AUSTRALIAN FEDERATION
OF AIDS ORGANISATIONS
Leading the community response to HIV

National HIV Strategy 2018-2022

A community perspective

Adj. A/Prof Darryl O'Donnell
Chief Executive Officer

Why even have a *National HIV Strategy?*

Surely…

- We know what to do

And by the way, the Strategy…

- makes no financial commitments
- has no binding compliance requirements
- has no redress mechanisms for failure to achieve targets

- So what is the point?
- Why do we need it?

The *National HIV Strategy* matters

- Each Strategy re-affirms the commitment of government to act
- Unifies the Commonwealth and States and Territories through COAG dialogue
- Tests and builds consensus across the Partnership
- Ministerial approval ensures cyclical political attention and guards against drift

- Rearticulates core principles (eg, centrality of community and harm reduction)
  - These are not to be taken for granted
- Development allows debate, refinement and priority setting
- Assesses and responds to new evidence (eg, U=U)
- Sets directions (and rejects directions, such as mandatory testing)

- Signals public health priority and the opportunity for greater gains
- Articulates targets that mobilise effort
- Provides a framework for resource prioritisation
- Provides foundation for assessing progress

So… back to why we should have a Strategy

- *We know what to do*
  - Actually, we don't always – Strategies help
  - The risk of creeping divergence is real

- *It makes no financial commitments*
  - Investments tend to follow policy commitments (but not perfectly)
  - States and territories held at table, incl those without local equivalents

- *It has no binding compliance requirements*
  - Misalignment invites political risk
  - Strategy operates as normative guidance

- There are no redress mechanisms for failure to achieve targets
  - Annual as well as cyclical review of progress against targets
  - Reorientation of priority and effort

What did we want?

- Ambitious goals with measurable targets to guide investment
- Investments and effort commensurate with ambition
- National programs to back in and amplify local efforts
- Prioritisation of underserved populations
- Increased sensitivity to gender and cultural diversity
- Rapid access to safe and effective technology
- Pathway to address Medicare ineligibility
- Stronger orientation to data and effective oversight
- Attention to the enabling environment, incl focus on stigma and discrimination
- National peaks recognised for their standing
- Centrality of communities

What happened and what can we learn from it?

- Five strategies
- A thorough yet true to form policy process (never linear)
- Deep responsiveness to community and others' input
- Investment – initial and subsequent
- COAG Health Council endorsement

Learnings

- Start early
- Align with political and budget cycle
- Inter-governmental dialogue and negotiated agreements
- Targets and indicators are hard work and exceedingly time-consuming
- Solution specifics are harder and slower again. Beware process solutions.
- Invest early and maintain momentum

How does this strategy measure up?

- A substantial policy statement
- The eighth of its kind and the most impressive for some time
- Principles up front
- Clear goals, including virtual elimination, with no ‘walking back’
- New measurable targets – (world-leading)
  - 95 95 95
  - Reduced incidence and sustained virtual elimination
  - PrEP coverage to 75%
  - 75% of PLHIV reporting good quality of life
  - Reduce experience of stigma by 75%
- Inclusion of trans and gender diverse people as a priority population
- Central recognition of Aboriginal and Torres Strait Islander communities
  … and a National Aboriginal and Torres Strait Islander BBV and STI Strategy

How does this strategy measure up?

- Better reflection of diversity of the epidemic…

  … while attending to its burden
- Recognition of the standing of community peaks
- Stronger, more direct language on priorities, including U=U
- Unambiguous statements of criminalisation and the enabling environment
- Rejection of mandatory testing of sex workers
- Pathway to dialogue on Medicare ineligibility
- Naming of the lack of sterile injecting equipment as a barrier in prisons
- Strong recognition of the role of peer education
- Valuing of success and the power of peer-led action
- And no awkward, late additions

Getting it done

- Supported by an Implementation Plan
- Driven by the inter-governmental BBV and STIs Standing Committee
  - Reporting to COAG Health Council
- Additional investment - $45m
- Annual reporting by BBVSS
  - Building ownership and coordination across partners
  - Quantitative and qualitative data
  - Annual Implementation Plan revision based on progress and emerging issues.

The Strategy in perspective

- ‘It does not explain everything, nor does it explain nothing’
- The chassis, if not the engine
- A vital framework and architecture, and a guard against drift
- A job now done, allowing focus on delivery.