2022-23 Federal Pre-Budget Submission

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Australian Federation of AIDS Organisations

The Australian Federation of AIDS Organisations (AFAO) is the national federation for the HIV community response in Australia. AFAO works to end HIV transmission and reduce its impact on communities in Australia, Asia and the Pacific. AFAO's members are the AIDS Councils in each state and territory; the National Association of People with HIV Australia (NAPWHA); the Australian Injecting & Illicit Drug Users League (AIVL); the Anwernekenhe National HIV Alliance (ANA); and Scarlet Alliance, Australian Sex Workers Association. AFAO's affiliate member organisations – spanning community, research, public health and clinical workforce – share AFAO's values and support the work we do.

Background

AFAO's 2022-2023 pre-budget submission provides the government with investment advice on issues that are central to the organisation's strategic directions. These issues include:

1. HIV in Australia;
2. The health of LGBTIQ communities in Australia; and
3. Strengthening HIV responses in Asia and the Pacific

HIV in Australia

On 16 June last year, the AFAO led *Agenda 2025* was launched in Parliament House, Canberra. This document is the organisation's platform ahead of the next federal election. Agenda 2025 is endorsed by the organisations and institutes that resource Australia's HIV response. The asks in the document are evidence-based and costed by health economists. These asks were developed to support the government to implement measures to end HIV transmission in the next parliamentary term. This goal is consistent with the targets in the eighth *National HIV Strategy 2018 – 2022.*

In reinforcing the goal to end HIV transmission, Agenda 2025 sets further targets applying to population groups at risk of HIV. These include **overarching** targets and then sub-targets addressing the four limbs of the national response: **prevention, testing, treatment** and **stigma.**

Overarching
1. A 90% reduction in preventable HIV diagnoses in Australia (compared to a 2010 baseline)
2. A reduction in preventable new HIV infections in gay and bisexual men (GBM) to less than one per 1,000 GBM per year

Prevention
1. 95% of people at risk of HIV infection use one or more forms of effective HIV prevention
2. 95% of people for whom Pre-Exposure Prophylaxis (PrEP) is beneficial to use it

Testing
1. 95% of people with HIV (PWHIV) are diagnosed
2. 90% of all people at heightened risk of acquiring HIV have a yearly HIV test
3. 80% of all GBM at risk of HIV have a test every three months

Treatment
1. 98% of PWHIV diagnosed with HIV are on treatment
2. 98% of PWHIV on treatment have an undetectable viral load
3. 90% of newly diagnosed PWHIV commence treatment within two weeks of diagnosis

Stigma
1. >95% of PWHIV report no stigma in the last 12 months
2. >95% of GBM report no stigma in the last 12 months
3. >95% of the general public indicate they would not behave negatively towards a person because of their perceived or actual HIV status or sexuality
4. >75% of PWHIV report good quality of life

To meet these elimination targets, a suite of activities (1-7 below) needs activation. The investment advice to achieve this is **$43,945,442** for the 2022-2023 financial year, with an additional contribution of **$131,836,326** over the four-year program ($43,945,442 is today's cost year-on-year for the three following financial years). Financial modelling shows this investment will avert over **2,834** new HIV infections by 2025, virtually eliminating HIV in Australia and saving the Commonwealth **$689,635,549** in healthcare costs in the next parliament term.

1. **The removal of the co-payment for the purchase of HIV combination antiretroviral therapy (cART) across Australia for PWHIV.**

Impact: Removing the co-payment on cART will remove the cost barriers many individuals experience in commencing and sustaining life-long adherence to daily medication. This prevents the risk of unnecessary HIV infection through onward transmission and improves the health of the person with HIV.

Investment advice: $4,645,442 per annum

Problem:

- The cost of the co-payment is a co-factor in sub-optimal adherence to cART alongside housing insecurity, poor mental health, substance use and stigma, which is likelier to be experienced by PWHIV, people of colour, people who are homeless, people who inject drugs (PWID), sex workers and people from some ethnic and cultural backgrounds.
- PWHIV who have been living *long term* with the virus are more likely to experience financial stress and problems affording prescription medications. This group is far more likely to be taking multiple medications (to combat an increased number of comorbidities) and combinations of cART medications (to combat resistance) that cannot be purchased in single pill formulations. Further, this group experienced long-term employment breaks due to illness in the days before HIV treatments were available, and they accessed their superannuation in anticipation of shortened life expectancy. Therefore, older PWHIV are significantly poorer than HIV negative people of the same age. This is a substantial adherence risk.
- Culturally and linguistically diverse (CALD) populations were less likely to commence cART within six months of HIV diagnosis than people born in Australia. Migrants to Australia from Southeast Asia, Eastern Asia and Europe had larger gaps in commencement of cART than non-migrants.
- Aboriginal and Torres Strait Islander PWHIV commenced cART and sustained an undetectable viral load later than non-indigenous Australians.
- It is estimated PWID who are living with HIV commence cART later than Australian born GBM who are diagnosed with HIV.

Activity to solve the problem:

- Invest in a scheme that removes the need for hospital and community pharmacies to charge the consumer for a co-payment when purchasing cART. The scheme would be funded by a Commonwealth-led scheme where the Commonwealth absorbs the dispensing costs associated with purchasing cART.

2. **Identify and implement a sustainable solution to inequitable access to PrEP in Australia based on citizenship**

Impact: Investment in this initiative will resolve the major structural barriers preventing equitable access to PrEP in Australia. Once implemented, this initiative will provide people at risk of HIV who have certain visa arrangements with the same access to PrEP as people with Medicare. This will save the government considerable long-term costs associated with the delivery of life-long healthcare costs for people diagnosed with HIV.

Investment advice: $10 million per annum

Problem:

- Individuals without Medicare do not have access to PBS subsidised medication that prevents HIV infection.
- A population without access to the tools of HIV prevention pose a significant risk of onward HIV transmission to the broader community. This undermines the public health investment in preventing communicable illnesses in Australia.
- Australia cannot meet its target of virtually eliminating HIV transmission until this gap in PrEP access is resolved.
- Most people on long-term temporary visas either return to their country of origin or ***transition to Medicare eligibility*** within three years. Maintaining the health of temporary visa holders, therefore, represents a cost saving to the healthcare system over the medium to long term.

Activity to solve the problem:

- Provide subsidised HIV PrEP to all who can benefit from it, regardless of visa status. It is important to note PrEP medication is no longer on a patent. Therefore, the cost of subsidising PrEP is negligible.

3. **Sustain gains and drive further reductions through community-led campaigns and peer education**

Impact: Prevent HIV transmission and reduce the prevalence of undiagnosed HIV and the pool of untreated HIV.

Investment advice: $20 million per annum

Problem:

- The bulk of HIV prevention efforts across Australia is concentrated on GBM.
- Continued investment is required, particularly in areas where research shows less success or differences emerging, including amongst men who are not living in the gay inner-urban centres, men who are overseas-born (particularly those who arrived in Australia in the last four years), and younger (under 25) and older men (55 and over).
- 'Hidden populations' will account for a greater proportion of the health impact of HIV.
- Reaching these populations will require highly nuanced programming, informed by the needs of each sub-population. Capacity does not exist across the sector to target the range of hidden populations, and a localised response to each hidden population would potentially duplicate effort across states and territories.
- The majority of community-led HIV organisations are small in size with a small education team and are staffed by individuals who are specialists in working with one population or delivering one aspect of community-led work.
- As these organisations endeavour to meet the needs of local populations, there is a risk of duplication and inconsistency in messaging, rather than collaboration.

Activities to solve the problem:

- Enhance investment in current national HIV education campaigns targeted at GBM, enabling the implementation of comprehensive advertising strategies to disseminate key messages and enhance audience engagement.
- Support community-led HIV organisations to develop and implement local campaigns targeted at population groups for their local context. This will ensure support for organisations with less capacity to develop messages that engage and reach to have impact, and to conduct local peer education activities to facilitate engagement with campaign messages.
- Implement comprehensive national campaigns, using mainstream and specialist media, targeting hidden populations not being reached by current education initiatives to help reduce undiagnosed HIV within the community and challenge outdated notions of HIV and misinformation about transmission.
- Evaluation program to evaluate the activities at the intervention and program levels:
    - intervention level – reach, impact and outcomes of specific initiatives to make recommendations about strengthening messages and marketing, and to identify transferability to other localities and/or populations.
    - program level – evaluate the health, economic and cost-effectiveness impact of the overall program of interventions within the Australian HIV response.

4. Develop models for peer-led contact tracing and wrap-around clinical and peer support at diagnosis

Impact: This investment will reduce:
a) the prevalence of undiagnosed HIV and the pool of untreated HIV;
b) the time between diagnosis and treatment commencement; and
c) improve individual health outcomes and reduce the risk of onward HIV transmission.

Investment advice: $300,000 per annum

Problem:

- Significant populations do not benefit from prevention and treatment science and peer support programs.
- These populations include GBM with infrequent HIV testing practices, people from CALD backgrounds, Aboriginal and Torres Strait Islander people, women living with HIV, and PWHIV who are not engaged in care.
- Late diagnosis and late commencement of treatment are a source of preventable morbidity and mortality for PWHIV.
- PWHIV who do not have access to HIV treatment or cannot achieve viral suppression may have complex social and comorbid health issues and/or may have difficulty accessing appropriate peer support and health services.
- Contact tracing requires highly nuanced, culturally appropriate and sensitive programming among populations, and if undertaken effectively, can help reduce undiagnosed HIV in the community, particularly among infrequent HIV testers.
- Peer workers have lived experience of the factors that put communities at risk of HIV transmission. They are well connected to communities, and they are a cost-effective way of improving outcomes post-diagnosis. Research shows immediate connection to peers post-diagnosis reduces the time between diagnosis and treatment uptake and improves resilience in newly diagnosed PWHIV.

Activities to solve the problem:

- Establish new and innovative peer-led models to provide contact tracing and wrap-around support for people who are not accessing treatment and/or may be at risk of being lost to care.

- To support the deployment of peers in clinical settings develop standards for peer-led models incorporating peer-led contact tracing approaches, use of peer support and peer navigator models, integrated clinical care and addressing systemic barriers that prevent access to care.
- In collaboration with community organisations, and with the input of clinical services and government public health officers, develop training programs for peer workforce to lead contact tracing services and to provide wrap-around support to individuals newly diagnosed with HIV.

5. Implement targeted education programs to reduce stigma in settings where it is especially acute

Impact: This investment will contribute to preventing poorer health outcomes among PWHIV, thereby reducing pressure on primary care and public health, and reducing late diagnoses and the healthcare costs associated with late HIV diagnosis.

Investment advice: $3 million per annum

Problem:

- HIV-related stigma and discrimination continue to be a defining and detrimental part of the lives of all PWHIV across Australia.
- HIV-related stigma and discrimination are experienced in a range of settings, including the gay community, the general community, healthcare settings, government agencies, workplaces and mainstream and online media.
- The effects of stigma and discrimination are multifaceted. HIV-related stigma and discrimination is a source of significant harm in the lives of individuals, causing both a decline in wellbeing and quality of life (through social isolation, shame, anxiety and depression) and in physical wellbeing (social isolation is correlated with poorer adherence to HIV treatment).
- Fear of stigma and discrimination is a constant barrier to people presenting for regular testing, disclosing HIV status, and sustaining contact with healthcare and treatment adherence. Sustained experience of stigma and discrimination reduces self-esteem and undermines people's ability to confidently seek out the services they need to manage their health.
- There has been limited investment to date in innovative activities to address stigma and discrimination.

Activities to solve the problem:

- Invest in interventions that build individual resilience among PWHIV so that individuals can withstand stigma and discrimination where it does occur.
- Develop strategies to address systemic factors that perpetuate stigma and discrimination, including policies, processes and laws that regulate key populations and have an adverse impact on those populations.
- Address HIV-related stigma and discrimination in clinical settings by designing interventions that address context-specific stigma and discrimination partnering with: professional health bodies, medical schools, colleges and other related vocational learning, and government health bodies.
- Fund a whole-of-government approach to HIV stigma eradication.
- Provide training to key workforces that represent sites of stigma reproduction: the police, the non-HIV-specialist clinical workforce, the legal workforce and elected officials.
- Conduct research to increase the evidence base for promising and effective stigma-reducing interventions.

6. **Establish an HIV media program to positively engage journalists, digital content developers and influencers to tackle stigma**

Impact: This investment will contribute to preventing poorer health outcomes among PWHIV, reducing pressure on primary healthcare and public health through reduced late diagnoses and the healthcare costs associated with late HIV diagnosis.

Investment advice: $1 million per annum

Problem:

- HIV-related stigma is driven by a range of factors, including outdated notions of HIV and misinformation about transmission and transmissibility.
- HIV-related stigma and discrimination is a source of significant harm in the lives of individuals, causing both a decline in wellbeing and quality of life (through social isolation, shame, anxiety and depression) and in physical wellbeing (social isolation is correlated with poorer adherence to HIV treatment).
- Stigma and discrimination are barriers to people presenting for regular testing, disclosing HIV status, and sustaining contact with healthcare and treatment adherence. These factors undermine the public health investment from governments in reducing HIV transmission.
- There are significant gaps in knowledge about stigma related interventions that have been shown to improve care or increase access to care for PWHIV.

Activities to solve the problem:

- Engage communication and media specialists to design a sophisticated, integrated communication plan that targets community settings, news and specialist media, social media and digital channels.
- Create a:
    - working document of key messages, supported by proof points, case studies and anecdotes; and
    - target list of national, specialist and community media journalists and outlets and monitor for opportunities to intervene in the news cycle with stories, commentary and other supportive content.
- Partner with community opinion leaders, social influencers and journalists to promote positive representations of PWHIV, challenge prejudice and challenge outdated notions about living with HIV and misinformation about transmission.
- Production of media assets (such as videos, advertisements, blog posts, website content, images, podcasts) for partners to use that involve PWHIV sharing their stories and experiences and challenging prejudices and incorrect assumptions.

7. **Fund foundational and implementation research to better understand and monitor HIV stigma and build evidence for effective interventions**

Impact: This investment will enable a stronger evidence base for HIV stigma related activities through ongoing HIV stigma program evaluation. This will reduce the barriers to healthcare access from stigma related decision-making, in turn, improving the health outcomes for PWHIV and, particularly, PWHIV who are diagnosed late.

Investment advice: $5 million per annum

Problem:

- Stigma reduces individual health, wellbeing, and quality of life and leads to social and economic exclusion, a fundamental cause of population health inequalities.
- Stigma is driven by a range of factors, including perceptions of blame and fear of contagion, and is entwined with stigma against homosexuality, as well as outdated notions of HIV and misinformation about transmission and transmissibility.
- Stigma reduces screening, diagnoses and treatment uptake and is a barrier to HIV testing, prevents disclosure of HIV status (for fear of violence, rejection or abuse) and reduces people's ability to engage in HIV treatment and care.
- Issues of layered stigma associated with multiple stigmatised identities require specific attention. These issues are particularly relevant for people living with (or at risk of) HIV who are Aboriginal or Torres Strait Islander or from CALD backgrounds. This is also a consideration for people who are multiply labelled because of their HIV status and other practices/identities which attract stigma (such as sexual orientation, injecting drug use, sex work or co-occurring health conditions).

Activities to solve the problem:

- Co-design a series of evidence-informed interventions in collaboration with PWHIV and affected communities to reduce stigma and challenge outdated notions about living with HIV in different settings.
- Conduct implementation research studies designed to demonstrate what interventions are effective at reducing stigma and discrimination in different settings, particularly in the provision of healthcare, as well as within the general community, and at multiple levels such as individual, interpersonal, organisational and structural.
- Scale up interventions that show promising outcomes, in collaboration with community, government and clinical partners, in reducing stigmatising and discriminatory attitudes and monitor impact and outcomes.
- Publish monitoring and evaluation reports on HIV-related stigma and discrimination and key findings of interventions that have been effective or show promise at combatting HIV stigma.

8. HIV Community Workforce Development Program – HIV Online Learning Australia (HOLA)

Impact: The program builds the capacity of the HIV community workforce to lead efforts to virtually eliminate HIV transmission and support the health and wellbeing of people affected by and living with HIV.

Investment advice: $4.55 million from 1 April 2023 across three years and three months. (The program is currently funded to the end of March 2023, so this investment includes the three months from April to June 2023 to bring it in line with financial year funding periods).

Problem: The program is unfunded from 1 April 2023

Activities to solve the problem:

The continuation of funding will sustain the program to allow for the delivery of learning activities to the community HIV workforce across the country and the impact of an effective workforce development program responding to a rapidly changing and progressing response to HIV.

The external monitoring and evaluation for the current program have already shown the success of the program, and also points to additional learning needs not part of the funding for the current program.

The program will include a range of activities, including the learning activities proven as effective in the external evaluation of the current project, the uptake of recommendations for updates and additional activities from the evaluation to reflect the learning needs of the community HIV workforce.
This includes building on the existing online activities of the program:

- Maintenance and hosting of existing integrated online learning platform for the delivery of training and peer learning events.
- Continued external monitoring and evaluation of the program.
- Update of existing self-directed e-learning modules (and new modules for emerging topics if required) providing evidence-based baseline knowledge at the depth required by educators to work effectively with communities to ensure these are contemporary and meet the needs of the workforce.
- Creation of skills development packages to equip educators with practical capabilities required to develop and deliver innovative, effective contemporary health promotion.
- Development of practice leadership packages that assist educators to interpret and apply knowledge and skills in ways relevant to their local communities.
- Knowledge progression and translation through the development of discussion papers on emerging new research, technology and practice, and the release of these through community workforce webinars and discussion generation, to ensure Australian community practice remains at the global forefront and to inform future strategies.
- Whole-of-workforce convenings to discuss major emerging issues with a focus on translating research to practice, showcasing innovation, enabling cross-disciplinary learning and coaching local health promotion staff to adapt community education and health promotion practice.
- Communities of practice with specific workforces (e.g. outreach workers) to share knowledge and further develop skills through peer learning.
- Convening a national HIV Education Manager's Forum of AFAO, NAPHWA, AIDS Councils and NAPWHA member organisations to provide project governance and advisory input, promote cross-jurisdictional sharing and coordination and strengthen local leadership for the life of the program.

This also includes additional activities identified as needs of the community HIV workforce in the external monitoring and evaluation of the current program that are not part of the current program:

- More in-depth, intensive formats to further support workforce development (for example, training courses that span over multiple days).
- Some program elements (e.g. skills development packages and communities of practice) to be delivered face-to-face to enhance learning opportunities and enable greater social connections and collaboration.

The health of LGBTIQ communities in Australia

As a national peak health advisory agency, AFAO's priorities have evolved to meet the needs of its member organisations. As the HIV epidemic evolved, our members have changed to respond to their communities' needs. These changes have been driven by member organisations' deep connections to, and understanding of, contemporary issues facing their communities. These organisations have evolved to provide services that range from General Practice and nurse-led care to peer-to-peer point of care testing, counselling and community support services for the LGBTIQ (lesbian, gay, bisexual, intersex and queer) community. In addition to HIV and sexual health services, these organisations now provide safe spaces for continuity of care in the areas of alcohol and other drugs and mental health, as well as services for people with comorbidities, in aged care and for trans and gender diverse communities.

In representing members' needs in this area of public health, we have observed a significant level of unmet healthcare needs among LGBTIQ communities in Australia. A recent study[1] of 6,835 LGBTIQ people in Australia indicates mental health in LGBTIQ communities is in crisis. The research shows that:

- 42% of participants reported suicidal thoughts in the past 12 months, with 5% attempting suicide in that time, compared with the national average of 2.3% and 0.4%, respectively.
- 39.5% of participants reported experiencing social exclusion, 34.6% verbal abuse, 23.6% harassment and 14.6% threats of physical violence.
- 57.2% reporting high or very high levels of psychological distress.
- In the context of accessing health or support services, almost half the participants (43.4%) did not feel accepted when accessing services.

While most participants reported accessing mainstream health services (83.5%), 25% reported accessing LGBTIQ-inclusive services, and 5.7% reported accessing LGBTIQ-specific services. There is evidence of an unmet need for inclusive services, with many more participants reporting a preference for these services than the number actually accessing them. These data were collected before the COVID-19 pandemic, and its lasting effect on the lives of LGBTIQ people requires ongoing attention to track the impact and recovery from these challenging events.

In response, AFAO, in collaboration with our state-based members, has developed a fully costed LGBTIQ Community Health Transition Program. The program will resource these members to transition into a cost-effective and sustainable pathway to improved primary healthcare for LGBTIQ people by leveraging the health system to work better for these communities.

9. LGBTIQ Community Health Transition Program

Impact: The proposal moves AFAO's state-based members beyond their dependency on ad hoc grants to provide a range of primary healthcare services through MBS billing revenue as a long-term solution to the absence of sustainable funding. This will allow these organisations to be funded for services that meet the demands of LGBTIQ people in their jurisdiction.

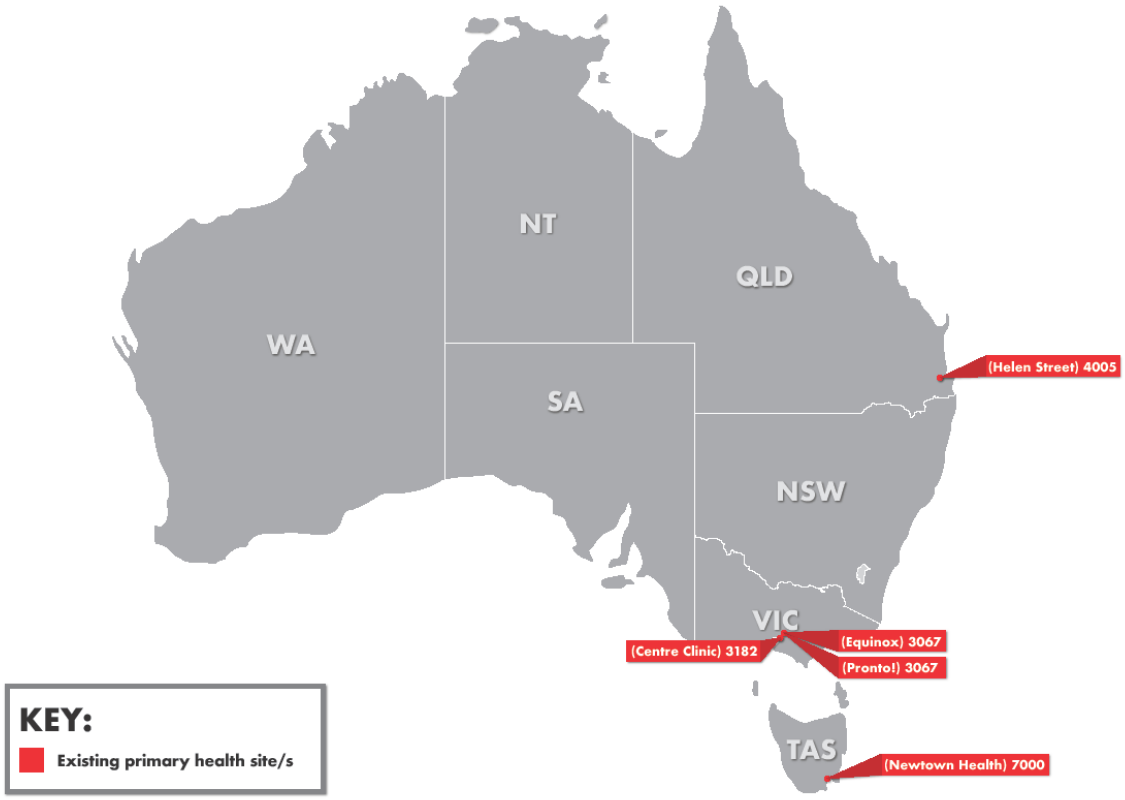
Investment advice: $17,910,227 across four years ($5,668,532 in 2022-23 – year one of the program)

Problem:

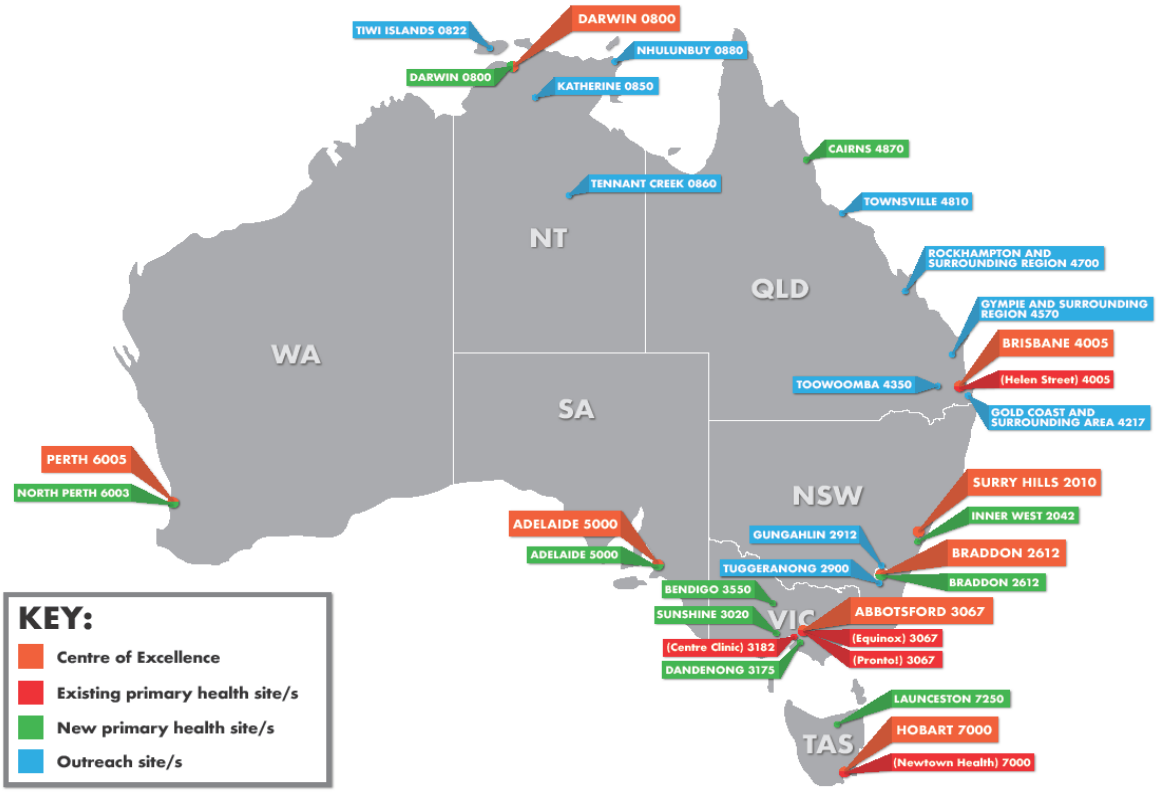
- AIDS Councils provide considerable unfunded primary healthcare services to LGBTIQ communities in safe and culturally inclusive settings.
- The ongoing delivery of these services is unsustainable without an investment in a dedicated program to resource the transition of these organisations into MBS billing agencies.
- The Councils vary in the scale and range of services they are funded to offer. They are still funded principally through grants from governments, although increasingly they also access a range of funding targeting diverse health issues, in mental health, alcohol and other drugs, suicide, and family violence, from Primary Health Networks (PHNs) and other sources.
- These organisations are at varying degrees of transition, and, as such, the budget for this transition program is customised to each organisation's point in their transition to MBS billing.

[1] Bourne, A., et al (2020). *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia*. ARCSHS Monograph Series No. 122. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University

CURRENT STATE:
Existing LGBTIQ primary health clinics



FUTURE STATE:
A national network of LGBTIQ primary health care services

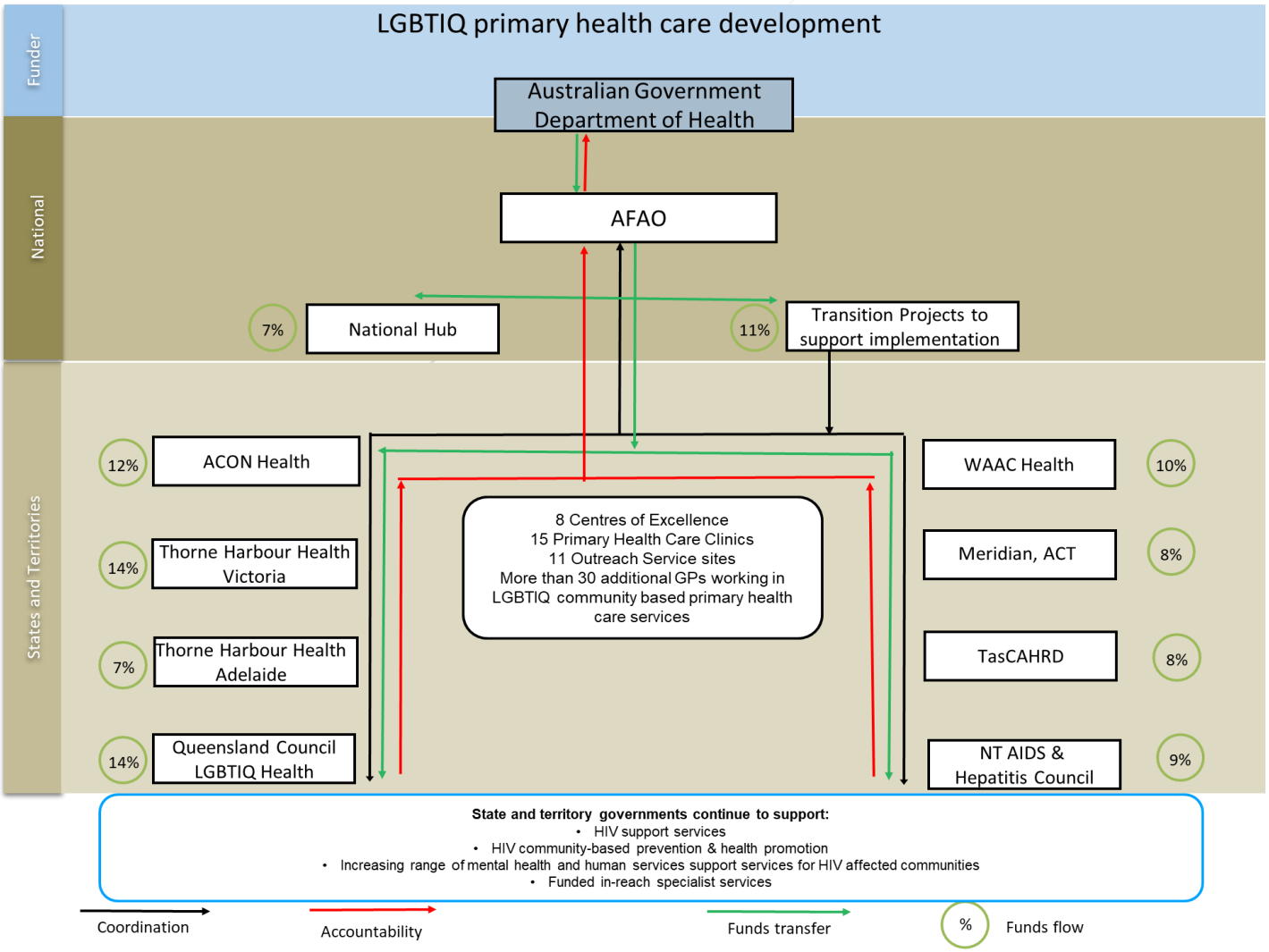


Activities to solve the problem:

The Transition Program has two elements:

- A costed transition plan to assist each Council in establishing or sustainably scaling up over the next four years as a local LGBTIQ Centre of Excellence and delivering a comprehensive primary health service for its communities. With time-limited support, the Councils can rapidly move beyond their current dependency on grants or other ad hoc funding for clinical services to provide a range of primary health services through revenue from MBS billing and co-payments. The resultant clinical services will complement their broader health promotion, HIV prevention and care programs that will remain state and territory funded.

- A costed central national network function, based in AFAO, will support the Councils to deliver financially sustainable and excellent models of primary health and ensure the rapid scale-up of the network. This Hub will contribute, on behalf of the network, to national dialogue and the development of primary healthcare thinking, systems and capacity. A key role of the Hub will be to manage a set of targeted projects that support Councils, particularly the smaller Councils and Councils that do not currently deliver MBS funded primary healthcare services. The projects have been designed to rapidly build leadership and governance capability, support business and financial planning, cost-effectively procure practice management systems, leverage bulk-purchasing opportunities (IT and clinical equipment), coordinate recruitment and workforce development, and achieve RACGP accreditation across the national network. The Hub will also manage a process and impact evaluation of the Transition Program.



Strengthening HIV responses in Asia and the Pacific

AFAO's international asks are informed by our relationship with the Pacific Friends for Global Health and the Australian Global Health Alliance.

10. **Commit $450 million to the Global Fund at the 7th Replenishment in 2022**

Impact: To support efforts to scale up community-led programming to reduce HIV incidence in Asia and the Pacific through increased investment in the Global Fund to Fight AIDS, Malaria and TB.

Investment advice: $450 million

Problem: For the first time in twenty years, the Global Fund to Fight AIDS, Malaria and TB reported declines in progress towards meeting HIV targets. This outcome has been a result of the devastating effects of COVID-19. Specifically, COVID-19 interrupted critical testing and prevention activities, particularly for key populations who are most at risk of HIV infection. Compared to 2019, HIV testing and prevention services administered by Global Fund programs in 2020 decreased by 22% and 11%, respectively.

Activities to solve the problem:

- The Global Fund will release its Investment Case for the 7th Replenishment (2024-2026) at the 7th Replenishment Preparatory Meeting on 23 February 2022.
- Significant additional resources will be needed to achieve global targets to end AIDS, tuberculosis (TB) and malaria as public health threats by 2030, strengthen health systems, and reinforce health security by better ability to prevent, detect and respond to future infectious disease threats.
- The G20 High Level Independent Panel (HLIP) argued for additional financing for pandemic preparedness to help build robust surveillance and detection networks and health and community systems in lower-middle-income economies.
- The Global Fund's proven model and distinctive attributes will not only not just to accelerate the fight against HIV, TB and malaria but also to defeat COVID-19.