Seventh National HIV Strategy

2014 – 2017
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1. Introduction

Despite a highly successful response to HIV - built on partnership and community mobilisation and resulting in low rates of infection - Australia is now at a crossroads. We are witnessing the highest rates of new infections in 20 years. There were 1,253 cases of HIV infection newly diagnosed in Australia in 2012, representing a 10 per cent increase from new diagnoses in 2011. Seventy per cent of these new diagnoses of HIV occurred among men who have sex with men (1).

Evidence of increasing rates of high risk sexual behaviour among some gay men and men who have sex with men suggests that messages around the importance of safe sex practices for preventing HIV transmission are having less impact. At the same time, HIV testing among gay men has been decreasing. The average time from infection to diagnosis remains too long at approximately 4.5 years.

The Seventh National HIV Strategy sets the direction for Australia to reverse the increasing trend of new HIV diagnoses. For the first time, the national HIV strategy includes discrete targets. These targets are informed by the 2011 United Nations Political Declaration on HIV and AIDS and adapted to the Australian context.

The targets come with enormous challenges. Reducing sexual transmission of HIV by 50% by 2015 will require considerable effort given Australia’s relatively low HIV prevalence, and high testing and treatment coverage. Modelling shows that to achieve this, a doubling of the current rate of HIV testing would be required, and 95% of people diagnosed with HIV would need to be using antiretroviral therapies, up from the current estimate of 70% (2).

To achieve the targets, we need to address the range of individual, social and structural barriers that we know impact negatively on prevention, testing, treatment, care and support for people living with and at risk of HIV.

The strong partnership approach that produced such an effective response in the 1980s is required now more than ever, but in the face of increasing rates of HIV infection a business as usual approach will not be enough.

Partners need to review and refresh existing approaches to ensure that the impact of traditional prevention messages, and new testing and treatment options, reach the population groups where surveillance shows that rates of HIV are high or rising. These include young gay men and men who have sex with men, people from high HIV-prevalence countries, and Aboriginal and Torres Strait Islander people who inject drugs.

Scientific advances in preventing and treating HIV have provided us with the knowledge and the means to make dramatic reductions in new HIV infections, HIV-related illnesses and deaths. People living with HIV can now expect to live long and productive lives, with HIV managed as a chronic condition. Yet there is a risk that complacency about the seriousness of this disease can continue to undermine the significant progress already made in this country.

After three decades of responding to HIV in Australia, now is the time for all Australian governments, clinicians and researchers, community and professional organisations, and individuals to step up the pace to create a future without HIV. At this point in the response, the
actions and decisions taken by individuals to embrace both prevention and treatment are paramount.

Together, we need to implement the solutions that will raise community awareness that HIV can be defeated, increase the impact of prevention messages, increase testing rates, reduce the time between infection and diagnosis, link people into treatment and support, and increase the number of people who stay on treatment.

The 2011 United Nations Political Declaration on HIV and AIDS is mobilising action globally and provides direction for the actions that are needed to defeat HIV and AIDS. Australia is experiencing increasing HIV diagnoses and collectively we need to maintain our focus and step up the pace. We must harness the success of the past – the early response to HIV that has been held up internationally as a success - to meet the challenges we face in 2014 and beyond. Australia is well placed to achieve this goal.
2. HIV in Australia

At the end of 2012, an estimated 28,000 to 34,000 people were living with HIV infection in Australia. The incidence of HIV notifications, a marker for incidence of new infections, has been increasing since 1999, with 1000 to 1300 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 per cent in 2012; the highest number of new cases in 20 years (1).

In 2012, 73.1% of people diagnosed with HIV acquired the infection through male homosexual contact, 15 per cent through heterosexual contact (approximately half of which was among people from high prevalence countries or their partners), and 3 per cent through injecting drug use (1). Mother-to-child transmission of HIV is very rare in Australia (1).

The prevalence of HIV infection in Australia is greatest among gay men and other men who have sex with men, at 14.0 per cent in this population group and around one per cent among People Who Inject Drugs (PWID). Female sex workers, including migrant sex workers, continue to maintain historically low rates of HIV (1).

Overall the annual number of HIV notifications among Aboriginal and Torres Strait Islander people is small, and rates of diagnoses are similar to the non-Indigenous population. However, the rates of heterosexual transmission and transmission related to injecting drug use are higher than the non-Indigenous population, requiring action to protect against more generalised spread among Aboriginal and Torres Strait Islander people (1).

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 smaller but important epidemics emerging. An important 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. Projected demographic modelling indicates this mode of HIV transmission may become increasingly more important, particularly in Western Australia.

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.
3. Achievements

<table>
<thead>
<tr>
<th>2010 to 2013</th>
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<tbody>
<tr>
<td>• Australia signed the United Nations Political Declaration on HIV/AIDS</td>
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<td>• The Therapeutic Goods Administration registered the first point of care test for HIV</td>
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<td>• Ongoing low rates of HIV transmission among sex workers and people who inject drugs</td>
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<tr>
<td>• Innovative programs implemented by states and territories to promote prevention among gay and bisexual men</td>
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<tr>
<td>• Enhanced primary health care linkages with specialist and allied health services</td>
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<td>• Improved systems implemented for monitoring and surveillance of HIV</td>
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<td>• Continued investment in behavioural, clinical, epidemiological, and social research to inform policy and priority setting in the response</td>
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<tr>
<td>• First HIV Stigma Audit documenting the experiences and effects of stigma on the lives of people living with HIV in Australia</td>
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4. Measuring progress

4.1 Goals

The goals of the Seventh National HIV Strategy are to:

- Work towards achieving the virtual elimination of HIV transmission in Australia
- Reduce the morbidity and mortality caused by HIV
- Minimise the personal and social impact of HIV.

4.2 Objectives

The Seventh National HIV Strategy has six objectives which, in combination, support achievement of the Strategy’s goal:

1. Reduce the incidence of HIV
2. Reduce the risk behaviours associated with the transmission of HIV
3. Decrease the number of people with undiagnosed HIV infection
4. Increase the proportion of people living with HIV on treatments with undetectable viral load
5. Improve quality of life of people living with HIV
6. Eliminate the negative impact of stigma, discrimination, legal and human rights issues on people’s health.

4.3 Targets

Targets are included for the first time in the Seventh National HIV Strategy, providing a renewed focus for action and a framework for accountability. These targets have been adapted to the Australian context from those in the 2011 United Nations Political Declaration on HIV and AIDS, and were endorsed by all members of the Council of Australian Governments (COAG) Standing Council on Health in 2013.

The targets of the Seventh National HIV Strategy are to:

1. Reduce sexual transmission of HIV by 50 per cent by 2015
2. Sustain the low general population rates of HIV in Aboriginal and Torres Strait Islander people and communities
3. Sustain the virtual elimination of HIV amongst sex workers
4. Sustain the virtual elimination of HIV amongst people who inject drugs
5. Sustain the virtual elimination of mother-to-child HIV transmission
6. Increase treatment uptake by people with HIV to 90 per cent
7. Maintain effective prevention programs targeting sex workers and for people who inject drugs.
Sexual transmission remains the primary mode of HIV transmission in Australia, and the primary focus to eliminating HIV transmission in Australia. A reduction of 50% is a substantial challenge, given the relatively low levels of transmission in Australia, and requires major increases in both testing and treatment.

A continuing emphasis on safe sex and injecting practices is required to contribute to the reduction in sexual transmission, and sustain low rates of HIV transmission in the priority populations. Effective prevention programs must be maintained to achieve this.

Current estimates suggest only 50-70% of people who know they are living with HIV are receiving antiretroviral treatment (2). To maximise the potential benefits for the individual and the prevention of transmission, treatment uptake must be improved greatly.

Further work is required on how the targets will be measured.

4.4 Indicators

Indicators will be used to monitor the implementation of the strategy, report against progress in achieving targets and objectives, and inform changes in the response as required.

The indicators listed below can currently be reported on. There are limitations in the ability to measure progress against many of the objectives and targets, both in the robustness of the available indicators and in some cases the lack of available data or appropriate methodology. Further work in particular is needed to define the indicators required to inform Targets 1, 3, 4 and 7.

There is no indicator currently available to measure progress in reducing the health impact of stigma, discrimination, legal and human rights. Revision of indicators is required in the measurement of treatment, and incidence measures for some of the priority populations, to monitor progress against target achievement. Further limitations and gaps are discussed in section 6.6.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
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<tbody>
<tr>
<td>Reduce the incidence of HIV</td>
<td>Incidence of recent HIV infection among HIV diagnoses</td>
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<td></td>
<td>Estimated incidence of HIV <em>(Target 2 and 5)</em></td>
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<tr>
<td>Reduce the risk behaviours associated with the transmission of HIV</td>
<td>Proportion of gay men who have engaged in unprotected anal intercourse with casual male partners in the previous six months</td>
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<td></td>
<td>Proportion of people who inject drugs reporting re-use of someone else’s needle in previous month</td>
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<tr>
<td>Decrease the number of people with undiagnosed HIV infection</td>
<td>Proportion of gay men who have been tested for HIV in the previous twelve months</td>
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<tr>
<td></td>
<td>Proportion of people who inject drugs who have been tested for HIV in the previous twelve months</td>
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<td></td>
<td>Median CD4 count at HIV diagnosis</td>
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<td>Increase the proportion of people living with HIV on treatments with undetectable viral load</td>
<td>Proportion of people living with diagnosed HIV who are receiving antiretroviral treatment (Target 1) Proportion of people receiving antiretroviral treatment for HIV infection whose viral load is less than 50 copies/mL</td>
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<tr>
<td>Improve quality of life of people living with HIV</td>
<td>Proportion of people with HIV who report their general health status and their general wellbeing to be excellent or good</td>
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<tr>
<td>Eliminate the negative impact of stigma, discrimination, legal and human rights issues on people’s health</td>
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### 4.5 Implementation and Evaluation

The Seventh National HIV Strategy 2014–2017 sets high level directions for action over the next four years. An Implementation and Evaluation Plan will be developed in consultation with partners and will detail how priority actions will be implemented, including roles and responsibilities, timeframes and lines of accountability.

Australia’s world recognised partnership approach will remain central to our response to blood borne viruses and sexually transmissible infections. Undertaking the actions set out in this strategy by December 2017 requires Australian, state and territory governments; community organisations; service delivery organisations; professional bodies; and, research institutions to work together. In doing this, we need to ensure that infected and affected individuals and communities remain at the heart of our response and involved in activities as they are proposed, developed and implemented.

This strategy builds on its six predecessors, which have guided Australia’s response to HIV and AIDS between 1989 and 2013. It is one of five interrelated national strategies aiming to reduce the transmission and impact of BBVs and STIs. The other strategies are the:

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

The five national strategies share common structural elements, designed to support a coordinated effort in addressing common concerns. Much of the prevention, health care and community responses contained in the strategies are intrinsically linked through co-infections, commonalities in risk factors and shared responsibility for the clinical management of BBVs and STIs.
5. Guiding principles underpinning Australia’s response

The guiding principles informing this strategy are drawn from Australia’s efforts over time to respond to the challenges, threats and impacts of HIV, STIs and viral hepatitis.

**Human rights:** People with HIV, STIs and viral hepatitis have a right to participate fully in society, without experience of stigma or discrimination, and have the same rights to comprehensive and appropriate health care as other members of the community (including the right to the confidential and sensitive handling of personal and medical information).

**Access and equity:** Health and community care in Australia should be accessible to all based on need. The multiple dimensions of inequality should be addressed, whether related to geographic location, gender, sexuality, drug use, occupation, socioeconomic status, migration status, language or culture. Special attention needs to be given to working with Aboriginal and Torres Strait Islander peoples to close the gap between Aboriginal and Torres Strait Islander health status and that of other Australians (3).

**Health promotion:** The Ottawa Charter for Health Promotion provides the framework for effective HIV, STI and viral hepatitis health promotion action and facilitates the:
- active participation of affected communities and individuals to increase their influence over the determinants of their health; and
- formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights.

**Prevention:** The transmission of HIV can be prevented by adopting and maintaining protective behaviours. Education and prevention programs, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures.

**Harm reduction:** Harm reduction approaches underpin effective measures to prevent transmission of HIV, including needle and syringe programs and drug treatment programs.

**Shared responsibility:** Individuals and communities share responsibility to prevent themselves and others from becoming infected, and to inform efforts that address education and support needs. Governments and civil society organisations have a responsibility to provide the necessary information, resources and supportive environments for prevention.

**Partnership:** An effective partnership of governments, affected communities, researchers and health professionals is characterised by consultation, cooperative effort, respectful dialogue and joint action to achieve this strategy’s goal. This includes:
- recognition that those living with, and at risk of, infection are experts in their own experience and are therefore best placed to inform efforts that address their own education and support needs
- timely and quality research and surveillance to provide the necessary evidence base for action
- a skilled and supported workforce
- leadership from the Australian Government and the full cooperative efforts of all members of the partnership to implement the strategy’s agreed priority actions.
6. Priority populations

While HIV is an issue for the whole of Australian society, targeting responses to priority populations is critical to maximise the impact and sustainability of our response. The priority populations for this HIV Strategy reflect Australia’s epidemiological data and social context. Individuals may be members of more than one priority population.

Priority populations identified in this strategy are:

- People living with HIV
- Gay men and other men who have sex with men
- Aboriginal and Torres Strait Islander peoples
- People from high HIV prevalence countries and their partners
- Travellers and mobile workers
- Sex workers
- People who inject drugs
- People in custodial settings.

Further details on the main reasons for priority population status, specific subpopulations of higher prevalence and/or higher risk, and the main barriers and facilitators to effective responses are at Appendix A.

People living with HIV

People living with HIV are a diverse group requiring tailored responses, and are a priority for all action areas of this strategy. The strategy aims to ensure that people living with HIV benefit from appropriate, effective and high quality health and community services covering prevention, management, care and support. The meaningful participation of people living with HIV in the development, implementation, monitoring and evaluation of HIV programs and policies is central to the partnership approach and the success of the strategy.

Gay men and other men who have sex with men

Gay men and other men who have sex with men, such as bisexual and homosexually active men who do not identify as being gay, are the population group most affected by HIV in Australia with the highest prevalence and risk. HIV transmission among men who have sex with men in Australia has been increasing nationally since 1999. Addressing this resurgence of HIV transmission is fundamental to achieving the goal and targets of this strategy. Men under the age of 25 years are a particular focus given evidence of increasing unsafe sex practices and low rates of testing.

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples experience HIV rates similar to the non-Indigenous population, however a larger proportion of HIV transmission occurs through injecting drug use and heterosexual contact. There is potential for HIV rates to increase in this population due to a range of factors including sustained high prevalence of viral and bacterial STIs in many remote and very remote communities; higher rates of injecting drug use and sharing of injecting equipment; geographical, cultural and social circumstances; and over-representation in prisons and juvenile detention.
People from high HIV prevalence countries and their partners

In Australia, HIV diagnoses have been increasing among people from high HIV prevalence countries, including South East Asia and sub-Saharan Africa. Women from these population groups have a higher risk of HIV than women in the general population. Among cases of HIV infection newly diagnosed in Australia over the past five years, 10% were in people who reported speaking a language other than English at home. Targeted prevention and treatment approaches that effectively address language, cultural and gender issues are needed.

Travellers and mobile workers

People who engage in unsafe behaviours while travelling, or who travel to or from high HIV prevalence countries, are at higher risk of exposure to HIV themselves or transmission of HIV to others. People from high HIV prevalence countries who are in Australia temporarily, such as mobile workers, are emerging as a significant factor in the epidemiology of HIV in some areas such as Western Australia.

Sex workers

HIV prevention among sex workers has been highly successful in Australia and resulted in HIV incidence rates among the lowest in the world. Sex workers remain a priority population because of the ongoing potential for an increase in HIV transmission due to occupational risks. Sex workers experience barriers to health service access, including stigma and discrimination. They face a range of legal and regulatory issues including criminalisation, licensing, registration and mandatory HIV testing in some jurisdictions.

People who inject drugs

HIV prevention among people who inject drugs has been highly successful in Australia and resulted in sustained low HIV prevalence. People who inject drugs remain a priority population because of the potential for an increase in HIV transmission, for example, through changes in the availability of injecting equipment. The ability to access health services and minimise the personal and social impact of HIV continues to be affected by barriers such as stigma, discrimination and social marginalisation.

People in custodial settings

People in custodial settings are at risk of HIV transmission through unsafe injecting drug use, unsafe tattooing and unprotected sex (including through sexual assault) as these behaviours increase risk of HIV transmission. If HIV is acquired in the custodial setting there is also an increased risk of transmission to others on their return to the community. Barriers to HIV prevention in custodial settings include lack of access to the means of prevention, including sterile injecting and tattooing equipment, and condoms.
7. Priority areas for action

Significant scientific advances in the prevention and treatment of HIV mean that we now have a wider range of approaches available which can be used in combination to prevent new HIV infections. New technologies are making HIV testing easier and more accessible and have the potential to significantly reduce the average time between infection and diagnosis.

The changing landscape of HIV prevention, testing and treatment has informed the development of priority actions to be undertaken over the life of this strategy. The strategy provides direction for how these new opportunities should be implemented in the Australian context to achieve the greatest impact, and to support our efforts to reach the target of a 50% reduction in the sexual transmission of HIV.

Research has confirmed that antiretroviral treatments not only have significant health benefits for individuals, but that they have the potential to greatly reduce the risk of HIV transmission (4). ‘Treatment as prevention’ refers to the use of antiretroviral therapy (ART) for HIV-infected people at earlier stages of disease in order to reduce their infectiousness and thus reduce the risk of onward transmission.

This approach is a paradigm shift from using ART solely for the purpose of increasing health and longevity of patients with HIV. Earlier treatment reduces the viral load within the community and has a population level health benefit. Several studies are further defining the level of risk reduction in different population groups. Other new treatment technologies include pre-exposure prophylaxis (PrEP). This is an emerging biomedical intervention that may be useful in very high risk population groups.

‘Combination prevention’ is the application of multiple prevention interventions to achieve a common outcome – the prevention of HIV transmission. Elements of combination prevention include safe behaviours and condom use, testing and counselling, linkage to and retention in care, and treatment. The success of this approach, which is increasingly being discussed and implemented internationally, relies on implementation of all the components.

The introduction of HIV ‘point of care’ or ‘rapid’ testing is a significant development which has great potential to increase the rate of voluntary and appropriate testing among priority populations. Implementation in Australia to date is demonstrating that this approach is working. Given the disproportionately high contribution to HIV transmission by people who do not know they are infected, efforts to ensure people know their status and are linked to treatment, care and support are crucial.
7.1 Prevention

Priority actions

- Increase the use of safe sexual and safe injecting practices in priority populations, particularly among gay men and men who have sex with men
- Build knowledge and skills in priority populations, primary care providers, policy makers and the general community in establishing innovative HIV risk reduction programs and activities
- Assess the emerging evidence on the uptake, experience and impact of the use of treatment as prevention to determine whether these approaches are feasible, acceptable and cost effective in the Australian context
- Strengthen mechanisms to monitor and benefit from innovations and advances in biomedical, social and behavioural prevention sciences

HIV transmission in Australia occurs mostly through sexual contact and to a lesser extent through injecting drug use. Prevention strategies to date have focussed on increasing the use of safe sexual practices and safe injecting practices in priority populations. Behaviour change has been supported through multilayered approaches involving community mobilisation, social marketing, health promotion, peer education and outreach, and harm reduction strategies including provision of sterile injecting equipment through needle and syringe programs. These traditional activities remain successful in sustaining low levels of HIV transmission among people who inject drugs in the general population and sex workers.

Evidence of increasing rates of high risk sexual behaviour among some gay men and men who have sex with men suggests that the impact of messages around the importance of safe sex practices for preventing HIV transmission is waning. This demands a move away from traditional health promotion activities to alternative means of communication to bring about behaviour change. We need to re-invigorate cultures of safe sex practices among gay men and men who have sex with men, including through community-driven and peer-based education and support approaches. Prevention efforts need a renewed focus on young men who have sex with men, given evidence showing an increase in risk behaviours and reduced levels of testing among this group. We need to establish a greater level of knowledge of new prevention and treatment options and the importance of testing among this population group.

Messages also need to be better tailored to meet the needs of new Australians from high HIV prevalence countries. Patterns of infection, including infections which may occur on visits to the country of origin or from partners who travel to Australia on temporary arrangements, are not well understood and require more research. We need to explore barriers such as lack of resources, stigma and discrimination and the lack of culturally appropriate initiatives and services with communities.

At the same time, we need to sustain prevention efforts in priority populations where rates of HIV are low but there is a risk that HIV rates could increase, such as Aboriginal and Torres Strait Islander people, sex workers, people who inject drugs, and among mobile workers need to support individuals to make informed decisions about practical HIV prevention actions they can take themselves.
HIV prevention approaches targeting Aboriginal and Torres Strait Islander people need to respond appropriately to social, cultural and environmental contexts. Prevention efforts should prioritise young people and people living in remote and very remote communities given the sustained high prevalence of STIs and the associated increased risk for HIV transmission; and people who inject drugs given high rates of HIV transmission among this population through injecting drug use. Efforts to engage young people need to be contemporary, culturally appropriate, supported by the community and should be inclusive of young people outside the school environment.

The success of HIV prevention among sex workers in Australia can be attributed to effective implementation of safe sex practices by sex workers supported by effective peer education and a culture of high levels of condom use and testing. The very low rates of HIV among sex workers, including migrant sex workers, provides evidence of the effectiveness of condoms as a prevention tool and of peer education and outreach strategies for informing hard-to-reach groups about HIV risk and establishing peer norms.

Preventing transmission of HIV through injecting drug use has been effectively underpinned by needle and syringe programs. The early introduction of these services, together with peer education and outreach, and opioid substitution therapy, has seen very low rates of HIV infection among people who inject drugs in Australia (1).

Health care providers, policy makers, priority populations and the general community must be better informed about the range of risk reduction strategies and testing options now available. While research demonstrates the great potential of new prevention approaches, Australia needs to continue to monitor the impact of implementing these approaches, both positive and negative, and respond accordingly to ensure that we successfully combine new approaches with the proven focus on safe behaviours.

7.2 Testing

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<th>Priority actions</th>
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<tbody>
<tr>
<td>Increase the number of people from priority populations, particularly gay men and men who have sex with men, who are testing in a timely way and at appropriate intervals, by making testing accessible and promoting its use</td>
</tr>
<tr>
<td>Improve knowledge among priority populations about the personal and public health benefits of early diagnosis and the testing, treatment and support options available</td>
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<tr>
<td>Support high quality, safe, appropriate and accessible testing that facilitates early diagnosis through continued review of regulatory, funding, legislative and policy mechanisms associated with HIV testing</td>
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It is estimated that 20 to 30 per cent of Australians living with HIV have not been diagnosed, and that this undiagnosed group of people contribute to a significant proportion of HIV transmission and new cases of HIV (1). In addition, up to 35 per cent of people living with HIV in Australia are diagnosed late, with an average of 4.5 years between infection and diagnosis (1). We need to improve testing rates to identify undiagnosed HIV infection earlier, and ensure people receive appropriate information, management, care and support, to both
meet the target to reduce new transmissions of HIV by 50 per cent and to maximise individual health outcomes.

In the past, Australia’s rates of HIV testing in at risk populations were among the world’s best. However, gay men and men who have sex with men now test for HIV less frequently than guidelines suggest they should (5). Australia needs to increase the number of people who have ever been tested and ensure that testing routines are appropriately matched to level of risk.

Australian research has identified psychological and structural barriers to HIV testing for gay men, for example, anxiety caused by waiting for test results, and co-payment costs incurred in some primary healthcare settings (6). Similar structural issues have been identified internationally (7).

Innovative, targeted messaging is required to improve testing in at risk population groups (8). Initiatives aimed at informing people of the personal and public health benefits of early diagnosis, the range of testing and treatment options available, and links to health services and community support are needed. The role that community peers can play in facilitating an increase in testing, such as delivery of information and support to access testing, should be further explored and developed.

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 exploring new testing technologies, such as self-collection screening and testing.

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

The principles of informed consent and confidentiality underpin high rates of voluntary testing in Australia, and these principles remain central to the management of HIV. The National HIV Testing Policy (9) provides guidance to those involved in testing and is reviewed regularly to accommodate changing epidemiology and technology and to reflect the needs of the sector. An updated version will be released in the life of this Strategy.

7.3 Management, Care and Support

**Priority actions**

- Promote treatment uptake by addressing barriers to commencing or continuing antiretroviral medications, and retention in care
- Improve access to and uptake of antiretroviral medications at earlier stages of infection
- Ensure that priority populations and health care professionals are aware of new treatment approaches including treatment as prevention
- Increase the use and effectiveness of shared care models between General Practitioners and HIV specialists
- Promote the use of evidence-based clinical guidelines
Antiretroviral treatments are now highly effective, generally well-tolerated and associated with lower pill burdens (in terms of daily number and frequency of doses). Scientific advances in HIV treatment indicate a benefit from early HIV treatment for the health of people with HIV, as well as the potential for a significant reduction in the risk of onward transmission of HIV (10). Efforts to improve treatment uptake must respect decisions made by some people with HIV, in conjunction with their care providers, to defer therapy on the basis of clinical and/or psychosocial factors.

Recent estimates of the treatment continuum (2) in Australia (diagram below) suggest that 30 to 50 per cent of people who know they are living with HIV are not receiving antiretroviral treatment. A proportion of these people are either not linked to HIV care or are not retained in care. We need to address these gaps if we are to achieve the target of 90 per cent treatment uptake.

For some people living with HIV, issues around side effects, adherence, treatment failure, drug resistance and arrangements that restrict dispensing of antiretroviral medication to selected hospital pharmacies present barriers to commencing or continuing treatment. Individual based support and monitoring continues to be essential to minimise these issues and maximise health and wellbeing outcomes. Systemic and structural barriers to treatment uptake, such as dispensing arrangements, need to be explored by Commonwealth, state and territory governments.

Extending the availability of ART at earlier stages of infection in Australia increases treatment options for people living with HIV and their care providers. Clinical guidelines in Australia (11) have recently been updated to support the initiation of earlier treatment, while recognising the importance of decisions being tailored to individual needs and circumstances. Guidelines play an important role in supporting and enhancing knowledge of health care providers, and should be disseminated and implemented more broadly.

The needs of people living with HIV often vary over time. For those with complex needs, the provision of comprehensive care requires a team based interdisciplinary approach which includes general practitioners, specialists, nurses, allied health teams, community-based
services, pharmacists and other care providers. It is critical that models of care, service
delivery and resourcing are reviewed and updated to ensure that the evolving needs of people
living with HIV are met.

Approximately one-quarter of people with HIV are diagnosed by a general practitioner who
has not previously diagnosed HIV (12). This indicates the need to provide support for general
practitioners, linked to the testing process, which enhances their capacity to provide an
informed diagnosis, initiate contact tracing, and refer to specialist and support services as
required.

Specialist services and publicly funded sexual health services continue to provide an essential
service, including management for people with more complex needs and support for the
primary health care and community workforce. Innovative arrangements must be implemented
to overcome existing gaps in the availability of specialist services, such as where there are no
or a limited number of general practitioners accredited to prescribe antiretroviral medications.
It would be of benefit to explore ways that general practitioners and HIV specialists can work
together more effectively to provide better management of people with HIV in the community.

Clear protocols and pathways would ensure treatment, care and support is delivered in a
cohesive and comprehensive way across a range of medical and community settings. These
need to address early referral to treatment services, strategies to retain newly diagnosed
patients in care, and efforts to re-establish links to services for people with established HIV
infection.

The effectiveness of antiretroviral therapy means there are more people with HIV living longer
and surviving into old age. There is a growing body of evidence that HIV can substantially
impact on people as they age, for example, diseases normally associated with ageing can occur
at younger ages (13). HIV models of care need to facilitate the monitoring, care and support of
people living with HIV to manage the comorbidities associated with living with HIV infection
long-term and the natural ageing process.

7.4 Workforce

<table>
<thead>
<tr>
<th>Priority actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that HIV testing and treatment providers have adequate training and support to deliver appropriate services</td>
</tr>
<tr>
<td>Work together with relevant organisations to ensure delivery of responsive and coordinated training, continued education and professional support programs, including in regional and remote areas and for new workforce entrants</td>
</tr>
<tr>
<td>Improve collaboration between mental health, drug and alcohol, disability, clinical and community services to address the care and support needs of people with HIV</td>
</tr>
<tr>
<td>Support the capacity and role of community organisations to provide education, prevention, support and advocacy services to priority populations</td>
</tr>
</tbody>
</table>

Ensuring that the health education and health care workforce is sustainable, appropriately
skilled and sufficiently resourced is critical to the provision of quality HIV prevention, testing,
treatment and long-term care and support services. Effective support needs to be maintained
across the range of health care providers, including in non-government and community
organisations.
Workforce issues include the recruitment and retention difficulties for Section 100 GP prescribers and clinicians with an interest in HIV, and the importance of ongoing training, support and financial resources for medical, nursing and health care professionals. Professional development should address 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 need to be explored for encouraging existing community s100 prescribers to maintain their HIV practice and to encourage new prescribers and shared care providers to enter the field.

The workforce supporting HIV point of care testing needs to be able to adjust to new technologies, including in non-specialist HIV services and community-based organisations. Inclusion of HIV point of care testing competencies should be considered in existing training packages or in new qualifications.

HIV education to address stigma and discrimination should be included in training programs for staff of all specialist, primary care and community service providers. It is also important that training of mental health care workers includes promoting awareness of interactions between HIV and psychiatric medications and understanding of the nature of HIV-related conditions.

Peer support programs offering HIV education will be used to enhance education and improve engagement in HIV assessment and treatment. The role of peer educators and counsellors trained to undertake HIV tests in helping to increase testing rates will be further explored. Such a service could be linked into community health services and needle and syringe programs.

### 7.5 Removing barriers

<table>
<thead>
<tr>
<th>Priority actions</th>
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<tbody>
<tr>
<td>Reduce stigma and discrimination in community and health care settings, and empower priority populations to increase individual and community resilience</td>
</tr>
<tr>
<td>Remove institutional, regulatory and systems barriers to equality of care for people infected and affected by HIV in the health sector</td>
</tr>
<tr>
<td>Establish a dialogue between health and other sectors aimed at reducing stigma and discrimination against HIV infected and affected individuals and communities</td>
</tr>
</tbody>
</table>

Enabling social and legal environments are important in ensuring access to HIV prevention, treatment, care and support. HIV continues to attract stigma that can have negative consequences for psychological wellbeing and on health outcomes for people with HIV.

Discriminatory or unfair treatment increases the negative impact on the health status of people with BBVs and can reduce access to care. Stigma and discrimination have been correlated with poor access to health care and risk behaviour (14).

People from affected communities require protection from multiple forms of discrimination (15), not only because they may be thought to be living with a BBV, but also because of the primary stigma they may suffer because of their vulnerable status, such as men who have sex with men, people who inject drugs, prisoners and sex workers (16).
All partners in Australia’s HIV response have a responsibility to work toward ensuring that the response to HIV is human rights based. Discrimination, unfair treatment and social burdens increase the negative impact of health status and can reduce access to care.

There is an ongoing need for Australian governments to continue to review and work towards removing barriers to access to HIV prevention, treatment, care and support; to promote and protect the human rights of people with HIV and people among affected communities; and to break down the stigma and discrimination associated with HIV.

Programs that address advocacy and empowerment of priority populations to access HIV prevention, treatment, care and support in community, education, workplace, health care and legal settings should be promoted. Approaches include awareness raising initiatives, education and training programs, supporting advocacy and empowerment, improving access to effective complaint systems, and promoting research.

Support must also be provided to health care professionals, such as clinicians at the front line of HIV diagnosis and treatment, to ensure they are well informed about legal issues, including their own legal obligations, and can provide optimal information and support to patients.

Implementation of this strategy rests within the health system. However, many of the barriers to access and equal treatment of affected individuals and communities fall outside the responsibility of the health system. For example, it could be argued that criminalisation perpetuates the isolation and marginalisation of priority populations and limits their ability to seek information, support and health care. It is important that the health sector enters into a respectful dialogue with other sectors to discuss impacts of wider decisions on the health of priority groups.

### 7.6 Surveillance, research and evaluation

<table>
<thead>
<tr>
<th>Priority actions</th>
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<tbody>
<tr>
<td>• Address critical data gaps for priority populations, including incident measures and information on risk behaviours</td>
</tr>
<tr>
<td>• Explore improved and innovative approaches to measuring testing rates among priority populations, antiretroviral treatment rates and quality of life indicators among people with HIV</td>
</tr>
<tr>
<td>• Enhance evaluation and implementation research to support evidence-based and evidence building policy and program development</td>
</tr>
<tr>
<td>• Assess new technologies that help identify HIV diagnoses that are newly acquired</td>
</tr>
<tr>
<td>• Undertake research across the relevant disciplines, including social, behavioural, epidemiological, clinical and basic research to inform the delivery of the strategy</td>
</tr>
<tr>
<td>• Evaluate health promotion, testing, treatment, care, support and education and awareness programs and activities to ensure they are effective</td>
</tr>
<tr>
<td>• Explore options for assessing the impact of stigma, discrimination, legislation and regulation on barriers to equal access to health care.</td>
</tr>
</tbody>
</table>
The United Nations *Political Declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV and AIDS* and the World Health Organization *Global Health Sector Strategy on HIV/AIDS 2011-15* (17) highlight the critical importance of ‘knowing’ the HIV epidemic to ensure an effective response. High quality surveillance, monitoring, research and evaluation inform our knowledge of our epidemic and the most effective response in the Australian context.

### 7.6.1 Surveillance and monitoring

The objectives of HIV surveillance in Australia are to continuously monitor the extent, characteristics and distribution of HIV infection, risk behaviours, quality of life of people with HIV, and HIV-related morbidity and mortality to provide timely evidence to assist with planning of appropriate public health strategies and to evaluate policies and services.

Surveillance programs need to adapt and evolve to accommodate innovation and advances in the scientific and health technology areas, such as advances in treatment and the implementation of rapid HIV testing.

Comprehensive behavioural surveillance encompassing risk behaviours, prevention practices, testing routines, treatment uptake, and health needs and service use with gay and other men who have sex with men must be maintained. There would be benefit in extending behavioural surveillance to other priority populations to better inform policy and programs addressing emerging prevention, testing, treatment, care and support needs.

A number of gaps and limitations in the indicators available to monitor implementation of the strategy and progress against the targets have been identified. The National BBV and STI Surveillance and Monitoring Plan will be regularly reviewed, and strengthened as appropriate, to address these.

While the data quality and method currently used to estimate population HIV incidence is relatively high, there are gaps in our ability to systematically measure the incidence of HIV in some priority population groups.

Indicator reporting on sexual risk behaviours requires consideration of a more expanded range of risk reduction practices. Research is likely to be available to inform development of this indicator during the life of this strategy.

Opportunities to strengthen surveillance of the extent and patterns of HIV testing in priority populations will be explored.

Surveillance measures of the uptake and patterns of treatment use, the adequacy of HIV treatment, and antiretroviral drug resistance across populations will be considered and strengthened.

While this strategy includes an indicator to report against quality of life for people living with HIV, it is acknowledged that the current indicator is not the best measure. Further work should consider international surveillance tools, and the development of an appropriate indicator which can be applied across all the national strategies.

An important gap is the ability to monitor the health impact of stigma, discrimination, legal and human rights on priority populations. Options need to be explored to develop an indicator related to removing barriers to equal care that informs activities and strategies in a meaningful way. We need to make a focussed effort during the life of this strategy to make headway on this important issue.
7.6.2 Research and evaluation

The implementation of this strategy is predicated on comprehensive and efficient data collection on epidemiological, behavioural and social changes over time among priority populations to provide evidence for program development and adjustment. Research plays a critical role in providing much of the evidence base to inform policy and for designing, monitoring and evaluating programs at all levels. It is important to create opportunities to promote and sustain interaction and collaboration between researchers, participants in research and the users of research.

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

It is important that research is undertaken in partnership with community-based organisations and a partnership approach is taken to identify research priorities. The translational mechanisms by which research can inform policy and practice, and vice versa, are strengthened through continued collaboration across disciplines. Social, behavioural and biomedical research should be well connected, including in relation to emerging issues in the changing landscape of prevention and treatment. A culture of continuous improvement needs to underpin program and service development, including strong formative and evaluation research.

Monitoring and evaluating the implementation of the priority actions, and the supporting indicators and Implementation Plan, will ensure we are progressing towards, and remain focused on, reaching the targets outlined in this strategy.

Systematic evaluation of activities and programs should also focus on aligning outcomes with identified priority actions. The interrelationship between priority actions and associated programs should be monitored and linkages enhanced where appropriate.

A significant number of activities and programs have been undertaken in previous strategies and by state and territory, peak and community organisations and research centres across all six priority action areas. The opportunities for scaling up these activities and programs to a national level should be evaluated and explored.
Acknowledgements

The Seventh National HIV Strategy 2014-2017 was developed through a broad and inclusive consultation process with contributions from governments, community organisations, researchers and expert health professionals. Thanks go to all those involved in developing this Strategy.
References

1 The Kirby Institute. *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013*. The Kirby Institute, the University of New South Wales, Sydney, NSW.


13 Justice, A. Aging with Complex Chronic Disease: The Wrinkled Face of AIDS, GMHC Treatment Issues, June 2010.


### Appendix: Priority Populations

<table>
<thead>
<tr>
<th>Priority Population</th>
<th>Reason for Priority Status</th>
<th>Issues and Considerations</th>
<th>Additional Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>People living with HIV</td>
<td>• An estimated 25,708 people were living with diagnosed HIV in Australia in 2012(^1)</td>
<td>• Late diagnosis of infection</td>
<td>People with HIV are a diverse group, requiring tailored responses. These groups include:</td>
</tr>
<tr>
<td></td>
<td>• Critical role to play in ensuring appropriate and effective HIV prevention, treatment, care and support</td>
<td>• Barriers to accessing treatment, care and support, including cost of treatments</td>
<td>• People with low income, including people who receive income support</td>
</tr>
<tr>
<td></td>
<td>• May have specific education, care and support needs</td>
<td>• Stigma and discrimination, including in health care settings</td>
<td>• People who are ineligible for subsidised health care and medicines, including HIV treatment</td>
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<tr>
<td></td>
<td></td>
<td>• Limited information and support surrounding the benefits of initiating and maintaining treatment while safeguarding individual’s informed choice</td>
<td>• People with specific needs (e.g. migrants from high HIV prevalence countries, people with mental health issues, people who are incarcerated)</td>
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<tr>
<td></td>
<td></td>
<td>• Need for better engagement with specific subgroups</td>
<td>• People in serodiscordant relationships, including people wanting to conceive</td>
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<td></td>
<td>• Sexually adventurous gay men with HIV</td>
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<tr>
<td>Gay men and other men who have sex with men</td>
<td>• Population group most affected by HIV in Australia, with highest prevalence and risk; 64% of all new HIV diagnoses are in gay men between 2008 and 2012(^2)</td>
<td>• Legal inequality and stigma and discrimination related to sexuality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HIV transmission among gay men in Australia has been increasing nationally since 1999, with differing trends across states and territories</td>
<td>• Marginalisation (e.g. migrant men, men with disabilities)</td>
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<tr>
<td></td>
<td>• Unprotected anal intercourse between men remains the most</td>
<td>• Potential HIV-status divide</td>
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<td></td>
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<td>• Community-driven engagement</td>
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<td></td>
<td>• Convenient and culturally appropriate HIV/ STI testing</td>
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<td></td>
<td></td>
<td>• Limited information regarding context of new HIV infections</td>
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<td></td>
<td></td>
<td>• Limited information on the benefits of frequent testing, early diagnosis and initiating of early ART.</td>
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<tr>
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<th>Issues and Considerations</th>
<th>Additional Focus</th>
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</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander peoples</td>
<td>• Potential for widespread HIV transmission, due to geographical, cultural and social circumstances eg:  - high mobility  - lower health literacy  - shame  - underlying poor health status  - sustained high prevalence of STIs in many remote and very remote communities  - higher rates of injecting drug use and sharing injecting and other equipment (16% of HIV cases attributed to injecting drug use compared with 2% in non-Indigenous Australians)  - over representation in prisons and juvenile detention</td>
<td>• Access to culturally appropriate services, including primary healthcare services for many communities  • Language and cultural issues, including family and community relationships  • Systemic discrimination</td>
<td>• Gay men and other men who have sex with men  • People who inject drugs  • Aboriginal and Torres Strait Islander peoples and communities in urban areas  • People in contact with migrants from high prevalence countries</td>
</tr>
<tr>
<td>People from high HIV prevalence countries and their partners</td>
<td>• High prevalence (people from high prevalence countries of origin) and high risk associated with</td>
<td>• Language, cultural and gender issues  • Low health literacy and perception of risk  • Limited health-seeking behaviour</td>
<td>• Women, due to contribution of heterosexual transmission, particularly those from South East Asia, sub-Saharan Africa and other regions with high HIV prevalence.</td>
</tr>
</tbody>
</table>
### Priority Population

**Reason for Priority Status**
- extra barriers to effective HIV response
  - HIV risk is also increased among partners of people from high prevalence countries

**Issues and Considerations**
- Lack of familiarity with health system and services
- Previous negative experiences of healthcare
- Issues relating to privacy and confidentiality (e.g. use of interpreters)
- Financial barriers
- Refugees and asylum seekers may have experienced significant trauma or violence

**Additional Focus**
- Gay men and other men who have sex with men
- People who inject drugs

<table>
<thead>
<tr>
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<th>Issues and Considerations</th>
<th>Additional Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travellers and mobile</td>
<td>High risk associated with some travellers who engage in higher risk behaviours while travelling or who are exposed to greater HIV prevalence</td>
<td>Healthcare affordability, Healthcare accessibility, Lack of information directly targeted to some groups (e.g. travel campaigns)</td>
<td>People who engage in unsafe sex while travelling, Fly in-fly out workers who travel to high prevalence countries and the communities they have contact with e.g. remote areas of WA and QLD, Gay men and other men who have sex with men who travel to a high prevalence country</td>
</tr>
<tr>
<td>mobile workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex workers</td>
<td>Sex workers are at occupational risk for HIV, associated with high number of sexual encounters, Continued prevention efforts among sex workers ensure that rates of HIV among Australian sex workers remain among the lowest in the world</td>
<td>Legal and regulatory frameworks, including criminalisation, licensing, registration and mandatory HIV testing, Lack of consistent and effective anti-discrimination protections</td>
<td>Street-based sex workers, Aboriginal and Torres Strait Islander sex workers, Sex workers who inject drugs, Migrant and culturally and linguistically diverse sex workers, Transpeople sex workers, Male sex workers, Sex workers with HIV</td>
</tr>
<tr>
<td>People Who Inject Drugs</td>
<td>HIV prevalence is currently low because of effective harm reduction, including NSPs and</td>
<td>Criminalisation of drug use, Access to injecting equipment, Accessibility of NSPs</td>
<td>Aboriginal and Torres Strait Islander people who inject drugs (19% of drug injecting population vs. 3% of non-drug injecting population), Gay men and other men who have sex with men</td>
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</tbody>
</table>

*Note: The table continues on the next page.*
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<tr>
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<th>Reason for Priority Status</th>
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</thead>
<tbody>
<tr>
<td>People in custodial settings</td>
<td>Risk is high as a result of:</td>
<td>Ensuring right to health</td>
<td>Incarcerated people with HIV</td>
</tr>
<tr>
<td></td>
<td>• injecting drug use and equipment re-use and sharing</td>
<td>• Institutionalisation issues relating to surveillance, punishment and violence</td>
<td>People who inject drugs in custodial settings</td>
</tr>
<tr>
<td></td>
<td>• unsafe tattooing</td>
<td>• Continuity of access to HIV treatment and opioid substitution treatment</td>
<td>Aboriginal and Torres Strait Islander peoples</td>
</tr>
<tr>
<td></td>
<td>• unprotected sex (including sexual assault)</td>
<td>• Access to prevention equipment, including sterile injecting and tattooing equipment and condoms (lack of access to condoms in all states and territories except New South Wales)</td>
<td>People with mental health issues</td>
</tr>
<tr>
<td></td>
<td>• overrepresentation of priority population groups (e.g. people who inject drugs and Aboriginal and Torres Strait Islander peoples)</td>
<td></td>
<td>People with cognitive disabilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gay men, men who have sex with men, trans people</td>
</tr>
</tbody>
</table>
1 Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013. The Kirby Institute, the University of New South Wales, Sydney, NSW

2 Kirby Institute. HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2013. The Kirby Institute, the University of New South Wales, Sydney, NSW


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