

Co-Designing Adherence:

Harnessing practice wisdom to create a first of its kind resource by and for the HIV community health workforce

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Background/Purpose

Antiretroviral (ARV) adherence is central to achieving the treatment and viral-suppression components of the UNAIDS 95–95–95 targets.^{1,2} Across Australia, community health workers (CHWs) play an important role in supporting ARV adherence among people living with HIV (PLHIV), enabled by the distinct scope of their work.

CHWs are staff based in community, non-clinical services, including peer and non-peer roles. They support people living with HIV with the social and practical aspects of life that affect health and may impact ARV adherence, including housing, finances, transport, mental health, alcohol and other drug use, family, and relationships.

The scope of CHW roles differs from that of clinicians, and this difference is a strength in supporting holistic HIV care and ARV adherence. While clinical advice can only be provided by a person's clinician, CHWs can support people to share important information with their healthcare team, navigate complex health systems and treatment-related questions, and support a clearer understanding of their care.

CHWs often work in outreach roles, meaning they can meet and interact with people outside clinical settings, in places and ways that may feel more comfortable and accessible. This can provide valuable insight into the day-to-day circumstances that influence adherence.

The time CHWs spend with people may also be longer and more flexible than in clinical settings. This allows space to build trust and rapport, supporting effective conversations about adherence and helping to identify the factors that influence adherence for each individual.

Despite the significant role of CHWs in supporting adherence, sector-led guidance on how CHWs can approach this work remains limited, highlighting the need for resources tailored to this workforce. Our project aimed to address this gap by co-designing a practice-informed resource with, and for, CHWs in one HIV community organisation.

Outcomes/Impact

Co-design challenged a simplified biomedical framing of adherence as simply taking medication as prescribed, instead highlighting how medication-taking is embedded within people's broader lives and influenced by intersecting personal, social, practical, cultural and health-system factors. This positions adherence as dynamic and contextual, rather than a fixed individual behaviour.

Participants identified psychological safety and shared understanding as central to effective adherence conversations. This means creating space for people to speak honestly about medication-taking without fear of judgement, while ensuring information can be understood, revisited and applied within the context of their lives.

The resource

These findings were translated into a practical, plain-language resource combining foundational information about adherence and resistance with practice guidance for CHWs. Designed to support conversations about HIV treatment and adherence, the resource aims to help people living with HIV be informed, heard and actively involved in decisions about their treatment. It will also be embedded within workforce development to strengthen shared knowledge, practice consistency and confidence among CHWs.



Innovation and Significance

This project demonstrates the value of co-design as a methodology for capturing and translating the substantial practice wisdom held within the HIV community workforce. In a workforce that has historically learnt through practice, the process made previously tacit knowledge explicit and addressed a significant gap in consistent, practice-based guidance for CHWs.

The significance of this work extends beyond the resource itself, with implications for CHW practice, workforce development and the broader HIV care system including:

Making community practice visible	Articulates the distinct scope, contribution and practice of CHWs in supporting adherence, making it visible, explicit, teachable and transferable.
Bridging community and clinical practice	Helps bridge differences in scope, perspective and language between community and clinical workforces, providing a shared point of reference to support communication, collaboration and understanding across the HIV care system.
Strengthening pathways to community support	Clearer understanding and visibility of the CHW role can support clinicians to recognise when community-based support may be valuable, strengthening referral and access pathways for PLHIV.
Building workforce capability and consistency	Translating practice wisdom into practical guidance creates a foundation for induction, workforce development and reflective practice, supporting greater consistency and confidence across CHW roles and potential adaptation across community settings.
Building the case for community-based care	Articulating the contribution of CHWs provides funders and policymakers with a clearer understanding of how community-based practice works alongside clinical care to support treatment engagement and HIV care cascade outcomes.

Next steps

The resource will be shared with national HIV community partners for feedback and broader sector input, before being embedded within workforce development activities to support greater consistency in community health worker practice.

Approach

Three iterative co-design sessions were held between February and June 2026 using online and in-person formats. Seventeen community health workers (CHWs) from Queensland Positive People participated, contributing a combined 99+ years of experience in the HIV sector, ranging from one month to 27 years.

Participants brought diverse professional backgrounds, lived experiences and intersecting identities, including differences in age, gender, culture and migration pathways. They were based in urban (n=13) and regional Queensland (n=4), and included people with lived experience of HIV (n=10). Participants worked across case management, peer navigation, aged-care navigation and leadership roles, with professional backgrounds including (but not limited to) social work, social welfare, mental health, community development, nursing, human services and counselling.



CASE MANAGEMENT



AGED CARE NAVIGATION



PEER NAVIGATION



LEADERSHIP

99+ years' experience working in the HIV sector

This breadth of lived, professional and community-based experience supported a more nuanced understanding of the individual, social, practical, cultural and health-system factors that can influence ARV adherence.

Co-design activities elicited participants' lived and practice-based expertise regarding barriers to ARV adherence and the distinctive ways CHWs support adherence. Discussions considered the content, language and format needed for a useful CHW resource.

Themes generated in the first session informed development of a draft resource. Participants reviewed and refined the draft in the second session; this feedback informed a revised draft, which was further reviewed, refined and finalised in the third co-design session.

Disclosure of Interest Statement:
Nothing to disclose.

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Reference list
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The Life+ model:

Community led, peer driven support for integrated HIV care in Queensland

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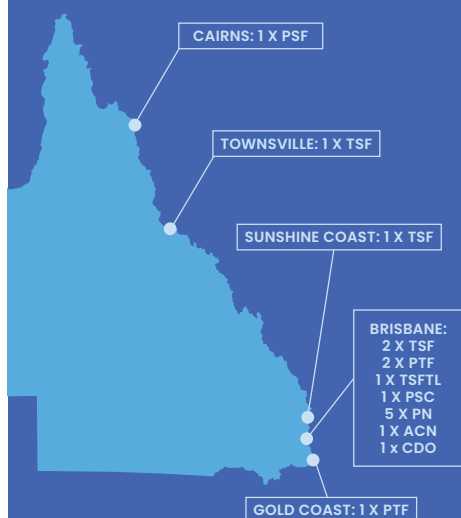


Background/Purpose

People living with HIV (PLHIV) experience diverse and changing needs across the life course, shaped by HIV-related stigma and broader social and structural determinants of health. While clinical services are central to achieving the 95-95-95 targets, disease-centric models organised through specialist, siloed systems of care are often unable to respond to this psychosocial complexity, increasing the risk of disengagement. The Life+ service model was designed to address this gap by providing a peer-led, person-centred, whole-of-life approach that integrates HIV specialist care with broader supports to strengthen engagement across the HIV care cascade.

Approach

Established in 2016, Life+ supports early treatment initiation, adherence and sustained engagement in HIV care through a peer-led, person-centred model. Support is guided by each person's needs, priorities and choices, recognising that these may change across the life course.



ACN = Aged Care Navigator
PSC = Peer Services Coordinator
PN = Peer Navigator

PTF = Peer Treatment Facilitator (case manager with lived experience)
TSF = Treatment Support Facilitator (case manager)
TSFTL = Treatment Support Facilitator Team Leader
CDO = Community Development Officer

Life+ is delivered statewide, with staff based across Queensland and outreach extending to communities across the whole state. Our workforce brings together lived experience of HIV and diverse professional expertise, including peer navigation, social work, social welfare, mental health, community development, nursing, human services and counselling. This combination of lived, professional and place-based expertise supports responsive, person-centred care across diverse communities and settings.

Community Development & Social Groups

Building connection, belonging and community through social groups, workshops and community activities.

Peer Navigation

Supporting people living with HIV to adjust to their diagnosis and navigate HIV treatment and care systems.

Case Management

Addressing complex psychosocial barriers to HIV treatment, care and engagement.

Aged Care Navigation

Supporting people living with HIV to access and navigate the aged care system.

Emergency Funding

Providing practical financial assistance to people living with HIV experiencing hardship.

AOD harm reduction

Providing co-designed harm reduction resources, information and support for people living with HIV.

Legal Assistance

Connecting people living with HIV across Queensland with specialist legal support through HALC.

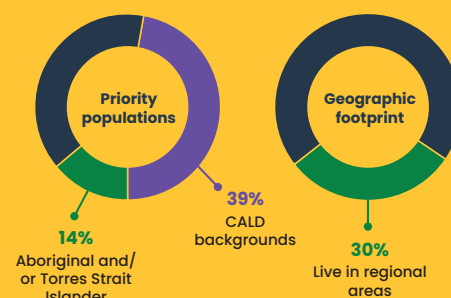
The Life+ program provides a flexible continuum of support ranging from social connection and community development to peer navigation, case management and aged care navigation, alongside practical, legal and harm-reduction supports. Rather than following a fixed or linear pathway, people living with HIV can access one or multiple supports, step up or down, exit and re-enter the program as their needs change over time.

The model works alongside HIV clinical services, connecting specialist treatment and care with community-based responses to the broader social and structural factors that influence engagement in care.

Outcomes/Impact

Since its commencement, Life+ has supported more than 1,455 unique individuals. Over the last five years, our highest referral sources have been sexual health clinics (28%, n = 330) and self-referrals (27%, n=319) demonstrating both strong clinical-community pathways and direct accessibility to people living with HIV.

Life+ has a broad geographic footprint, with around 30% of clients living in regional areas. The program also has strong reach into priority populations, with 14% of clients identifying as Aboriginal and/or Torres Strait Islander and 39% from CALD backgrounds. Approximately 63% of Life+ case closures occurred because clients met their goals and felt confident to self-manage, reflecting a model designed to build capacity and independence rather than create ongoing service dependence. Together, these data highlight Life+ as effective in supporting cascade-of-care targets.



Innovation and Significance

The Life+ model demonstrates how community-led organisations can operationalise integrated HIV care. It connects clinical treatment with the peer, psychosocial, practical and structural supports that enable people living with HIV to engage with and remain in care.

Its statewide, place-based and person-centred model provides multiple pathways into, through and out of support as people's needs change over time. Support can step up or down as needed, enabling people living with HIV to transition towards greater independence, self-management, community connection and belonging.

By addressing barriers to treatment and care alongside clinical services, community-led models such as Life+ contribute to sustained engagement across the HIV care cascade and achievement of the 95-95-95 targets, while strengthening connection, wellbeing, quality of life and capacity to live well for people living with HIV.

Disclosure of Interest Statement:
Nothing to disclose.

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Life+



Queensland Positive People

Overlapping Realities:

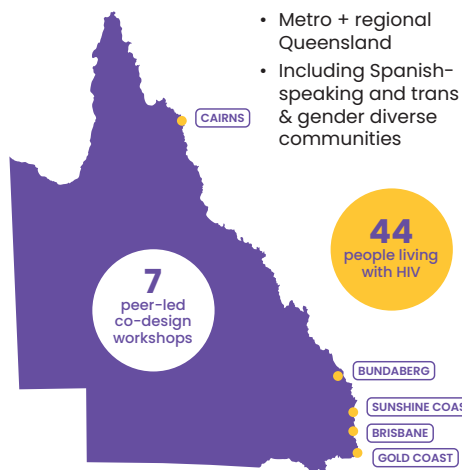
Mapping the structural and social complexity of HIV and AOD use among people living with HIV

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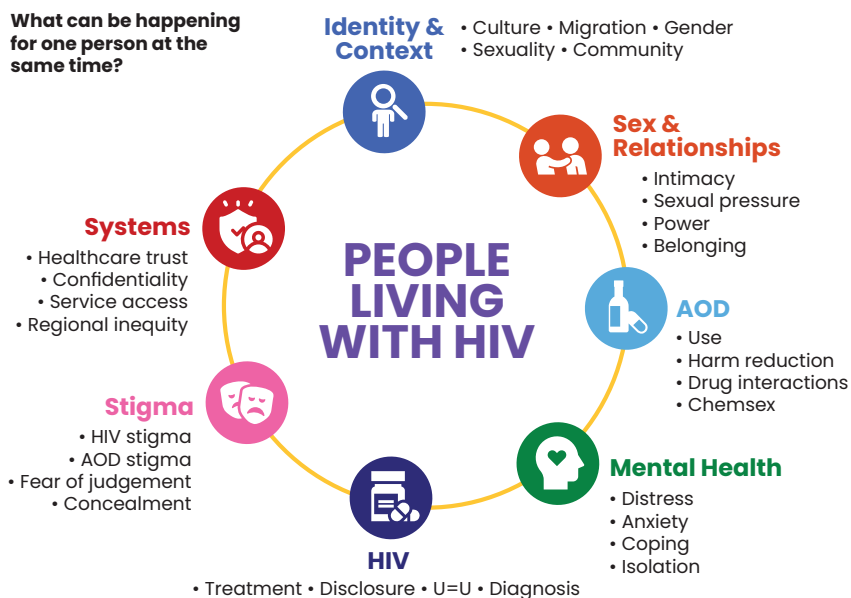
What we did

Listening to lived experience across Queensland



The overlapping realities

What can be happening for one person at the same time?



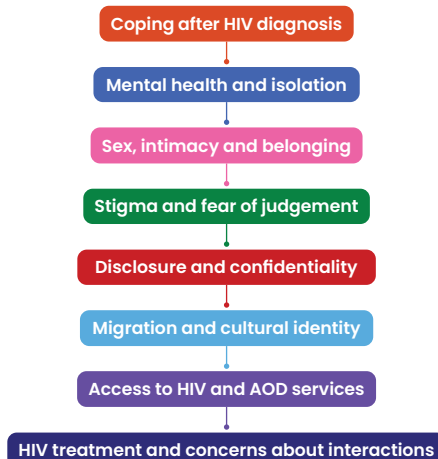
When these realities overlap, vulnerability can accumulate.

We explored how HIV, alcohol and other drug use, treatment, stigma, relationships and access to care intersect in everyday life.



AOD use doesn't happen in isolation

Participants rarely described AOD as a stand-alone issue. AOD use was connected with:



The issue was not one individual behaviour. It was the accumulation of multiple pressures.

What this looks like in real life

Participants described situations where:

- **AOD became a way of coping** with distress, isolation or difficult life experiences. Where **double stigma created silence** as people could fear judgement both for living with HIV and for using AOD. And at the same time disclosure became complicated, particularly around sex, relationships, substance use and healthcare.
- **Trust in healthcare was not automatic**, previous discrimination and concerns about confidentiality shaped whether people felt safe discussing AOD with health professionals. So then **treatment decisions could become harder** making people to feel unsure about medication interactions, side effects or what was safe.
- For regional, migrant and other marginalised people living with HIV, these pressures could be even harder to navigate.

The response must be as connected as the problem

We cannot address overlapping realities with siloed services.

Participants' experiences point towards a response that is:

PEER-LED

Lived experience creates trust and safer conversations.

HARM REDUCTION FOCUSED

Information should support informed choices rather than judgement or abstinence-only responses.

TRAUMA-INFORMED & CULTURALLY RESPONSIVE

Support must recognise identity, migration, gender, sexuality and previous experiences of healthcare.

ACCESSIBLE WHERE PEOPLE ARE

Including regional communities and people who may never present to a specialist AOD service.

HIV + AOD INTEGRATED

AOD conversations should be part of HIV care, not a separate issue.

If people's realities overlap, our RESPONSES AND SERVICES must overlap too.

Supported by



Disclosure of Interest Statement:

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From first test to living well: supporting people living with HIV every step of the way

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Background/Purpose

Queensland Positive People (QPP) is a peer-led, community-based HIV organisation that has been providing services in Queensland since 1989. In 2014, QPP was Australia's first HIV peer organisation to incorporate a prevention program: RAPID, a peer-led HIV and STI point of care testing program. In addition, the Life+ Program provides integrated psychosocial support through peer navigation and case management for people living with HIV.

While QPP has successfully supported individuals through both programs, QPP relied entirely on external clinical services for access to HIV and STI treatment and management.

In July 2025, QPP received 12 months of funding to pilot a Nurse Practitioner (NP) service within RAPID, QPP's established peer-led service providing free, non-judgemental point-of-care HIV and STI testing, including for people who are Medicare ineligible. Previously 100% peer-led and focused on HIV and STI prevention and testing, the integration of an NP expanded RAPID's scope to include treatment and HIV management, creating a more complete continuum of care within a community-based setting. This integrated peer and clinical model enables QPP to better support people with complex needs, with low health literacy or for whom mainstream services may not be appropriate, strengthening engagement and continuity of care and supporting people to remain connected across the HIV care cascade.

As well as the clinical continuum of care, RAPID has provided paid opportunities for QPP community members, supporting work experience, and strengthening connections across the organisation and community.

QPP community members have opportunities to engage through social groups, workshops, and volunteer roles as Community Hosts, Community Advisory Group participants, and Board positions, further strengthening Australia's HIV response.

Approach

QPP has now become a single-access point from peer-led prevention and testing, into clinical treatment, and ongoing HIV peer navigation and case management support.

For people living with HIV experiencing complex psychosocial needs, the RAPID NP works closely with QPP's Life+ Peer Navigators and Case Managers and the HIV Public Health Team (HPHT), strengthening coordination across services that support people at increased risk of disengagement from HIV care. This includes people experiencing homelessness or housing instability, mental health and alcohol and other drug use, and other social circumstances that can disrupt access to treatment, adherence and ongoing care. Recognising the importance of providing care when opportunities for engagement arise, two appointments are reserved each day for urgent or opportunistic access to HIV treatment and care, supporting timely re-engagement and continuity across the HIV care cascade.

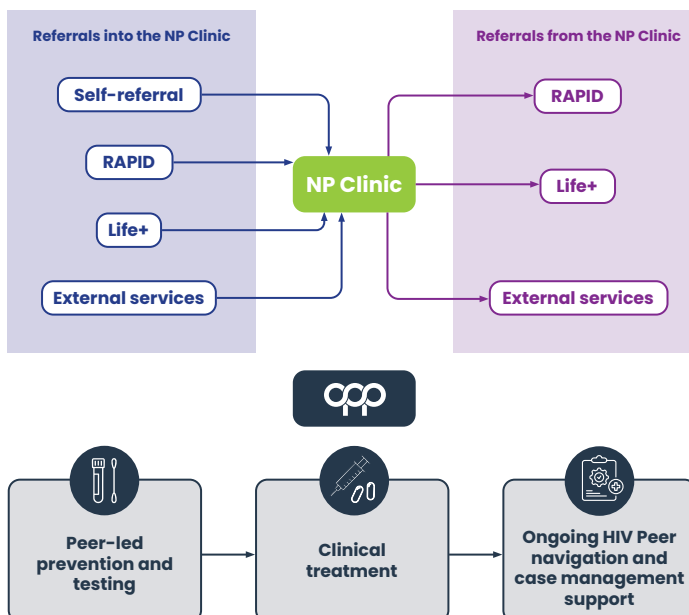
Queensland's vast geography and uneven access to HIV s100 prescribers create significant barriers to equitable HIV treatment and care, particularly for people living in rural and remote communities. As a statewide service, QPP uses telehealth to extend the NP service beyond metropolitan Brisbane, providing timely access to HIV treatment and management regardless of location. This model helps address geographic inequities in access to HIV care, supports continuity of treatment and reduces reliance on already stretched public health services.

Outcomes/Impact

From October 2025 to June 2026, 391 referrals were made to the NP clinic from across QPP's RAPID and Life+ programs, demonstrating strong integration of clinical care within QPP's existing peer-led services.

Referrals covered a broad range of sexual health needs, including symptomatic STI testing; STI treatment, including presumptive treatment and for people identified through contact tracing; vaccinations; doxy-PEP; non-occupational (HIV) PEP; PrEP initiation; Sex Work Certificates; and HIV treatment and management.

Nine people living with HIV received collaborative support from the NP and Life+ case management team, strengthening engagement and continuity of HIV care.



Innovation and significance

Embedding an NP within QPP's established peer-led services creates a unique integrated model of HIV care, providing an internal pathway from testing and diagnosis through to treatment, HIV management, peer navigation and case management.

This innovative model has reduced the need to navigate multiple services, providing continuity and a trusted point of care, particularly for people who experience barriers to mainstream healthcare, including people born overseas, people ineligible for Medicare and people with lower health literacy.

The model enables rapid transition from diagnosis to treatment and direct pathways to Life+ peer navigation and case management for people experiencing barriers to treatment and care or at greatest risk of disengagement from the HIV care cascade.

By bringing peer and clinical care together within a trusted community-based setting, the model increases choice in how and where people access HIV care and provides a flexible pathway responsive to individual social, psychosocial and geographic circumstances. In doing so, it has the potential to address inequities in access, strengthen retention across the HIV care cascade and contribute to progress towards the 95-95-95 targets.



From vision to impact: 12 years of Brisbane's peer-led RAPID clinic

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Background/Purpose

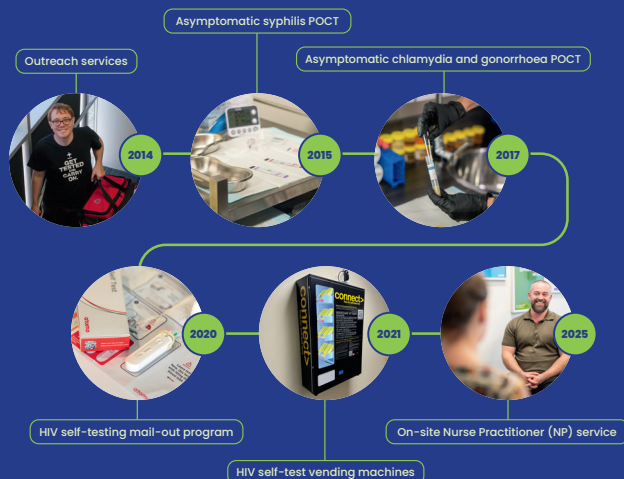
Responding to increased HIV diagnoses in Queensland, particularly late diagnoses among gay, bisexual and other men who have sex with men (GBMSM), gaps in accessible, acceptable and timely HIV testing were identified. Leveraging the Therapeutic Goods Administration's (TGA) approval of HIV point-of-care testing (POCT), Queensland Positive People (QPP), HIV Foundation Queensland, and Queensland Health established a peer-led testing model.

Launched in 2014, RAPID aimed to increase testing uptake through free, walk-in, rapid HIV screening and information in a non-judgemental, community-based setting. As Australia's first entirely peer-led testing service—with no clinical staff on site—RAPID pioneered a new model of trusted, community-led care.

With RAPID, QPP became the first HIV organisation in Australia to integrate prevention into its core work supporting people living with HIV, helping reshape the sector's approach to comprehensive, community-centred HIV services, and establishing QPP as a national innovator.

Approach

RAPID has continually expanded its HIV/STI screening, prevention and treatment services. Key developments include:



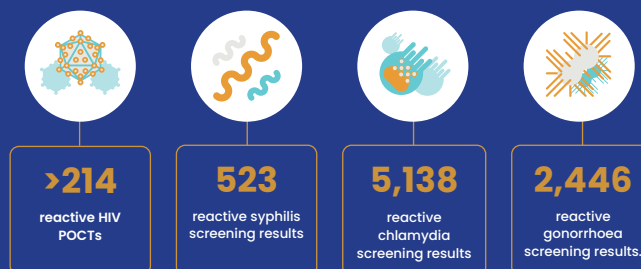
RAPID has also delivered numerous HIV, blood-borne virus and STI prevention and awareness initiatives through research partnerships, supported by ethics and clinical-trial approvals and established clinical oversight. Together, these initiatives have increased testing and treatment options for communities across Queensland.

From 2017 to 2025, RAPID provided asymptomatic screening for *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (NG) using on-site molecular POCT with the Cepheid GeneXpert under ethics approval. This research generated substantial evidence supporting pooled-sample testing in a peer-facilitated, community setting, as an accurate and cost-effective alternative.

The integration of an NP model of care in 2025 marked a significant evolution for RAPID. For the first time, clinical care was available on site, enabling RAPID to provide testing, treatment, HIV prevention and ongoing HIV care and management within one community-based service.

Outcomes/Impact

Overall, RAPID has delivered more than 75,000 occasions of service identifying:

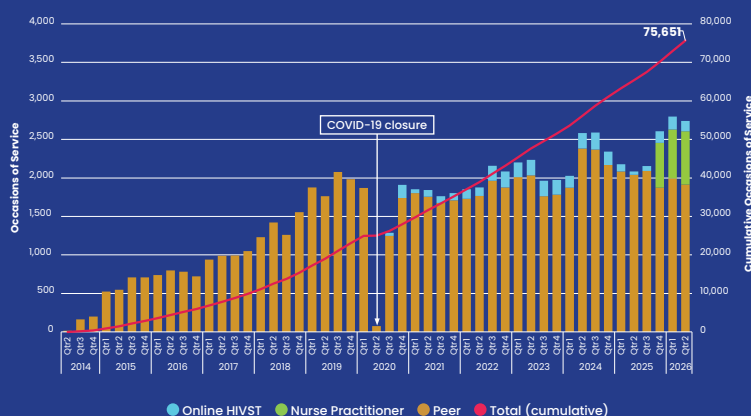


Although initially established for GBMSM, RAPID now supports a broader population that may experience barriers to traditional health services or access them less frequently, including people born overseas and people without Medicare.

By offering a trusted, accessible community-based alternative, RAPID reduces demand on publicly funded sexual health services and allows specialist services to focus their limited resources on more complex care.

Clients requiring treatment or further sexual healthcare can now access the NP service, while people newly diagnosed with HIV are connected directly with QPP's peer navigation and support programs. This creates a more complete continuum of care and reduces the risk of people becoming lost in the system or disengaging from care.

RAPID Occasions of Service by quarter, cumulatively and service (Peer, HIVST and Nurse Practitioner), Quarter 2, 2014 to Quarter 2, 2026



Innovation and Significance

RAPID has made a significant contribution to Australia's HIV response through novel approaches to service delivery, often serving as a forerunner of new HIV technologies, research, and innovation. RAPID demonstrates how POCT and self-testing can be effectively established in community settings to reduce barriers and increase choice.

RAPID provides transferable evidence for cost-effective peer-based care aligned with national HIV testing and prevention targets. Regulatory constraints affecting peer-delivered CT/NG POCT illustrate the structural barriers that remain, while RAPID's response demonstrates the adaptability and resilience of community-led models.



Securing peer-led screening service continuity: Validating screening accuracy of intra-client pooled samples for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* using the Abbott Alinity m STI assay

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Background

Peer-led sexual health services play a critical role in reaching priority populations, yet regulatory restrictions prohibit the use of molecular point-of-care testing (mPOCT) by peers in community settings.

Since 2017, Queensland Positive People's peer-led RAPID clinic has provided asymptomatic *Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (NG) screening using on-site mPOCT under ethics approval. Without foreseeable regulatory pathways to sustain this model, a cost-effective, community-led alternative was evaluated to maintain equitable access.

Methods

We prospectively evaluated the feasibility and accuracy of intra-client pooled specimen testing conducted by peer workers, with off-site analysis using the Abbott Alinity m STI assay at Pathology Queensland (PQ). Over 12 weeks, asymptomatic clients self-collected anorectal and oropharyngeal swabs and first-catch urine. Peer testers pooled samples on-site, with both pooled and individual specimens tested in parallel.



12 weeks

INTRA-PATIENT POOLING OF ANORECTAL SWAB, OROPHARYNGEAL SWAB AND FIRST-CATCH URINE

POOLING DONE ON-SITE BY TRAINED PEERS

TESTING DONE AT LABORATORY WITH ABBOTT ALINITY M STI ASSAY

Outcomes included concordance, sensitivity, specificity, and invalid rates, with equal or greater than 95% concordance defined priori as acceptable.

Results

Among 118 clients, invalid results were infrequent (4.2%, 5/118) and limited to rectal samples consistent with routine testing.

Pooled testing demonstrated high concordance with individual-site testing (98.2%, 111/113), exceeding predefined thresholds. Concordance among CT/NG-detected cases was 97.0% (64/66).

Overall sensitivity was 100% (95% Confidence Interval (CI) 99.4%-100%) and specificity was 95.9% (95%CI 86.0%-99.5%).

For CT, concordance, sensitivity, and specificity were 99.1% (112/113), 100% (95%CI 90.0%-100%) and 98.7% (77/78; 95%CI 93.1%-100%) respectively. For NG, concordance, sensitivity, and specificity were 98.2% (111/113), 100% (95%CI 89.4%-100%) and 97.5% (78/80; 95%CI 91.3%-99.7%) respectively.

Demographic Characteristics of the Study Sample (n=113)

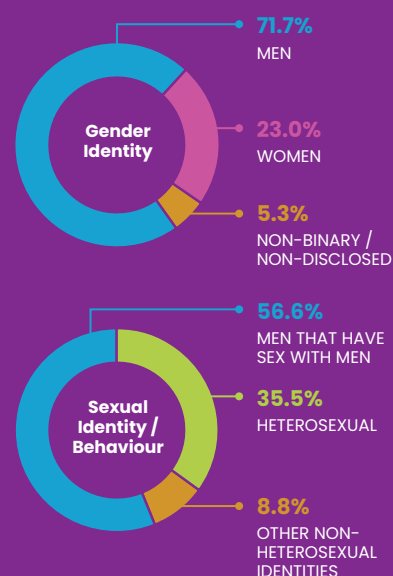


Table 1: Concordance, sensitivity and specificity of the pooled Alinity test as compared with the individual site-specific Alinity test

Alinity pooled test	Detected	Not detected	(90.0% to 100%)	%	(95% Confidence Interval)
<i>C. trachomatis</i>					
Concordance			$\frac{TP+TN}{TP+TN+FN+FP}$	112/113	99.1%
Detected	35	1	Sensitivity $\frac{TP}{TP+FN}$	35/35	100% (90.0% to 100%)
Not detected	0	77	Specificity $\frac{TN}{TN+FP}$	77/78	98.7% (93.1% to 100%)
<i>N. gonorrhoeae</i>					
Concordance			$\frac{TP+TN}{TP+TN+FN+FP}$	111/113	98.2%
Detected	33	2	Sensitivity $\frac{TP}{TP+FN}$	33/33	100% (89.4% to 100%)
Not detected	0	78	Specificity $\frac{TN}{TN+FP}$	78/80	97.5% (91.3% to 99.7%)

Conclusion

Peer-led pooled sampling with laboratory-based testing maintained high screening accuracy while reducing potential costs and operational barriers. This model represents a pragmatic, community-driven response to regulatory constraints, supporting continued access to comprehensive STI screening. In the absence of regulatory pathways for peer-delivered mPOCT, strengthening partnerships between community organisations and public laboratories may enhance equity and sustainability of sexual health services, informing policy pathways for broader implementation.

- Proved feasible and acceptable
- Intra-patient pooled methodology highly accurate
- RAPID can continue to offer free CT/NG screening – now via off-site pathway
- Turnaround time for results increased
- Would still love to see a regulatory pathway for peer-led, affordable STI mPOCT



Beyond viral suppression:

Integrating alcohol and other drug harm reduction into peer-led services to support treatment adherence

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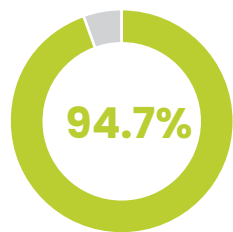
¹Queensland Positive People, ²University of Southern Queensland, ³University of the Sunshine Coast

Viral suppression tells us treatment is working.

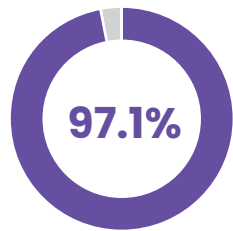
It doesn't tell us what someone is navigating.

HIV treatment outcomes can look excellent while people are still navigating alcohol and other drug use, distress, stigma, disclosure, relationships and fragmented systems of care. **Adherence does not happen in a vacuum.**

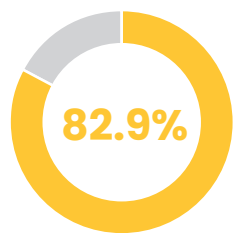
01 – The Paradox



of people living with HIV participants were on HIV treatment



of those on treatment reported an undetectable viral load



reported recreational drug use in the previous six months

Queensland GBQ+ Community Periodic Survey 2024.

Clinical success and AOD use can coexist.

Viral suppression alone cannot tell us whether someone needs harm reduction information, feels safe discussing AOD use, or is struggling to maintain treatment during difficult periods.

02 – We Listened

44 people living with HIV.



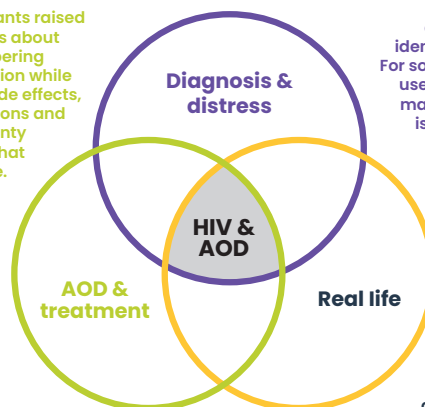
7 peer-led workshops.



One consistent message: Life around medication matters.

Workshop participants explored how HIV, AOD use and treatment interact in everyday life. What emerged was not a simple story of “drug use = poor adherence”. Instead, participants described a web of influences:

Participants raised concerns about remembering medication while using, side effects, interactions and uncertainty about what was safe.



A diagnosis can disrupt routines, identity and coping. For some people, AOD use became part of managing distress, isolation or social connection.

AOD use, relationships, mental health, disclosure and access to care all sit around the medication.

03 – Change the conversation

Instead of only asking:

“Are you taking your medication?”

Also ask:

“What is happening around your medication?”

A harm reduction approach creates space for honest conversations about AOD, adherence and what support would actually help.

04 – Why peer-led?

Peers can go where a clinical question sometimes can't.



Build trust

Safer conversations without judgement.



Make it real

Turn health information into practical strategies for everyday life.



Connect

Bridge HIV care, AOD support, mental health and community.

Peer work helps connect clinical care to real life.

05 – The shift we need

From
AOD is somebody else's service.
To
AOD harm reduction as part of routine HIV support.

That means:

- 01 Introduce peer-led AOD conversations early, including around diagnosis and other periods of vulnerability.
- 02 Equip peer workers with HIV-specific AOD harm reduction knowledge and practical resources.
- 03 Make conversations about AOD routine, voluntary, non-judgemental and relevant to the person's goals.
- 04 Strengthen warm referral pathways between HIV, AOD and mental health services.
- 05 Build HIV competency within mainstream AOD services and AOD confidence within HIV services.

AOD harm reduction is not separate from adherence support.

It is part of it.

We need to support more than the medication.

We need to support the life happening around it.

Supported by



Disclosure of Interest Statement:
The PALS project is funded by the Queensland Mental Health Commission.

