The Western Australian HIV Strategy 2019–2023 builds on the strengths and progress from our previous strategies, and is closely aligned to the Eighth National HIV Strategy 2018–2022. This strategy outlines the guiding principles, goals, targets and priority areas needed for an effective, coordinated and comprehensive statewide response in the prevention, treatment and management of the HIV epidemic in Western Australia (WA).

Australia has committed to the United Nations’ 95-95-95 goal to end the HIV/AIDS epidemic by 2030, with a set of targets to drive the response to ensure that 95% of people with HIV have been tested and know their status, that 95% of people diagnosed with HIV are receiving effective antiretroviral treatment, and that 95% of people on treatment are virally suppressed.

The pillars of combination HIV prevention, which include safer sex by using condoms and harm reduction initiatives, have been bolstered by biomedical interventions like rapid testing, preventing mother-to-child transmission, post-exposure prophylaxis, pre-exposure prophylaxis and ‘treatment as prevention.’ The current scientific evidence on treatment as prevention now clearly demonstrates that people living with HIV who have a suppressed viral load that is undetectable, no longer pose a risk for sexually transmitting the virus. This has led an unprecedented global movement in recent years on transforming public health messaging to include ‘Undetectable = Untransmissible or U=U, which is helping to improve the lives of people living with HIV and to eliminate HIV-related stigma.

With new antiretroviral treatments in the research and development pipeline, longer lasting antiretrovirals with alternate modes of delivery, and exciting developments in the HIV vaccine and functional cure arenas, the HIV epidemic is certainly at a tipping point. While there are big developments on the horizon, we already have the tools now to halt new HIV infections and improve the health outcomes for those at risk of or living with HIV.
The goals and targets of the *WA HIV Strategy 2019–2023* are based on those detailed within the *Eighth National HIV Strategy 2018–2022*. It is imperative that a consistent set of goals and targets are committed to across the nation, with local actions proposed to meet these targets and ultimately to reach the goals.

The personal and social impact of HIV among affected target populations must also be minimised, by eliminating the negative impact of stigma, discrimination, and legal and human rights issues impacting on the health of people living with HIV.

As we move forward, it is crucial that we implement this strategy with inspiration from our strong collegial work with health professionals, government departments, community and public health organisations, researchers and members of our communities affected by HIV. The key motivation for our work here, nevertheless, must be the optimum health and wellbeing of these communities. I look forward to seeing the positive outcomes of this strategy over the next four years.

*Honourable Roger Cook MLA*
Minister for Health
Strategy at a glance

Goals
1. Virtually eliminate human immunodeficiency virus (HIV) transmission in Australia within the life of this strategy.
2. Maintain the virtual elimination of HIV transmission among people who inject drugs (PWID), sex workers and from mother to child.
3. Reduce mortality and morbidity related to HIV.
4. Minimise the personal and social impact of HIV.
5. Eliminate HIV-related stigma, discrimination, and legal and human rights issues on people’s health.

Targets
1. Increase the proportion of people with HIV (in all priority populations) who know their HIV status to 95%.
2. Increase the proportion of people diagnosed with HIV on treatment to 95% within six weeks of diagnosis for those newly diagnosed, reducing this timeframe further over the life of the strategy.
3. Increase the proportion of people on treatment with an undetectable viral load to 95%.
4. Reduce the incidence of HIV transmission in men who have sex with men (MSM).
5. Reduce the incidence of HIV transmission in other priority populations other than MSM - people living with HIV; Aboriginal people; culturally and linguistically diverse (CALD) people from high HIV prevalence countries; people who travel to high prevalence countries; sex workers; PWID; people in custodial settings; and sexually and gender diverse people.
6. Maintain the virtual elimination of HIV among sex workers, PWID and from mother to child through the maintenance of effective prevention programs.
7. Ensure all people attending public sexual health services and general practices are assessed for pre-exposure prophylaxis (PrEP) eligibility.
8. Ensure at least 75% of people living with HIV report good quality of life.
9. Reduce the reported experience of stigma among people living with HIV, and the expression of stigma, in respect to HIV status.
Key actions

1. Ensure all health promotion initiatives for HIV are based on contemporary evidence, and communicated clearly and consistently through innovative mixed media channels.

2. Sustain community-led and peer-based approaches for engaging with priority populations on strategies for safer sex, STI and HIV testing, and harm reduction.

3. Ensure that people newly diagnosed with HIV receive evidence-informed counselling and support on living with HIV and the benefits of rapid antiretroviral treatment commencement.

4. Strengthen models of care to holistically meet the needs of people living with HIV (PLWH) who have more complex psychosocial needs by facilitating supported linkages to relevant services.

5. Monitor and evaluate the quality standards within models of aged care, ensuring that they are inclusive, respectful and meet the needs of PLWH.

6. Develop the awareness of the mainstream healthcare workforce on identifying stigma and discrimination related to HIV or to priority populations, alongside methods for addressing these identified forms of stigma and discrimination.

7. Continue to promote accessible evidence-based clinical guidelines and tools covering the HIV cascade of care to enable the professional development of workforce sectors, particularly general practices, delivering services to priority populations.

Priority populations

- people living with HIV
- gay and bisexual men, and MSM
- Aboriginal people
- CALD people from high HIV prevalence countries
- people who travel to high prevalence countries
- sex workers
- PWID
- people in custodial settings
- sexually and gender diverse people.
Other related strategies

- Eight National HIV Strategy 2018–2022
- Humanitarian Entrant Health Service – policies and information
- National Drug Strategy 2017–2026
- Western Australian Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy (In progress)
- Western Australian Aboriginal Health and Wellbeing Framework 2015–2030
- Western Australian Alcohol and Drug Interagency Strategy 2018–2022
- Western Australian Country Health Service Aboriginal Health Strategy 2018–2023 (to be published)
- Western Australian Health Aboriginal Workforce Strategy 2014–2024
- Western Australian Sexually Transmissible Infections Strategy 2019–2023
- Western Australian Aboriginal Sexual Health and Blood-borne Viruses Strategy 2019–2023
- Western Australian Hepatitis B Strategy 2019–2023
- Western Australian Hepatitis C Strategy 2019–2023
- Western Australian Immunisation Strategy 2016–2020
- Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025
- Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018–2025 (to be published)
- Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018–2025
- Western Australian Methamphetamine Action Plan
- Western Australian Youth Health Policy 2018–2023
- World Health Organisation Global Health Sector Strategy on HIV 2016–2021
- UNAIDS Strategy 2016–2021
## List of acronyms

Consistent list of terms across the suite of sexually transmissible infections and blood-borne virus strategies 2019–2023

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
</tr>
<tr>
<td>ACIR</td>
<td>Australian Childhood Immunisation Register</td>
</tr>
<tr>
<td>AHCWA</td>
<td>Aboriginal Health Council of WA</td>
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<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<tr>
<td>AHS</td>
<td>Aboriginal Health Service</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal health worker</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMR</td>
<td>antimicrobial resistant</td>
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<tr>
<td>ANSPS</td>
<td>Australian Needle and Syringe Program Survey</td>
</tr>
<tr>
<td>APNA</td>
<td>Australian Primary Health Care Nurses Association</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral treatment</td>
</tr>
<tr>
<td>ASHM</td>
<td>Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine</td>
</tr>
<tr>
<td>AOD</td>
<td>alcohol and other drug</td>
</tr>
<tr>
<td>BBV</td>
<td>blood-borne virus</td>
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<tr>
<td>BBVSS</td>
<td>Blood-borne Viruses and Sexually Transmissible Infections Standing Committee</td>
</tr>
<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CDCD</td>
<td>Communicable Disease Control Directorate</td>
</tr>
<tr>
<td>CLAI</td>
<td>condomless anal intercourse</td>
</tr>
<tr>
<td>CSRH</td>
<td>Centre for Social Research in Health</td>
</tr>
<tr>
<td>DAA</td>
<td>direct-acting antiviral</td>
</tr>
<tr>
<td>GDHR</td>
<td>Growing and Developing Health Relationships</td>
</tr>
<tr>
<td>GIPA</td>
<td>greater involvement of PLWH</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HPV</td>
<td>human papillomavirus</td>
</tr>
<tr>
<td>HTLV1</td>
<td>human T-cell lymphotropic virus type 1</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<td>---------</td>
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<tr>
<td>LASH</td>
<td>WA Law and Sex Worker Health</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
</tr>
<tr>
<td>MIPA</td>
<td>meaningful involvement of PLWH</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
</tr>
<tr>
<td>NCHECR</td>
<td>National Centre in HIV Epidemiology and Clinical Research</td>
</tr>
<tr>
<td>NGO</td>
<td>non-government organisation</td>
</tr>
<tr>
<td>NHVPR</td>
<td>National Human Papillomavirus Vaccination Program Register</td>
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<tr>
<td>NiPHC</td>
<td>Nursing in Primary Health Care</td>
</tr>
<tr>
<td>NSP</td>
<td>needle and syringe program</td>
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<tr>
<td>NSEP</td>
<td>needle and syringe exchange program</td>
</tr>
<tr>
<td>OTP</td>
<td>opioid treatment programs</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<tr>
<td>PEP</td>
<td>post exposure prophylaxis</td>
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<tr>
<td>PGCPs</td>
<td>Perth Gay Community Periodic Survey</td>
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<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
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<tr>
<td>PIS</td>
<td>Patient Information System</td>
</tr>
<tr>
<td>PLWH</td>
<td>people living with HIV</td>
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<tr>
<td>POCT</td>
<td>point-of-care testing</td>
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<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
</tr>
<tr>
<td>PWID</td>
<td>people who inject drugs</td>
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<tr>
<td>RDT</td>
<td>rapid diagnostic test</td>
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<tr>
<td>RNA</td>
<td>ribonucleic acid</td>
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<tr>
<td>RSE</td>
<td>relationships and sexuality education</td>
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<tr>
<td>RTO</td>
<td>Registered Training Organisation</td>
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<tr>
<td>SASA</td>
<td>Structured Administration and Supply Arrangement</td>
</tr>
<tr>
<td>SHBBVP</td>
<td>Sexual Health and Blood-borne Virus Program</td>
</tr>
<tr>
<td>SiREN</td>
<td>WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network</td>
</tr>
<tr>
<td>SMS</td>
<td>short message service</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmissible infection</td>
</tr>
<tr>
<td>s100</td>
<td>section 100</td>
</tr>
<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
</tr>
<tr>
<td>TasP</td>
<td>treatment as prevention</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNSW</td>
<td>University of New South Wales</td>
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</tbody>
</table>
UTI urinary tract infection
U=U Undetectable = Untransmissible
VL viral load
WA Western Australia
WACHS WA Country Health Service
WA health system The WA health system consists of the Department of Health, Child and Adolescent Health Service, North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service and WA Country Health Service, and Health Support Services.
WANIDD WA Notifiable Infectious Diseases Database
WHO World Health Organization
WA SHaBBVAC WA Sexual Health and Blood-borne Viruses Advisory Committee
WA SORG WA Syphilis Outbreak Response Group

Clarifications
* This strategy uses the terms ‘regional’ and ‘remote’ which applies to all non-metropolitan areas in Western Australia (WA).
* The WA health system uses ‘Aboriginal’ rather than ‘Aboriginal and Torres Strait Islander’ or ‘Indigenous’ in all forms of communication. The use of the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition of the Aboriginal people as the original inhabitants of WA. No disrespect is intended to our Torres Strait Islander colleagues and community. Where referenced documents use the term Aboriginal and Torres Strait Islander, that term is used instead.
* ‘Aboriginal Health Service’ (AHS) refers to all health and medical services targeting Aboriginal people including government-run health services and Aboriginal Community Controlled Health Services (ACCHS).
* ‘Chronic’ refers to diagnosis of infection lasting longer than six months.
* ‘Newly acquired’ refers to evidence of infection having been acquired in the 24 months prior to diagnosis.
* ‘Unspecified’ refers to infections of unknown duration.
Contents

Why is this strategy needed? 12
Progress under the last strategy 14
Guiding principles 16
Goals and targets 18
Priority populations 20
Evidence to support the action areas 25
Consultation undertaken 25
Consultation findings 26
Evidence to support actions 27
Action areas 31
Prevention and education 31
Testing and diagnosis 32
Disease management and clinical care 33
Workforce development 34
Enabling environment 35
Data collection, research and evaluation 36
Surveillance, monitoring and evaluation framework 37
Governance, implementation and reporting 39
References 41
What is HIV?
The human immunodeficiency virus (HIV) weakens a person’s immune system making it hard to fight off infections. HIV can be passed on when body fluids containing the virus such as blood, semen, vaginal fluid, anal fluid or breast milk enter the bloodstream of a person who does not have HIV. If left untreated, HIV can cause acquired immune deficiency syndrome (AIDS). AIDS occurs when the body’s immune system is compromised and unable to fight off infections and illnesses effectively.

What health issues does HIV cause?
Soon after HIV infection, some people feel as if they have the flu, with symptoms such as fever, headache, tiredness and a rash. Some people may not have any symptoms. As the virus continues to attack the immune system, a person will start to develop symptoms. These can include constant tiredness, swollen glands, rapid weight loss, night sweats and diarrhoea. Without effective treatment these symptoms can progress to the point where the immune system becomes fragile and susceptible to multiple infections (AIDS), which may be life threatening.

How is HIV managed?
HIV can be effectively managed through antiretroviral treatment (ART), also known as antiretroviral medication, allowing a person living with HIV to lead a full and healthy life.

New diagnoses
The number of new HIV diagnoses in 2017 (n = 79) was the lowest number of annual cases reported in WA since 2009 (n = 75), representing a 27% decrease in annual cases since 2015 (n = 108). In 2017, 47% (n = 37) of new HIV diagnoses were notified in men who have sex with men (MSM), followed by male heterosexual (35%; n = 28) and female heterosexual (13%; n = 10). Where injecting drug use was reported as the main risk factor, cases remain low with only one notification in this category for 2017. The decline in HIV notifications was mainly driven by a decrease in cases among MSM, which decreased by 42% between 2016 (n = 64) and 2017(n = 37).
Treatment and care

In 2017, 1760 WA residents were provided HIV treatment subsidised by the Pharmaceutical Benefits Scheme (PBS), which was a 15.7% increase compared to the number of residents provided treatment in 2015 (n = 1521).

Corresponding with this increase, estimated treatment coverage among WA residents diagnosed with HIV also rose from 83% in 2015 to 89% in 2017.

Behavioural data

In WA, gay and bisexual men make up a significant proportion of HIV notifications. Condom use among gay and bisexual men has declined, as reported by participants in the 2017 Perth Gay Community Periodic Survey (PGCPS). The 2017 PGCPS reported that 44.6% of participants had unprotected anal intercourse with casual male partners in the six months prior to the survey. This was the highest ever reported in the PGCPS and an increase from 39.8% (n = 200) reported in the 2010 survey. While reported condom use has declined, there was also an increase in the proportion of PGCPS participants aware about the availability of pre-exposure prophylaxis (PrEP), which rose from 21.7% (n = 148) in 2014 to 67.8% (n = 415) in 2017.

Cases reporting heterosexual acquisition in WA have remained relatively stable over time; however, in the five-year period from 2013 to 2017, the number of male cases reporting heterosexual HIV acquisition in South-East Asia increased by 40%, compared to the previous five-year period.

While HIV incidence remains low in people who inject drugs (PWID) in WA, receptive needle sharing continues to be reported, and will require sustained harm reduction interventions.
Through a comprehensive public health response to HIV prevention and control, progress has been made against the goals of the *WA HIV Strategy 2015–2018*, with low numbers of HIV cases in Aboriginal people, sex workers and PWID sustained over the strategy period. Further, by the end of 2017, estimated treatment coverage among all people diagnosed with HIV increased to 89%. A survey of participating HIV specialist clinics responsible for managing 92% of HIV cases diagnosed in 2017 found that of those cases, 95% had achieved an undetectable viral load (VL) within 12 months of diagnosis. In 2018, 91% of people diagnosed with HIV commenced treatment within one month of diagnosis.

The public health response included the launch of a PrEP implementation trial in late 2017, giving free access to PrEP for HIV negative people at medium or high risk of HIV. The trial ran for just over 10 months with a total of 901 study participants enrolled across four sites.

Following the listing of PrEP on the PBS from 1 April 2018 as a section 85 (General Schedule) medication, face-to-face training was delivered across the state to support the clinical workforce in prescribing and managing PrEP. This training was delivered in partnership with the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), with over 200 health professionals attending the sessions delivered at six locations around the state. A listing of PrEP prescribers in WA has been published online.

Other workforce development initiatives included the development of a nationally accredited course in HIV and ageing to support aged-care organisations, a face-to-face HIV update for nurses and general practitioners (GPs), and HIV section 100 prescriber courses. As a result there are currently 16 GPs accredited as HIV section 100 prescribers in WA.

WA continued to support priority population research initiatives, including the PGCPS and an interview-based study of MSM in Perth who use crystal methamphetamine. The WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN) coordinated by Curtin University continued to provide support in this area to the sector.
Case management has moved towards providing holistic care to people with highly complex needs and has achieved high rates of clinical service re-engagement with clients. People living with HIV experiencing complex psychosocial issues were provided intensive case management and personalised support through the Integrated Case Management Program and through community-based services.

Partners from the non-government sector provided health promotion and prevention strategies, and support services targeting priority groups. This included initiatives such as peer-based programs, support groups, educational workshops and social media campaigns to improve awareness of HIV and to address stigma and discrimination. World AIDS Day grants continued to be provided to support organisations and groups based in regional areas to deliver health promotion focused activities.
The Guiding Principles for this strategy reflect those in the *Eighth National HIV Strategy 2018–2022*, adapted for the Western Australian context.

1. **Meaningful involvement of priority populations**
   People living with HIV (PLWH) should be central to the HIV response and, along with other priority populations, should have meaningful participation in the development, implementation, monitoring and evaluation of effective programs and policies within the HIV response. This is known as the MIPA principle (meaningful involvement of PLWH) or the GIPA principle (greater involvement of PLWH).4,5

2. **Human rights**
   PLWH, or those at risk of HIV, have the right to live without stigma and discrimination. It is vital to safeguard the human rights of priority populations so as not to face stigma and discrimination based on their actual or perceived health status, cultural background, socio-economic status, age, sex, sexual or gender orientation or identity. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.

3. **Access and equity**
   Health and community care in WA should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to gender, sexuality, disease status, drug use, occupation, socio-economic status, migration status, language, religion, culture or geographic location, including in custodial settings. Health and community services should be welcoming, and should work towards increasing access for priority populations.

4. **Health promotion**
   All actions related to the prevention of HIV transmission, the provision of clinical services, and ongoing support and care for those living with or at risk of HIV should reflect the Ottawa Charter for Health Promotion.6

5. **Prevention**
   The transmission of HIV can be reduced through the appropriate combination of evidence-based biomedical, behavioural and social approaches within a supportive and enabling environment. Education and prevention programs, together with access to the means of prevention, will be vital going forwards in achieving the targets set within this strategy.
6. **Quality health services**

   Supporting and coordinating a multidisciplinary workforce of motivated, trained and informed health professionals, community and peer-based workers is essential in delivering culturally appropriate and quality services for priority population across WA. Health service delivery should respond to new technologies and best practice in models of care for those living with or at risk of HIV.

7. **Harm reduction**

   Harm reduction approaches strengthen effective measures to prevent the transmission of HIV and minimise the health and social burden of HIV in the community. Approaches include needle and syringe programs (NSPs), alcohol and other drug (AOD) treatment programs, counselling and mental health support, and measures to address social determinants of health.

8. **Shared responsibility**

   Individuals and communities are empowered when they can prevent themselves and others from acquiring HIV. Government and community organisations have a shared responsibility to address education and support needs through the provision of resources and supportive environments that facilitate priority population-led prevention action.

9. **Commitment to evidence-based policy and programs**

   The response to HIV in WA has been built on a strong evidence base, informed by high-quality research and surveillance, monitoring and evaluation. With new research findings, it will be essential to refine the evidence base in order to meet new challenges, evaluate current and new interventions, and to develop effective social policy and clinical guidelines.

10. **Partnership**

    Effective and collaborative partnerships between priority populations, health services, community organisations, the clinical workforce, researchers and government are fundamental to the response to HIV and to achieve the goals and targets set out in this strategy. A partnership approach is characterised by consultation, cooperative effort, clear roles and responsibilities, meaningful contributions, empowerment, respectful dialogue and appropriate resourcing in order to achieve the goals and targets within this strategy.
The goals and targets presented in this strategy are aligned with the goals and targets detailed within the *Eighth National HIV Strategy 2018–2022*. It is imperative that a consistent set of goals and targets are committed to across the nation, with local actions proposed to meet these targets, and ultimately reach the goals.

**Goals**

1. Virtually eliminate HIV transmission in Australia within the life of this strategy.
2. Maintain the virtual elimination of HIV transmission among PWID, sex workers and from mother to child.
3. Reduce mortality and morbidity related to HIV.
4. Minimise the personal and social impact of HIV.
5. Eliminate HIV-related stigma, discrimination, and legal and human rights issues on people’s health.

**95–95–95 global targets**

Australia supports the 2016 United Nations Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030,\(^7\) which provides a global framework for the HIV response. In 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) launched a set of targets to build momentum for the detection of HIV in those yet to be diagnosed, and to accelerate action enabling the early uptake of treatment for people living with HIV.\(^4,8\)

The targets, known as 90–90–90, set the bar for 2020, whereby it is expected that 90% of all people with HIV will know their HIV status (access to testing), 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (treatment coverage), and 90% of all people receiving antiretroviral therapy will be virally suppressed.\(^8\) It is anticipated that Australia is on track to achieving these targets ahead of 2020, and sights are now set on achieving the UNAIDS Fast-Track 95–95–95 global targets to end the HIV epidemic.\(^9\)

Achieving the 95–95–95 targets, centred on testing and treatment, will only be possible if real progress is made towards achieving zero forms of HIV-related stigma and discrimination.\(^5,9,10\)
Targets – by 2023

1. Increase the proportion of people with HIV (in all priority populations) who know their HIV status to 95%.
2. Increase the proportion of people diagnosed with HIV on treatment to 95% within six weeks of diagnosis for those newly diagnosed, reducing this timeframe further over the life of the strategy.
3. Increase the proportion of people on treatment with an undetectable VL to 95%.
4. Reduce the incidence of HIV transmission in MSM.*
5. Reduce the incidence of HIV transmission in other priority populations.†
6. Maintain the virtual elimination of HIV among sex workers, PWID and from mother to child through the maintenance of effective prevention programs.
7. Ensure all people attending public sexual health services and high priority population caseload general practices are assessed for PrEP eligibility.
8. Ensure at least 75% of people living with HIV report good quality of life.
9. Reduce the reported experience of stigma among people living with HIV, and the expression of stigma, in respect to HIV status.

* Compared with 2016 data.
† Compared with 2018 data.
Historically, trends in HIV epidemiology across Australia, and within WA, have demonstrated that effective public health responses to HIV should have tailored approaches to populations most at risk of acquiring or transmitting HIV, known in this strategy as priority populations.\textsuperscript{1,11} It is important to remember that assessments of HIV risk in one population may change over time due to a range of factors, therefore monitoring epidemiological trends and having the flexibility to respond to emerging issues should always be at the forefront of designing HIV programs and interventions. Furthermore, while this strategy provides guidance on priority populations, it is acknowledged that HIV can affect anyone, regardless of whether they fit within a priority population or not.

**People living with HIV**

In 2017, there were an estimated 27 545 PLWH in Australia, of which an estimated 2899 people (11\%) were unaware of their HIV status (undiagnosed).\textsuperscript{12} Testing for HIV, as part of routine sexual health testing, leads to early detection of HIV infection and the opportunity to commence ART as soon as possible. Effective ART regimens coupled with good ART adherence, suppresses the progression of HIV resulting in an ‘undetectable viral load.’\textsuperscript{13,14,15,16,17} An undetectable VL improves health outcomes and quality of life for PLWH and, if sustained, results in effectively no risk of onward transmission of HIV through sexual contact.\textsuperscript{18} While advances in modern ART has improved the lives of many PLWH, other health issues associated with HIV and the management of comorbidities also impact the lives of PLWH, particularly the increasing proportion of aging PLWH.

Key subpopulations of PLWH include:

- older people
- people who are co-infected with other blood-borne viruses (BBVs)
- people with comorbidities
- people with complex needs
- rural and regional residents
- children, young people and families living with HIV
- women
- transgender and gender diverse people
- Aboriginal people
- people from culturally and linguistically diverse (CALD) backgrounds
- people who are ineligible for subsidised health care and medicines.
Gay and bisexual men, and men who have sex with men

Gay and bisexual men, and MSM continue to be disproportionately affected by HIV, accounting for around 59% of all HIV notifications in WA in 2017.\(^1\) In the 2017 PGCPS, which interviewed a sample of 612 men, 89% had taken an HIV test at some point in time, signalling an increase in HIV testing when compared to previous surveys.\(^2\) However, the 2017 PGCPS highlighted that condomless anal intercourse (CLAI) with either regular or casual partners had increased, along with serosorting and awareness of PrEP.\(^2\) Supporting findings of the 2017 PGCPS, other behavioural research suggests that subpopulations of MSM continue to be at increased risk of acquiring HIV when compared to other population groups due to a combination of risk behaviours including increased CLAI with multiple casual sex partners, often in conjunction with the use of illicit drugs as a part of those sexual encounters.\(^2,19,20\) With high rates of STIs in MSM in WA,\(^1\) along with decreasing condom use and evolving use of PrEP for HIV prevention, there will be a greater need for increased efforts to promote combination approaches to HIV and STI prevention, PrEP adherence and routine comprehensive HIV and STI testing.

Key subpopulations of gay and bisexual men, and MSM include:

- PLWH
- PWID
- people from CALD backgrounds.

Aboriginal people

Nationally, the HIV notification rate has been higher in Aboriginal people than in the Australian-born non-Aboriginal people since 2009, and in 2017 it was 1.6 times higher (4.6 compared to 2.8 per 100 000 population).\(^21\) In those aged 35 years and above, the rate was almost twice that among Australian-born non-Aboriginal people (3.0 per 100 000) underscoring the disproportionate burden of HIV in Aboriginal people.\(^21\) In WA between 2013 and 2017, the male to female notification ratio was 2.5:1 for Aboriginal people and 6.7:1 for non-Aboriginal people.\(^1\) Nationally from 2013 to 2017, a higher proportion of HIV notifications among the Aboriginal population were due to heterosexual sex (21%) and injecting drug use (18%) when compared to the Australian-born non-Aboriginal population (18% and 3% respectively).\(^21\) Overall, the health disparities in Aboriginal people when compared to the Australian-born non-Aboriginal population, coupled with a higher prevalence of STI’s, increasing injecting drug use and the social and structural barriers to accessing health care increases the HIV risk for this priority population.\(^1,21,22,23\) Together with the Aboriginal Sexual Health and Blood-borne Virus Strategy 2019–2023, initiatives within this strategy will aim to engage and support Aboriginal people living with or at risk of HIV.

Key subpopulations of Aboriginal people include:

- PLWH
- people living with other BBVs
- PWID
- gender and sexually diverse
- living in regional and remote communities
- experiencing homelessness
- young
- engaging in sex work
- living with other undiagnosed or untreated STIs.

**Culturally and linguistically diverse people from high HIV prevalence countries**

Nationally between 2008 and 2017, the HIV notification rate differed by region of birth, and among people born overseas, with the highest HIV notification rates in 2017 among people born in Southeast Asia (14.0 per 100,000 population), North, Central and South America (13.5 per 100,000), and Sub-Saharan Africa (13.1 per 100,000). Trends in WA among people born overseas have changed over time, and between 2013 to 2017, 32% of males reporting heterosexual acquisition of HIV in Southeast Asia were overseas born, and 37% of males reporting MSM acquisition in Southeast Asia were born within the region. There has been a notable decline in WA in the number of cases acquiring HIV in Sub-Saharan Africa, which decreased by 46% between the 2008 to 2012 and 2013 to 2017 periods, with 67% of cases during 2013 to 2017 being heterosexually-acquired cases among people born in that region.

Key sub-populations of people from CALD backgrounds include those who are:
- born in countries with high HIV prevalence
- gay and bisexual men, and MSM from high prevalence countries
- return to visit high HIV prevalence countries of birth
- refugees and humanitarian entrants
- ineligible for subsidised health care, including international students.

**People who travel to high prevalence countries**

The close proximity of WA to high prevalence countries, particularly in Asia, and increasing movement of people due to work for international companies, tourism (including sex tourism), and fly-in fly-out work in the resources sector has increased the HIV risk for this diverse and mobile population. Between 2008 to 2017 in WA the number of cases who acquired HIV overseas decreased by 10%. However, over the same period, the number of men reporting HIV acquisition in Asia (particularly Southeast Asia) increased by 40%, with the majority of these men being Australian-born. Tailored approaches across the HIV cascade of care will be required for this diverse group, and couched within the context of travel, in addition to reviewing WA’s epidemiological trends in overseas acquired HIV by country of birth.
Sex workers

In Australia, HIV incidence among female sex workers has remained at or below 0.13 per 100 person-years in the past five years (2013–2017), and was 0.13 per 100 person-years in 2017. While this has been a success within Australia’s HIV response, sex work continues to be associated with high exposure risks for BBV and STI transmission, and for this reason sex workers continue to be a priority population requiring sustained evidence-based and tailored approaches to HIV prevention. Whilst the sex industry has been proactive in engaging the sex workers in preventative efforts such as condom use and regular STI testing, recent evidence suggests decreasing condom use among sex worker populations and an increase in the number of clients requesting services without a condom, or refusing to use prophylactics, posing an increased risk of STI/BBV acquisition to sex workers. Experiences of stigma and discrimination related to sex work, instances of sexual assault committed against sex workers, coupled with regulatory and legal approaches, such as the criminalisation of sex work, can present barriers for this priority population to access prevention, testing and health services which negatively impacts on the health, safety and well-being of this priority population.

Key subpopulations sex workers include those who are:
- sexually or gender diverse
- using or injecting drugs
- migrant or from a CALD background
- street based
- working in isolation
- based in regional and remote communities
- Aboriginal
- affected by STIs
- living with BBVs
- living with a disability.

People who inject drugs

In Australia, HIV transmission among PWID due to sharing of injecting equipment has remained low due to highly successful NSPs and access to sterile injecting equipment. However, this population continues to remain a priority due to the ongoing risk of BBV transmission or acquisition as drug use and injecting behaviours change over time. Of the 458 respondents attending NSPs in WA in 2017, 28% reported re-using someone else’s needle and syringe once or more in the past month. Further, the coalescing of injecting drug use as a part of sexual practices among MSM in WA may require nuanced harm reduction initiatives. Similarly, and as noted above, targeted approaches will also be required to address the higher proportion of HIV notifications in Aboriginal people due to injecting drug use when compared to the Australian-born non-Aboriginal population.
Key subpopulations of PWID include those who are:
- young
- new initiates to injecting
- living in regional and remote areas
- Aboriginal
- in custodial settings
- from CALD backgrounds
- gay and bisexual men, and MSM.

People in custodial settings
Although prevalence of HIV among people entering custodial settings has remained low, risk behaviours within these settings increases the risk of HIV transmission or acquisition, in particular, receptive needle and syringe sharing, condomless sex, unsterile tattooing, body piercing and other blood-to-blood contact prior to entering and while within custodial settings. It is important to target strategies not only for those imprisoned, but also to those on remand, awaiting sentencing and exiting custodial settings.

Sexually and gender diverse people
The prevalence of HIV in sexually and gender diverse people in Australia is unknown, due limitations in the data. However, internationally the high prevalence of adverse health outcomes in this population, including HIV, STIs and other BBVs, are often elevated due to complex biological, social and structural factors, which increase risk and reduce access and options to health care. Sexually and gender diverse people may have individual risk factors that vary, and likewise specific sexual health needs across the HIV cascade of care. Concentrated initiatives for this priority population should prioritise training and quality standards within the health care workforce to ensure inclusive and stigma-free service delivery.

Key subpopulations of sexually and gender diverse people include those who are:
- youth
- PLWH
- Aboriginal, including brotherboys and sistergirls
- undergoing hormonal or medical treatment or procedures to assist with gender affirmation.

*Terms used for transgender people within some Aboriginal communities.*
Consultation undertaken

The Sexual Health and Blood-borne Virus Program (SHBBVP) undertook consultations between August and November 2018 to inform the development of the WA Sexual Health and Blood-borne Virus Strategies 2019–2023. The consultations were conducted via an online survey and nine face-to-face workshops held in Perth and regional areas of WA.

Various online platforms were used to promote the consultations including social media, websites, e-newsletters and via email.

Online survey

The online survey opened on 1 August 2018 and closed on 31 October 2018. Data was collected through SurveyMonkey with a total of 103 responses received. The majority of participants (85%) identified as health professionals while community members represented 16%. Some respondents selected more than one category. Health professionals who completed the survey were from state government organisations, non-government organisations (NGOs), universities or research-based organisations, local governments, Aboriginal health organisations and private organisations. Most participants were based in metropolitan Perth (62%), followed by regional WA (24%) and remote WA (14%).

Metropolitan consultations

There were two face-to-face consultations held in Perth in early September 2018 facilitated by an external consultant, Tuna Blue. Data was collected through software that allowed for real-time responses from participants as each of the strategies were discussed. The 41 participants attending the consultations represented hospitals, health consumers, prisons, NGOs, Aboriginal health services (AHSs), affected communities, education and research institutes.

Regional consultations

The regional consultations were facilitated by SHBBVP staff in all WA Country Health Service (WACHS) regions including the South West, Goldfields, Wheatbelt, Pilbara, Midwest, Great Southern and the Kimberley. Regional sexual health coordinators and NSP coordinators were contacted to assist with arranging the consultation workshops and existing networks were utilised where possible, such as Aboriginal Health Planning Forum Sexual Health subcommittees. Data was collected by SHBBVP staff and categorised into each of the priority action areas as they were discussed. Over the seven regional workshops, a total of 79 participants attended with representation from state government organisations, NGOs, health networks, family support services, local government, AHSs and research institutes.

Evidence to support the action areas
Once data collection was completed, the responses were analysed to inform the development of the *WA Sexual Health and Blood-borne Virus Strategies 2019–2023*.

**Consultation findings**

Through these consultations, you told us that:

- HIV-related stigma and discrimination needs to be targeted through improved education programs, including to the wider community, on the reality of living with HIV in the context of the Undetectable = Untransmissible (U=U) message.

- There is a need to normalise HIV testing and educate GPs that the inclusion of a HIV test into routine STI testing should be standard practice.

- There is a need to increase priority population’s engagement with HIV testing and PrEP, particularly among subpopulations such as Southeast Asian MSM.

- PrEP access options need to be increased in regional areas, understanding that risk behaviour profiles may vary outside of the Perth metropolitan area.

- A better understanding of the gaps in the HIV cascade of care needs to be developed, especially in terms of treatment uptake and reasons why there is a treatment uptake delay.

- The aged-care setting needs to be equipped to manage an ageing population living with HIV.

- Service integration is important in ensuring PLWH who have other comorbidities experience coordinated care and management.

- There is a need to maximise the use of technology and digital platforms to overcome geographical challenges, such as online mapping of HIV services to improve health-seeking behaviour.

- Laws and policies that reinforce stigma and discrimination towards people living with HIV need to be reviewed and need to be evidence based.

- Prevention and education messages should be increasingly disseminated across social media channels and include contemporary information about safer sex, online dating and hook-up safety.

- Innovation and new ideas for condom promotion and uptake are wanted, along with responding to perceptions of the need to not use condoms.
Evidence to support actions

**Risk of sexual transmission of HIV from a person living with HIV whom has an undetectable viral load**

The overwhelming scientific evidence demonstrating that people living with HIV whose HIV VL is suppressed and stable have a negligible (so small or unimportant as to be not worth considering; insignificant) to non-existent risk of sexually transmitting the virus is an individual and public health game changer for:

- encouraging patients to start and adhere to ART to achieve and maintain an undetectable VL
- enabling people living with HIV to discuss their HIV status and have intimate sexual relationships without fear
- increasing knowledge and understanding about HIV and busting long-held misconceptions about transmission that perpetuate HIV-related stigma and discrimination.14–19

Achieving and sustaining an undetectable VL status is primarily dependent on consistent and daily ART adherence. Due to a range of factors, some PLWH may not be able to achieve or maintain an undetectable VL.18 Using condoms, PrEP and PEP are effective options in preventing the sexual transmission of HIV, and form the toolbox for combination HIV prevention to meet the diverse needs of priority populations.

**Prevention and education**

- Campaigns delivering health promotion messages on HIV are most effective when delivering clear and consistent messages in high-quality engaging formats across different media platforms.28,29,30

- Peer-led and peer-developed health promotion activities have been shown to be effective in reaching and engaging priority populations.31,32

- When adhered to daily, PrEP is an effective prevention option for blocking the acquisition of HIV in people who are at substantial and ongoing risk of acquiring HIV.16,17

- Within 72 hours, the use of two or three antiretrovirals for post-exposure prophylaxis (PEP) is effective in preventing the acquisition of HIV following a risk exposure event.33

- Most HIV diagnoses in WA are made in general practice and primary care settings, which is why awareness raising on contemporary HIV prevention options within a stigma-free service is critical to eliminating barriers in accessing health services for priority populations.34,35

- NSPs are a very cost-effective public health intervention for averting HIV infections and other BBVs, reducing injecting-related injury and providing opportunities for support, referral, education and prevention on BBVs.36
Testing and diagnosis

- Different modes of HIV testing such as rapid testing and home-based testing may reduce barriers faced by priority populations seeking HIV testing and facilitate more frequent HIV testing within high-risk population groups.37,38

- Healthcare professionals who conduct best practice provider-initiated discussions on sexual health, HIV risk, STI and BBV testing can contribute to normalising HIV testing and improve health outcomes for priority populations.39,40,41

- Post-test discussions for people who test negative for HIV provide an important opportunity for promoting risk reduction strategies and for providing referrals to relevant HIV prevention services such as NSPs.17,18,40

- Linking people who test positive for HIV as soon as possible into relevant HIV health and support services can ensure the newly diagnosed person receives appropriate support at a critical time to manage their diagnosis.17,18,40

Disease management and clinical care

- Starting ART during the early stages of HIV infection prevents viral replication while improving immune function and health outcomes for the individual when compared to delayed treatment initiation.42 Best practice recommendations on ‘rapid ART initiation’ is within seven days from HIV diagnosis, with the recommendation for ART initiation on the same day as HIV diagnosis if practical, and if the individual is willing and ready to commence lifelong ART, unless there are clinical reasons to delay.16,17,43

- PLWH have a diversity of healthcare needs across the HIV cascade of care, which will vary over the course of their lives and which will require differentiated models of care that facilitate transition between different healthcare services and providers.16,17,40,44

- Beyond medical and healthcare support, PLWH may need psychosocial, physical, socio-economic, nutritional and legal support from the point of diagnosis and throughout the course of their life, as social and structural factors can affect a person’s ability to link into and remain in connection with disease management and clinical care services.16,17,45

- As HIV science rapidly evolves, the availability of new agents and new clinical data may not always be reflected in current guidelines, therefore patient management decisions should be based on evidence review, clinical judgement and attention to unique patient circumstances.46

- In 2017, 46% of PLWH in Australia were aged over 50 years, underscoring the need for a greater focus on the ageing population of PLWH.11 While changes in treatment options have improved since the start of the epidemic improving median life expectancy and decreasing HIV-associated morality, the incidence of age-related and other comorbidities are higher in the in the ageing population of PLWH due to a range of factors, and this will continue to require more intensive support across the HIV cascade of care.47
**Workforce development**

- Increasing caseloads of patients, along with effective ART in stable cohorts of patients, are driving changes within models of disease care and clinical management in HIV specialist services. However, challenges remain in linking PLWH into general practice, where knowledge on HIV is variable, and low caseloads in some areas present challenges for engaging GPs. The rollout of PrEP through the PBS presents an opportunity to engage GPs in discussions on identifying HIV risk while also promoting professional development opportunities from committing to a shared care plan with a HIV clinician, to becoming a PBS section 100 (s100) prescriber for HIV ART.

- GPs (particularly s100 prescribers) and other clinicians involved in the diagnosis, treatment and management of HIV have raised the need for ongoing support and access to current and best practice evidence for new ART options and management of HIV, including the management of multiple comorbidities, toxicities associated with chronic therapy and ongoing health maintenance.

- In 2016, 74% of PLWH in Australia reported stigma related to their HIV status, with 52% reporting experiences of negative or different treatment by health workers. In populations where HIV prevalence is lower such as heterosexual populations, experiences of both general HIV stigma and treatment-related stigma can be higher. Such reports of stigma and discrimination related to HIV creates barriers in accessing services across the HIV cascade of care, and while the pervasive nature of stigma and discrimination can be seen across communities, eliminating them from the healthcare sector should be a priority.

**Enabling environment**

- HIV interventions in health and community systems are most effective when they operate in appropriate social, legal, policy and institutional environments that encourage and enable people to access and use services that are free from stigma and discrimination, and that are grounded in health equity and human rights.

- Stigma and discrimination experienced by PLWH and priority populations have been correlated with poor access to health care and poorer health outcomes. Evidence demonstrates that effective interventions to reduce HIV stigma should:
  - be developed and delivered in partnership with PLWH
  - ensure PLWH are aware of their rights
  - increase access to accurate information on HIV and HIV transmission using a range of formats and media tools
  - expose people to a range of consistent messages that cover the impact of stigma and dismantle negative attitudes towards HIV or priority populations
  - challenge negative media messaging on HIV while providing leadership and guidance on accurate reporting
involve staff across an organisation in developing strong policies that promote zero tolerance to discrimination

 amend or remove policies that reinforce negative attitudes towards PLWH or priority populations.55,57

Beyond biomedical and behavioural risk factors, social determinants of health (factors such as income, education, employment and social support) can act to strengthen or undermine the health of individuals and communities.45,55 In the health service provision setting, strategies to support individuals experiencing marginalisation include conducting a holistic initial assessment to identify issues that can potentially undermine an individual’s care, providing support in navigating and linking in with other social services, and integrating clinical and community-based care protocols.58

Data collection, research and evaluation

Gaps in data or where data collection could be improved within the Australian and WA HIV cascade of care include:

 estimating the number of people diagnosed with HIV living within Australia

 estimating within subpopulations of PLWH

 estimating the burden of undiagnosed HIV

 estimating the number of PLWH retained in care

 estimating ART coverage

 estimating virological suppression

 estimates on PrEP access and use.11

Systematically monitoring rates of HIV drug resistance and treatment failure will be critical in ensuring that gains made in reducing HIV incidence and improving the health outcomes of PLWH can be sustained.59,60

In the modern ART era, health outcomes for PLWH have improved, in part due to superior ART agents, more options for the management of patients developing resistance, fewer drug interactions and better management of opportunistic infections and comorbidities.61 However, long-term effects of newer first line ART agents need to be systematically and more inclusively monitored, as has been highlighted in recent research demonstrating adverse birth outcomes with certain ART agents.62,63

Monitoring and evaluating HIV-related stigma and discrimination, particularly within healthcare settings, requires a commitment to developing the appropriate tools to measure HIV-related stigma and discrimination across the HIV cascade of care to inform remedial action.10,35,55,57
The key actions for the *WA HIV Strategy 2019–2023* are condensed into six action areas to align with the *Eighth National HIV Strategy 2018–2022*. These action areas are not discrete categories but may frequently overlap and can exist on a continuum. A successful approach towards reducing the transmission of and the morbidity, mortality and social impact of HIV requires focus on all action areas.

### Prevention and education

Approaches to HIV prevention and education should combine community mobilisation, behavioural strategies, biomedical interventions and harm reduction initiatives in an organised effort to reduce the transmission of HIV. Further, a strong enabling environment can support the access and reach of combination HIV prevention initiatives. Biomedical approaches to HIV prevention such as PrEP, treatment as prevention (TasP) and achieving an undetectable VL have revolutionised the HIV prevention toolbox. These biomedical interventions have also instigated a movement that aims to eradicate HIV-related stigma and discrimination through providing accurate and meaningful information based on a solid foundation of scientific evidence.15

1. Review and revitalise generalised (wider community) and targeted (priority population) health promotion initiatives for HIV, ensuring that contemporary evidence is embedded within relevant, clear and consistent messaging, communicated through innovative mixed media channels.

2. Sustain effective HIV programs that encompass community-led and peer-based approaches for engaging with priority populations on strategies for safer sex, STI and HIV testing, and harm reduction.

3. Provide contemporary HIV prevention and education programs in a range of settings, including community health services, schools and organisations or services that interact with priority populations.

4. Improve access to PrEP and PEP by identifying gaps where knowledge among priority populations is low, or where healthcare provider options for PrEP and PEP is limited, and by introducing initiatives to mitigate these gaps.

5. Seek to improve the health outcomes for PLWH by increasing awareness on:
   - the benefits of rapid ART initiation
   - achieving and sustaining an undetectable VL
   - TasP
   - supporting mental health
   - diet and nutrition
6. Ensure the wide distribution and availability of sterile injecting equipment, safer injecting education and other drug harm reduction education among PWID, including a focus on people living in regional, rural and remote areas.

**Testing and diagnosis**

HIV testing is the gateway to HIV prevention, treatment, care and other support services. Testing that is conducted based on risk and in accordance with principles of informed consent, confidentiality, counselling and connection to appropriate services enables people to know their HIV status and adopt safer behaviours. Efforts to increase access to testing should be underpinned by community education and linkages to clinical services, particularly for home-based and point-of-care testing (POCT). Effectively directed HIV testing can support early diagnosis and in combination with rapid linkage into specialist care, can ensure the newly diagnosed person receives relevant support and guidance on initiating ART and managing their health.

1. Expand the use and accessibility of a range of HIV and STI testing options, that incorporate new testing technologies (such as home-based and POCT) with proven modalities for facilitating testing (such as peer-based and community-based initiatives) to improve rates of early diagnosis, and to reduce the structural, social and community barriers to testing faced by priority populations.

2. Improve the capacity of GPs, primary and community healthcare professionals to diagnose HIV by supporting essential knowledge on:
   - conducting discussions covering sexual health and regular STI testing
   - identifying and assessing known and unknown HIV and BBV risk factors
   - indications for opportunistic testing at different stages of HIV infection
   - contemporary HIV prevention including PEP, PrEP and TasP
   - best practice for conveying a positive or negative HIV diagnosis.

3. Ensure that all people diagnosed with HIV are linked to specialist care and offered referrals to relevant support services as soon as possible following diagnosis.

4. Continue to promote the use of evidence based clinical guidelines and resources in both training and clinical service delivery settings.

5. Continue to identify efficiencies in the HIV cascade of care that will improve individual and public health outcomes.
Disease management and clinical care

The lifelong management of PLWH requires a multidisciplinary approach to supporting disease management and clinical care in order to meet the varying needs of the individual. The ongoing clinical management for PLWH needs to factor in the management of HIV along with supported pathways for referral to manage any other health issues, encompassing models of shared care with GPs and communication protocols with other clinical specialists. Approaches to onwards referral for PLWH should consider any geographical, social, cultural and gender barriers with regards to accessing other services. As HIV treatment options evolve and newer simplified regimens become available, clinical monitoring of both the patient and emerging evidence on newer treatments should be integral to decision making. PLWH have a unique knowledge of their own treatment and management and need to be actively engaged as equal participants in the planning and delivery of their own care.4

1. As a priority, ensure that people newly diagnosed with HIV receive evidence-informed counselling and support on living with HIV, the benefits of rapid ART commencement and preventing onwards transmission.

2. Improve the health care provided to PLWH across WA, including regional and remote locations, by strengthening and coordinating linkages between:
   ▶ GPs
   ▶ community health services
   ▶ sexual health physicians
   ▶ psychosocial support services
   ▶ community pharmacies
   ▶ specialists
   ▶ aged-care services.

3. Strengthen models of care to holistically meet the needs of PLWH who have more complex psychosocial needs by facilitating supported linkages to relevant services for:
   ▶ mental health
   ▶ AOD
   ▶ housing
   ▶ employment
   ▶ disability
   ▶ social welfare
   ▶ legal support.

4. Monitor and evaluate the quality standards within models of aged care, ensuring that they are inclusive, respectful and meet the needs of PLWH.
5. Increase options to facilitate access to HIV treatment and care in those health services providing culturally relevant care to Aboriginal people and CALD populations.

6. Ensure that PLWH receive the necessary support for developing health literacy on understanding life with HIV and sustained ART adherence, with support options that include community-based and peer-led approaches.

7. Facilitate options for PLWH that aim to improve mental health, resilience and social connectedness.

**Workforce development**

The delivery of high-quality services that understand and respond to the needs of priority populations requires a multidisciplinary workforce of trained healthcare professionals and peer-based workers established in community and public health, aged care, sexual health clinics, general practices, AHSs, AOD and mental health services. The development and promotion of up-to-date evidence-based clinical guidelines and training modules should be accessible to WA’s healthcare workforce to support the delivery of best practice health care. Education on current scientific evidence on the prevention and management of HIV, and methods to address HIV or priority population related stigma and discrimination should be included in all STI and BBV training programs for community service providers and primary healthcare and specialist services.

1. Facilitate innovative workforce development initiatives that include multiple options for education and training, which include online learning, videoconference/ teleconference, information sharing platforms and face-to-face learning opportunities.

2. Develop the awareness of the mainstream healthcare workforce on identifying stigma and discrimination related to HIV or priority populations, alongside methods for addressing these identified forms of stigma and discrimination.

3. Target training for identified healthcare workforce sectors engaging with priority populations to ensure that high-quality professional development and support is provided for:
   - conducting culturally and non-binary discussions on sexual health
   - identifying and assessing HIV risk across different priority populations
   - indications for opportunistic testing at different stages of HIV infection
   - testing options and new testing technologies
   - testing policy and protocols
   - contemporary HIV prevention including PEP, PrEP and TasP
   - harm reduction education
   - partner/contact notification
   - HIV treatment and ongoing management of PLWH
   - identifying and managing HIV or priority population related stigma.
4. Continue to regularly update and strategically promote accessible evidence-based clinical guidelines and tools covering the HIV cascade of care to enable the professional development of healthcare workforce sectors, particularly general practices, delivering services to priority populations.

5. Continue to explore and share experiences of innovative multidisciplinary models of care for HIV prevention and management, particularly models such as telehealth for rural and remote areas.

6. Continue to support and promote s100 prescriber training and accreditation, particularly in areas of need, alongside the promotion of HIV shared care protocols.

7. Support the capacity and role of community organisations to implement GIPA/MIPA principles in the provision of education, prevention, support and advocacy services to priority populations.

Enabling environment

The foundation supporting the HIV response is the framework of principles, protocols, policies and laws that seek to create an enabling environment for public health and social change. It is however widely recognised that stigma and discrimination related to HIV and directed at priority populations remains as one of the most significant barriers to the HIV response. Increased efforts are needed to address stigma and discrimination, and also to ensure the meaningful involvement of PLWH and priority populations in all aspects of the HIV response.2 This strategy has a focus on the health and community sector; however, it acknowledges that issues such as “criminalisation impact on priority populations by perpetuating isolation and marginalisation and limiting their ability to seek information, support and health care.”4

1. For HIV health promotion and educational initiatives, prioritise consistent evidence-based messaging that dispels myths around HIV transmission and living with HIV, ensuring that all content produced counteracts stigma and discrimination related to HIV or directed at priority populations.

2. Provide initiatives to assist PLWH to challenge and address incidences of stigma and discrimination.

3. Make sure that health services are transparent in their approach to quality standards, including standards that uphold patient rights and address privacy and patient confidentiality.

4. Using an evidence base, review and address institutional, regulatory and system policies that create barriers within the HIV cascade of care, impact on health-seeking behaviour or perpetuate stigma and discrimination.

5. Engage in dialogue with other government sectors to promote the use of up-to-date HIV-related science to improve policies affecting PLWH, and to discuss the impacts of wider public policy decisions on the health of priority populations.2
Data collection, research and evaluation

The Australian HIV response has been successful to date due to the active partnership between PLWH and the community sector, researchers, clinicians and government. Identifying gaps and areas for improvement in mechanisms that collect and store data is critical in developing a clear picture of HIV in WA, and how the epidemic may be changing. While gaps in surveillance data exist across priority populations, the role of social, behavioural and clinical research continues to assist in providing information that bridges these gaps. The maintenance of a strong research agenda and evidence-base informing action should be balanced by avoiding unnecessary burden on service providers. Importantly, the principles enshrined within this strategy should inform all research, evaluation and surveillance activities.

1. Contribute towards and continue to support national research and evaluation projects on HIV and priority populations.
2. With a focus on the HIV cascade of care, identify areas where data collection and storage can be improved or where data linkage projects can be developed to better monitor trends in priority populations.
3. Ensure that relevant research, evaluation and surveillance data is disseminated to services and organisations involved in the HIV response to inform future planning and delivery of projects.
4. Build the capacity of services and organisations involved in the HIV response to appropriately evaluate the effectiveness of current projects so that areas for improvement can be identified and incorporated into future planning.
5. Investigate reported incidences of stigma or discrimination encountered by PLWH and using appropriate research frameworks, monitor actual and perceived drivers, facilitators and power structures causing HIV-related stigma and discrimination.
The monitoring and evaluation framework includes indicators and details data sources to monitor progress against the targets previously mentioned.

<table>
<thead>
<tr>
<th>Targets by the end of 2023:</th>
<th>Indicators</th>
<th>Sources</th>
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<tbody>
<tr>
<td>Achieve the 95–95–95 HIV diagnosis and treatment targets:</td>
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<tr>
<td>1. Increase the proportion of people living with HIV (in all priority populations) who know their HIV status to 95%</td>
<td>Estimated proportion of people living with HIV who have been diagnosed</td>
<td>Indicator to be developed</td>
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<tr>
<td></td>
<td>HIV testing rates in WA:</td>
<td>Laboratory data and Rates Calculator</td>
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<tr>
<td></td>
<td>Numerator: Number of annual HIV tests conducted in WA</td>
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<tr>
<td></td>
<td>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population, Aboriginal and non-Aboriginal, all ages</td>
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<tr>
<td>2. Increase the proportion of people diagnosed with HIV on treatment to 95% within six weeks of diagnosis for those newly diagnosed, reducing this timeframe further over the life of the strategy</td>
<td>Estimated proportion of people living with HIV dispensed treatment for HIV infection:</td>
<td>PBS treatment data and WA HIV Database</td>
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<tr>
<td></td>
<td>Numerator: Number of people dispensed treatment for HIV infection</td>
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<td></td>
<td>Denominator: Estimated number of people diagnosed with HIV living in WA</td>
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<tr>
<td>3. Increase the proportion of people on treatment with an undetectable VL to 95%</td>
<td>Proportion of HIV patients on treatment with an undetectable VL:</td>
<td>HIV specialist clinics in WA</td>
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<tr>
<td></td>
<td>Numerator: Number of people diagnosed with HIV on treatment with an undetectable VL</td>
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<td></td>
<td>Denominator: Number of people diagnosed with HIV on treatment</td>
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<tr>
<td>4. Reduce the incidence of HIV transmission in MSM</td>
<td>Number of annual HIV notifications reported in MSM</td>
<td>WA HIV Database</td>
</tr>
</tbody>
</table>
5. Reduce the incidence of HIV transmission in other priority populations other than MSM - people living with HIV; Aboriginal people; CALD people from high HIV prevalence countries; people who travel to high prevalence countries; sex workers; PWID; people in custodial settings; and sexually and gender diverse people.

   Number of annual HIV notifications reported in Aboriginal people, people from high HIV prevalence countries, people travelling to high HIV prevalence countries, people in custodial settings and gender diverse people.

   WA HIV Database

6. Maintain the virtual elimination of HIV among sex workers, PWID and from mother to child through the maintenance of effective prevention programs.

   Number of annual HIV notifications in sex workers and cases reporting injecting drug use and vertical acquisition

   WA HIV Database

7. Ensure all people attending public sexual health services and high priority population caseload general practices are assessed for PrEP eligibility

   Number of individual dispensed HIV drug regimens for PrEP

   Proportion of eligible people on PrEP

   PBS data

   PGCPS Survey

8. Ensure at least 75% of people with HIV report good quality of life

   Proportion of HIV Futures Study participants who report their general health status and their general wellbeing to be excellent or good

   HIV Futures Study

9. Reduce the reported experience of stigma among people living with HIV, and the expression of stigma, in respect to HIV status

   Proportion of people living with HIV who report experiencing stigma and discrimination in respect to their HIV status

   Proportion of the general public who report feelings of stigma and discrimination towards people living with HIV

   Proportion of health professionals who report feelings of stigma and discrimination towards people living with HIV

   Centre for Social Research in Health, University of New South Wales
Governance

The WA Department of Health is committed to a partnership approach between priority populations, government, community-based organisations, health service providers, researchers and policymakers to guide the public health response to STIs and BBVs.

The Department established the WA Sexual Health and Blood-borne Viruses Advisory Committee (WA SHaBBVAC) in accordance with the Public Health Act 2016 (WA) to provide a forum for a multi-agency partnership in the prevention and control of BBVs and STIs. Its purpose is to advise the Chief Health Officer on the development of state policies and programs relating to STIs and BBVs. The Advisory Committee members and other partners work closely with the Department in a joint approach towards the development, implementation and evaluation of the Department’s strategies and implementation plans for HIV, hepatitis B, hepatitis C and STIs, with special consideration for the impact of STIs and BBVs on Aboriginal communities, taking into account matters such as prevention, education, treatment, care, surveillance, research, legal and policy issues, monitoring and evaluation.

The Advisory Committee membership includes agencies that represent the interests of priority populations or are at the forefront of service delivery. Members include health consumers and representatives from the WA Primary Health Alliance, Health Consumers’ Council, WA AIDS Council, Peer Based Harm Reduction WA, Sexual Health Quarters, Magenta, HepatitisWA, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Mental Health Commission, WA Network of Alcohol and Drug Agencies, Youth Affairs Council WA, Aboriginal Health Council of WA, WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN) – Curtin University, Aboriginal Health Directorate (Department of Health), Department of Justice, Australian Department of Health and SECCA. Secretariat services are provided by SHBBVP.

Monitoring and reporting

The Communicable Disease Control Directorate (CDCD) within the Department is responsible for the collation, analysis and reporting on STI and BBV notifications. Consistent with the role of system manager, the CDCD will publish ongoing quarterly and annual epidemiology reports on STI and BBV notifications, testing data and test positivity data. The STI and BBV Quarterly Forum, convened by the Department, will present up-to-date STI and BBV epidemiology reports to the service sector. CDCD will also publish a mid-term and a final report on the progress towards achieving the strategy’s targets, including performance indicators relating to the cascades of care, behavioural surveillance and stigma and discrimination as described in the monitoring and evaluation framework detailed within this strategy.
The Department will provide an activity report on the implementation of the strategy to the Advisory Committee at each meeting to monitor progress towards achieving the targets and to monitor emerging issues.

The Department is also required to report to the Blood-borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS) on the implementation of the public health response in WA and progress towards meeting the national targets set out in the suite of national STI and BBV strategies.


