

Global AIDS Progress Report

COUNTRY PROGRESS REPORT
2012

Australia

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I. Status at a glance

Inclusiveness of the stakeholders in the report writing process

A partnership approach is central to the development, continuation, implementation, surveillance and monitoring of HIV strategies in Australia. Governments, the community sector (representing people living with HIV and their communities), researchers, clinicians and the health sector workforce are all partners in Australia's response to HIV and have contributed to this 2012 Country Progress Report.

The Kirby Institute for infection and immunity in society, one of four key national research bodies funded by the Australian Government for blood borne virus and sexually transmissible infections research, was a key contributor to this report¹. Other key contributions came from:

- Non-government organisations including the Australian Federation of AIDS Organisations, the Australasian Society for HIV Medicine, the National Association for People Living with HIV/AIDS and Scarlet Alliance.
- Government departments including the Australian Government Attorney General's Department, the Department of Education, Employment and Workplace Relations and the Department of Defence.

Status of the epidemic

By the end of 2010, an estimated 30 486 cases of HIV infection had been diagnosed in Australia and an estimated 25 166 people were living with HIV infection. This corresponds to an overall prevalence of approximately 0.1 percent.

The incidence of HIV infection in Australia, as measured through diagnoses (and considering stable testing rates) and also through modelling adjustments, is stable at approximately 1 000 cases per year. Maternal transfer of HIV remains extremely low, and there were only 2 perinatally exposed children diagnosed with HIV infection in 2009 and 2010.

In the period 2006-2010, an estimated 66% of new HIV diagnoses occurred among men who have sex with men, 25% were attributed to heterosexual contact, 3% to injecting drug use and exposure was undetermined in 7% of new HIV diagnoses. The number of cases attributed to heterosexual contact (excluding cases from a high prevalence country) increased by 38% between 2001-2005 and 2006-2010. Little to no HIV is transmitted through female commercial sex.

¹ **Note:** At the time of writing, confirmed data on HIV and AIDS in Australia are available only to the end of 2010. This report confines itself to the reporting of confirmed data.

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

Policy and programmatic response

National strategies

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 is facilitated by the Australian Government Department of Health and Ageing. The current strategies cover the years 2010-2013 and were endorsed by all Australian Health Ministers from the Australian Government and each of the states and territories in 2011. They are:

- The Sixth National HIV Strategy
- The Second National Sexually Transmissible Infections Strategy
- The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy
- The National Hepatitis B Strategy
- The Third National Hepatitis C 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 Sixth National HIV Strategy 2010–2013 (the HIV Strategy) provides guidance and policies relating to the prevention, testing and treatment of HIV in Australia. This strategy was developed in a partnership with community stakeholders, affected communities, research organisations, medical professionals and state and territory health departments in a cooperative approach to fight HIV. The partnership approach has been recognised as a success globally.

Key priority action areas in the HIV Strategy are:

- Prevention
- Diagnosis and testing
- Treatment, health and wellbeing
- Human rights legislation and anti-discrimination
- Surveillance
- Research.

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 (or who travel to) high prevalence countries
- Sex workers
- People in custodial settings

- People who inject drugs (PWID)

An implementation plan for the national strategies is in place which provides guidance as to how each priority action will be addressed. The plan also outlines steps to measure the progress in meeting the goals of the national strategies.

The first National BBV & STI Surveillance and Monitoring Plan was developed in 2011 to measure ongoing progress towards reaching the goals of the national strategies. The plan provides a national framework and tool for regular monitoring and reporting of the progress and performance of HIV, STIs and viral hepatitis in line with the national strategies.

Australia's national strategies can be found at the following link:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010>

More information regarding the National BBV & STI Surveillance and Monitoring Plan can be found at the following link:

<http://www.health.gov.au/internet/publications/publishing.nsf/Content/ohp-bbvs-plan10-13-1~ohp-bbvs-plan10-13-1-1>

A mid-term review of the all the national strategies on BBVs and STIs is scheduled for 2012. This review will determine the priorities that still require action under each national strategy. It will also seek to determine any barriers that may prevent priority actions from being addressed and identify gaps.

The HIV Strategy is also being reviewed in light of new developments in treatment and prevention and also in relation to the United Nations 2011 Political Declaration on HIV/AIDS to intensify efforts to eliminate HIV/AIDS.

Indicator data in an overview table

Key

DNA – Data not available

* – Different data source/indicator used

N/A – Not applicable

Targets and indicators

%

1.1	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	
	Source: Respondents to Fourth National Survey of Secondary Students and Sexual Health (2008) who correctly answered the following questions:	
	<i>Question 1:</i> Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	DNA
	<i>Question 2:</i> Can a person reduce the risk of getting HIV by using a condom every time they have sex?	88.4
	<i>Question 3:</i> Can a healthy looking person have HIV?	82.9
	<i>Question 4:</i> Can a person get HIV from mosquito bites?	36.1
	<i>Question 5:</i> Can a person get HIV by sharing food with someone who is infected?	97.8
1.2*	Percentage of young men and women aged 15-24 who have had sexual intercourse before the age of 15	27.4
1.3	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	DNA
1.4	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	DNA
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	DNA
1.6*	Percentage of young people aged 15 -24 who are living with HIV	0.009

Indicators for sex workers

1.7	Percentage of sex-workers reached with HIV prevention programs	DNA
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	99.0
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	59.6
1.10	Percentage of sex workers who are living with HIV	0.04

Indicators for men who have sex with men

1.11	Percentage of men who have sex with men reached with HIV prevention programs	DNA
1.12*	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	39.0-89.7
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	71.5
1.14	Percentage of men who have sex with men who are living with HIV	11.2
Target 2	Reduce Transmission of HIV among people who inject drugs by 50 per cent by 2015	
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	202.9
2.2*	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	38.0
2.3*	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	12.4
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	47.6
2.5	Percentage of people who inject drugs who are living with HIV	1.0
Target 3	Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	85.7
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	100
3.3	Mother-to-child transmission of HIV (modelled)	DNA
Target 4	Have 15 million people living with HIV on antiretroviral treatment by 2015	
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	90 (53.9-70 of all People living with HIV)
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	DNA
Target 5	Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	DNA

Source: The Kirby Institute, February 2012

II. Overview of the AIDS epidemic

By the end of 2010, an estimated 21 391 people were living with diagnosed HIV infection in Australia². With an estimated 15 per cent of undiagnosed infections (modelling, back-projections, recruitment into trials, cross-sectional study on unrecognised infections), this corresponds to 25 166 people living with HIV in Australia (population of approximately 22 000 000) and an overall prevalence of 0.11 per cent. The HIV epidemic in Australia is concentrated particularly among MSM.

HIV prevalence among men who have sex with men

Eighty percent of the estimated 21 391 people living with diagnosed HIV infection in Australia reported male-to-male sexual contact as the likely route of exposure. Adjusting for undiagnosed infections, this provides a numerator of 20 133.

With an estimated 180 000 MSM in Australia, the prevalence is approximately 11.2 percent. Sentinel surveillance in six metropolitan sexual health clinics in the capital cities Sydney, Melbourne, Brisbane and Adelaide yielded positivity rates in 2010 of 1.0 percent for men aged less than 25 years and 2.2 percent for men aged greater than 25 years (overall of 1.9 percent); however, this is not indicative of overall prevalence. Studies from earlier years have suggested prevalence levels of 8-12 percent across different Australian states/territories. There is no evidence that prevalence has changed substantially in recent years. Prevalence levels of 10-12 percent are accepted as accurate among MSM in Australia.

HIV prevalence among female sex workers

The prevalence of HIV in female sex workers in Australia is extremely low. Among 5,413 women who had a self-reported history of sex work at any time (who accessed one of six metropolitan sexual health clinics in 2010) two were living with diagnosed HIV infection, suggesting a prevalence of 0.037 per cent.

HIV prevalence among people who inject drugs

Behavioural surveillance among People who inject drugs (PWID) is carried out for a two week period each year through the Australian Needle and Syringe Program Surveys. In 2010, and consistent with previous years, 21/1578 male PWIDs tested positive for HIV (prevalence of 1.3 per cent) and 2/758 female PWIDs tested positive

² All data in this overview has been compiled by the Kirby Institute.
The Kirby Institute: HIV, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2011. The Kirby Institute, the University of New South Wales, Sydney, NSW

for HIV (prevalence of 0.3 per cent). Overall, the HIV prevalence among PWIDs in Australia is 1.0 per cent.

HIV prevalence among Aboriginal and Torres Strait Islanders

No studies have been carried out to directly measure HIV prevalence in this population group. However, the age-standardised rate of newly diagnosed HIV infection per 100 000 population is similar in Aboriginal and Torres Strait Islander people compared with the non-Indigenous population (4.6 per 100 000 vs 4.0 per 100 000). Adjusting the overall Australian prevalence by this ratio suggests that the prevalence of HIV among Aboriginal and Torres Strait Islander people is approximately 0.13 per cent.

HIV prevalence among general population males and females

The priority populations identified in the HIV Strategy account for a very small proportion of the denominator of the total population size in Australia. However, they account for the majority of HIV infections (particularly MSM). Adjusting the numerator and denominator in the prevalence calculation by removing PWIDs (estimated population size of 163 130) and MSM (estimated population size of 180 000 with 14.2 per cent of HIV-positive men injecting drugs and 2.7 per cent of HIV-negative men injecting drugs), the estimated general population prevalence is 0.023 per cent.

III. National response to the AIDS epidemic

Prevention

Australia has a targeted HIV prevention and health promotion response that is expressed in the Sixth National HIV Strategy. Prevention focuses on populations most at risk and most affected by HIV.

Prevention, education and health promotion is delivered nationally on behalf of the Australian Government by community based organisations representing priority populations, and by state and territory government health services. 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.

Australia makes use of effective partnerships between government, clinicians, researchers and the community to ensure inclusiveness in our prevention strategies. There are clear, well-supported mechanisms for liaison and priority-setting, frankness of debate and the sharing of evidence. Mechanisms include the Blood Borne Virus and Sexually Transmissible Infections Subcommittee which has jurisdictional representation and reports to all Australian Health Ministers. Another key mechanism for inclusiveness is the Ministerial Advisory Committee on BBVs and STIs, which

comprises experts in the field of BBVs and STIs, and reports to the Australian Government.

In Australia there is a comparatively high per capita investment in HIV prevention programs targeting homosexually active men. A skilled workforce in HIV health promotion and policy is maintained through personnel working across different settings, including community-based organisations, area health services and national research centres. Workforce development approaches include the development of nationally consistent approaches to testing and support for dissemination of testing and other policies throughout the workforce.

The Australian Government has funded effective social marketing initiatives that have engaged both broad and specific audiences of MSM, including HIV positive men. The material is comprehensive in terms of both the diversity and volume of education material and in the range of different MSM to whom it speaks. It is also integrated with other interventions (e.g. a comprehensive range of community development and group support programs, sexual health testing and treatment, mental health and self-esteem and drug harm initiatives). The involvement of affected communities, through peer education, and their representative organisations has been fundamental in the development and dissemination of this material.

Australia's health promotion response prioritises and integrates issues of service access, clinician support and education. The evidence is that health promotion social marketing works best when reinforcing well thought through clinical and service responses. That is, linking social marketing to a health promotion message and investment in the development of more appropriate sexual health services in high prevalence areas.

Nationally, major achievements in prevention activities include the establishment of successful partnerships between jurisdictional and community-based organisations and affected individuals for the development and delivery of targeted prevention education and other health promotion activities.

Care, treatment 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.

The HIV positive population in Australia is made up of a large proportion of people living with manageable HIV disease³.

Treatment and care embrace a range of services, including testing, early access to health maintenance programs, antiretroviral therapy, counselling, treatment adherence programs and management of HIV associated conditions. Initiatives have been tailored to the identified needs of priority groups under the Sixth National HIV Strategy.

The Australian Government also provides considerable funding for testing and treatment through HIV testing pathology items on the Medicare Benefits Schedule

³ The Sixth National HIV Strategy 2010-2013, Commonwealth of Australia, Canberra, ACT

and the Highly Specialised Drugs program of the Pharmaceutical Benefits Scheme. In 2009-10, HIV antiretrovirals continued to be made available through the Highly Specialised Drugs program.

Testing Policy

In 2011 Australia updated its National HIV Testing Policy. The Policy aims to provide high level advice and direction, to inform more practical and detailed guidelines, protocols and practices for testing HIV. The Policy sets out the framework for providing quality testing and removing real and perceived barriers to testing. It identifies requirements and provides guidance and/or links regarding best practice procedures for the provision of HIV testing. The audience for the policy includes all health workers who are able to offer HIV testing services, other professionals whose work relates to HIV testing (e.g. surveillance staff), community-based workers involved in HIV client service delivery/ HIV education and health promotion and policy/program planners.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander communities continue to face significant public health issues and challenges around BBVs and STIs. Exacerbating these challenges is that many communities lack access to culturally appropriate treatment, care and support through primary healthcare services. There are also significant gaps in the workforce to adequately deal with this reality.⁴

While the Aboriginal and Torres Strait Islander populations are estimated to have approximately the same rates of HIV as the non-Indigenous population, in recognition of a range of factors, including much higher rates of other STIs, the National HIV Strategy recognises Aboriginal and Torres Strait Islander people as a priority population.

The Australian government has developed health promotion programs to increase the awareness of HIV risk among Aboriginal and Torres Strait Islander people in both remote and urban settings, including specific programs focused on gay and other homosexually active men, women and people who inject drugs within Indigenous communities. A Sexually Transmissible Infections and Blood Borne Viruses Infections Manual has been developed by the Aboriginal Health and Medical Research Council of NSW to improve access to early detection and treatment programs for Aboriginal and Torres Strait Islander people and communities in that state. In addition to the National HIV Strategy, the Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy also focuses on the treatment, care and support of people living with HIV.

⁴ The Third National Aboriginal and Torres Strait Islander Strategy 2010-2013, Commonwealth of Australia, Canberra, ACT

Workforce Development

The importance of ensuring that the healthcare workforce involved in HIV is sustainable and supported to provide long-term care under nationally endorsed best practice models is recognized.⁵

The Australian government and non-government organisations work to enrich workforce development for health care workers to maintain high quality expert knowledge and skills in relation to HIV. Partner organisations continue to develop and deliver high quality training and education to health care professionals and focus attention on the need for resources for culturally and linguistically diverse communities.

Knowledge and behaviour change

To ensure that knowledge and research effectively informs policy and practice, the Australian Government communicates extensively and regularly with research centres and community organisations and provides tailored advice relating to behaviour change. The development of knowledge, behaviour change and maintenance of behaviour change are priority areas for action under the Sixth National HIV Strategy. The promotion of safe sex practices, in particular, among MSM and sex workers, and the avoidance of contaminated drug injecting equipment among intravenous drug users, have been, and remain, important prevention education messages.

Four national research centres, funded by the Department of Health and Ageing, undertake research and surveillance of blood borne viruses, sexually transmissible infections, social determinants contributing to behavioural change, and other virological research. The research centres collect and publish surveillance data, and research and analyse behavioural data. The data collected by these research centres are critical to identify trends in infection patterns and assist in guiding governments' targeted responses to blood borne viruses and sexually transmissible infections. Research also targets the development of new treatments for viral infections of national and international public health importance including HIV, hepatitis B and C, human papilloma virus and herpes simplex virus.

Awareness of safe sex practices

From 2009-2010, the Australian Government implemented the National STI Prevention Program: Sexual Health Campaign to raise awareness of STIs and encourage safe sexual practices among target populations to contribute to a reduction in the prevalence of STIs.

The advertising campaign included radio, magazine, street and medical press, and online advertising. Outdoor activity included phone booth highlights, roadside billboards, cross tracks (subway billboards), chalking, street posters, bus side panels and interiors, and licensed venues featuring the heat and water sensitive decals in urinals and mirror decals in bathrooms.

⁵ The Sixth National HIV Strategy 2010-2013, Commonwealth of Australia, Canberra, ACT

Needle and syringe programs

One of the most dramatic factors contributing to Australia's success in HIV prevention has been the success of needle and syringe programs in keeping HIV rates low among injecting drug users.

From a public health perspective it is recognised that harm reduction leads to reduced risks of transmission of blood borne viruses, and does not lead to an increase in drug usage. Needle and syringe exchange programs (NSPs) are a tested and effective way to minimise the spread of HIV, and Australia pioneered their introduction into its broader community.

Harm reduction and minimisation has been a cornerstone of Australia's response to HIV. It is estimated that between 2000 and 2009, for every dollar invested in NSPs four dollars were returned in health care cost savings, and over 32,000 HIV infections averted. The Australian Government provides funding to states and territories for the provision of NSPs.

Negotiation of high levels of condom use amongst sex workers

Due to the work of community-based sex worker organisations and projects conducted in partnership with state and territory governments there is presently a low prevalence of HIV among Australian sex workers. Sex workers are able to negotiate high levels of condom use in their work and voluntary testing has also been an effective component.

World AIDS Day

In Australia, World AIDS Day aims to raise awareness in the community about issues surrounding HIV/AIDS, including the need to provide support for and not discriminate against people living with HIV/AIDS, and the continued need to prevent the spread of HIV/AIDS through means such as safe sex practices. Coordinated national and local events are held each year on World AIDS Day across Australia, with the close involvement of affected communities, and supported by the Australian and state and territory governments. In 2011 the WAD launch was held at the Sydney Opera House and was opened by the Prime Minister the Hon Julia Gillard MP.

IV. Best practices

Australia's HIV response is recognized globally as a success. National prevalence is lower than in most other comparable countries. Australian gay communities, sex workers and people who inject drugs mobilized early and effectively to the emergent crisis, providing care and support and educating each other through peer education and community based organisations about safe sex and injecting practices. Government and healthcare professionals demonstrated strong leadership in their engagement with affected communities and the epidemic in its early days. This leadership produced a level of policy innovation that Australia continues to benefit

from, for example, in the implementation of needle and syringe programs that prevented a large-scale HIV epidemic among people who inject drugs⁶.

National Blood Borne Viruses and Sexually Transmissible Infections Strategies

During the years 2010-2013, Australia's response to HIV and other blood borne viruses is guided by the National Blood Borne Viruses and Sexually Transmissible Infections Strategies. These documents guide policies in relation to the prevention, testing, treatment and more in relation to HIV and other BBVs and STIs. The strategies were developed in partnership with community stakeholders, research organisations, medical professionals and state and territory health departments.

Monitoring and Surveillance of the BBVS Strategies

Australia's National Blood Borne Virus and Sexually Transmissible Infections Surveillance and Monitoring Plan is a supporting document to the National Strategies for BBVs and STIs. The Plan has been developed to measure progress towards reaching the goals of the National Strategies. This National BBV and STI Surveillance and Monitoring Plan details how each of the indicators in the National Strategies will be measured and reported, and outlines the next steps that need to be taken for measures that are not currently reported. The development of the National BBV and STI Surveillance and Monitoring Plan was led by a steering committee under the auspices of the Communicable Diseases Network Australia.

V. Major challenges and remedial actions

Progress made

Australia has endorsed the United Nations General Assembly Declaration of Commitment on HIV (2001), the UN Political Declaration on HIV 2006 and the UN 2011 Political Declaration on HIV/AIDS, including commitments to universal access to HIV prevention, care, support and treatment.

The strength of Australia's response to HIV/AIDS remains grounded in the continued partnership adopted for the coordination and implementation of activities under the Sixth National HIV Strategy 2010-2013.

During this reporting period, Australia has been successful in maintaining the low rates of HIV among PWID and sex workers, and has seen the rates of newly diagnosed infections stabilise at around 1 000 per annum.

A major policy achievement has been the development and endorsement of the Sixth National HIV Strategy and the Third National Aboriginal and Torres Strait Islander BBV and STI Strategy by all Australian Health Ministers. Significant progress has

⁶ Sixth National HIV Strategy 2010-2013, Commonwealth of Australia, Canberra, ACT

also been made in implementing a number of key priority action areas identified in the National Strategies, including in anti-discrimination and destigmatisation.

A Legal and Discrimination working group, under the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections, was convened to identify legal barriers and impediments to a human rights approach to the prevention, management, treatment, reporting and monitoring of blood borne viruses and sexually transmissible infections, and to provide advice on these issues to the Australian Government.

Australia also developed its First National Blood-borne Virus and Sexually Transmissible Infection Surveillance and Monitoring Plan, which is a supporting document to the National Strategies for BBVs and STIs. The Plan was developed to measure progress towards reaching the goals of each of the National Strategies, and represents the first consolidated approach to capturing data and identifying any data gaps in relation to the specific indicators in the strategies.

Challenges faced

While Australia maintains its low rates of HIV, it is vital that prevention messages are not lost among the general population. It is also crucial that priority and at risk populations remain at the centre of the response.

While rates among target populations remain low and stable, there has been an increase in new diagnoses of heterosexually transmitted HIV in Australia. The number of new HIV diagnoses for which exposure to HIV was attributed to heterosexual contact increased from 848 in 2001-2005 to 1 297 in 2006-2010. This represents an increase from 19 percent to 25 percent of total HIV diagnoses in the same periods.

Australia also faces a challenge in engaging younger generations in the HIV response. The importance of engaging upcoming generations in the global response to HIV was acknowledged at the 2010 International AIDS Conference in Vienna. Young people are not identified as a priority population in Australia's National HIV Strategy, as they are not a high risk group. However, in order to ensure the continuity of prevention messages and safe practices in the general population and in upcoming generations, their direct and active involvement and engagement is important.

Planned remedial actions

In addition to needing to reach the broader population and containing heterosexually transmitted HIV, Australia also needs to maintain its track record of low HIV rates among identified priority populations through targeted interventions, while avoiding stigmatising these already marginalised groups.

The incidence of HIV in female sex workers in Australia is extremely low, due to establishing safe sex as a norm, making safe-sex equipment available, and because of community based and peer based interventions. The HIV epidemic also remains

stable among PWID. However, rates are very sensitive to change among both of these groups, due to the risks associated with high numbers of sexual partners, or risks associated with injecting drug use, and continued support and recognition of these groups in policy and programmatic responses is essential. In order to achieve this, Australian governments will continue to:

- Support the partnership approach which is inclusive of community organisations, researchers, clinicians, the health sector workforce and those people living with HIV
- Provide leadership to facilitate national policy formulation and coordination
- Take opportunities to involve younger people with expertise and youth focused organisations into the national HIV response
- Scale-up targeted messages to MSM about the importance of regular testing.

In addition to the Australian government, each state and territory has its own government department responsible for health services, and its own AIDS councils. Ongoing coordination of the activities of all levels of government and community and research organisations continues to be important to ensure that services are not unnecessarily duplicated and to eliminate instances of overlapping research in order to improve the efficiency and effectiveness of Australia's HIV response.

VI. Support from the country's development partners (if applicable)

Not applicable - Australia does not have development partners that contribute to the achievement of United Nations Global AIDS Progress reporting targets within Australia.

VII. Monitoring and evaluation environment

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

Diagnoses of specific sexually transmissible infections are notified by state and territory health authorities to the National Notifiable Disease Surveillance System, maintained by the Australian Government Department of Health and Ageing.

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.

The Australian HIV Observational Database (AHOD) is a collaborative study that records observational data on the natural history of HIV infection and its treatment. The primary objective is to monitor the pattern of antiretroviral and prophylactic treatment use by demographic factors and markers of HIV infection stage. Other objectives are to monitor how often people with HIV infection change antiretroviral treatments and the reasons for treatment change.

All blood donations in Australia have been screened for HIV-1 antibodies since 1985 and HIV-2 antibodies since 1992. Prior to donation, all blood donors are required to sign a declaration that they do not have a history of any specified factors associated with a higher risk of HIV infection and other blood borne infections.

Monitoring Australia's response

The implementation and effectiveness of the National HIV Strategy and the status of the HIV/AIDS epidemic in Australia are monitored through mechanisms that include:

- publication of an annual surveillance report on HIV, viral hepatitis and sexually transmissible infections in Australia by the Kirby Institute and an annual report of HIV, hepatitis and sexually transmissible infections in Australia - trends in behaviour by the National Centre in HIV Social Research in collaboration with the Kirby Institute and the Australian Research Centre in Sex, Health and Society.
- monitoring and surveillance activities of state and territory health authorities and AIDS councils, including activities undertaken in support of the Sixth National HIV Strategy 2010-2013.
- state and territory government reporting against the National Healthcare Agreement Indicators to reduce the incidence of HIV and to reduce the risk behaviours associated with the transmission of HIV.
- regular meetings of the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections to consider ongoing and emerging issues and provide advice to the Australian Government Minister for Health.

- monitoring and evaluation of activities undertaken by national community-based organisations concerned with HIV.
- a mid-term review of the all the national strategies is scheduled for 2012. This review will determine the priorities that still require action under each national strategy. It will also determine what barriers may prevent priority actions from being addressed.
- an update to the National HIV Strategy is being considered in light of new developments in treatment and prevention and also in relation to the United Nations 2011 Political Declaration on HIV/AIDS to intensify efforts to eliminate HIV.

Note regarding data collection in Australia

Data presently collected in Australia are not completely aligned with the UN Global AIDS Progress Report data set and some indicators in the NCPI are not able to be reported on. In particular, a breakdown of HIV spending to the level of detail required by the UN Report is not available. Instead, a summary of the Australian Government's spending on HIV is provided. Other indicators, e.g. programs for children orphaned by AIDS are, by and large, not relevant to the nature of Australia's epidemic, with very low rates and concentrated prevalence.

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

ANNEX 2: Australia's AIDS Spending

ANNEX 3: National Commitments and Policy Instrument (NCPI) Parts A & B

ANNEX 1

Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

In Australia, the report writing process commenced in December 2011. The Australian Government Department of Health and Ageing coordinated the response. Government departments and non government organisations were contacted to seek their engagement with the reporting process.

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

- The Kirby Institute
- The Australian Federation of AIDS Organisations
- The Australasian Society of HIV Medicine
- National Associations for People Living with HIV
- Scarlet Alliance
- The Australian Government Department of Defence
- The Attorney General's Departments
- The Department of Education, Employment and Workplace Relations

The Australian Government Department of Health and Ageing was involved in pre production for the GAPR by attendance at the Webinar, hosted by UNAIDS on 15 February 2012.

Coordination and collation of data for the GAPR was conducted during February and March 2012.

ANNEX 2

AIDS Spending in Australia

Local currency: Australian Dollar

Average exchange rate with US dollars during the reporting cycle:

USD\$1=AUD\$1.0060.

All amounts are in Australian dollars (AUD).

A detailed breakdown of AIDS spending for 2010-11 financial year to the level required for the 2012 Global AIDS Progress Report National Funding Matrix is not available in Australia.

Specific BBVs and STI funding

Expenditure for specific blood borne viruses and sexually transmissible infections (BBVS) programs administered by the Australian Government Department of Health and Ageing in the 2010-11 financial year was \$52 million. These programs included:

- four national research centres;
- seven community based organisations for education, prevention and advocacy activities;
- social marketing campaigns, including promotion and participation in World AIDS Day;
- the National Serological Reference Laboratory which protects the nation's blood supply from HIV and hepatitis contamination through its quality control and quality assurance and confirmatory testing programs;
- the National STI Prevention Program;
- research support into HIV/AIDS from the National Health and Medical Research Council;
- expenditure for Aboriginal and Torres Strait Islander sexual health; and
- Secretariat support for the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections.

Additional funding

Domestic programs

Funding for HIV/AIDS pharmaceuticals is provided by the Australian Government under the Highly Specialised Drug Program. In 2009-10 a total of \$169 million was funded for HIV/AIDS medication. Testing for HIV/AIDS is funded through Australia's medical benefits schedule, Medicare, but funding for this cannot be disaggregated.

Australian Government funding is also provided to Australian states and territories through the National Healthcare Agreement (NHA). These are five year agreements with states and territories and are for acute care focussing on the health care needs of all Australians, access to support and education for healthy lifestyle choices, an emphasis on patient experience, social inclusion, Indigenous Health and sustainability. Current agreements are for the period 2008-09 to 2012-13 for the total amount of \$64.4 billion, over five years.

Regional and International programs

Funding for basic health care, health systems and disease control through the Australian Government's overseas aid program was an estimated \$634 million in 2010-11. The Australian Government, through the Australian Agency for International Development (AusAID), supports large bilateral HIV programs in Papua New Guinea and Indonesia, regional programs in Asia and the Pacific, and global programs through multilateral organisations, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Joint United Nations Programme on HIV/AIDS (UNAIDS). HIV specific funding through the aid program in 2010-11 was an estimated \$105 million. In addition, Australia provides funding to strengthen health systems in partner countries as HIV responses are directly dependant on well-functioning health systems. For example Australia supports health workforce development, health financing and health data collection and statistics.

ANNEX 3

National Commitments and Policy Instrument (NCPI)

(Also submitted online)