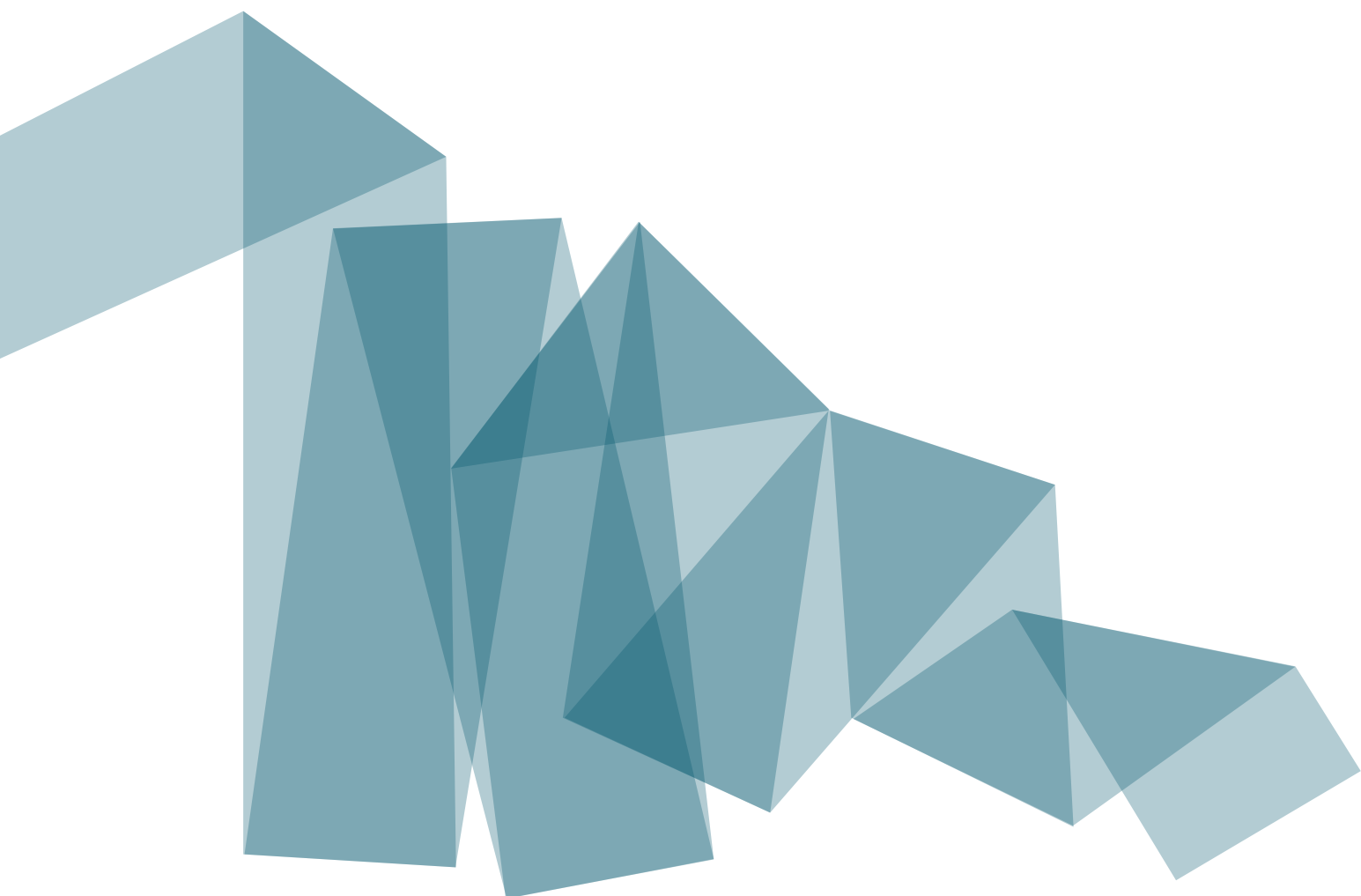


VICTORIAN STATE ELECTION 26 NOVEMBER 2022
HIV & AIDS PRIORITIES



ACKNOWLEDGEMENT OF COUNTRY

We acknowledge the traditional custodians of the land we are on, and pay our respects to their Elders past and present.

We respectfully acknowledge Aboriginal and Torres Strait Islander people living with HIV and their families, and that in addition to HIV-related stigma and discrimination, our Aboriginal and Torres Strait Islander community members experience racially-motivated prejudice.

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INTRODUCTION

We are at an unprecedented moment in the history of HIV in this state. We have never had so many tools to prevent HIV. Undetectable viral load (UVL), pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and condoms all effectively prevent transmission of HIV.

The 60th Parliament of Victoria could oversee the virtual elimination of new HIV transmissions in this state and be the first jurisdiction in the world to do so.

It has been almost 40 years since Australia's first human immunodeficiency virus (HIV) diagnosis, with over 40,553 diagnoses since¹. Over the course of the last four decades, community members, volunteers, researchers, health professionals, and governments have worked together to fight HIV. For the most part, Victorians have benefited from long-standing bipartisan support for effective actions on HIV and the shared understanding that key to an effective response is government working in meaningful partnership with community-controlled health services and people living with HIV (PLHIV).


Ahead of the upcoming Victorian state election, in continuation of the proud history of constructive community consultation and collaboration with government, Thorne Harbour Health (THH), Living Positive Victoria (LPV) and Positive Women Victoria (PWV) have produced this document to help guide the next Victorian Government's policy responses to HIV.

Advances in HIV treatment, care and prevention mean achieving virtual elimination of new HIV transmissions is a real possibility. However, the final stretch may be the most difficult. Subpopulations that have not seen significant reductions in new cases require targeted approaches across prevention, testing and treatment.

These include people from Aboriginal and Torres Strait Islander backgrounds, overseas-born men who have sex with men (MSM), heterosexual men and women, and people from certain culturally and linguistically diverse communities. It is important to remember that HIV is a preventable and treatable infectious disease. HIV prevention and HIV treatment options must be available to all people in Victoria regardless of Medicare eligibility - the same principle that has underpinned Victoria's COVID-19 response.

If we are to support Victorians living with HIV manage their chronic condition and stay well, as well as end new HIV transmissions, it is not enough to focus on biomedical treatment and prevention; we must also work to end HIV-related stigma, discrimination, and criminalisation as well as improve the social determinants of health in people living with HIV. This includes the option of referral to HIV peer support as part of a holistic approach to any new diagnosis. Whilst an HIV diagnosis in Victoria no longer needs to be considered 'life threatening', it is still 'life changing' and the need to support people living with HIV and prevent HIV transmission must remain a high priority for all Victorians. With more than half of all people living with HIV now being over 50 years of age, a comprehensive approach to HIV and ageing needs to be implemented across all aspects of service delivery models.

Positively, the Victorian Government recently amended the *Public Health and Wellbeing Act*, removing specific references to HIV and Hepatitis C (HCV) to reduce stigmatising language within legislation, which followed decriminalisation of HIV transmission in 2015. However, further reforms are needed.



Janet Jukes
President
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Craig Brennan
President
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Stephanie Raper
Chair
Positive Women Victoria

TARGETS

ACTIONS

- Provide the resources needed to achieve virtual elimination of new HIV transmissions in Victoria by 2025.
- Ensure that virtual elimination of new HIV transmissions is achieved in all priority populations.
- Support strategies to educate healthcare workers and the community about U=U and other initiatives to tackle HIV stigma.

Why

The Victorian Government should commit to achieving virtual elimination of new HIV transmissions by 2025². Virtual elimination is defined as:

- A 90 per cent reduction in preventable HIV diagnoses in Victoria (compared with a 2010 baseline).
- A reduction in preventable new HIV infections in gay and bisexual men who have sex with men (GBMSM) to less than one per 1,000 gay and bisexual men per year.

To achieve this ambitious goal, we must meet the following targets³ by 2025:

HIV prevention targets

1. 95 per cent of people at risk of HIV infection use one or more forms of effective HIV prevention (e.g., condoms, PrEP, U=U).
2. 95 per cent of people for whom PrEP is beneficial use it.

HIV testing targets

1. 95 per cent of people living with HIV are diagnosed.
2. 90 per cent of all people at heightened risk of acquiring HIV have a yearly HIV test.
3. 80 per cent of all GBMSM at risk of HIV have a test every three months.

HIV treatment targets

1. 98 per cent of people living with HIV who have been diagnosed are on treatment.
2. 98 per cent of people living with HIV on treatment have an undetectable viral load.
3. 90 per cent of newly diagnosed people living with HIV commence treatment within two weeks of diagnosis.

HIV stigma targets

1. >95 per cent of people living with HIV report no stigma in the last 12 months.
2. >95 per cent of GBMSM report no stigma in the last 12 months.
3. >95 per cent of the general public indicate they would not behave negatively towards a person because of their perceived or actual HIV status or sexuality.

Quality of life of people living with HIV

1. >75 per cent of people living with HIV report good quality of life.

In 2020, 90 per cent of people living with HIV in Victoria had been diagnosed. Of these people, 92 per cent were on treatment, and 96 per cent of those on treatment had an undetectable viral load (90-92-96). Virtual elimination of new HIV transmissions will require 95-98-98 targets. 95-98-98 targets should also be achieved for all priority populations, to ensure that any subpopulation groups are not left behind.

The Victorian Government should commit to achieving virtual elimination of new HIV transmissions by 2025.

HIV PREVENTION

ACTIONS

- Establish a trial for pharmacy-initiated PrEP.
- Provide free PrEP to all people who will benefit from it, aged 18-25 and residing in Victoria, regardless of visa status.
- Scale up prevention programs for hard-to-reach populations of GBMSM such as those residing outside inner Melbourne, culturally and linguistically diverse men, Aboriginal and Torres Strait Islander men, and non-gay-identified men who have sex with men.
- Design interventions to promote and increase access and awareness of PrEP, including event driven PrEP, among other priority populations.
- Trial new PrEP technologies such as long-acting injectable PrEP.
- Direct all hospitals to make PEP available to members of the public through Emergency Departments and expand the PEP phone line hours of operation to 24 hours a day, 7 days a week.
- Develop a Victorian Prisoner Blood-Borne Virus Action Plan, as has been done in South Australia (2017-2020)⁴.
- Expand the availability of spaces where people who use drugs are able to do so safely and with medical support.

Why

To achieve virtual elimination of new HIV transmissions, prevention efforts must be expanded, particularly to reach groups that have not seen as rapid a decrease in infection rates as others. These groups include overseas-born men who have sex with men, heterosexually-identified men and women, people from Aboriginal and Torres Strait Islander backgrounds, and people from culturally and linguistically diverse backgrounds. HIV prevention work is at its most effective when people living with HIV are meaningfully involved in the design, implementation and evaluation of HIV prevention strategies⁵. The critical roles of people living with HIV need to be acknowledged and supported in the future.

In 2022, according to the Gay Community Periodic Surveys, 82 per cent of HIV negative gay and bisexual men who had casual partners were regularly using at least one HIV prevention strategy – up from 69.4 per cent in 2014. Conversely, this means 18 per cent were not consistently using any prevention strategies in 2022 - well below the target of 95 per cent by 2025.

The lifetime cost of treatment and care for someone with HIV is on average \$1 million³. Modelling shows investment in preventing HIV transmissions will save billions of healthcare dollars through averted infections³.

PrEP

PrEP is the use of antiretroviral medications by people who are HIV-negative, to prevent acquiring HIV. The Victorian PrEPX study (2016-2018) contributed to a 30 per cent decline in new HIV infections in GBMSM in the three years after the study started⁶. Since PrEP was listed on the Commonwealth Pharmaceutical Benefits Scheme (PBS) in April 2018, it has proved instrumental in further reducing the numbers of new HIV infections. However, more needs to be done to increase uptake and continuation of PrEP use for whom PrEP is beneficial.

Given not all people with increased vulnerability to HIV can access federal government-subsidised PrEP as listed on the PBS, this structural inequity is producing increased risk of HIV transmission, particularly for people ineligible for Medicare².

PrEP costs \$42.50 per month for Medicare card holders and \$6.40 per month for concession card holders. For people ineligible for Medicare, PrEP costs \$926 per month^{i,7}, or approximately \$20 per month to import generic PrEP from overseas⁸. For many, particularly young people, the cost of PrEP is prohibitive, and creates a barrier to uptake and adherence. The Victorian Government covering the PBS copayment on PrEP for people 18-25 is an efficacious means of prevention. It is cost-effective, given the average lifetime cost of HIV treatment and care is \$1,000,000 per person³.

Many general practitioners are unaware of PrEP and its benefits for people at high risk of acquiring HIV. It is important that PrEP is readily available for all Victorians who need it.

PEP

PEP is a month-long course of antiretroviral drugs that can prevent HIV acquisition if taken within 72 hours of exposure to HIV. However, access to PEP is difficult due to geographically limited distribution sites, particularly after hours and on weekends. Victoria has a PEP phone line staffed 9am-5pm, Monday to Friday, alongside a website with advice and information about access locations. In line with other states, Victoria should operate the PEP phone line 24 hours a day, 7 days a week.

U=U

U=U (undetectable = untransmittable) means that people living with HIV who receive antiretroviral therapy and maintain an undetectable viral loadⁱⁱ cannot transmit the virus to others^{9,10}, making this prevention method the most effective. This allows people living with HIV to live the healthy sexual and reproductive lives they so richly deserve and further supports people living with HIV to safely experience pregnancies and have babies that are HIV negative. All legislations and policy relating to sexual,

ⁱ For brand-name Truvada, as of July, 2022

ⁱⁱ Current HIV viral load tests measure down to 20 copies of the virus per mL of blood. Any level lower than 20 copies/mL is deemed to be undetectable.

HIV PREVENTION (CONT)

reproductive and public health should be systematically reviewed and updated to reflect HIV science, including U=U.

Prevention in Custodial Settings

Victorians have long benefited from community needle and syringe programs (NSPs), and since 2018 a medically supervised injecting room (MSIR) in North Richmond. Every dollar spent on needle and syringe programs saves the community \$27 in healthcare costs¹¹. However, people in prisons currently do not have access to clean injecting equipment, despite people in custodial settings being identified as a priority population in the National HIV Strategy¹².

People living with HIV entering prison should be able to disclose their status, have their privacy respected, and have continuity of access to ART for both prisoner health, and to prevent onward transmission. Since most prisoners will eventually return to the community, lack of NSPs and other HIV prevention methods in prisons is both a threat to the health of prisoners but also creates a risk to public health and challenge to virtual elimination of new HIV transmissions in Victoria.

Community Awareness

Community-controlled health promotion campaigns have been the cornerstone of Victoria's response to HIV, promoting regular testing and prevention options, from condoms to biomedical interventions. The community-based management of these campaigns ensures that they are cost-effective, capable of being rapidly developed, and able to successfully build awareness and engagement. Continuing these campaigns and expanding their reach is essential to maintain hard-won gains.

To achieve virtual elimination of new HIV transmissions, prevention efforts must be expanded, particularly to reach groups that have not seen as rapid a decrease in infection rates as others. These groups include overseas-born men who have sex with men, heterosexually-identified men and women, people from Aboriginal and Torres Strait Islander backgrounds and people from culturally and linguistically diverse backgrounds.

TESTING ACTIONS

- Action key findings from the *Review of Victorian Sexual Health and Service Needs*¹³ (2019), including strengthening statewide clinical sexual health system architecture, anchored in primary care and clear referral pathways to specialist services.
- Subsidise HIV and other sexually transmissible infection (STI) testing for all people residing in Victoria, regardless of visa status.
- Implement consent-based opt-out HIV testing as part of all sexual health screenings.
- Expand community-controlled sexual health services such as Thorne Harbour Health's PRONTO! service, to establish permanent sexual health clinics that provide statewide coverage.
- Make use of innovative testing approaches and technologies such as self-testing kits, self-test dispensing vending machines, online testing and follow-up care coordination.
- Establish additional locations for Melbourne Sexual Health Centre in outer suburban areas.

Why

The progress of Victoria's Sexual Health Service System Review was impeded due to COVID-19. All people residing in Victoria, regardless of visa status, should have accessible sexual health services, across metropolitan and regional areas that remove financial and geographical access barriers to testing and treatment. A comprehensive sexual health sector requires a mixture of peer-led and mainstream services.

Routine HIV testing is essential to achieve virtual elimination of new transmissions. The longer someone has HIV and does not know it, the more likely they are to pass HIV on to others and the greater the impact on their health. Bringing down the time between HIV infection and diagnosis requires that HIV testing be free, frequent, and accessible.

In 2020, an estimated 9 per cent of people living with HIV in Australia (2,610) were unaware of their HIV status (undiagnosed). People born in South East Asia (28 per cent) and Latin America (22 per cent) are significantly more likely to be undiagnosed.

The proportion of late HIV diagnosesⁱⁱⁱ was higher among people born in Sub Saharan Africa (54 per cent) and Southeast Asia (52 per cent), compared to 44 per cent of all new diagnoses. People who reported heterosexual sex as their HIV risk exposure were more likely to receive a late diagnosis compared to male-to-male sex¹. The proportion of those who were categorised as late HIV diagnoses was the highest since 1997 and is a continuation of a longer-term trend. This reinforces the need for improved access to testing among people at increased risk in order to reduce the time between HIV acquisition and diagnosis¹. COVID-related service interruptions in 2020 and 2021 will likely further increase the proportion of late diagnoses.

The Melbourne Sexual Health Centre (MSHC) is Victoria's only public sexual health centre that provides free sexual health care to anyone, regardless of visa status. Capacity within the Centre has not kept up with rapidly increasing population and STI infection

rates. Over the past decade, demand for its services have steadily increased. Sexual health services must be expanded to accommodate Victoria's growing population.

Steady progress has been made to achieve high levels of regular testing among key populations in Victoria. Testing rates significantly dropped off during the COVID lockdowns and work is needed to ensure that this reduction in testing frequency is not sustained. Reduction in testing and the subsequent impact on the number of HIV diagnoses, will likely mean an increase in the duration of time between HIV acquisition and diagnosis and also potentially an increase in the proportion of newly diagnosed people who were diagnosed late.

Routine HIV testing is essential to achieve virtual elimination of new transmissions. The longer someone has HIV and does not know it, the more likely they are to pass HIV on to others and the greater the impact on their health.

iii Late HIV diagnosis is defined as newly diagnosed HIV with a CD4+ cell count of less than 350 cells/ μ L, and advanced HIV as newly diagnosed infection with a CD4+ cell count of less than 200 cells/ μ L.

TREATMENT ACTIONS

- Ensure PBS co-payments present no barrier to accessing HIV treatment by covering co-payments.
- Ensure all structures, policies and procedures to support the availability of HIV treatment to people without Medicare cards are promptly implemented and maintained.
- Fund a pilot project similar to San Francisco's Getting to Zero Rapid ART Program Initiative for HIV Diagnoses, enabling all people newly diagnosed with HIV to commence treatment within 14 days of their diagnosis.
- Establish systems for same-day (telehealth) referral to a HIV specialist if diagnosed at a clinic that lacks the necessary expertise and training.
- Establish systems that enable referral to peer navigation and support becomes the standard of care at point of HIV diagnosis.

Why

Improvements in antiretroviral therapy (ART) have made HIV a chronic manageable condition that requires lifelong adherence to treatment. ART significantly increases health and wellbeing by lowering one's viral load to undetectable levels, which when sustained eliminates the risk of HIV transmission.

However, several barriers exist to accessing treatment immediately following diagnosis, including perceptions among healthcare professionals that newly diagnosed people need time to process the diagnosis, preferences by some specialists to do genotyping tests, and linkage to specialist care from low-case load clinics.

Transmission of HIV in the community would be virtually eliminated if all Victorians living with HIV were receiving effective antiretroviral treatment.

ASHM guidelines on Initiation of Antiretroviral Therapy recommend starting ART immediately after diagnosis¹⁴, yet more needs to be done to increase immediate uptake of treatment. Between 2014-2018, San Francisco's Getting to Zero Rapid ART Program Initiative for HIV Diagnoses, saw the median time from diagnosis to care decrease by 71 per cent (7 to 2 days), care to antiretroviral therapy decrease from 19 to 0 days, and diagnosis to virologic suppression decrease 51 per cent (94 to 46 days)¹⁵. The Victorian Government should pilot a similar project to improve linkage and retention in care. This should include ensuring linkages to peer support and peer navigation services, which are strongly associated with improved linkage to and retention in HIV care¹⁶.

Financial barriers still prevent treatment uptake and adherence, as well as reducing quality of life for some Victorians. Subsidised HIV medication can be accessed under the PBS, but consumers are still required to pay dispensing fees (or co-payments) when they collect their medication from a pharmacy. There is an ageing population of people living with HIV, and many have multiple co-morbidities requiring multiple medications, incurring consultation and other fees. Combined out-of-pocket expenses can make treatment and care unaffordable for many.

In 2015, the New South Wales Government began subsidising co-payments for HIV treatments to help ease the financial burden for people with chronic conditions. This has assisted people living with HIV to access and adhere to treatment. Addressing the financial burden of treatment is key to reaching wellbeing targets.

People living with HIV have higher rates of financial stress, and for many this has meant having to choose between antiretrovirals (ARVs) and other essentials (and will only likely increase with rising costs of living pressures). In *HIV Futures 9*, 7.8 per cent of PLHIV indicated that they had not taken their HIV medication at least once in the last 12 months due to financial reasons, and 38.2 per cent stated that it was somewhat or very difficult to access medication for financial reasons¹⁷. A cost-benefit analysis has shown that one new infection is averted for every 31.4 PLHIV who are on treatment. The cost to government of covering copayment fees for ART are less than the costs of treating extra HIV infections that could result under current conditions of financial barriers to treatment¹⁸.

Transmission of HIV in the community would be virtually eliminated if all Victorians living with HIV were receiving effective antiretroviral treatment.

STIGMA & DISCRIMINATION

ACTIONS

- Fund and implement an annual attitudes survey of Victorian healthcare workers regarding HIV and other blood borne viruses (BBVs), as well as diverse gender identities and sexualities.
- Ensure that all hospitals that provide HIV clinical services undertake a MIPA^{iv} audit to ensure service delivery is culturally safe and appropriate.
- Establish a standing community-led, whole-of-sector working group that works with government to inform and implement stigma-reduction initiatives.
- Develop and embed evidence-based frameworks of accountability to address stigma across all aspects of the Victorian HIV response.
- Repeal or amend legislation which criminalised the transmission of HIV, stigmatises people living with HIV, or which is based on outdated or non-evidence based information about HIV, its transmission, or its treatment (see HIV Law Reform).

Why

Stigma is multi-dimensional, multi-layered and cumulative. Discrimination is a result of stigma and both stigma and discrimination are further complicated by intersectional issues related to sexuality; gender; past, present or perceived drug use; engagement in sex work; and certain ethnic, cultural and linguistic backgrounds.

HIV stigma and discrimination impede access to health services for people living with or at risk of HIV. For those affected, these barriers can contribute to missed and late diagnoses, disease progression, onward transmission, more costly tertiary care and reduced quality of life. For far too long, tackling stigma and discrimination has fallen disproportionately on the shoulders of people living with HIV. The responsibility to reduce stigma should be equally shared across all aspects of the local HIV response. We call for the development of systems of evaluation and accountability to ensure addressing HIV stigma is everyone's responsibility.

The Victorian Government has committed to a target of less than 10 per cent of people living with HIV experiencing stigma or discrimination in health and community settings by 2030. In 2020, two thirds of men who have sex with men who are living with HIV reported stigma or discrimination in the previous 12 months¹⁹, and 56 per cent of all people living with HIV have. In that same year, 27 per cent of Victorians surveyed reported that they would behave negatively towards other people because of their HIV status, including 4 per cent who indicated they would 'often' or 'always' do so²⁰.

HIV stigma fuels misconceptions about affected populations and renders women's HIV risk invisible, as well as affects the ability and willingness of primary care providers to discuss HIV testing with women. Declines in new HIV diagnoses among Australian-born GBMSM have not been seen in women.

HIV stigma and discrimination impede access to health services for people living with or at risk of HIV. For those affected, these barriers can contribute to missed and late diagnoses, disease progression, onward transmission, more costly tertiary care and reduced quality of life.

QUALITY OF LIFE

ACTIONS

- Facilitate and enable stronger partnerships with Primary Health Networks (PHNs) to ensure equity of access to quality standards of care and support for people living with HIV outside of metropolitan Melbourne.
- Improve referral pathways, accessibility and applicability of alcohol and other drug (AOD) services, mental health services, and other essential service systems for people living with HIV.
- Embed referral to peer support into HIV care pathways and protocols for state-funded services.
- Implement PozQoL quality of life measures across all high case load clinics to identify in advance areas of concern and potential intervention.
- Fund programs to ensure medical interpreter services are available and accessible to people living with HIV in all health and service settings.
- Invest in programs to support health interpreters to understand HIV, its treatment, and the lived experience of HIV, to tackle stigma and discrimination.
- Ensure in-home support programs continue to be available to allow people living with HIV to live at home.

Why

The quality of life (QoL) of people living with HIV—beyond clinical outcomes—is an important indicator of how well we are responding to the HIV epidemic.

The Australian government has committed to a target of 75 per cent of PLHIV reporting good quality of life by the end of 2022¹². Australian researchers developed the PozQoL scale (a quality of life measure developed specifically for people living with HIV), which incorporates domains of physical health, psychological health, social connection and functional ability²¹.

The latest national PozQoL dataset from 2019 shows 63.1 per cent of PLHIV reporting good QoL, short of the 75 per cent target in the National HIV Strategy. More than half of those respondents reported at least one experience of HIV-related stigma or discrimination in the past 12 months, while 38 per cent reported that they had been treated differently by a healthcare worker due to their HIV in the past 12 months.

Lower QoL among people with HIV is associated with lower levels of wellbeing, social connection, financial security and importantly, adherence to HIV treatments. Communities who experience poor quality of life are very likely to experience health inequities across the domains of social determinants of health, including migrant and refugee communities, people with substance use or mental health issues, and people experiencing housing instability.

In efforts to improve the quality of life of people living with HIV, equity must remain central. It is fundamental that QoL targets span the diverse demographics of people living with HIV, and that those most at risk of poorer quality of life are not left behind.

Quality of life varies greatly for people living with HIV who reside outside of inner Melbourne. We call for the rapid implementation of the findings of the *Victorian Sexual Health Service System Review*¹³. In a funding-constrained environment, equity of access to quality care requires the Victorian Government to actively advocate and

facilitate greater opportunities to partner with PHNs in outer metropolitan Melbourne and rural Victoria to ensure consistency in standards of care, increased health literacy and access to stigma-free quality supports.

Communities who experience poor quality of life are very likely to experience health inequities across the domains of social determinants of health, including migrant and refugee communities, people with substance use or mental health issues, and people experiencing housing instability.

HIV LAW REFORM

ACTIONS

- Review Victorian legislation and regulatory documents to identify remaining areas of HIV-specific discrimination, where legislation may not be concordant with current science and public health evidence surrounding HIV.
- Amend s 45 of the *Crimes Act (1958)* to ensure that people living with HIV cannot be prosecuted for misrepresenting their HIV status where reasonable precautions have been taken to prevent transmission^v.
- Ensure implementation of the *Sex Work Decriminalisation Act 2022* (Vic) does not discriminate against sex workers living with HIV.
- The Director of Public Prosecutions should establish guidelines that acknowledge the negative public health impacts of HIV criminalisation and make it clear that prosecutions will only be in the public interest where there was intentional transmission of HIV, or where management of the case through the public health system is inadequate or has failed.

Why

Progress continues to be made following the repeal of s 19A of the *Crimes Act 1958* (Vic) in 2015. The *Public Health and Wellbeing Amendment Bill* (PHWA) 2022 removes specific references to HIV and HCV, further removing structural stigma from the PHWA Act.

Still, people living with HIV can face criminal charges for reckless HIV transmission, as well as reckless endangerment in cases where no transmission occurs.

People living with HIV can be charged under s 45 of the *Crimes Act (1958)* relating to procuring sex by fraud, if they misrepresent their HIV status to someone before having sex with them, even if they take reasonable precautions to prevent transmission and there is no risk²². This can be punished by up to five years in prison.

There are many legitimate reasons why someone living with HIV may choose not to disclose their HIV-positive status. People living with HIV who choose to share their HIV status with their partners or prospective partners often face negative consequences including being 'outed' to family, colleagues or community; being shunned or ostracised; being blackmailed; being subjected to verbal abuse; being wrongly reported to police or health authorities; being subjected to physical abuse, violence and, on at least one occasion, homicide²³.

No one should face prosecution where they have taken reasonable precautions to prevent transmission. The mere existence of laws that can result in prosecution for being HIV-positive perpetuates stigma, and runs contrary to public health targets set out by the Victorian Government.

The *Sex Work Act 1994* (Vic) effectively prohibited people living with HIV from working as sex workers²⁴. We commend the Victorian Government for repealing this discriminatory Act. Sex workers have high rates of condom use and extremely low rates of HIV. Implementation of the *Sex Work Decriminalisation Act 2022*²⁵ provides an important opportunity to ensure that reform does not continue to perpetuate HIV stigma and discrimination. Effective HIV treatment means that HIV cannot be passed on sexually. Sex workers living with HIV

should be supported by evidence-based public health measures that remove barriers to treatment rather than punitive laws that drive them away from care.

No one should face prosecution where they have taken reasonable precautions to prevent transmission. The mere existence of laws that can result in prosecution for being HIV-positive perpetuates stigma, and runs contrary to public health targets set out by the Victorian Government.

^v Reform of s 45 should also ensure that people of diverse sexualities and/or gender identities cannot be prosecuted under the same law.

GLOSSARY

AIDS – acquired immune deficiency syndrome

ART – antiretroviral therapy

ASHM – Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine

BBV – blood-borne virus

GBMSM – gay, bisexual and other men who have sex with men

HCV – hepatitis C Virus

HIV – human immunodeficiency virus

HIV-related stigma – negative beliefs, attitudes, fears and judgements held against PLHIV and members of groups that are perceived to be associated with HIV, such as gay and bisexual men, people who inject drugs and sex workers

HIV-related discrimination – the enactment of HIV-related stigma – the unfair and unjust treatment of a person or group of people based on their real or perceived HIV status

LGBTIQ+ – lesbian, gay, bi+, trans and gender diverse, intersex, queer, and other sex, sexuality and gender diverse identities

MIPA – meaningful involvement of people living with HIV and AIDS

MSIR – medically supervised injecting room

NSP – needle and syringe program

PBS – pharmaceutical benefits scheme

PEP – post-exposure prophylaxis

PLHIV – person/people living with HIV

PozQoL – The PozQoL scale is a validated tool to measure quality of life for PLHIV, incorporating the domains of physical health, psychological health, social connection and functional ability.

PrEP – pre-exposure prophylaxis

QoL – Quality of Life

s100 – Section 100 Highly Specialised Drugs

STI – sexually transmissible infection

U=U – Undetectable = Untransmittable – having an undetectable viral load means you cannot transmit HIV.

UVL – undetectable viral load – current HIV viral load tests measure down to 20 copies of the virus per mL of blood. Any level lower than 20 copies/mL is deemed to be undetectable.

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24. *Sex Work Act 1994 (Vic)*, ss 19-22, Parliament of Victoria.
25. *Sex Work Decriminalisation Act 2022 (Vic)*, Parliament of Victoria.

RESOURCES

Thorne Harbour Health | www.thorneharbour.org

Living Positive Victoria | www.livingpositivevictoria.org.au

Positive Women Victoria | www.positivewomen.org.au

PRONTO! | pronto.org.au

Melbourne Sexual Health Centre | www.mshc.org.au

Thorne Harbour Health

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

Living Positive Victoria

Living Positive Victoria is a not for profit, community-based organisation representing all people living with HIV in Victoria since 1988 and is committed to the advancement of human rights and wellbeing of all people living with HIV.

Positive Women Victoria

Positive Women Victoria is the only community-based organisation specifically funded to support women living with HIV in Australia and was established by and for women living with HIV. For over 30 years, PWV has responded to the changing needs of women living with HIV; recognising the impact gender has on the way women, femmes, cis women, and trans women experience HIV; and addressing the specific needs and emerging issues that affect these women.

