



Aboriginal and Torres Strait Islander people living with or at risk of HIV

Health and Needs Assessment Co-Designed Project Report



Positive Life NSW

The voice of all people living with HIV

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Acknowledgements

Positive Life NSW acknowledges that we operate and function on the lands of the Gadigal people of Sydney's First Nations People known today as 'the Eora Nation'. Positive Life NSW is the state-wide peer led organisation representing and advocating for all people living with HIV (PLHIV) in New South Wales (NSW).

We function throughout the colonial border of NSW, of which there are 120 Local Aboriginal Land Councils, each constituted over a specific area in NSW. Their boundaries may not align with cultural or traditional association with Country.

The Metropolitan Local Aboriginal Land Council is the contact point for enquiries as to the boundaries of Aboriginal land, best practice in cultural protocols, and Welcomes and Acknowledgements to Country.

We recognise the past atrocities against Aboriginal and Torres Strait Islander people of this land and that Australia was founded on the genocide and dispossession of its first inhabitants.

We pay our respect to these lands that provide for us.

We acknowledge and respect the ancestors of Aboriginal people who walked and co-existed with the land for many generations.

We acknowledge and pay our respects to Aboriginal Elders both past and present, and the young leaders who will be future Elders and knowledge holders.

We acknowledge and honour the memory of Aboriginal and Torres Strait Islander people who have gone before us and recognise their contribution to Aboriginal and Torres Strait Islander people, their communities and culture.

We acknowledge the Aboriginal identity of NSW – the Koori identity of NSW Aboriginal nations, clans, and language groups, and the kin and language connection that exists over the southern border with the Koori people of Victoria. We acknowledge First People's connection to the unique landscape, river systems, and coastal waters of NSW.

Sovereignty was never ceded. Always was, always will be, Aboriginal land.

Positive Life NSW would like to thank Aboriginal and Torres Strait Islander people living with and at risk of HIV in NSW who took the time to respond to this needs assessment and share their knowledge and experiences.

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Overview of the project

The Aboriginal and Torres Strait Islander People Living With or at Risk of HIV Health Co-Designed Project is a needs assessment of the Aboriginal and Torres Strait Islander (Indigenous) community of NSW, regarding and with consideration to: accessing and engaging with services (including health and social determinants of health-related services); accessing pre-exposure prophylaxis (PrEP) and antiretroviral medication (ART); lifestyle choices, including transience; rates of incarceration/custody; and public health orders.

Aboriginal and Torres Strait Islander people, including PLHIV, experience poorer health and social determinants of health outcomes across the board. Data from the NSW Ministry of Health and The Kirby Institute confirm that Indigenous people are at higher risk of acquiring HIV than non-Indigenous populations, are diagnosed at a later stage of infection and at a later age, and transmission routes have a different profile than in non-Indigenous populations. In NSW between 2011 and 2015, while the most frequently reported route of HIV transmission was sexual contact between men among Aboriginal people (55%), a higher proportion of notifications of newly diagnosed HIV infection among Aboriginal people were attributed to injecting drug use (8% vs 5%), and heterosexual sex (24% vs 10%), as compared with non-Indigenous Australian-born population.¹

Indigenous people are at higher risk of acquiring HIV than non-Indigenous populations, are diagnosed at a later stage of infection and at a later age, and transmission routes have a different profile than in non-Indigenous populations



While there is a considerable wealth of data on the social determinants that impact health outcomes for Aboriginal and Torres Strait Islander people and the drivers of these, there is a paucity of research on what Aboriginal people themselves are thinking or saying about this. This is to the best of our knowledge, the first needs assessment conducted and co-designed by and with Aboriginal and Torres Strait Islander people in NSW.

1. Health Protection NSW, NSW Health: Notifiable Conditions Information Management System.

The project's primary target population are Aboriginal and Torres Strait Islander PLHIV in NSW (secondary is Aboriginal and Torres Strait Islander people at risk of acquiring HIV in NSW). The Australian Bureau of Statistics reports that in 2021 there were an estimated 278 043 Aboriginal and/or Torres Strait Islander people residing in NSW². The number represents 3% of the NSW population³, and approximately 33% of the total Australian Aboriginal and/or Torres Strait Islander population, and the highest of any state or territory.

Aboriginal and Torres Strait Islander people are a priority population in the NSW HIV Strategy 2021–2025⁴, the combined governmental and community response to ending the virtual transmission of HIV by 2025.

The Kirby Institute Annual Surveillance Report 2022 states that between 2012 and 2016, the HIV notification rate among Aboriginal and Torres Strait Islander peoples increased from 4.9 to 6.5 per 100 000, declined to 3.3 per 100 000 in 2019, and then declined further to 2.3 per 100 000 in 2021. By comparison, in 2021, the HIV notification rate was 2.2 per 100 000 among the nonIndigenous population. Trends in HIV notification rates in the Aboriginal and Torres Strait Islander population are based on small numbers (17 new notifications)⁵, but HIV testing rates overall decreased over this period likely due to the impacts of the COVID19 pandemic, so these figures should be interpreted with caution. The current NSW HIV Strategy acknowledges that while HIV diagnoses among Aboriginal people remained low in NSW between 2015 and 2019, a greater recognition of diverse social and cultural factors which can influence the health and wellness of Aboriginal people is required to maintain these low rates. This population experiences lower HIV testing rates; lower PrEP uptake and adherence rates; higher HIV diagnosis rates; higher rates of late HIV diagnoses; and higher rates of HIV diagnosis among women, compared to their non-Indigenous counterparts. Additionally, the rates of gonorrhoea and chlamydia infections are higher in Aboriginal people in NSW (compared to non-Aboriginal people), highlighting the need for increased HIV and STI prevention efforts.⁶

The needs assessment (the project) utilised foundational evidence that Positive Life NSW will use to develop a co-designed culturally sensitive program/service model which achieves higher health and social determinants of health outcomes for Indigenous people in NSW, including those living with HIV and those at risk of acquiring HIV (target population). The needs assessment incorporated an environmental scan of the population of Indigenous PLHIV in NSW, utilising aggregated data from the NSW Ministry of Health and the Kirby Institute's Treatment Cascade data to ascertain the demographic profile and treatment uptake and adherence of the target population.

The project engaged an advisory group of representative members of the target population to provide guidance and advice during each stage of the project. An ethics approval was sought, to enable culturally safe interviews which were conducted with the target population. An integral part of the co-design process was to have conversations with Indigenous people where they are, at places and a time convenient to them, remunerating them for their time and expertise, rather than expecting them to come to us. Unfortunately, the COVID-19 pandemic severely limited this, and most interviews were conducted via Zoom.

2. ABS 2021 Census. <https://dbr.abs.gov.au/region.html?lyr=ste&rgn=1>

3. NSW Aboriginal Blood Borne Viruses and Sexually Transmissible Infections Framework 2016-2021. NSW Health.

4. NSW HIV Strategy 2021-2025. NSW Ministry of Health 2020.

5. King, J, McManus, H, Kwon, A, Gray, R & McGregor, S 2022, HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2022, The Kirby Institute, UNSW Sydney, Sydney, Australia. <http://doi.org/10.26190/sx44-5366>

6. NSW HIV Strategy 2021-2025. NSW Ministry of Health 2020.

This is to the best of our knowledge, the first needs assessment conducted and co-designed by and with Aboriginal and Torres Strait Islander people in NSW.



Glossary

ACCHS	Aboriginal Community Controlled Health Services
AH&MRC	Aboriginal Health & Medical Research Council
AMS	Aboriginal Medical Service
AIDS	Acquired Immunodeficiency Syndrome
ARVs/ART	Antiretrovirals/Treatment
GNP+	Global Network of People Living with HIV
HIV	Human Immunodeficiency Virus
LGBTIQA+	Denotes the variety of sexual orientations such as lesbian, gay, bisexual, transgender, intersex, queer, asexual plus
MSM	Men who have sex with men
MSMW	Men who have sex with men and women
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
STI	Sexually transmitted infection

Executive Summary

If Aboriginal and Torres Strait Islander people living with HIV are to achieve healthy futures it will require a collaborative, culturally appropriate and sustained programmatic approach to eliminating HIV related stigma and discrimination. This will ensure that PLHIV can strengthen their own health, their family and communities, they will be better informed and have access to resources to build resilience, live in supportive environments and build sustainable and healthy lives.

Demographics of participants ranged from 31 to 53 years old. The sample size was small and mainly concentrated within the inner city of Sydney, although several participants came from rural and remote areas/communities. This indicates further work needs to be undertaken in rural and remote areas/communities.

Identified Barriers and Enablers

The COVID pandemic and subsequent lockdowns may have been contributing factors to the sample size with people unwilling to put themselves at risk or unable to access technology for interviews. This raises the issue of access to technology for Aboriginal and Torres Strait Islander people more broadly. The lockdowns restricted the ability to hold interviews face-to-face, and travel to rural and regional parts of NSW to interview potential participants. With regard to recruitment in AMS or by s100 providers, the instigation of telehealth appointments due to COVID restrictions meant that potential participants were not engaging in person with health services, and were therefore less likely to be made aware of the needs assessment or access promotional material advising them of this.

Stigma surrounding a person's HIV status is considerable within Aboriginal communities and this can also be seen as a reason for the lack of participation. Additionally, participants indicated a mistrust of Aboriginal Medical Services (AMS) in relation to confidentiality and negative experiences around sexual health and HIV status, which given they were primary targeted organisations for recruitment, could have also contributed to the smaller sample size.

In trying to comprehend the small sample size and the reluctance of some to engage, a comment was posted on Blak social media, *"When people are researching, it is important to participate."* The responses received were overwhelmingly negative and referred to Aboriginal and Torres Strait Islander people being the most over researched in the world, yet not seeing any perceived benefit deriving from such research.

Additional barriers included potential participants not believing they were at risk of HIV because they identified as heterosexual, mental health and alcohol issues, and those who claimed to be too busy to participate. This could also be because of the lack of perceived benefit from participating in research per the previous paragraph.

Conversely, the employment of an Aboriginal Health Program Officer to the needs assessment project supported the recruitment process due to their existing relationships and ongoing engagement with the Aboriginal and Torres Strait Islander community. While the COVID pandemic and subsequent lockdowns threatened to restrict the scope of the project, it pivoted to enable interviews to continue over this period. Participants were offered interviews to be conducted over Zoom, when technology permitted. The Aboriginal Health Program Officer, having established a rapport with the participant, would check in later with them around their needs, provide them

with health promotion resources, and was able to provide onward referrals to other programs and services that Positive Life offers. The majority of referrals were to Positive Life's housing and work and vocational support programs.

Whilst there may have been an issue in collecting robust data, the evidence collected from all participants raised similar issues around dedicated HIV services, the role of the AMS, the need for dedicated Aboriginal Health Workers for people living with HIV, the need for dedicated mental health services for Aboriginal people and the need for sensitivity training for NSW Police around HIV issues.

Effort has been made to ensure the wide range of ideas and opinions expressed in the interviews have been captured. It is also important to note that there was considerable overlap in the responses to questions during the interviews and many of the issues raised are interrelated.

Priority Area/Issues Raised in the Needs Assessment

The following priority issues were highlighted by participants:

Individual Health and Wellbeing

- Housing stability continues to remain an issue for Aboriginal and Torres Strait people
- HIV-related stigma and discrimination affects participants' ability to earn an income, impacts on family and intimate relationships, mental health and wellbeing, self-confidence, and increases social isolation
- Participants were forced to disclose their status or have experienced rights abuses when using health settings, justice, and prisons
- Concern with decline in a quality of life associated with the ageing process
- Isolation from family
- Lack of confidence to disclose: complicated and fear of rejection
- Certain police stations in NSW demonstrate insensitivity toward Aboriginal and Torres Strait Islander PLHIV.

Family Health and Wellbeing

- Participants had experienced disclosure in healthcare or institutionalised settings without their consent
- Participants had experienced HIV-related stigma and discrimination from family or other people
- There is a lack of information around PrEP and PEP specific to Aboriginal and Torres Strait Islander people, including eligibility, and more education and awareness programs around PrEP and PEP are needed including how and where this can be accessed.

Environmental Health and Wellbeing

- Aboriginal Medical Services (AMSs) are accessed for mainstream health, but not for sexual health or LGBTIQ+ issues
- HIV-specific health services such as The Albion Centre are seen as being culturally appropriate and leaders in accessing HIV treatment (noting that this is based in inner Sydney)
- Participants expressed a need for more culturally appropriate services for Aboriginal and Torres Strait Islander PLHIV, and dedicated Indigenous support workers for Aboriginal and Torres Strait Islander PLHIV
- Experiences of racism, discrimination and insensitivity were reported by participants from NSW police officers because of Aboriginal and Torres Strait Islander and/or HIV status
- Participants advised that while friends knew their HIV status, many had had their status disclosed to friends without consent
- Participants felt their rights are not respected despite the norms and protocols of international human rights agreements.

Preliminary Findings

- An easy-to-use, culturally appropriate online HIV stigma and discrimination complaints legal process designed with and for Aboriginal and Torres Strait PLHIV in NSW
- Specific targets/strategies to eliminate HIV-related stigma and discrimination as experienced by Aboriginal and Torres Strait Islander PLHIV
- Sexual and reproductive health should be grounded in the principles of GIPA and MIPA
- Connect and build a working relationship with the International Indigenous Working Group on HIV & AIDS to share strategies and build partnerships
- There is a need for increased HIV/STI prevention initiatives and education around PrEP and PEP, their availability and accessibility
- Continue to build partnerships with NSW Police and Corrections
- Continue to build partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs), BlaQ, research institutes and affected communities
- Commit to the targets and outcomes in the National Agreement on Closing the Gap to improve the health outcomes of Aboriginal and Torres Strait Islander people by providing culturally appropriate health services in NSW
- 77% of participants indicated that it was easy to access treatment such as ARVs or PrEP
- 88% of participants living with HIV had an undetectable viral load
- 38% of participants living with HIV had taken a break from their HIV medications for more than a week
- 25% of participants indicated that their HIV status had been disclosed without their consent
- 50% of participants had experienced some form of stigma or discrimination because of their HIV status
- 31% of participants indicated that they had a very good quality of health/life.

Methodology

Positive Life NSW launched the needs assessment on 01 May 2020 whose purpose was to better understand the needs of NSW-based Aboriginal and Torres Strait Islander people in NSW including those living with HIV and those at risk of acquiring HIV, in regard to accessing and engaging in HIV prevention, testing, and treatment services between September 2020 and May 2022. As an integral part of the co-design process, we aimed to conduct community-based participatory research by meeting and having conversations with Aboriginal and Torres Strait Islander people where they are, at places and a time convenient to them, remunerating them for their time and expertise.

The needs assessment of the NSW-based Aboriginal and Torres Strait Islander communities drew on a literature review and a series of semi-structured, in-depth qualitative interviews and focus groups. As noted, it had originally been planned to utilise both individual interviews and focus groups to explore the HIV prevention, testing and treatment needs of NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV. These qualitative approaches offer opportunities for understanding the meaning of HIV treatment and prevention technologies, HIV testing, and access to HIV care for Aboriginal and Torres Strait Islander people. Due to the constraints of the COVID-19 pandemic, individual interviews were conducted that allowed Positive Life NSW's peer researcher to create a space where participants could share stories of how they have drawn on their and their community's strengths to keep themselves engaged with the HIV care continuum.

An Aboriginal Advisory Committee provided guidance and advice throughout all project stages. Ethics approval to conduct culturally safe interviews with the target population of Aboriginal and Torres Strait Islander people in NSW was sought and approved by the Aboriginal Health and Medical Research Council (Approval Number 1704/20).

The Aboriginal Advisory Committee participated in the co-design of the promotion material and the 'Don't be Shame! Time to yarn about HIV' culturally appropriate postcards and posters were distributed to all AMS (Aboriginal Medical Services) and S100 prescribers in NSW. Further follow-up contact was made and the promotional resources were redistributed to services another two times over an 18-month period in an effort to recruit additional participants to be interviewed. However as highlighted previously, health services clients may have been limited in accessing medical services in person due to COVID restrictions, and the resources not being displayed in waiting rooms.

The primary outcome of the project was the advancement of knowledge about the HIV-related needs of NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV. This knowledge will have direct policy and practice applications, benefiting not only those Aboriginal and Torres Strait Islander peoples living with HIV but also their families in managing the challenges of diagnosis, treatment, and care as well as the social isolation and stigma associated with blood-borne infectious diseases. Participants will also benefit indirectly from this research, as their participation in the study will generate new and significant knowledge about the needs and challenges of individuals living with or at risk of acquiring HIV, which can inform or strengthen existing service design and delivery for this population.

Advisory Committee

An Aboriginal Advisory Committee comprising nine members was formed. The members were:

1. **Ms Michelle Tobin**, Positive Life NSW
2. **Mr John Leha**, BlaQ Aboriginal Corporation
3. **Ms Rusty Nannup**, Sex Workers Outreach Project (SWOP)
4. **Ms Jade Christian**, NSW Users and AIDS Association (NUAA)
5. **Mr Stephen Morgan**, Positive Aboriginal and Torres Strait Islander Network (PATSIN)
6. **Mr Tim Moffitt**, Positive Aboriginal and Torres Strait Islander Network (PATSIN)
7. **Ms Jane Strang**, ACON
8. **Ms Annette Slater**, Hunter New England Local Health District, NSW Health
9. **Dr Michael Doyle**, University of Sydney

The Advisory Committee met four times during the project.

The Advisory Committee reviewed the ethics documents, terms of reference and letter of introduction and interview guide and approved them as being culturally appropriate.

Qualitative Interviews

An interview guide was developed, reviewed, and approved by the Advisory Committee. The guide included questions in relation to:

- a) accessing sexual health services
- b) men's business and women's business
- c) assessing awareness of and engagement with Positive Life's established rural outreach program
- d) levels of engagement with existing local health and other social services
- e) frequency and uptake of HIV testing
- f) quality of life
- g) and uptake and ongoing treatment/adherence to antiretroviral medication.

Interviewees were recruited via word of mouth, recruitment posters and postcards and direct contact made with AMSs and s100 prescribers requesting recruitment of participants. A gift card of \$30 was offered to interview participants to reimburse their time and expertise in accordance with GIPA and MIPA principles.

All interviews were recorded, and transcripts made. Those recordings and transcripts are confidential, and will be destroyed after submission of this report.

Interviewees

Interviewees ranged from 26 to 53 years old, eight positive and five negative participants. The majority live in the Sydney inner city and access services such as the Redfern AMS and The Albion Centre Clinic.

Table 1. Interview Participant Demographics

Age	Gender	Suburb	HIV status
50	M	Redfern	HIV positive
45	M	Tamworth	HIV negative
48	M	Zetland	HIV positive
45	M	Sutherland	HIV positive
46	M	Alexandria	HIV positive
33	M	Darlinghurst	HIV negative
26	M	Sydney	HIV negative
31	F	Central Coast	HIV negative
36	M	Waterloo	HIV positive
36	M	Redfern	HIV positive
38	F	Sydney	HIV negative
32	M	Chippendale	HIV positive
53	M	Waterloo	HIV positive

Thematic Analysis

Assumptions Impacting Health

Interviewees reported that in some mainstream medical services, their health issues were wrongly attributed to drug and alcohol abuse:

We ran out of HIV meds in that point of time, that I found frustrating and annoying, and I didn't expect to be slotted in straight away [um] cause [GP named] is open from 8-8. And we were happy to see anyone else, but this [um] receptionist shut us down. I thought that was bad. When I've dealt with [hospital named], they weren't focused on the [um] health problem at hand, they wanted to focus on drug use and HIV, and I wasn't there for that. They thought I was having a stroke. (M 53 Pos)

One lady didn't believe that I was trans. So she sent me referred me to an endocrinologist. And they have big waitlist. Sometimes they cost money as well. So I was not accessing hormones... Some places face to face couldn't really believe me. Because it's a high scheduled drug. Yeah, you're asking for testosterone. People could think you're like a bodybuilder or drug dealer. But I'm not. No. Look at me up and down, and you get no way. I'm not a bodybuilder. I'm not a drug dealer. I'm just like, this is me. (M 26 Neg)

Stigma and Discrimination

Stigmatising attitudes around HIV were strong. One transgendered interviewee said:

I get deemed dirty, you know, that I spread disease around and I'm not clean, and I don't practice safe sex. And being transgender, and black, our multi-label and have those labels on me. (F 38 Neg)

One interviewee recounted the issues with stigma and discrimination in navigating online dating apps as a person living with HIV, and the ongoing need to educate others about HIV:

And somehow it slipped out, or I've told someone like confidentially that I'm HIV positive. And then some random comes up to me. Oh, are you HIV positive? Yeah. Oh, so I can't drink out of the same cup. Rah rah rah...And then, yeah, I'm on Scruff, Grinder, those dating apps. I disclose my status. I find that it's much easier for my mental health. To just put it out there and straight away without having to tell each potential partner when it comes to in getting intimate that I'm HIV positive. Because at the moment I'm experiencing that people who get to chat to me on online forums, they don't tend to read my profile. And then we're initiating a conversation, everything goes well, and then bang they disappeared. Yeah. Okay, they have read my status. (M 32 Pos)

An interviewee who was HIV negative, but accessing PrEP also felt stigmatised around a chemist's attitude to their PrEP use:

I think I definitely did feel stigmatised, because you definitely had a few people look at you and sort of never once you know, the chemist, and I guess they shouldn't be looking at me like that if I'm wanting PrEP like that. I'm not sure if antiretrovirals come straight from the chemists as well? There's another process. But if that's what they're doing to someone who's on PrEP, then what are they doing to someone who's HIV positive and getting the medication or...? (M 33 Neg)

Mental Health

Mental health was intrinsically linked to physical health and wellbeing, and the absence of good mental health was also co-related to an increase in co-morbidities. Interviewees reported that when their mental health was stable, their physical health was good and vice versa.

My physical health hasn't been good. I've been having like some heart problems. And I've gained lots of weight, but my mental health pretty, pretty, pretty average, I guess... I struggle with anxiety and overthinking sometimes. And have good days. Happy and content with life. But the days where I can overthinking really feel bad about myself and have low self-esteem. Yeah. But [um], overall, I'll say my health is ...poor to average. Because of this, because of my physical health, which can really affect the mental health as well. (M 26 Neg)

In the past I've been too embarrassed and too ashamed to disclose [um] all of my other stuff with addiction and mental health simply because I am black with HIV. (M 36 Pos)

A number of interviewees commented on the increased demand for mental health services, particularly following the COVID pandemic and lockdowns.

I definitely think probably more access to mental health for people would probably improve health. My health as well, just I think, probably just knowing, I guess if there are times in life too stressful, so and just knowing that that's that access, is there or you don't have to wait, I think there's as well long waiting periods as well, maybe it's a result of COVID. It could be, but it's if someone does need access to mental health services that actually not as accessible as we should be. And I think that will probably help. (M 33 Neg)

The benefits of having Aboriginal peer workers in publicly funded mental health services were also acknowledged and the empathetic ability a dedicated worker had to create greater understanding and facilitate better linkages to support systems from a cultural lens.

Because what happened was at the hospital..., there was an Aboriginal peer worker. So that was really positive for me. Being able to have a yarn, get away from the setting of a hospital, go to the park and have a real good chat. And having them understand what it's, what it's like. Being Aboriginal having mental health and [yeah], just coping with the like family dynamics that were happening at the time. (M 45 Neg)

Service Experiences

Data from the interviews revealed that the majority of participants went to the AMS for mainstream services, and HIV-focused providers such as The Albion Centre clinic in central Sydney for specialised HIV services. All the interviewees who accessed services at The Albion Centre found the clinic to be culturally appropriate and professional, and were very happy with the level of care afforded to Aboriginal and Torres Strait Islander people.

Interviewees highlighted the reasons why they would differentiate between AMSs and mainstream health providers for HIV and/or sexual health care. Comments included:

[The AMS] needs to be structured, positive outcomes under Closing the Gap. (M 46 Pos)

The AMS are not HIV doctors. (M 45 Pos)

I don't go there; I don't think they are good at their job. (M 50 Pos)

So currently, I've had a doctor since always, when we first moved. Now. There is an AMS here. And I don't use that service. (M 45 Neg)

So, for example, when I was going to be part of the Aboriginal medical service, I didn't go back there because some of the people in the in the workforce there, they were not as confidential as they should have been. So that kind of made me feel like, well, that's not a service that I will use and haven't used since. And, and that could, could have changed like a lot of the staff could be gone, they might be a lot more professional now. I've just decided that it's not a service for me based on an experience that I had there. And it's sad because being an Aboriginal person that is very proud, using the AMS and being a part of somebody who was very proactive in wanting our, [our], our town to have an AMS because there were other places that had AMS and what just didn't. And then you rally around the people who in the community who are really fighting for it, and then you have the service. And you feel like confidentiality is the biggest thing that you need when it comes to your health. And some of the staff weren't exactly confidential in the way they used to talk in the community. (M 45 Neg)

One interviewee noted the diversity and differences within populations of Aboriginal and Torres Strait Islander peoples attending AMSs, and commented:

Will they need more training? Like, because, you know, culture is very, it's not the same. Like, my culture is different from the culture down here. Like there needs to be more united timing and watch, you know, training workshop around cultural around culture and that they need to realize that Sydney has a lot of Aboriginal people from around Australia and all our culture is not the same. Yeah. (F 38 Neg)

Aboriginal workers in mainstream health organisations on the other hand, were seen as culturally appropriate and supportive. Having an Aboriginal worker was considered an asset to the organisation.

[Um], health wise I have Aboriginal workers but not as a psychologist there, there's not an Aboriginal psychologist. So, [um], but the person I got was very understanding of, of the circumstances of what I was going through. (M 45 neg)

I guess yeah, they have drug alcohol services at work. Yeah. They have an Aboriginal mental health facility. Well, they're in our [hospital named] so yeah, yeah. Ready, just ready for me to go to if I need assistance and whatnot. (M 32 Pos)

In addition to specific culturally appropriate services, there was also a perceived need for specific transgender services which was highlighted by the following interviewee's struggle to access hormone therapy.

And I was refused hormones a lot of times, because of that, like the lack of understanding of transgender issues, lack of trust between me and my service providers. Maybe it's embedded in racism, or maybe it's embedded in, like my mental health as well, because a lot of people know I have health issues. (M 26 Neg)

Housing

Interviewees spoke of housing insecurity and how that impacted on their mental health.

Interviewees also discussed the intersection between accommodation affordability and living expenses:

My current accommodation. I've been in since I moved to Sydney since September 2020. Affordable, it's not affordable. I would say it's more of a choice. You make it work. It's definitely not affordable. But I mean, I make I make it work. I don't struggle, but it's yeah, it's definitely quite expensive. It's at least stable. I will definitely feel safe. (M 33 Neg)

Another interviewee described his need for safety considerations and the action he took daily to protect himself:

My current accommodation is housing suddenly been down near the towers. It's affordable, it's stable, it is safe. I've been there for five years. But prior to that, I'd move like every six months, or I was living overseas for a long time and just travelling around and doing my thing. But it is ultimately safe. But recently, we've had a few Karen's move in in the street, because it's half housing, half not housing. So, you know, I have to be very, I have to make sure that my back's covered, because some of them have made complaints about me just because I live in housing. So, I don't know, like, yes, it's safe. But no, it's not really because now I have to video myself leaving my house to make sure that nobody...like I have everything on film. Like, it's not okay. (M 36 Pos)

Employment

Interviewees spoke about employment specifically in terms of being Aboriginal, and experiencing racism within the workplace.

A number of interviewees touched on the perception that they did not look 'Aboriginal' enough, and were stigmatised within the Aboriginal community in this respect. One interviewee commented on the issues they experienced when trying to apply for Aboriginal-identified positions, and being asked to provide proof of Aboriginality.

They've helped me get into or help me with applications for Aboriginal based jobs, positions and everything, which still I haven't been successful yet, but they've been able to give me tips on that with the interviews. And it's just been hard to because they need proof of Aboriginality... I'm still having trouble finding where my identity and where I belong. (M 32 Pos)

One interviewee who identified as a transgender woman, indicated that many trans and gender diverse Aboriginal people chose to work in the sex industry because they did not feel stigmatised by that particular sector.

I'm actually speaking for all trans but it resonates more with you know, being black and trans and visible. [Yeah]. Because a lot of us we do fall underneath that umbrella of sex working and stuff like that because that's one of the one of the only industries that doesn't discriminate against us. (F 38 Neg)

For those interviewees living with HIV, there appeared to be a conscious decision made not to reveal their HIV status in the workplace, and many agreed that they were not required to do so.

I don't talk about that [HIV status in the workplace]. That's not their business. But when I got sick a couple years ago, they wouldn't let me go back to work till I could get a workplace fitness assessment. Or something, done it was something dodgy. I ended up quitting my job. I want to get back to work now. I'm not working at the moment. (M 50 Pos)

General Health Support

One of the themes that came through from a number of the interviewees was that as Aboriginal people, it was assumed they would automatically take on a leadership mantle around health and wellbeing for their community. Given the small number of Aboriginal PLHIV generally, the perception was that there was an unrealistic expectation on Aboriginal and Torres Strait Islander people's capacity to do so, and that many struggle with a work/life balance.

This is the interesting thing, how do you define community, I have deliberately been taking less of a leadership role in the community over the years, because, [um], if so many people, so many of Aboriginal people who are HIV positive, or just positive or gay or whatever, have come to me over the years for their issues, and so on through work. And then there are times where I was doing more work outside of work than at work, and things. (M 45 Pos)

Police Interaction

Several interviewees spoke about their interactions with the NSW Police Force in central Sydney. One person outlined the trauma he faced from police in the cells at a central Sydney Police Station when they found his HIV antiretroviral medication.

They tested those drugs and essentially outed me as HIV Positive in front of other prisoners. (M 36 Pos)

Another interviewee recounted.

Yeah, they've fully put me on show, and they suspected me of being a drug dealer. You know, they did the whole search, you know, looking in my tobacco pouch. The whole pack waving my antidepressants around because it wasn't in its box. What's this mate? Yeah, a busy train station. Everyone's just looking. Yeah. It was just a bit. Yeah. A bit Intimidating. And it happened a second time. And I just said, well, this looks just like harassment. (M 32 Pos)

Limitations

The empirical findings of this needs assessment should be considered in the light of some limitations. However, given this needs assessment is the first of its kind to be conducted in NSW and to the best of our knowledge Australia, these limitations could be addressed in future research and through the creation of a culturally sensitive, dedicated and fully funded Aboriginal Health Program. The first limitation is the sample size which was impacted significantly by the COVID pandemic and extended lockdown periods which prevented the ability to conduct interviews and data collection in person across NSW, by travelling to meet Aboriginal people where they are. The second is sample profile, whereby the majority of the interviewees reside in urban or metropolitan areas, and there is little representation from rural or remote areas in NSW, again due to the impact of COVID and a lack of access to technology. The third is the methodological approach in that while the needs assessment was conducted by an Aboriginal woman who is a peer, this may have created obstacles around the differentiation of 'women's business and men's business'. The fourth and final limitation was around time constraints particularly as concerned health issues which impacted on the needs assessment through its reliance on having only one Aboriginal peer health worker able to conduct interviews.



The primary outcome of the project was the advancement of knowledge about the HIV-related needs of NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV.

Identified Gaps

Although the sample size was small, similar themes emerged around health services, support workers, and housing.

As there were only two participants outside of the Great Sydney area, there are also 'hidden' statistics that relate to Aboriginal and Torres Strait people living with or at risk from HIV in regional and rural NSW, whose experiences have not been captured.

The need to have dedicated Aboriginal health workers or support workers was a significant theme amongst the community. Dedicated Aboriginal Health Services were seen as good for non-stigmatised health conditions. HIV on the other hand as well as sexual health was seen as specialised, and Aboriginal and Torres Strait Islander people living with HIV preferred to access specialist services, which are co-located in mainstream health services.

It was noted/commented on that there are diverse groups of Aboriginal people residing in Sydney, including those of different ages and experiences. This is an important observation and highlights that services cannot claim to be culturally appropriate if they are only delivering/following one model of service delivery for all.

The specific service gap identified was the need to have specialised Aboriginal support worker/s or health worker/s in mainstream health services who can access appropriate services for clients. Interviewees spoke about the disparate nature of trying to juggle different services, and needing someone who could advocate for them in an appropriate manner. This is particularly important in relation to accessing ART medicine or PrEP. A limited number of participants knew what they were, but the majority did not.

Conclusion

The needs assessment sought to understand if additional co-designed HIV service delivery models are required to facilitate NSW-based Aboriginal and Torres Strait Islander people's access and engagement with HIV testing, prevention, and treatment services in a culturally safe, targeted, and appropriate manner.

The secondary outcome of the project was to directly inform the development and implementation of a co-designed HIV service delivery model for NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV within an Aboriginal Health Program at Positive Life. This model would be generated in collaboration with Aboriginal and Torres Strait Islander people living with or at risk of HIV in NSW, service providers, researchers and 'others' to be identified using a community-based participatory research or 'co-design' approach.

There needs to be a degree of agility in service provision models that are flexible enough to support diverse Aboriginal people with different experiences and ages within the region.

Closing the Gap identified the following priority reforms to accelerate improvements in life outcomes of Aboriginal and Torres Strait Islander people. These are:

1. Developing and strengthening structures to ensure the full involvement of Aboriginal and Torres Strait Islander people in shared decision making at the national, state, and local or regional levels and embedding their ownership, responsibility, and expertise to close the gap.
2. Building the formal Aboriginal and Torres Strait Islander community-controlled service sectors to deliver Closing the Gap services and programs in agreed priority areas.
3. Ensuring all mainstream government agencies and institutions that service Aboriginal and Torres Strait Islander people and communities undertake systemic and structural transformation to contribute to Closing the Gap.

These priority areas and engagements were discussed with Aboriginal and Torres Strait representatives in NSW and subject matter experts. It is clear that the interviewees were not aware of initiatives under Closing the Gap, with one participant said they were able to obtain their PrEP through the Closing the Gap initiatives.

The latest government directive has meant that all health care including pharmaceuticals accessed under Closing the Gap means the recipient must register with Services Australia to do so. For people living with HIV, this is a further stigmatising barrier. The interviewees were unsure where to access all services and raised the need for dedicated Aboriginal health workers who are specifically trained in HIV issues.



There needs to be a degree of agility in service provision models that are flexible enough to support diverse Aboriginal people with different experiences and ages within the region.

Current service provider models for Aboriginal and Torres Strait Islander people living with or at risk from HIV in NSW are disparate. There are multiple organisations in NSW which provide services to Aboriginal and Torres Strait Islander people, which are often specific programs that target specific groups. There are none that cater for all Aboriginal people living with or at risk from HIV or which can negotiate the myriad of bureaucracies in the health, sexual health and housing systems, and other services in a culturally appropriate manner.

Given that 'ensuring the full involvement of Aboriginal and Torres Strait Islander people in shared decision making at the state, local and regional levels which embeds their ownership, responsibility and expertise to close the gap' is a priority reform in Closing the Gap, Positive Life NSW is in a strong position to develop a co-designed program/service model to address engagement with services for Aboriginal and Torres Strait Islander people in a confidential, culturally appropriate manner to achieve higher health and social outcomes for this target population living with or at risk from HIV.

Recommendations

Develop targeted, culturally appropriate, nuanced strategies of health promotion, testing, treatment, and engagement in care.

Facilitate greater access to, education about and uptake of PrEP and other forms of prevention initiatives specifically tailored for Aboriginal and Torres Strait Islander people.

In order to prevent transmission, improve the frequency, regularity and targeting of testing, decrease the rates of late diagnoses, as well as improve the early uptake of sustained treatment and engagement in health care and improve the quality of life for PLHIV and the priority population of Aboriginal people in NSW, we need to meet Aboriginal people where they are at, by asking the right questions of affected populations in an appropriate way, listening to the answers, and creating culturally appropriate solutions and programs based on what we learn.

Positive Life should consider applying for further funding to develop and implement a co-designed culturally sensitive program/service model to address engagement with services for Aboriginal and Torres Strait Islander people in a confidential, culturally appropriate manner. The aim would be to achieve higher health and social determinants of health outcomes for Aboriginal and Torres Strait Islander people in NSW living with or at risk from HIV.

Development and co-design of the program undertaken in partnership with a culturally appropriate Aboriginal consultancy.

Dedicated male and female Aboriginal Health Worker or Support Worker to provide peer navigation for Aboriginal people living with or at risk from HIV in NSW.

Facilitate dialogue with the NSW Police to improve the interactions between the Police and the HIV Indigenous community.



We need to meet Aboriginal people where they are at, by asking the right questions of affected populations in an appropriate way.

Appendix I

Building a co-designed HIV service delivery model for NSW-based Aboriginal and Torres Strait Islander peoples

Participant Information Sheet

1. About the project

You are invited to take part in a project about the needs of NSW-based Aboriginal and Torres Strait Islander people for accessing and engaging with HIV prevention, testing, and treatment services. This Information Sheet tells you about the project and what your participation in a face-to-face interview would involve.

2. What does participation involve?

You are invited to participate in short (15-20 minute) interview face-to-face, to share your views and experiences of accessing and engaging with NSW-based HIV prevention, testing, and treatment services, including identifying areas of improvement (if any). The interview will be audio-recorded and transcribed. Transcripts will be de-identified and kept confidential. If you do not wish to be recorded, the interviewer will take written notes instead.

3. Do I have to take part?

Your participation is voluntary. You can choose not to participate or to stop at any time without giving any reason and without any consequences. Your decision to participate or not will not affect your access to Positive Life NSW services. If you decide to take part and then change your mind later, you are free to withdraw at any time.

4. What are the possible benefits of taking part?

You will receive a \$30 Woolworths gift voucher. Your input will be invaluable for identifying the unique HIV prevention, testing, and treatment needs of NSW-based Aboriginal and Torres Strait Islander people, and also directly inform a co-designed HIV service delivery model which is culturally-safe and appropriate for NSW-based Aboriginal and Torres Strait Islander people.

5. What risks are involved if I participate?

Apart from your time, we do not anticipate any risks associated with your participation in this study. If participation makes you feel upset or uncomfortable, please contact Aboriginal Health Program Officer, Ms Michelle Tobin at michellet@positivelife.org.au or by phone on (02) 9206-2177/ 1800 245 677 (freecall outside metro areas) and ask to speak to Michelle.

6. How will the information collected be used?

Findings from the interviews will be used to inform the development, implementation, and evaluation of a co-designed HIV service delivery model, and contribute to the limited evidence of the needs of Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV.

7. Who has reviewed this project?

The ethical aspects of this project have been approved by the Aboriginal Health and Medical Research Council (approval number 1704/20)

8. What if I have any questions or need more information?

If you have any questions about the project or your participation, please contact Aboriginal Health Program Officers, Ms Michelle Tobin at michellet@positivelife.org.au

9. What if I have a complaint or concerns about this project?

If you have a complaint or concern, please contact Positive Life NSW Chief Executive Officer, Ms Jane Costello at janec@positivelife.org.au or by phone on (02) 9206-2177/ 1800 245 677 (freecall outside metro areas).

Appendix II

Participant Interview Consent Form

Project: Building a co-designed HIV service delivery model for NSW-based Aboriginal and Torres Strait Islander people

Principal Researchers: Ms Michelle Tobin and Mr Neil Fraser

Research Organisation: Positive Life NSW

I, _____
have consented to participate in the above research project on the following basis:

1. I have received the Participant Information Statement and have had the opportunity to ask questions. I understand the purpose of the research and my involvement in it.
2. I have the right to withdraw my consent and cease any further involvement in the research project at any time without giving reasons and without any penalty. This will not affect any services that I receive by contacting Positive Life NSW's Aboriginal Health Program Officer: Ms Michelle Tobin at michellet@positivelife.org.au or by phone on (02) 9206-2177/ 1800 245 677 (freecall outside metro areas) and ask to speak to Michelle.
3. Any information I provide during the course of this research will remain confidential. Where the results of the research are published, my involvement and my personal results will not be identified
4. I understand that interviews may be audio-taped or videotaped, but the tapes will be secured and then destroyed at the completion of the project.
5. I understand that if I have any complaints or grievances regarding this project, I will contact Positive Life NSW CEO Ms Jane Costello and/or the Chairperson of the AH&MRC Ethics Committee as follows:

Jane Costello
Positive Life NSW
P.O. Box 831
Darlinghurst Hills NSW 2010
Telephone: 02 9206 2177

The Chairperson
AH&MRC Ethics Committee
P.O. Box 1565
Strawberry Hills NSW 2012
Telephone: 02 9212 4777

6. I agree for the interview to be (tick one box only):

☐ Audio-recorded ☐ Not audio-recorded

Name: _____

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

Researchers Signature: _____ Date: _____

Appendix III

Interview Guide

The questions will cover Health, Social and Emotional wellbeing.

Demographics:

- Age
- Gender
- HIV status
- Location

Health outcomes:

- Can you talk a little of how your overall health has been?
- How would you rate your quality of health right now, is it very good, good or poor? And why?
- Which AMS or Mainstream service do you currently attend? If you have accessed any pathways within this service, what were they and were they helpful? Do they meet your needs and are they culturally appropriate?
- Are there other services that you access such as Drug & Alcohol and or NSP? Are they easy to access? If not, why?
- What are your positive and negative thoughts around access to primary health care? Tell us about your experiences.
- What health services do you think would improve your quality of health?
- What is your understanding of PrEP and Antiretroviral Treatment? Are you adherent with your medications, if not what has prevented you from taking your medication?
- What has been your experience on ARV treatments, has there been any impacts on other health conditions that you may have?
- How accessible is it for you to see a S100 Prescriber, to access treatment such as ARV's or PrEP?

Social & Emotional outcomes:

- Can you tell us a bit about your family and where you're from, how are they supportive?
- Are you connected to your Community, tell us how your connected and how does this impact on your health?
- Tell us about your current accommodation, is it affordable, is it stable and do you feel safe, how often have you needed to move?
- Have you ever been to prison or arrested, what problems did you face, were you able to access your medication? Tell us about the issues you faced.
- Tell me what services you engage with for social connection. Are they a HIV related service? Or an LGBTIQ organisation.
- Would you like information about the programs that Positive Life offer.

Appendix IV

Research Protocol

Protocol title: A needs assessment and co-designed HIV service delivery model for New South Wales-based Aboriginal and Torres Strait Islander people

Short title: Needs assessment and co-designed HIV service delivery model for NSW Aboriginal and Torres Strait Islander people

Protocol date: 05/08/2020

Version: 1

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Protocol Synopsis

Title	A needs assessment and co-designed HIV service delivery model for NSW-based Aboriginal and Torres Strait Islander people
Project initiation date	May 2020
Background and rationale	New HIV notifications amongst Aboriginal and Torres Strait Islander people in NSW accounted for 4% of the total 277 new HIV notifications in 2018 in NSW. This population experiences lower HIV testing rates; lower pre-exposure prophylaxis (PrEP) uptake and adherence rates; higher HIV diagnosis rates; higher rates of late HIV diagnoses; and higher rates of HIV diagnosis among women, compared to their non-Indigenous counterparts. It is proposed that additional co-designed HIV service delivery models are required to facilitate access and engagement with HIV testing, prevention, and treatment services in a culturally safe, targeted, and appropriate manner.
Study aims	To better understand the needs of NSW-based Aboriginal people including those living with HIV and those at risk of acquiring HIV; and to increase the proportion of NSW-based Aboriginal and Torres Strait Islander people accessing and engaging in HIV prevention, testing, and treatment services between September 2020 and February 2021.
Participant population	Eligible NSW-based Aboriginal and Torres Strait Islander persons people living with or at risk of acquiring HIV may participate in interviews and development of the co-designed HIV service delivery model.
Study design	The proposed Positive Life NSW project will conduct a needs assessment of the NSW-based Aboriginal and Torres Strait Islander communities via a literature review and a series of semi-structured, in-depth qualitative interviews and focus groups. This needs assessment will directly inform the development, implementation, and evaluation of a co-designed HIV service delivery model. This model will be generated in collaboration with Aboriginal and Torres Strait Islander people living with or at risk of HIV, service providers, and researchers using a community-based participatory research approach. An Advisory Committee will provide guidance and advice throughout all project stages.
Chief Investigator/s	Ms Michelle Tobin, Positive Life NSW Mr Leslie Peters, Positive Life NSW
Associate Investigator/s	Mr Neil Fraser, Positive Life NSW Ms Jane Costello, Positive Life NSW
Advisory Committee Members	Mr John Leah (BlaQ) Ms Rusty Nannup (SWOP) Ms Jade Christian (NUAA) Mr Stephen Morgan (PAT SIN) Mr Tim Moffitt (PAT SIN) Ms Jane Strang (ACON) Ms Annette Slater (Hunter New England Local Health District, NSW Health) Dr Michael Doyle (University of Sydney)

Research team

Administering Institution

Positive Life NSW

Participating Institutions

Positive Life NSW; University of Sydney; ACON; BlaQ Aboriginal Corporation (BlaQ); Sex Workers Outreach Project (SWOP); National Users and AIDS Association (NUAA); Positive Aboriginal Torres Strait Islander Network (PATSIIN); NSW Health

Principal Investigator (PI)

Ms Michelle Tobin – Aboriginal Health Program Officer, Positive Life NSW

Mr Leslie Peters – Aboriginal Health Program Officer, Positive Life NSW

Chief Investigators (CI)

Mr Neil Fraser – Deputy Chief Executive Officer, Positive Life NSW

Ms Jane Costello – Chief Executive Officer, Positive Life NSW

1.0 Background

Human immunodeficiency virus (HIV) is a critical public health challenge for Aboriginal and Torres Strait Islander people across Australia, including New South Wales (NSW). In 2018, HIV notifications amongst Aboriginal and Torres Strait Islander people accounted for 4% (N = 11) of the total 277 new HIV notifications recorded in NSW (Kirby Institute, 2018). HIV notification rates within this population have increased by 41% between 2013 and 2016, and in 2017, remained 1.6 times as high in this population compared with the Australian-born non-Indigenous population (The Kirby Institute, 2018). Uptake and adherence to HIV pre-exposure prophylaxis (PrEP) is lower, and monitoring of CD4 count and HIV viral load are less frequent among Aboriginal and Torres Strait Islander people than their non-Indigenous counterparts (Templeton et al., 2015; The Kirby Institute, 2018; Ward, Hawke & Guy, 2018). Aboriginal and Torres Strait Islander people are more likely to be diagnosed at an advanced stage of HIV infection compared with their non-Indigenous counterparts (Ward et al., 2018). This suggests a lower proportion of Aboriginal and Torres Strait Islander people achieving viral suppression (Ward et al., 2018). Henceforth, despite the relatively small numbers, HIV disproportionately burdens Aboriginal and Torres Strait Islander people across Australia, including NSW.

HIV epidemiology differs significantly between Aboriginal and Torres Strait Islander people and non-Indigenous people. Compared with the non-Indigenous population, a lower proportion of HIV diagnoses have occurred among Aboriginal and Torres Strait Islander men who have sex with men (MSM). Inversely, a higher proportion of diagnoses are attributable to injecting drug use and heterosexual sexual contact acquisition (Ward, Hawke & Guy, 2018; Ward et al., 2018). The rate of HIV diagnosis among Aboriginal and Torres Strait Islander women is also three times higher than the rate for non-Indigenous women (Ward, Hawke & Guy, 2018). In general, Aboriginal and Torres Strait Islander sex workers including those who are gender and sexuality diverse (Sistergirls/Sistagirls, Brotherboys, and other two-spirit) are also more vulnerable to HIV acquisition (ACON, 2019; Commonwealth of Australia, 2018). This indicates that additional public health efforts are required to develop, implement, and evaluate culturally-safe and appropriate HIV prevention, testing, and treatment services for vulnerable populations within Aboriginal and Torres Strait Islander communities.

A complex interplay of social determinants of health contribute significantly to sub-optimal HIV prevention, testing, and treatment outcomes amongst Aboriginal and Torres Strait Islander people. These social determinants include lack of appropriate housing, poverty, homelessness, mental health diagnoses, incarceration, colonialism, and racism (Commonwealth of Australia, 2016; Larson, Gillies, Howard, & Coffin, 2007; Negin et al., 2015). A culturally aware, culturally appropriate, and skilled workforce with flexible approaches to care, *inter alia*, are requisite characteristics of effective Aboriginal and Torres Strait Islander primary care services (Harfield et al., 2018). The importance of culture underpins current state and national Australian HIV prevention policies for Aboriginal and Torres Strait Islander people (Australian Health Ministers' Advisory Council, 2016; Centre for Population Health, 2016). Effective HIV prevention, testing, and treatment for Aboriginal and Torres Strait Islander people requires culturally safe and appropriate programs combined with service delivery models which address the unique needs of these communities.

The history of colonisation has produced an Australian healthcare system embedded with racism and discrimination, contributing to an avoidance of HIV prevention, testing, and treatment services by Aboriginal and Torres Strait Islander people (Negin et al., 2016). Effective HIV prevention, testing, and treatment services for Aboriginal and Torres Strait Islander people require culturally safe and appropriate programs combined with service delivery models which address the unique needs of these communities. To be effective, they must recognise and include the diversity of Aboriginal and Torres Strait Islander people's identity, agency, individual and collective consent, and cultural knowledge from a co-design process, which would ensure that health services, including HIV prevention, testing, and treatment services, work *with* and *by* Aboriginal and Torres Strait Islander people, rather than *about* and *at* Aboriginal and Torres Strait Islander people (Dreise & Mazurski, 2018). A co-design process would address the unique needs of Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV with an aim. Accordingly, ongoing community consultation and collaboration would be required for public health practitioners to work with Aboriginal and Torres Strait Islander people and generate knowledge about and solutions to problems the community experiences (Mooney-Somers & Maher, 2009). Moreover, through strong community participation and consistent consultation, co-design recalibrates new and existing health services, including HIV prevention, testing, and treatment services, to be reoriented by and for Aboriginal and Torres Strait Islander people (Cochran et al., 2008; Dreise & Mazurski, 2018).

The proposed project is a needs assessment conducted by Positive Life NSW (Positive Life) which aims to co-design a culturally sensitive program/service model which will achieve higher health and social determinants of health outcomes for Aboriginal and Torres Strait Islander people in NSW, including those living with HIV and those at risk of acquiring HIV. Approximately fifteen, semi-structured, in-depth interviews will be conducted with NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV, and selected via 'snowball' or 'chain' recruitment sampling method. Free, prior, informed, written participant consent will be obtained prior to the interview process, to ensure interviews are conducted in an ethical manner as per Aboriginal Health and Medical Research Council (AH&MRC) guidelines (AH&MRC, 2018). Interviewees will be asked a series of open-ended questions about their views and experiences of HIV risk, and experiences with: HIV risk behaviours; HIV prevention biomedical technologies, namely PrEP; HIV anti-retroviral treatments; and access to HIV and sexual health services (see appendices). An Advisory Committee comprising ten members will be established to provide guidance and support throughout the project, including nine Aboriginal and/or Torres Strait Islander people, at least four of whom will be living with HIV.

Findings will inform the development of a co-designed HIV service delivery model aiming to improve HIV outcomes amongst NSW-based Aboriginal and Torres Strait Islander people. This co-designed HIV service delivery model will comprise three steps: design, implementation, and evaluation.

2.0 Aims

Aims

The aim of this needs assessment is to develop and co-design a culturally sensitive program/service model which achieves higher health and social determinants of health outcomes for Aboriginal and Torres Strait Islander people in NSW, including those living with HIV and those at risk of acquiring HIV.

Objectives

- To convene an Advisory Committee representative of the NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV to provide advice on project development and disseminate key findings
- To apply for ethics to conduct interviews with Aboriginal and Torres Strait Islander people for the purposes of development of the program
- To identify and analyse barriers and enablers for HIV prevention, testing, and treatment for NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV through culturally safe conversations
- To develop, implement and evaluate a co-designed HIV service delivery model for NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV
- To produce a final report that informs the development of a co-designed program/service model to address engagement with services in a culturally sensitive way and achieve higher health and social outcomes for Aboriginal and Torres Strait Islander PLHIV and those at risk of HIV in NSW.

3.0 Methodology

3.1 Community-based participatory research, co-design, and integrated knowledge translation

This project draws on “community-based participatory research” (CBPR), or “co-design”, principles. CBPR refers to research, including health service delivery models, which draws on the knowledge, experience, and wisdom of Aboriginal and Torres Strait Islander people through their direct and active engagement in the research process (Mooney-Somers & Maher, 2009). CBPR moves toward research relationships with and by Aboriginal people (Aboriginal Affairs NSW, 2019). Genuine partnership which shares power across all stakeholders within the project, including decision-making, prioritisation, resources, and knowledge is key to successful CBPR. Mutual accountability established through formal and informal, continuous communication ensures that CBPR proceeds with consensus and collaboration. Importantly, CBPR will enable the establishment and maintenance of Aboriginal community control over all stages of the project as required by the AH&MRC (AH&MRC, 2020). Effective, culturally-safe, and appropriate approaches to HIV service delivery should have flexibility to reflect the local content and diversity of Aboriginal and Torres Strait Islander communities (Australian Health Ministers’ Advisory Council, 2016).

3.2 Framework

Project Staff

The project will be led by a Positive Life staff research team comprising two principal investigators (PI) and two associate investigators (AI). Positive Life is the administering institution responsible for this project.

PI Michelle Tobin will lead study design; contribute to proposal development and ethics application; lead recruitment and data collection; and contribute to data analysis and write-up.

PI Leslie Peters will lead study design; lead proposal development and ethics application; support recruitment and data collection; and lead data analysis and write-up.

AI Neil Fraser will contribute to and oversee proposal development and ethics application; support recruitment activities; contribute to analysis and write-up; and provide oversight over all other project activities

AI Jane Costello will contribute to and oversee the proposal development and ethics application; support recruitment activities; contribute to and oversee the analysis and write-up; and provide oversight over all project activities.

Advisory Committee

An Advisory Committee comprising nine members (all of whom are Aboriginal and/or Torres Strait Islander people, at least four of whom will be living with HIV) will be established in line with the diversity of Aboriginal and Torres Strait Islander members of the community. This Advisory Committee will provide guidance and advice during each stage of the project and further ensure the centrality of NSW-based Aboriginal and Torres Strait Islander voices within this project.

A minimum of four meetings of the Advisory Committee will be held over the duration of the project to incorporate the views and advice of NSW-based Aboriginal and Torres Strait Islander people on the direction and progress of the study. Committee members will be invited to participate based on their expertise and interest in the project. The role of the committee will be to advise the project team on project design, fieldwork, thematic analysis, and research dissemination and translation.

3.3 Study design

The methodology will interact iteratively with the project aims and objectives. The needs analysis comprises two components – a literature review and qualitative interviews.

Interviews will be semi-structured and in-depth, and free, prior, informed, written participant consent will be secured from all interview participants. Interviews will take a conversational approach rather than interrogative. They will be conducted by principal investigator Michelle Tobin, assisted by Leslie Peters. Requests for further information associated with the project will be handled by both principal investigators.

The literature review will iteratively employ a systematic literature search strategy across the SCOPUS, Medline, and ClinicalKey database reference platforms. Grey literature and citation chaining will be reviewed to identify and analyse any articles missing from the preliminary database searches. The literature review will be conducted by principal investigator Leslie Peters, assisted by Michelle Tobin.

The co-designed HIV service delivery model will comprise three key steps: development, implementation, and evaluation. Currently, there is no standard practice for designing, implementing, and evaluating co-designed Aboriginal and Torres Strait Islander health service delivery models. Notwithstanding, the project will follow the “Australian National Framework for Developing Health Services for Aboriginal and Torres Strait Islander Children and Families” (Commonwealth of Australia, 2016). The resultant co-designed service delivery model will: utilise a multi-disciplinary, collaborative, team-based approach; build a skilled and culturally competent workforce; provide continuity of care; conduct comprehensive and holistic assessment; offer flexible service delivery; and utilise an integrated, place-based approach (Commonwealth of Australia, 2016). The specific trajectory of the model will formatively evolve following completion of the needs assessment interviews, in collaboration with the Advisory Committee. Once developed and implemented, the co-designed HIV service delivery model will aim to achieve higher levels of engagement existing local health and other social services; higher frequency and greater uptake of HIV testing; improved quality of life; and increased early uptake and adherence to anti-retroviral (ARV) medication for NSW-based Aboriginal and Torres Strait Islander people.

The Advisory Committee will ensure Aboriginal oversight and meaningful engagement will be present at all stages of the project and that there is appropriate Aboriginal governance at all stages of the project, in accordance with AH&MRC guidelines (AH&MRC, 2020). Within the first Advisory Committee meeting, members will finalise a Terms of Reference (TOR) document stipulating clear expectations of code of conduct, privacy and confidentiality. The Advisory Committee TOR is outlined in the appendices.

3.4 Ethical considerations

Ethics approval will be sought from the AH&MRC. An Advisory Committee will be established in line with AH&MRC guidelines, which requires at least four Aboriginal people living with HIV. All aspects of the project will be continuously communicated and co-designed in collaboration with the Advisory Committee.

All Positive Life staff and contractors abide by the Positive Life confidentiality, privacy policy and code of conduct in accordance with the NSW Privacy Act (1994). In the event of a breach of privacy and confidentiality, this will be managed in accordance with current Positive Life policies and procedures. All interviewees will sign a consent form and Positive Life privacy policy form, confirming that they have read and understood Positive Life's privacy and confidentiality policy. Signed consent forms and private policy forms are stored in electronic form on Positive Life's OneDrive; hard-copy consent forms will be shredded immediately. Access is password-protected and restricted to Positive Life staff directly involved in the project.

In the event that interviewees experience anxiety or distress associated with events or experiences recalled within interview, they will be offered the contact details (phone and email) of Positive Life's two Aboriginal Health Program Officers: Michelle Tobin and Leslie Peters. The gender pronouns of each Program Officer (Ms/Mr) will be clearly displayed for interviewees to choose when seeking follow-up care in a gender-specific manner, where appropriate. Interviewees who seek emotional debriefing, will be offered a list of culturally-safe and appropriate mental health support options (helplines or counselling). Where an interviewee is identified as being distressed, a minimum of two follow-up phone calls will be made to each interviewee one- and two-weeks post-interview, with additional follow-up phone calls made appropriately. In the event that an interviewee is distressed and prefers not to engage with the Positive Life Aboriginal Health Program Officers, or engage in a complaints resolution process with them, they will be informed they can contact the Positive Life Administration Officer to arrange a meeting with Positive Life CEO, Jane Costello directly to discuss their concern. This procedure aims to ensure all interviewees are supported, and any concerns experienced from the interviews are managed appropriately and effectively. Positive Life Aboriginal Health Program Officers will also refer interviewees experiencing emotional distress to Redfern Aboriginal Medical Service for professional mental health support services.

There should be no costs to Aboriginal and Torres Strait Islander people incurred as part of this research study. It is standard practice in research in this field to offer participants a small reimbursement for their time and effort in participating. As per current practice, rather than providing cash payments, all interview participants will be offered Woolworths gift cards to the value of \$30 per participant. Participants who do not wish to receive this will be able to elect to donate it to a charity of their choice. Interviews will take place in a location convenient for participants. No transport cost is anticipated but where there is a cost, Positive Life will provide full reimbursement for transport. A small catering budget of approximately \$20 per head, will cover the cost of refreshments for all Advisory Committee members for all scheduled meetings. Advisory Committee members will be given one \$20 Woolworths gift card each, per meeting.

Breaches of privacy and confidentiality by Positive Life staff, or inadvertently through consultation interviews, may potentially occur. Any breach of privacy or confidentiality will be managed by Positive Life policies and procedures. All interviewees will sign a participant information sheet and consent form, confirming that they have read and understood Positive Life's privacy and confidentiality policy. Additionally, all Positive Life staff have signed the Positive Life Privacy Policy and will act in accordance with the NSW Privacy Act (1994), to safeguard the privacy of personal information, including health-related information, that we hold, collect, and store in relation to individuals who participate in interviews. Furthermore, once hardcopy signed consent forms are stored in electronic form, printed copies will be shredded. Electronic access is password protected and restricted to Positive Life staff who are directly involved in the project.

3.5 Study population

Inclusion criteria for the qualitative interviews include residing in NSW, identifying as an Aboriginal and/or Torres Strait Islander person, aged 18 years or older, and being able to provide free, prior, informed, written participant consent.

Exclusion criteria include living outside the state of NSW, not identifying as an Aboriginal and/or Torres Strait Islander person, being 17 years or younger, and/or unable to provide free, prior, informed, written participant consent. Participants will be able to enrol in an interview within six weeks of the commencement of the interviewing stage.

3.6 Recruitment strategy

Several recruitment strategies will be utilised:

- 'Snowball' or 'chain' recruitment method whereby prospective interviewees are identified using Michelle Tobin's professional networks in the HIV sector and invited by phone and/or email to participate. Respondents would also be invited to offer names of other prospective interviewees.
- Contact will be made with all NSW-based Aboriginal Medical Services and s100 prescribers to refer potential eligible interviewees.
- Arms-length approach whereby interviewees will be invited to contact the principal investigators if they wish to be interviewed, to avoid any sense that participants feel obliged or coerced to take part, in order to ensure a culturally-appropriate and safe environment for participants. .
- Recruitment posters, postcards and/or business cards will be printed for partner organisations to make available to their client groups at their discretion.
- Promotion materials will be publicised via the Positive Life website and social media platforms, notices in the Positive Life online newsletter (Life.mail), and the online and print media platforms of partner organisations and networks.

3.7 Data collection

Project co-lead, Michelle Tobin will lead the qualitative interviews, assisted by fellow project co-lead, Leslie Peters. Before an interview, free, prior, informed, written participant consent will be obtained. Interviews will be recorded using audio-only with free, prior, informed, written participant consent then transcribed. These will be stored on the Positive Life data filing system under password accessible to staff directly involved in this project. Any physical audio-recordings will be destroyed (deleted) upon upload to the Positive Life OneDrive. Field notes will supplement interviews where participants decline recording. These field notes will also be uploaded to the Positive Life OneDrive and destroyed (shredded) immediately afterward.

3.8 Data analysis

Eligible quantitative, qualitative, clinical, and health economic articles relating to the research questions will be identified post-execution of the planned literature search strategy. Research findings will be synthesised and discussed from an emic perspective.

In accordance with the step-by-step processes outlined by Braun and Clarke (2006), transcripts and field interview notes will be read and re-read to identify recurrent patterns, or themes, related to the project questions. Initial codes will be generated followed by a search for preliminary themes. These themes will be reviewed then defined and named. Findings will be written up in a needs-based assessment report.

Consistent and iterative reflexivity throughout all stages of the qualitative data analysis stage is critical. Reflexivity is quality control in qualitative health research. Throughout the qualitative data collection and analysis, project staff will continuously communicate and proactively seek advice and support from the established Advisory Committee to ensure that there is Aboriginal and Torres Strait Islander oversight and meaningful engagement.

3.9 Expected outcomes of the project

A primary outcome of the project will be the advancement of knowledge about the needs of Aboriginal and Torres Strait Islander people for accessing and engaging with the HIV care continuum, that is, HIV prevention, testing, and treatment services. This knowledge will have a direct influence on the development of policy and practice applications that will benefit these Aboriginal and Torres Strait Islander people living or at risk of acquiring HIV. Furthermore, the development of a co-designed HIV service delivery model will identify culturally sensitive and appropriate components in delivering Positive Life's HIV prevention, testing, and treatment services to NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV. Unique insights are also anticipated in broader areas of debate in health sociology, social policy, and public health.

3.10 Dissemination plan

All findings and report(s) will be published in accordance with Positive Life's privacy and confidentiality policy, and in accordance with Positive Life's communications and marketing strategies and networks. All interviewee information will be de-identified to maintain their confidentiality and privacy.

The dissemination plan is as follows:

- Community report titled "Building a co-designed HIV service delivery model for NSW-based Aboriginal and Torres Strait Islander people: a needs assessment" made available online via Positive Life's website and in print
- Electronic community shoutouts (emails to Positive Life members and subscribers)
- Blog post(s)
- Media releases
- Social media promotion (Facebook, Twitter, Instagram, LinkedIn, Tumblr)
- Conference(s) abstract and presentation
- Hard copy distribution at community events, AGM, etc.
- Digital and hardcopy distribution to key stakeholders and partner organisations.

3.11 Duration of project

The proposed project will be undertaken over approximately nine months ending in early February 2021. See below project timeline for further detail.

3.12 Timeline

Dates	Activity
04/06/2020 – 18/08/2020	Ethics application
11/08/2020 – 30/10/2020	Interviews – data collection
01/10/2020 – 30/11/2020	Interviews – data analysis
01/11/2020 – 20/02/2020	Interviews – data-write up
23/07/2020; 23/09/2020; 23/11/2020; 23/01/2021	Advisory Committee meetings*
01/10/2020 – 30/11/2020	Co-designed service delivery model – design
01/11/2020 – 30/12/2020	Co-designed service delivery model – implementation
01/12/2020 – 30/01/2021	Co-designed service delivery model – evaluation

* Additional Advisory Committee meetings will likely occur pending project evolution

3.13 Data management

Data management, including data storage, record retention, and confidentiality of data, will be managed according to Positive Life policies and procedures.

Data storage

All documents are scanned and stored in Positive Life's data system, with hard copy versions shredded immediately. Soft copies of research materials and audio-recordings of the semi-structured interviews will be stored on a password-protected folder on Positive Life data system, accessible to the staff directly involved in this program, such as the research investigators, Deputy CEO and CEO.

Record retention

As per Positive Life's policy and procedures, all materials will be kept for seven (7) years following completion of the interviews and then destroyed. Positive Life will use de-identified data for the purposes of policy, advocacy and funding applications.

Confidentiality of data

Participants' confidentiality will be respected throughout the entire study. Only authorised Positive Life staff directly involved in the project will have access to study materials over the course of the study and throughout the data retention period.

4.0 References

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5.0 Appendices

5.1 Advisory Committee Terms of Reference

5.2 Positive Life NSW Privacy & Confidentiality Form

5.3 Participant Information Sheet

5.4 Participant Consent Form

5.4 Interview guide

5.5 Participant Consent Forms

5.6 Positive Life NSW Data Management Policy

5.7 AH&MRC Five Criteria

5.8 Advisory Committee Membership List and Contact Details

Appendix V

AH&MRC Five Criteria Addressal

1. Net benefits for Aboriginal: the research will advance scientific knowledge and result in a demonstrated net benefit for the health of Aboriginal people and communities.

The primary outcome of the proposed project will be the advancement of knowledge about the HIV-related needs of NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV. This knowledge will have direct policy and practice applications, benefiting those Aboriginal and Torres Strait Islander peoples living with HIV but also their families in managing the challenges of diagnosis, treatment and care as well as the social isolation and stigma associated with blood-borne infectious disease. Participants will also benefit indirectly from this research, as their participation in the study will generate new and significant knowledge about the needs and challenges of individuals living with or at risk of acquiring HIV, which can inform or strengthen existing service design and delivery for this population. Additionally, deciding to participate in research having one's story validated as significant can be a positive and liberating experience for some people who live with a stigmatised condition such as HIV, which is often surrounded by secrecy and silence. There is currently a paucity of research on the needs of NSW-based Aboriginal and Torres Strait Islander people living with or at risk of acquiring HIV. Hence, findings will provide benefits for NSW communities by informing recommendations for increasing recognition of the needs of this group in the prevention, management, and treatment of HIV, and provide evidence to invest additional resources in services that can support them.

2. Aboriginal Community Control of Research: there is Aboriginal community control over all aspects of the proposed research included research design, ownership of data, data interpretation, and publication of research findings

Our project team has given great consideration in consulting carefully regarding the research design from the conception of this project. This project is co-lead by Michelle Tobin, an Aboriginal woman of the Yorta Yorta nation, descendant of the Stolen Generation, and one of two women across Australia who advocate for Aboriginal and Torres Strait Islander peoples living with HIV. She has served on several Australian HIV boards and committees at a state and national level. Michelle currently sits on the board of the Anwernekenhe National HIV Alliance (ANA) as the HIV-positive representative and Chair; is a member and convener of the Positive Aboriginal Torres Strait Islander Network (PAT SIN); and is an active member of Femfatales, which is the national network of women living with HIV. With her expert knowledge and experiences within the Aboriginal and Torres Strait Islander community living with HIV, Michelle will ensure all appropriate processes are followed throughout the project, especially where members of the Aboriginal and Torres Strait Islander community are engaged.

An Advisory Committee comprising all members of the NSW Aboriginal and Torres Strait Islander community will also be established. The authority and oversight of this Advisory Committee throughout all stages of the project represents real Aboriginal community control over the present project. This committee represents another way in which Aboriginal community representatives will be engaged meaningfully and continuously, with appropriate reimbursement provided.

3. Cultural sensitivity: the research will be conducted in a manner sensitive to the cultural principles of Aboriginal society and will recognise the historical aspects and impact of colonisation on Aboriginal people

Every effort has been made to ensure that interview questions are sensitive to the diversity among the prospective participant group, specifically sensitivities regarding mental and emotional well-being, gender and sexuality, cultural differences, illness and disability, ensuring that participants are permitted to define and describe their life experiences in their own terms. Additionally, Michelle and all Advisory Committee members will provide advice and input throughout all stages of the project, and will be available to discuss the project and any issues arising. This will further ensure that all project activities, not limited to the needs assessment interview questions and subsequent co-designed service delivery model are highly sensitive to the cultural principles of Aboriginal society.

The project staff have approached a local NSW-based Aboriginal artist living with HIV to paint an artwork representing the diverse needs of Aboriginal and Torres Strait Islander peoples living with HIV. This artwork will be on the letterhead of all official correspondence pertaining to the project; the physical artwork will adorn the front-facing wall of the Positive Life NSW Surry Hills-based office. The importance and centrality of this artwork represents Positive Life NSW's genuine commitment to ensuring that the project activities are safe, welcoming, and sensitive to the cultural principles of Aboriginal society.

4. Reimbursement of costs: Aboriginal communities and organisations will be reimbursed for all costs arising from their participation in the research process

There should be no costs to Aboriginal and Torres Strait Islander people incurred as part of this research study. Providing participants with a small reimbursement for their time and effort in participating in the research is standard practice in research in this field. All participants will be offered Woolworths gift cards to the value of \$30 per participant. Participants who do not wish to receive this will be able to elect to donate it to a charity of their choice.

Interviews will take place in a location convenient for participants. No transport cost is anticipated but where there is a cost, Positive Life NSW will provide full reimbursement for transport.

A small catering budget at \$20 per head, will cover the cost of refreshments for all Advisory Committee members for all scheduled meetings. Additionally, Advisory Committee members will each receive a \$20 Woolworths gift card per meeting.

5. Enhancing Aboriginal skills and knowledge: the project will utilise available opportunities to enhance the skills and knowledge of Aboriginal people, communities, and organisations that are participating in the project

As noted, Michelle is employed by Positive Life NSW to co-lead the project. Michelle is an Aboriginal woman of the Yorta Yorta nation, descendant of the Stolen Generation, and one of two women across Australia who publicly advocate for Aboriginal and Torres Strait Islander people living with HIV. Michelle's role as project co-lead reflects Positive Life NSW's genuine commitment to working with and learning from Aboriginal people, community and organisations, and to build capacity among Aboriginal communities to conduct research and improve the delivery of HIV health services to Aboriginal and Torres Strait Islander communities. To support Michelle's relevant skill sets and knowledge for the project, Positive Life NSW has supported Michelle to enroll and work towards completing a Certificate II in Study Skills at TAFE NSW. This Certificate II in Study Skills will directly benefit Michelle's study methods and techniques, as well as her reading, writing, numeracy, and digital literacy skills. Positive Life has also agreed to partially support Michelle for the time it takes to complete the requirements of this course. These investments will ensure that Michelle's time and finances are not burdened by completing this course. The project offers a direct opportunity for Michelle to gain important skills, including research, interviewing techniques, stakeholder engagement, and health service delivery model design, implementation, and evaluation.

Appendix VI

Promotional Resources

Postcard



Time to yarn about HIV

Participation
is voluntary and
confidential

You will receive
a \$30 Woolworths
gift voucher upon
completion

NSW-based Aboriginal and Torres Strait Islander mob living with HIV or at risk of contracting HIV are invited to participate in a short (15–20 minute) interview face-to-face, to share your views and experiences of accessing and engaging with NSW-based HIV prevention, testing, and treatment services.

We need to include your voice to identify what is or isn't working. Have a yarn about HIV, call for a confidential conversation.

For more information or to participate:

Please contact Positive Life NSW Aboriginal Health Program Officer, Ms Michelle Tobin

Phone: 02 9206 2177

Freecall: 1800 245 677 (outside metro)

Email: michellet@positivelife.org.au

Images do not imply any HIV status, sexuality, behaviours or characteristics.

The voice of all people
living with HIV

Positive Life NSW



Don't be shame!

Time to yarn about HIV

NSW-based Aboriginal and Torres Strait Islander mob living with HIV or at risk of contracting HIV are invited to participate in a short (15–20 minute) interview face-to-face, to share your views and experiences of accessing and engaging with NSW-based HIV prevention, testing, and treatment services.

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Participation is voluntary and confidential
You will receive a \$30 Woolworths gift voucher upon completion



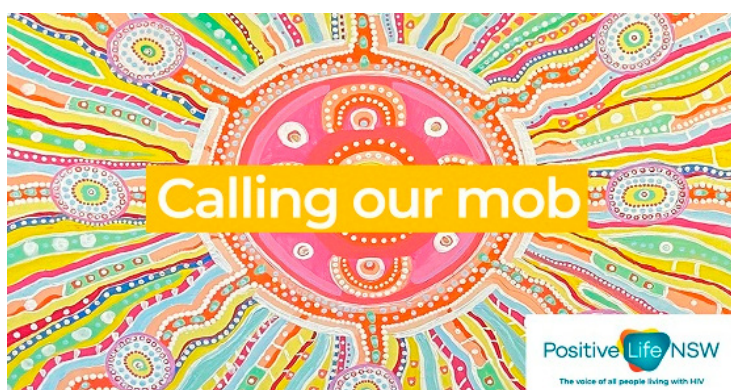
Images do not imply any HIV status, sexuality, behaviours or characteristics.



The voice of all people
living with HIV

Positive Life NSW

Social media





**For more information phone 02 9206 2177 or 1800 245 677 (freecall)
or visit www.positivelife.org.au**

*Images used in this publication are sourced stock photography and are used for illustrative purposes.
They do not imply any particular HIV status, sexuality, attitudes, or behaviours.*