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30 January 2015

Dear Dr Hobbs,

**Re: Proposed Performance Requirements and Risk Mitigation Strategies for HIV Tests**

AFAO is pleased to provide comments to the consultation on Proposed Performance Requirements and Risk Mitigation Strategies for HIV Tests. Our comments are informed by AFAO's long-term work in seeking to get access to HIV rapid-tests, for clinical, community, and individual use. AFAO has provided responses to the specific questions posed in the paper, below. The following are overarching comments that underpin the detailed responses.

It is crucial that, where possible, the TGA's policies and assessment guidelines are consistent with and support commitments made by Australia under the *Seventh National HIV Strategy* and the *National HIV Testing Policy*, and they support Australia's international obligations in responding to HIV. Central to these policies and instruments is that testing, except in certain proscribed circumstances, HIV testing should be voluntary.

Australia's *Seventh National HIV Strategy 2014-2017* notes that:

'Testing models need to focus on simplifying the testing process for individuals, and addressing access and acceptability issues including cost, time and convenience. This will require continued development and expansion of existing testing methods, such as rapid testing, and exploration of new testing models, such as home self-testing.

'The introduction of HIV rapid tests in Australia at both point of care (in settings such as sexual health clinics and general practice) and in non-clinical community settings is underway and evaluating well.

'It is important to ensure that testing methods remain high quality, safe and appropriate while access is increased. There is a particular role for all governments to explore how regulatory, legal, policy and funding mechanisms can best work together to increase HIV testing and early diagnosis.' (Section 7.2 of the Strategy)

*AFAO is the peak body for Australia's eight State and Territory AIDS Councils. AFAO's national members are the National Association of People Living with HIV Australia (NAPWHA), the Australian Injecting & Illicit Drug Users League (AIVL), Scarlet Alliance, Australian Sex Workers Association and Anwernekenhe National Aboriginal & Torres Strait Islander HIV/AIDS Alliance (ANA).*

AFAO's discussion paper, *HIV testing among gay men and other men who have sex with men* (accessible at [http://www.afao.org.au/library/topic/msm/HIV\\_Testing\\_DP\\_ONLINE-July-2014.pdf](http://www.afao.org.au/library/topic/msm/HIV_Testing_DP_ONLINE-July-2014.pdf)), argues that a substantial increase in the access to and uptake of voluntary HIV testing among gay men and other men who have sex with men (MSM) is required in order to have a significant impact on the HIV epidemic in Australia. Increased testing among gay men and other MSM will enable more people to know their HIV status, improving individual health outcomes for people with HIV and reducing health impacts associated with late diagnosis. Increasing testing will increase the number of people aware of their HIV status and reduce delays between infection and diagnosis, and diagnosis and treatment - thereby reducing the number of onward transmissions.

As outlined in the AFAO discussion paper, accessing convenient HIV testing has been a major priority for gay men and other men who have sex with men. Facilitating community-based testing is one crucial aspect of this. While rapid HIV tests had been readily available in comparable countries for around a decade, only in late 2012 did the TGA approve a rapid HIV test for use in Australia. This process of seeking to have HIV rapid-tests approved by the TGA has highlighted some systemic/broader issues.

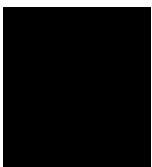
To date the TGA has taken a cautious approach to its assessment of HIV rapid testing, framed from a perspective that rapid HIV tests must meet the "gold-standard" of confirmatory laboratory tests. This inquiry is a great opportunity to ensure that greater weight is given to the important public-health benefits that may be derived from facilitating greater access to HIV testing – specifically through targeting HIV rapid-testing to gay men and MSM, thereby allowing for earlier diagnoses and connection to care and reducing the number of onward transmissions. We are pleased that the discussion paper alludes to the potential public health benefits of streamlining approval processes for rapid tests and agree that consideration of performance requirements needs to be accompanied by carefully developed risk mitigation strategies.

The lack of approval of rapid HIV tests for self-use can raise significant individual health issues. While these products cannot legally be purchased in Australia, individuals have (legally) sourced these kits for themselves, usually online from overseas suppliers. For these consumers there is no guarantee of product safety or efficacy, and instructions for use may be inadequate. There is also generally no information on linking to ongoing care and support. Consumers potentially fail to understand that the rapid test is a screening rather than diagnostic tool, with potential for confusion regarding both positive and negative test results.

AFAO has had the opportunity to review the comments provided by ACON, VAC, Scarlet Alliance, the Kirby Institute, and the Australian Society of HIV Medicine (ASHM) and we have highlighted particular comments made in these submissions in our comments below. We note ACON and VAC's understandable frustration regarding regulatory barriers to the smooth rollout of community rapid testing services, and urge that regard be had to their expert and well-informed perspectives.

AFAO believes that the TGA performs a crucial function. Clear and appropriate guidance, resulting from this consultation process, will be an important step in facilitating greater access to HIV testing. AFAO would be pleased to discuss further our views. Rob Lake can be contacted at [REDACTED]

Yours sincerely,



Rob Lake  
Executive Director

## TGA REVIEW: “PROPOSED PERFORMANCE REQUIREMENTS AND RISK MITIGATION STRATEGIES FOR HIV TESTS”

AFAO broadly supports the proposed stratified model for assessing performance and risk mitigation strategies. We are pleased that the paper acknowledges the need for clear guidance on the performance criteria to be met, with stratified performance criteria depending on whether the intended use of an HIV rapid test is for laboratory testing, point-of-care testing or for self-testing.

Regarding intended use of a device for which approval is sought, we note that apart from monitoring test performance there is a need to ensure effective post-market monitoring of use of devices, to ensure that they are not being used for other than the use for which the TGA provided approval.

Conditions of approval and risk mitigation strategies must take into account particular issues for populations who may be inappropriately targeted for PoC testing (such as sex workers – Scarlet Alliance’s submission refers), and also for populations who may be encouraged, coerced or forced to self-test (for example, new SA and WA legislation providing for forced testing of certain alleged offenders). Apart from the human rights issues associated with forced testing and coercion to test, rapid HIV testing is inappropriate for these low prevalence populations/sub-populations because there would be an unacceptably high rate of false positives.

Risk mitigation should include placing restrictions on manufacturers and sponsors regarding sale and distribution of the device, to ensure that other than in limited proscribed situations, HIV testing is voluntary and that informed consent is obtained. It is crucial that, where possible, the TGA’s policies and assessment guidelines are consistent with and support the Seventh National HIV Strategy, the National HIV Testing Policy and Australia’s international human rights obligations.

AFAO also made comments on Chapter 7 of the *Review of Medicines and Medical Devices Regulation Consultation Paper*, restricting our comments to issues relating to TGA policies and processes affecting the approval of HIV rapid test devices. We proposed that there is a need to allow for greater flexibility in approval of certain narrow categories/classes of device, including rapid BBV tests, by allowing the TGA to have regard to overseas regulators which are ‘trusted’ for the purposes of regulation of specified classes of device (such as BBV rapid tests). Given that some of these comments are relevant to consideration of how the TGA may best take into account test performance issues in its assessment processes for HIV rapid tests that have been approved for use in comparable countries to Australia, a copy of that submission is attached (also available at: [http://www.afao.org.au/library/topic/hiv-prevention/submission\\_review-of-medicines-and-medical-devices-regulation\\_jan-2015.pdf](http://www.afao.org.au/library/topic/hiv-prevention/submission_review-of-medicines-and-medical-devices-regulation_jan-2015.pdf)).

### 2.1 Laboratory Tests

No comment from AFAO regarding laboratory tests.

### 2.2 HIV Point of Care Tests (PoCTs)

We make the following comments and suggestions for consideration in developing guidelines for TGA assessment of HIV rapid test devices intended for use at point-of-care, including in non-clinical community settings:

AFAO broadly agrees with the summary of proposed performance requirements outlined in the paper for HIV rapid tests for use at Point of Care, using the comparison of performance requirements of tests approved in comparable jurisdictions. In addition, Australian data could also be utilised to help finalise a decision on the appropriate performance requirements. We support the Kirby Institute's comments on these issues.

- Regarding the comparison tests for assessing the sensitivity and specificity of HIV Point of Care Tests, the paper refers to "...the expected performance of the test for confirmed HIV positive samples based on a direct comparison with a currently accepted state-of-the-art device (e.g. third or fourth generation EIA)...". This comparison would not be useful, given that third and fourth generation EIAs have different window periods in samples from people with recent HIV infections (seroconverters). Additionally, although the paper refers to 'confirmed HIV positive samples', it does not reference, and is inconsistent with the Australian case definition for confirmed cases of HIV infection.
- The paper also states that "a direct comparison to western blotting is of limited value due to the relative poor sensitivity of a western blot compared to a third or fourth generation EIA, particularly during early seroconversion." We note that it is already known that rapid HIV tests generally have slightly longer window periods than many laboratory tests, and are generally not appropriate for detecting people in seroconversion. Comparison to these laboratory tests would therefore not be appropriate. We support the Kirby Institute's comments on an appropriate comparison test.
- Sensitivity and specificity rates of a particular test are calculated outside of the window period defined for that test. This should be stated.
- The paper states that "Manufacturers are also required to provide studies that demonstrate the performance of the test with seroconversion panels and establish the limitations of the test with regard the detection of HIV antibodies (and, if applicable, antigen) in the window period." Given that HIV rapid tests are measured for their effectiveness outside the window period, the reason for requiring that this data be provided needs clarification. If the data is required to confirm the window period of the test submitted by the manufacturer/sponsor as part of the assessment documentation, this needs to be stated.
- The consultation paper does not explicitly state whether studies must be Australian-specific studies. If studies are not required to be Australian they would need to reflect the performance of the test in a comparable setting and population.
- As proposed in AFAO's comments on Chapter 7 of the *Review of Medicines and Medical Devices Regulation Consultation Paper*, regulatory reforms to allow regard to be had to decisions made by 'trusted' overseas regulators for certain specified classes of device, such as HIV rapid tests, would streamline the TGA's consideration of performance of a device that has been in use for some time overseas in comparable countries, settings and populations. If a particular rapid HIV test for use at point of care has been approved by a comparable country at different sensitivity and specificity rates than the generally applicable Australian rates, this overseas approval could also be used as a guide as part of the decision making process. Information regarding the relevance of comparable country studies, and of any flexibility in assessment of evidence, would need to be clearly outlined in the guidelines for manufacturers. Ensuring a focus on risk mitigation strategies relevant to approval of the device for use in Australia would ensure that performance issues are not compromised.

### **Risk Mitigation Strategies:**

AFAO supports the risk mitigation strategies for HIV point of care tests outlined in the consultation paper. We make the following further observations:

- The paper notes that instructions for use of PoCTs need to state that “negative results obtained within three months of a high risk event should be repeated at three months to confirm the initial negative result (i.e. false negatives results can be obtained if testing is performed during the ‘window period’)”. The window period for the particular test should be defined in the product information, and be the basis of the timeframe required for repeated testing. This definition should also relate to the window period for calculation of performance rates for sensitivity and specificity.
- Patients/clients presenting for a test after a high-risk event and within the defined window period, should be offered a venous blood draw for a laboratory HIV test (or referred for a venous blood draw elsewhere), in addition to or as an alternative to a rapid test.
- Information regarding the comparative window periods for the rapid test used by the clinic/service and laboratory tests should be provided as part of the pre-test discussion with the patient/client (see comments hereunder and below re pre- and post-test discussions).
- References to pre-test ‘counselling’ are outmoded and inconsistent with current practices and the terminology used in the National HIV Testing Policy, which focuses on obtaining informed consent before testing, and on conveying test results. Professional counselling is part of the referral pathway, separate to obtaining informed consent and conveying test results; while discussions to obtain informed consent and to convey test results may be with a peer worker.

### Conditions of Approval

AFAO broadly supports the conditions of approval for HIV point of care tests outlined in the consultation paper. We further propose that:

- The meaning of “supervision” of non-clinical staff needs to be clarified. The TGA has advised previously that as well as healthcare workers, other appropriately trained people (such as peer educators) may administer tests approved for use at point-of-care, including in a range of non-clinical community settings, provided that they are under the supervision of a health professional. Reference should be made to sections of the *National HIV Testing Policy* that relate to service accreditation, training of test operators and supervision of staff. It should be made clear that the supervising health professional’s role is to ensure that staff are appropriately accredited to perform tests; that policies and procedures are adhered to; and that non-clinical staff do not need to be directly observed by or in the same testing service as the supervising health professional when administering a rapid test.
- The definition of “supervision” should be followed by examples of situations where trained non-clinical staff may perform the test in non-clinical community contexts. For example, some community rapid HIV testing services currently operate utilising peer educators to perform the tests, with a designated health professional “supervisor” providing ongoing clinical oversight to ensure that all operators in the service are correctly performing all aspects of the testing process and complying with policy and procedural requirements.
- The definition of “supervision” should be included in the Conditions of Approval.
- This clarification regarding the meaning of “supervision” would mean that the wording of the conditions placed on the supply of the Alere Determine HIV Combo point of care test, currently registered on the ARTG, should be amended to include these changes outlined. This would include changing of the wording of the conditions of the Alere test (and other rapid tests approved in the future) from “healthcare professional” to “appropriately trained and accredited staff”.
- References to pre-test and post-test counselling are outmoded. Guidelines should instead reflect terminology used in the Australian *National HIV Testing Policy*, which refers to “gaining informed consent” (instead of “pre-test counselling”), and “conveying HIV test results” (instead of “post-test counselling”). This terminology makes it clear that informed

consent may be obtained by a trained peer, and that test results may also be conveyed by a peer worker - not necessarily a person with professional counselling qualifications.

- Product inserts should include: a statement that PoC HIV rapid testing is not suitable for people among communities/populations with low prevalence of HIV, with an explanation that use by people among low prevalence populations can give higher rates of false positive results; a statement that that rapid testing should not be used in workplaces as part of mandatory testing for BBVs; a statement that that rapid testing should not be used by agencies as part of compulsory testing for BBVs; and that PoC HIV testing must comply with TGA approval conditions (as determined and as set out), as well as the *National HIV Testing Policy* and the *Seventh National HIV Strategy*.

## 2.3 HIV Self-Tests

### Performance Requirements

AFAO broadly supports the performance requirements and conditions for approval of HIV rapid tests for self-testing outlined in the consultation paper. We further note the following:

- The paper is unclear regarding proposed effective performance requirements for self-tests and what is to be required of manufacturers in applications for use of a device for self-testing. Given the impossibility of providing data regarding use of the test for self-testing, manufacturers need clear information regarding acceptable evidence.
- The paper makes no reference to any window period requirement in relation to device approvals for self-testing. Any minimum window period requirement for rapid HIV test approval for self-testing needs to be set out in the guidelines for manufacturers and in the guidance notes for the TGA delegate.
- Sensitivity and specificity rates are calculated outside of the window period defined for that test. This should be stated.
- For applications seeking approval of a device for self-testing, assessment should ideally have regard to evidence from comparable countries and with study participants from among like populations (such as gay men/MSM), so as to offset any issues relating to a small number of samples.
- In relation to the usability studies required to establish adequate performance in a self-testing setting, there is no reference in the paper to setting a minimum level for the effective sensitivity in a self-testing environment. We propose that the effective sensitivity of rapid HIV tests approved for self-testing in comparable countries (with “trusted” regulators, see above), could be taken into account as part of the decision making process to determine the appropriate level. Information regarding the relevance of comparable country studies, and of any flexibility in assessment of evidence, would need to be clearly outlined in the guidelines for manufacturers.
- Similarly, what is defined as an appropriately low level of inter-reader variability could also be guided by HIV-self test approvals in comparable countries.
- We have concerns about the last paragraph of the “HIV Self-Tests” section, which states that “the overall acceptability of an HIV self-test would depend on the manufacturer/sponsor demonstrating that any benefits gained from use of the test (i.e. increased testing rates) would outweigh any risks associated with the use of the product (i.e. false negatives).” Although we anticipate that approval of HIV self-tests for sale and distribution in Australia would increase testing rates, it would not be possible for a manufacturer/sponsor to “demonstrate” these benefits, given the inability to collect reliable data from people who have used an approved device to self-test.

## Risk Mitigation Strategies

AFAO broadly supports the risk mitigation strategies for HIV self-tests outlined in the consultation paper, and we further note the following:

- The reference to a user potentially not “electing” to have pre- or post-test counselling is out of place here. Product inserts must reflect the fact that most users will administer the test at home, or in another context where they have no access to counselling and/or any form of pre- post-test discussion. “Informed consent” to be tested is irrelevant for people who have purchased a test to self-test. The issue to be addressed is how best to ensure that the manufacturer meets its responsibility to: provide accurate and complete information to consumers that clearly explains the limitations of the test (including the window period); explain how to read the results, and what a reactive reading means; and outline what to do in the event of a reactive result – including contact details for services for confirmatory testing, and for support and advice. All this information must be provided in clear English and in key community languages.
- For approval of a test for self-testing the manufacturer/sponsor of a rapid test must be required to provide clear instructions on how to interpret the test – with information including clear explanations and diagrams of all the possible results the test can give, in clear English and community languages.
- The paper notes “the need to consult a medical practitioner for confirmatory testing of positive results by a laboratory test”. It is crucial that such information leaflets and other materials clearly and succinctly explain that the rapid tests are a screening test and that positive or reactive results are not a diagnosis – that a diagnosis requires a full blood test.
- Product information should state that the test is most appropriate for high prevalence populations – explaining that in Australia, this means gay men and other MSM. The risk of a higher rate of false positives for other people other than gay men and MSM should be clearly explained.
- Product information should also include information about HIV, risk, a range of safer sex information and strategies, and information about testing for other STIs as part of comprehensive sexual health care.

## Conditions of Approval

AFAO broadly supports the conditions of approval for HIV self-tests outlined in the consultation paper. We further note that:

- The manufacturer/sponsor of an HIV self-test should be required, as a condition of approval, to clearly outline the limitations of the test. This information should be in plain English and translated into key community languages. Packaging/instructions for use should recommend regular comprehensive STI testing, and include information regarding online support services and/or 24-hour phone support for users. Relevant counselling services, including LGBTIQ and sex worker friendly counsellors, should be listed.

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