Australian HIV response is beginning to consider the reality of minimal HIV transmission rates and, with it, changed epidemic characteristics. The national consensus statement on the future of Australia's HIV response has provided a world-first opportunity to voice the response's priorities and key considerations around the future of HIV in Australia.

It has also emphasised the progress that has been made towards Australia's goal of reaching the 95:95:95 targets and, in the longer term, achieving and moving beyond virtual elimination. Maintaining long-term, population-level viral suppression will require sustained and, in some cases, increased support from relevant organisations. These include research, clinical and community organisations and government bodies.

The statements in this report have outlined future priority activities and themes for the response and identified necessary supports, including additional resourcing, increased workforce capacity and changes to policies.

A community-led partnership with government, clinical and research groups is critical to achieve and move beyond virtual elimination.

As strategies and workplans from the various organisations that are part of the HIV response are constructed, we hope this report becomes a key piece of evidence to support their development. We also encourage policymakers and government departments to use the statements in this report to continue to support the HIV response and engage communities when building programs.

To ensure no one is left behind, the response will need to become more nuanced and bespoke to deal with priority sub-groups and localised differences in public health interventions. This will require a greater degree of evidence, policy change, and more financial and human resources.

The response will lean on technologies, stigma-reduction projects and established interventions with proven effectiveness. Continued leadership and investment from the government are imperative to prevent regression and the emergence of new priority populations and to continue to improve the quality of life of PWHIV and address inequalities in the response.

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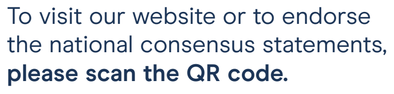
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