Global AIDS Progress Report

COUNTRY PROGRESS REPORT

Australia

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UNAIDS Global AIDS Response Reporting 2015

Country Progress Report - AUSTRALIA

Reporting Period: January 2013 – December 2014

Contents

I. Status at a glance

a) Inclusiveness of the stakeholders in the report writing process

A partnership approach is central to the development, implementation, surveillance and monitoring of HIV strategies in Australia. Governments, the representatives and advocates for people affected by and most at risk of HIV, researchers, clinicians and the health sector workforce are all partners in Australia's response to HIV and have informed the 2015 Country Progress Report.

The Australian Government Department of Health led the report writing process for the 2015 Global AIDS Response Progress Reporting (GARPR) with input from The Kirby Institute, University of New South Wales on the surveillance and epidemiological data to support progress against indicators.

b) Status of the epidemic

In the global context, Australia has maintained a low level of HIV epidemic for the past 30 years, concentrated among men who have sex with men. Recent years, however, have seen an increase in notifications, including in cases of heterosexual transmission.

By the end of 2013, an estimated 35 287 cases of HIV infection had been diagnosed in Australia and an estimated 26 800 people were living with HIV infection. The rate of HIV diagnosis per 100 000 population was 5.1 in 2009-2013, and the overall national prevalence of HIV was 116 per 100 000.

A total of 1 236 cases of HIV infection were newly diagnosed in Australia in 2013, similar to the number in 2012. The annual number of new HIV diagnoses has gradually increased over the past 14 years, from 724 diagnoses in 1999.

Transmission of HIV in Australia continues to occur primarily through sexual contact between men. In 2009 – 2013, 64% of new HIV diagnoses occurred among men who have sex with men, 25% were attributed to heterosexual contact, 2% to injecting drug use and exposure was undetermined in 6%. Sexual contact between men accounted for 85% of diagnoses of newly acquired HIV infection.

1 417 cases of HIV infection newly diagnosed in 2009 – 2013 were attributed to exposure through heterosexual contact. Of these, 56% were in people from high prevalence countries or their partners.

Maternal transfer of HIV remains extremely rare. HIV prevalence remained low among women self-identifying as sex workers, regardless of injecting drug use.

Very few cases of AIDS or HIV-related deaths are recorded each year in Australia due to the wide availability of multiple lines of antiretroviral therapy.

Data source:
HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2014 (available from: http://kirby.unsw.edu.au/surveillance/2014-annual-surveillance-report-hiv-viral-hepatitis-stis *)*

c) Policy and programmatic response

Australia's national response to HIV and other blood borne viruses and sexually transmissible infections includes the ongoing implementation of a series of National Strategies which is lead by the Australian Government Department of Health. The current strategies cover the years 2014-2017 and were endorsed by all Australian Health Ministers from the Australian Government and each of the states and territories in 2014. The strategies are:

- The Seventh National HIV Strategy
- The Fourth National Hepatitis C Strategy.
- The Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy
- The Third National Sexually Transmissible Infections Strategy
- The Second National Hepatitis B Strategy

Each strategy contains priority actions as a means of achieving the goals of reducing the burden of blood borne viruses (BBVs) and sexually transmissible infections (STIs).

The Seventh National HIV Strategy 2014–2017 (the HIV Strategy) provides guidance and policies relating to the prevention, testing and treatment of HIV in Australia. This strategy was developed in partnership with state and territory health departments, community stakeholders, affected communities, research organisations and medical professionals in a cooperative approach to address HIV. This partnership approach has been recognised as a success globally.

Targets are included for the first time in the National Strategies, providing a renewed focus for action and a framework for accountability. The targets for the HIV Strategy have been adapted to the Australian context from those in the UN Declaration. The targets are to:

- Reduce sexual transmission of HIV by 50% by 2015
- Sustain the low general population rates of HIV in Aboriginal and Torres Strait Islander people and communities
- Sustain the virtual elimination of HIV amongst sex workers
- Sustain the virtual elimination of HIV amongst people who inject drugs
- Sustain the virtual elimination of mother-to-child HIV transmission
- Increase treatment uptake by people with HIV to 90%
- Maintain effective prevention programs targeting sex workers and for people who inject drugs.

Key priority action areas in the HIV Strategy are:

- Prevention
- Testing
- Management, Care and Support
- Workforce
- Enabling Environment
- Surveillance, Research and Monitoring.

The HIV Strategy also identifies high risk populations as priorities for targeted engagement and programs. The priority populations in the HIV Strategy are:

- People living with HIV (PLHIV)
- Gay men and other men who have sex with men (MSM)
- Aboriginal and Torres Strait Islander people
- People from high prevalence countries and their partners
- Travellers and mobile workers
- Sex workers
- People who inject drugs (PWID)

An Implementation and Evaluation Plan will support achievement of and reporting against the goals and objectives of the Strategy.

A Surveillance and Monitoring Plan for the National Strategies will inform and monitor progress on achieving the targets and reaching the goals of the National Strategies. The Surveillance and Monitoring Plan is currently being developed.

Australia's national BBV and STI strategies are available at:
http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-hiv

II. Overview of the AIDS epidemic

At the end of 2013, an estimated 26 800 to 30 900 people were living with HIV infection in Australia. The incidence of HIV notifications has been increasing since 1999, with 1 000 to 1 300 new cases per year since 2006. While trends in newly diagnosed HIV infection vary across state and territory health jurisdictions, the number of newly diagnosed HIV cases increased by 10% in 2012; the highest number of new cases in 20 years. The number of cases in 2013 was 1 236, which is slightly lower, but consistent with 2012.

In 2013, 71% of people diagnosed with HIV acquired the infection through male homosexual contact, 13% through heterosexual contact (approximately half of which was among people from high prevalence countries or their partners), and 3% through injecting drug use. Mother-to-child transmission of HIV is very rare in Australia.

The prevalence of HIV infection in Australia is greatest among gay men and other men who have sex with men, at 14.0% and around one per cent among people who inject drugs. Female sex workers continue to maintain extremely low rates of HIV.

Overall, the annual number of HIV notifications among Aboriginal and Torres Strait Islander people is small, and the prevalence is similar to that in the non-Indigenous population. The rates of heterosexual transmission and transmission related to injecting drug use, however, are higher among Aboriginal and Torres Strait Islander people than the non-Indigenous population.

While the HIV epidemic in Australia remains concentrated, primarily focused and resurgent among gay men and other men who have sex with men, there are also clear indications of rises in HIV diagnosis in other priority populations. An example is the recent increase in

heterosexually acquired HIV among some communities of people who have migrated from Africa or Southeast Asia and sexual partners of people from these locations.

The ageing of the population of people living with HIV is an important feature of the changing epidemiology of HIV. Advances in HIV antiretroviral therapy has decreased HIV and AIDS associated mortality and morbidity. The increasing numbers of PLHIV and the ageing nature of this population have important implications for the health care system.

Further surveillance data is available from the HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2014 - http://kirby.unsw.edu.au/surveillance/2014-annual-surveillance-report-hiv-viral-hepatitis-stis

III. National response to the AIDS epidemic

a) Prevention

Australia targets its prevention and health promotion response on the populations most at risk and most affected by HIV. This is aimed at reversing the increasing rates of HIV among gay men and other men who have sex with men, and maintaining low rates of HIV among other at risk populations including sex workers and people who inject drugs.

National prevention, education and health promotion, including safe sex messaging, is delivered on behalf of the Australian Government by community based organisations representing priority populations. State and territory government health services are responsible for local programs. Community based organisations are funded by both the Australian Government and state and territory governments and contribute to the development and implementation of programs supporting the HIV strategy.

The HIV Strategy endorses 'combination prevention' which includes safe behaviours and condom use, testing and counselling, linkage to and retention in care, and treatment.

The Australian Government is monitoring the potential effectiveness of Pre-Exposure Prophylaxis (PrEP) in the Australian setting and a number of demonstration projects are underway to examine PrEP's place in the Australian prevention response.

b) Testing

Australia is focused on the need to increase the number of people who have ever been tested and ensure that testing routines are appropriately matched to level of risk, particularly among the populations most at risk. The purpose of this is to both decrease the level of undiagnosed HIV in the community and to shorten the time between infection and diagnosis and treatment.

Testing models will focus on simplifying the testing process for individuals and address access and acceptability issues including cost, time and convenience. This requires 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 testing in non-laboratory settings is a significant development which has great potential to increase the rate of voluntary and appropriate testing among priority populations. Implementation of HIV rapid testing at point of care and in non-clinical community settings in Australia is underway.

c) Management, Care and Support

Initiatives in care, treatment and support are aimed at improving access to systems that promote the health and quality of life for people living with HIV. In particular, improving models of care by adapting chronic disease models to the HIV context and supporting the transition of HIV treatment to the primary health care, and shared health care settings.

In 2014, Australia removed of CD4 count requirements to receive subsidised ART medicine allowing access to ART regardless of CD4 count. In July 2015, ART medicine will be available in community pharmacies.

It is important to understand that Australia's strong response in HIV management, care and support is situated in the context of an established and resourced universal health care system with subsidised drugs and medical services available to all citizens. Australia's initiatives in this area are therefore focused on improving the accessibility of these systems for the populations in need.

d) Workforce

Australia is focused on ensuring that the health promotion and healthcare workforce is sustainable, appropriately skilled and sufficiently resourced.

Workforce issues include the recruitment and retention difficulties for general practitioner HIV treatment prescribers and clinicians with an interest in HIV, and the importance of ongoing training, support and financial resources for medical, nursing and healthcare professionals. Professional development addresses multidisciplinary team roles, effective case management, and the delivery of culturally appropriate services for priority populations.

HIV care is accessed in mainstream services, and shared-care audits and protocols have been implemented. Strategies are being explored to encourage existing community general practitioner HIV prescribers to maintain their HIV practice and to encourage new prescribers and healthcare providers in shared-care arrangements to enter the field.

The workforce supporting HIV rapid testing in non-laboratory settings is being supported to adjust to new technologies, particularly in non-specialist HIV services and community-based organisations.

e) Enabling Environment

Enabling social and legal environments are important in ensuring access to HIV prevention, treatment, care and support. Australia is committed to challenging stigma and discrimination that can have negative consequences for psychological wellbeing and on health outcomes for people with HIV, and this is a priority action under the HIV Strategy.

The Australian Government works with all partners in Australia's HIV response, including representatives from affected populations, to meet these challenges.

f) Surveillance, Research and Evaluation

Australia's commitment to a high quality surveillance, research and evaluation program reflects the United Nations Declaration and the World Health Organization's position on the importance of 'knowing' the HIV epidemic.

Australia continues to produce robust annual surveillance reports regarding HIV and other BBV and STI, informed through a national notification system. This surveillance is regularly reviewed to ensure that the data collected informs targeted activities for populations most at risk and most affected.

Australia maintains a strong research program that informs and responds to strategic priorities to ensure that policy and programs continue to be supported by a strong evidence base. Social, behavioural, epidemiological, clinical and evaluative research continues to inform health promotion, treatment, care and support.

g) Protection of the National Blood Supply

In addition to the efforts made implementing the Strategies, Australia maintains established mechanisms to protect the national blood supply through quality assurance and quality control policies and processes.

IV. Best practices

A publicly funded universal health care system provides the necessary infrastructure to allow affordable, reliable and accessible testing and treatment of HIV. The two primary components of this system are Medicare and the Pharmaceutical Benefits Scheme.

Medicare is the publicly funded health care scheme that provides subsidised medical treatment from doctors and a number of other medical practitioners for a comprehensive list of medical services.

Medicare is complimented by the Pharmaceutical Benefits Scheme (PBS), which provides access to subsidised prescription medicines. The PBS ensures affordable and reliable access to a comprehensive list of medicines.

The availability of needle and syringe programs continues to contribute to the consistent low HIV prevalence among people who inject drugs.

Community led and peer based interventions among gay men, sex workers and people who inject drugs provide trusted programs to priority populations.

Partnerships with affected communities, research organisations and service providers inform policy and program responses.

Regular and reliable monitoring and surveillance, such as through annual surveillance reports, maintain understanding of the HIV epidemic in Australia.

V. Major challenges and remedial actions

a) Progress made

- Maintaining low rates of HIV among sex workers and people who inject drugs and virtual elimination of mother to child transmission
- Introduction of HIV rapid tests
- The removal of CD4 count requirements to receive subsidised ART medicine
- Australia's successfully hosting of the 20th International AIDS Conference in 2014
- Australia's 2014 AIDS Melbourne Declaration
- Community pharmacy dispensing of ART medicines, available from July 2015

b) Challenges faced

- The notification rate in 2013 demonstrated a maintained increase in the rate of HIV infection over the last 20 years.
- Continuing to address HIV related stigma and discrimination, particularly in health care settings.

VI. Support from development partners (if applicable)

Not applicable.

VII. Monitoring and evaluation environment

National surveillance of HIV and AIDS is coordinated by the Kirby Institute in collaboration with state and territory health authorities, the Australian Government Department of Health, the Australian Institute of Health and Welfare and other collaborating networks in surveillance of HIV.

Newly diagnosed HIV infections and AIDS are notifiable conditions in each state and territory health jurisdiction in Australia. Under national HIV surveillance procedures, AIDS notifications are forwarded to the National AIDS Registry and newly diagnosed HIV infections are reported to the National HIV Registry for national collation and analysis. A range of information is sought at notification, including state/territory of diagnosis, name code, sex, date of birth, country of birth, Aboriginal and Torres Strait Islander status, date of diagnosis, CD4+ cell count at diagnosis, source of HIV exposure and AIDS defining illness.

Information on sexual behaviour in a cross section of gay men is collected annually via Gay Community Periodic Surveys conducted in six state and territory capitals. HIV incidence and incidence of specific sexually transmissible infections among gay and other homosexually active men is determined from longitudinal studies, such as the Health in Men study of HIV-negative men, and the Positive Health study of HIV-positive men, both based in New South Wales.

HIV seroprevalence among people who have injected drugs is determined via a blood test and self-administered questionnaire of people attending needle and syringe program sites during one week each year. HIV seroprevalence among people seen at sexual health clinics is determined through a network of selected metropolitan sexual health clinics that quarterly and annually provide tabulations of the number of people seen, the number tested for HIV antibody and the number newly diagnosed with HIV infection.

A Surveillance and Monitoring Plan for the National Strategies will inform and monitor progress on achieving the targets and reaching the goals of the National Strategies. The Surveillance and Monitoring Plan is currently being developed.

ANNEX 1

Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV and AIDS

In Australia, the report writing process commenced in January 2015. The Australian Government Department of Health coordinated the response.

The following organisations and government departments were engaged to assist in the data collection:

- The Kirby Institute, University of New South Wales
- The Australian Department of Foreign Affairs and Trade.

Coordination and collation of data for the GARPR was conducted during February and March 2015.