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Reflections on a decade of HIV/AIDS surveillance in Australia

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Australians are often heard claiming that "we have the best HIV/AIDS response in the world" or words to that effect. While one could debate the basis for this conclusion, there is little doubt that Australia has achieved much with its series of HIV/AIDS strategies, and that many aspects of our model have been influential in other countries.

In fact, no individual country's response can be uncritically adopted elsewhere. HIV/AIDS involves too many political, cultural and social factors for a single approach to be easily transportable, whether it relates to prevention or care. In particular, the development of surveillance systems for HIV/AIDS has followed a unique pathway in almost every country. The system that has been adopted in Australia shares some features with other countries, but has characteristics that distinguish it from all others. On the occasion of the ten-year anniversary of the first issue of the *Australian HIV Surveillance Report*, it is appropriate to reflect on the system that we have adopted, and consider how it might evolve to optimally serve the national response to HIV/AIDS.

A central challenge in setting up any national activity in Australia is the federal system of government. In public health, the States and Territories have primary responsibility for service provision, while the Commonwealth provides funding and strategic coordination. When AIDS appeared in the early 1980s, national surveillance structures in the area of communicable diseases were not strong. The designation in 1986 of the NHMRC Special Unit in AIDS Epidemiology and Clinical Research, which was to become the National Centre in HIV Epidemiology and Clinical Research (NCHECR) in 1990, provided a formal national focus for surveillance, but was only a starting point because the States and Territories, while supportive, were not formally committed to working with the new centre.

It was not until 1989, when the National HIV Surveillance Committee was formed, with all jurisdictions represented, that nationally consistent procedures for HIV surveillance started to be adopted. This lesson, that nothing truly national can be achieved in Australia without the direct involvement of all States and Territories, seems an obvious one, but it seems that it must be discovered over and over again.

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The National Centre is funded by the Commonwealth Department of Health and Aged Care and is affiliated with the Faculty of Medicine, The University of New South Wales. Its work is overseen by the Australian National Council on AIDS, hepatitis C and related diseases.

Announcements

National meetings

The Australasian Sexual Health Conference Ven Troppo will be held in Darwin, Northern Territory, on 21 – 24 June 2000.

Further information may be obtained from Dart Associates,
PO Box 781, Lane Cove NSW 2066.
Telephone: 02 9418 9396 / 97
Facsimile: 02 9418 9398
E–mail: dartconv@mpx.com.au

The 12th Annual Conference of the Australasian Society for HIV Medicine will be held in Melbourne, Victoria, on 12 – 15 October 2000.

Further information may be obtained from ASHM Conference Secretariat,
GPO Box 2609, Sydney NSW 2001.
Telephone: 02 9241 1478
Facsimile: 02 9251 3552
E–mail: ashm2000@icmsaust.com.au
Website: http://www.unsw.edu.au/ashm/ashm.html

International meeting

The XIII International AIDS Conference will be held in Durban, South Africa, on 9 – 14 July 2000. Program updates are available through the web page: http://www.aids2000.com

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Because the committee worked as a collaboration, and the NCHECR had no direct power to implement national procedures, all proposals had to be worked through on a consensus basis. There was also an understanding that a jurisdiction might endorse a procedure, but delay its implementation until a time that fitted more comfortably with its other agenda. For example, all States and Territories agreed in the mid 1990s that Indigenous status should be reported to the NCHECR for all diagnoses of HIV infection and AIDS, but it was not until 1998 that the appropriate revisions had been made to public health legislation to allow all states to comply.

Another challenge to the development of national surveillance procedures was the uneven population impact of HIV/AIDS. Over 60% of cases were detected in New South Wales, and within New South Wales, the vast majority of cases were concentrated in a relatively small area of inner Sydney. Inevitably, the allocation of resources for surveillance has only partially reflected this distribution, and the implementation of procedures has varied accordingly.

When tests for HIV antibody became widely available in 1985-86, a number of countries adopted surveillance methods that relied on so called “unlinked anonymous” HIV testing of blood specimens that had been obtained for other purposes. The United States and the United Kingdom, both with strong central communicable disease surveillance centres, mounted large programs of unlinked anonymous testing, and their experts influenced the World Health Organization to recommend this approach as the standard for surveillance.

Australia was one of the few countries to resist this trend, for several reasons. Firstly, HIV testing had been made widely available, coordinated through a small number of reference laboratories, and it was considered that maximum use should made of the information arising from this testing. Estimates of HIV prevalence in Australia were also available through populations at higher and lower risk for HIV infection such as prison entrants, people attending sexual health clinics and blood donors. It was also considered that the extra testing that would not be used for individual benefit was a waste of resources. But probably the major reason that we did not adopt unlinked anonymous testing was a basic Australian mistrust of any data-gathering scheme that seemed to be going on in secret. It is worth noting that almost all Western countries have now rolled back their anonymous unlinked programs.

In fact a particular local variant of unlinked testing was eventually developed, to address the difficult problem of monitoring HIV infection in people who inject drugs. It had long been recognised that the routine reporting of cases may not provide a sufficiently early warning of any increase in HIV prevalence in this population, even though attempts had been made to ensure that HIV testing was available to people with limited access to the health system. Through a collaborative network of needle and syringe programs, clients attending during a one week period each year have been asked to give a fingerprick blood specimen for HIV and hepatitis C testing, fully aware that neither they nor anyone else will be able to gain access to their individual test results. In 1999 some 3,000 clients at over 30 exchanges participated in the program, now entering its sixth consecutive year. There have been no real or perceived breaches of confidentiality, and clients who wish to know their HIV or hepatitis C status can be referred to appropriate counselling and testing services.

The surveillance based on needle and syringe programs has also included a short questionnaire on demographic and behavioural characteristics. The results of these annual surveys have complemented the serological data by providing information on both who is accessing the needle and syringe programs, and what level of risk behaviour they report. Behavioural surveillance in gay and other homosexually active men was begun in Sydney in 1997 as a joint project of the NCHECR and the National Centre in HIV Social Research, in collaboration with the AIDS Council of New South Wales and the New South Wales Department of Health, and has since been supported by State health departments in Queensland, South Australia, Victoria and Western Australia. Although these surveys are not linked to serological surveillance, they provide key behavioural data for assessing the direction and impact of prevention programs.

Another particularly Australian innovation in HIV surveillance has been the monitoring at a national level of newly acquired infection. Despite some confusion, among some users of the data, between new infections and new diagnoses, the collection of this information has confirmed that transmission has continued to occur. Although there are inherent biases towards those more likely to be tested and seen by HIV-experienced doctors, the reports of newly acquired infection have given some indication of populations most at risk. Ideally, these cases should provide comprehensive information about the current patterns of transmission, but it is also not always realistic to try to collect detailed demographic and behavioural data in people who have recently become HIV positive.

A new challenge for surveillance has been the need to provide comprehensive information on the uptake and effectiveness of the new antiretroviral agents that have had such a major impact on the health of people with HIV infection since about 1996. As the numbers of AIDS cases have fallen, an increasing proportion have occurred in people who have not previously been diagnosed with HIV infection, and who therefore have not benefitted from the new therapy. The development of observational databases involving a number of HIV-specialised clinical centres around Australia will in the near future start to provide much more detailed information on treatments and outcomes than would ever be possible from routine national reporting.

Probably the most satisfying development in HIV surveillance over the past 10 years has been the increasing ownership of its output by all sectors involved in responding to the HIV epidemic in Australia. Programs and policies are always assessed and adapted in light of the best data currently available. In turn, the surveillance systems evolve according to the needs of service implementation and policy development. As with most facets of Australia's response to HIV/AIDS, the oft-lauded partnership is a reality in the area of surveillance, and our systems are all the stronger for it.

The value of sentinel surveillance of HIV infection in sexual health clinics in Australia

Basil Donovan[1] and Ann McDonald[2]

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2 National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales

Since 1992 the *Australian HIV Surveillance Report* has published data on HIV testing rates – and the results of those tests – from a national network of sexual health clinics. Over 112,500 patients have been tested up to 1998, which makes it easily the largest clinical surveillance dataset in Australia (NCHECR 1999). Because all patients attending each of those services are denominated according to standardised "exposure categories" (Table 1.1), HIV testing rates and testing yields can be put into some sort of perspective, though it is recognised that these are populations skewed toward increased risk of HIV.

Of course, maintaining such a network is sometimes a little like keeping your marbles in a fishnet marble-bag. Clinics close, or get "re-engineered" (we don't say downsized anymore, do we?), databases crash and key personalities go on holidays. As there is considerable work involved in such a resource, it seems timely to briefly review what this system of surveillance offers us.

Strengths of the system

1. **It is cheap.** The system relies on data that already exist and testing that was occurring anyway for clinical purposes, so there are no additional clinical staff or laboratory costs. This contrasts with expensive unlinked anonymous programs run by the British (Unlinked Anonymous HIV Surveys Steering Group 1999). But then the British are strangely coy about getting tested for HIV (Danziger 1999) so they may have few options. This is not an Australian problem (Lupton et al 1995).
2. **It is ethical.** Using clinical data obviates ethical concerns around anonymous delinked testing.
3. **It is national.** Currently data are pooled from five states, with the odd extra state and territory also contributing.
4. **It is expansible.** While the number of clinics currently contributing is limited, those clinics have been selected for their proximity to population centres. If needed, dozens of other clinics around Australia collect data in a compatible way and could be incorporated into the network.
5. **It is verifiable.** People who test HIV positive can be clinically re-assessed to confirm their "exposure category".
6. **It is longitudinal.** Almost nine years of trends – or lack of trends – can now be reviewed.
7. **It is denominated.** Denominators collected include total clinic numbers according to gender, age and "exposure category"; prior HIV testing histories; proportions accepting testing; and proportions testing positive.

Table 1.1 HIV exposure categories used in national HIV/AIDS case surveillance among adult/adolescent cases and those used in sentinel HIV surveillance in sexual health clinics

HIV/AIDS case surveillance	Sentinel HIV surveillance in sexual health clinics
Male homosexual/bisexual contact *Male with an HIV/AIDS diagnosis who reports a history of homosexual/bisexual contact.*	**Male homosexual/bisexual contact** *Male patient who reports a history of homosexual/bisexual contact in the last 12 months.*
Male homosexual/bisexual contact and injecting drug use *Male with an HIV/AIDS diagnosis who reports a history of male homosexual/bisexual contact and injecting drug use.*	**Male homosexual/bisexual contact and injecting drug use** *Male patient who reports a history of homosexual/bisexual contact in the last 12 months and injecting drug use ever.*
Injecting drug use *Cases with an HIV/AIDS diagnosis who report a history of injecting drug use, without a reported history of male homosexual/bisexual contact.*	**Injecting drug use** *Patients who report a history of ever injecting drugs without a reported history of male homosexual/bisexual contact in the last 12 months.*
Heterosexual contact *Cases with an HIV/AIDS diagnosis who report a history of heterosexual contact only, with a person with/at risk of HIV infection —* *Sex with an injecting drug user.* *Sex with a bisexual male.* *From a high HIV prevalence (> 1%) country.* *Sex with person from a high HIV prevalence country.* *Sex with person with medically acquired HIV infection.* *Sex with person with HIV infection, other or undetermined exposure.* *Heterosexual contact, not further specified.*	**Heterosexual contact** *Patients who report a history of heterosexual contact only in the last 12 months —* *Heterosexual contact outside Australia in the last 12 months (includes patients from high prevalence countries and patients who report heterosexual contact with people from high prevalence countries).* *Within Australia only in the last 12 months.*
	Sex work *Females who report that they are currently engaged in sex work.*
	Sex work and injecting drug use *Females who report that they are currently engaged in sex work and have ever injected drugs.*
Haemophilia/coagulation disorder *Cases with HIV infection acquired following treatment for haemophilia/coagulation disorder.*	
Receipt of blood/tissue *Cases with HIV infection acquired following transfusion with HIV-contaminated blood, blood products or tissue.*	
Health care setting *Cases with HIV infection acquired following occupational exposure in an health care setting.*	
Other/undetermined exposure *Case interviewed with respect to exposure to HIV and an exposure other than those above applies or exposure could not be established, or case was not interviewed with respect to exposure to HIV.*	**Other/undetermined exposure** *Patient interviewed with respect to exposure to HIV and an exposure other than those above applies (includes patients with a history of receipt of blood) or exposure could not be established.*

8. **Some of the populations are unique.** These are the only longitudinal surveillance data available for female sex workers, heterosexuals who have had sex overseas, and heterosexuals at risk of sexually transmissible infections in general. Most of the injecting drug users (IDUs) can be described as "socially functional" in that they inject irregularly (often only once ever!) so they are quite a different population to those accessed by services for dysfunctional IDUs such as methadone clinics and prisons. Amphetamine injectors outnumber heroin injectors at the Sydney clinic (Donovan et al 1997).
9. **Incidence as well as prevalence.** Because prior testing and re-testing data are available, HIV incidence can be determined for these clinic populations.

Weaknesses of the system

1. **Biases within biases.** It needs to be recognised that public sexual health clinic populations are 'sentinel' rather than 'representative' samples. While those who test HIV positive will have their exposure category reassessed, often those who test HIV negative will not: thus the denominators will be skewed to some extent. While the potential bias of previously diagnosed HIV patients referred to the clinics is accounted for, the biases caused by contact tracing are not. And, of course, those patients who are tested will tend to be at higher risk than those who are not tested.
2. **General practice is excluded.** The great bulk of clinical HIV testing, and thus most HIV diagnosis, occurs in general practice in Australia.
3. **The exposure categories are crude.** The tyranny of standardising categories can mask important detail. For example, data from itinerant sex workers from other countries are pooled with their local counterparts though their HIV risk and prevalence of infection differs substantially (O'Connor et al 1996).
4. **The presentation format is somewhat inaccessible.** We're thinking about it.

On balance

Though the system may have a few warts (excuse the pun), it makes a lot of longitudinal data available with a modest consumption of resources. While the results represent skewed samples within skewed samples, they provide a quasi-upper limit of HIV incidence and prevalence within important populations. In that context the system should provide 'early warning' if HIV moved substantially into 'transitional' populations. The system has proven to be robust and durable, and much of the information gained is unique.

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Evaluation of the *Australian HIV Surveillance Report*

Ann McDonald
Editor
Australian HIV Surveillance Report

The *Australian HIV Surveillance Report* has been published each quarter from July 1990. From 1997, the *Annual Surveillance Report* has been published which provides a comprehensive summary of the pattern of HIV/AIDS, other sexually transmissible infections and hepatitis C infection in Australia (NCHECR 1999). In view of the availability of the *Annual Surveillance Report*, we carried out a survey to determine whether it is useful to continue to publish the quarterly *Australian HIV Surveillance Report*. We also sought to determine which sections should be retained and whether information on hepatitis C and specific sexually transmissible infections should be included in the quarterly *Australian HIV Surveillance Report*, if its publication were to continue.

In February, a questionnaire on the continuing publication and the content of the quarterly *Australian HIV Surveillance Report* was forwarded to 71 selected contributors and end-users. Members of the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD), State/Territory health authorities and sexual health clinics accounted for 30%, 21% and 15%, respectively, of organisations to which the questionnaire was sent (Table 2.1). By 30 April 2000, 30 questionnaires had been returned, giving a response rate of 42%. The response rate was highest for State/Territory health authorities, sexual health clinics and AIDS Councils, and was lowest for ANCAHRD.

Table 2.1 Number of questionnaires forwarded to selected contributors or end users and number of questionnaires returned by 30 April 2000, by category of contributor/end user

Category of contributor/ end user	Number of questionaires forwarded	Number of questionaires returned	Response Rate (%)
AIDS Council	7	4	57
ANCAHRD	21	3	14
Hepatitis C Council	5	2	40
Sexual Health Clinic	11	6	55
State/Territory Health Authority	15	10	67
Other contributor	12	5	42
TOTAL	**71**	**30**	**42**

Of the 30 respondents, 28 (93%) indicated that the quarterly *Australian HIV Surveillance Report* should continue to be published. In response to the question on whether the *Report* should be available electronically only or in both paper and electronic formats, 16 (53%) indicated that they preferred electronic copy only and 11 (37%) preferred both electronic and paper formats. Almost all (97%) respondents reported that they had routine access to the Internet.

The usefulness of the content of the quarterly *Report* was assessed by asking three questions on each of the five sections in the *Report*

(1) Do you ever read this section of the *Report*?

(2) Have you ever made use of the information included in this section of the *Report*?

(3) Would you be disadvantaged if this section were excluded from future issues of the *Report*?

Ninety three percent of respondents indicated that they had read the special reports on aspects of the epidemiology of HIV and related infections, 76% indicated that they had made use of these reports and 70% reported that they would be disadvantaged if the special reports were not available (Table 2.2).

Table 2.2 Percentage of respondents who reported that they had ever read, ever used and would be disadvantaged if the section was not published, by section of the quarterly *Australian HIV Surveillance Report*

Section of the *Australian HIV Surveillance Report*	Ever Read (%)	Ever used (%)	Disadvantaged (%)
Special Reports	93	76	70
National AIDS Registry	83	72	76
National HIV Database	90	86	83
Sentinel HIV surveillance in sexual health clinics	79	55	62
WHO Western Pacific Region	69	52	48

The majority of respondents reported that they had ever read and had ever made use of the sections on the National AIDS Registry, the National HIV Database and Sentinel HIV surveillance in sexual health clinics, and would be disadvantaged if these sections were not published. Less than 70% of respondents indicated that they had ever read the WHO Western Pacific Region section of the *Report*, and less than 50% indicated that they would be disadvantaged if the section was not available.

Eighty percent of respondents indicated that they would like information on diagnoses of hepatitis C infection to be included in the quarterly *Report* and 70% indicated that they would like information on specific sexually transmissible infections to be included.

Based on the responses to the questionnaire, it was decided that the quarterly *Australian HIV Surveillance Report* should continue to be published, in both paper and electronic formats. Information on new diagnoses of AIDS and HIV infection and estimates of HIV prevalence and incidence available through a network of sexual health clinics will continue to be updated quarterly. Updates of the number of diagnoses of HIV infection and AIDS in the WHO Western Pacific Region will no longer be published in the quarterly *Report* but detailed information on AIDS incidence and HIV prevalence in Australia and other countries, including countries in the WHO Western Pacific Region, will be published in the *Annual Surveillance Report*. Information on diagnoses of hepatitis C and sexually transmissible diseases will be published in the quarterly *Report* following development and implementation of the specific surveillance strategy.

We thank all respondents who completed and returned the questionnaire for their help with the evaluation.

Reference

National Centre in HIV Epidemiology and Clinical Research. *HIV/AIDS, Hepatitis C and Sexually Transmissible Infections in Australia Annual Surveillance Report 1999*. National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, 1999. http://www.med.unsw.edu.au/nchecr

National AIDS Registry

Table 3.1 Cases of AIDS and deaths following AIDS by sex and State/Territory in which diagnosis of AIDS was made, cumulative to 31 December 1999, and for two previous yearly intervals.

Cases

State/Territory	1 Jan 98–31 Dec 98		1 Jan 99–31 Dec 99		Cumulative to 31 Dec 99			
	Male	Female	Male	Female	Male	Female	Total	%
ACT	4	1	0	0	86	8	94	1.1
NSW	155	9	77	12	4630	184	4826	58.2
NT	3	0	3	0	36	0	36	0.4
QLD	35	2	26	2	817	47	866	10.5
SA	16	3	7	2	345	25	370	4.5
TAS	2	1	0	0	44	3	47	0.6
VIC	54	1	15	0	1603	68	1678	20.2
WA	10	2	3	0	347	26	375	4.5
TOTAL†	**279**	**19**	**131**	**16**	**7908**	**361**	**8292**	**100.0**

Deaths

ACT	0	0	1	1	65	3	68	1.2
NSW	67	1	48	1	3167	113	3288	56.4
NT	1	0	0	0	24	0	24	0.4
QLD	24	2	12	1	564	31	597	10.2
SA	13	1	4	0	230	15	245	4.2
TAS	2	0	1	0	29	2	31	0.5
VIC	37	3	23	0	1260	47	1313	22.5
WA	2	1	2	0	246	16	263	4.5
TOTAL†	**146**	**8**	**91**	**3**	**5585**	**227**	**5829**	**100.0**

† Total columns in Tables 3.1 - 3.5 and 6.1 include 23 AIDS cases and 17 deaths following AIDS in people whose sex was reported as transgender.

Table 3.2 Incidence of AIDS per million current population[1] by sex and State/Territory of diagnosis for the two most recent yearly intervals.

State/Territory	1 Jan 98–31 Dec 98			1 Jan 99–31 Dec 99		
	Male	Female	Total	Male	Female	Total
ACT	26.1	6.5	16.2	0.0	0.0	0.0
NSW	49.3	2.8	26.1	24.2	3.7	13.9
NT	29.9	0.0	15.8	29.4	0.0	15.6
QLD	20.2	1.2	10.7	14.8	1.1	8.0
SA	21.8	4.0	12.8	9.5	2.6	6.0
TAS	8.6	4.2	6.4	0.0	0.0	0.0
VIC	23.5	0.4	11.8	6.4	0.0	3.2
WA	10.9	2.2	6.6	3.2	0.0	1.6
TOTAL	**29.9**	**2.0**	**16.0**	**13.9**	**1.7**	**7.8**

1 Population estimates by sex, State/Territory and calendar period from *Australian Demographic Statistics* (Australian Bureau of Statistics).

Table 3.3 Cases of AIDS and deaths following AIDS by sex and age group, cumulative to 31 December 1999, and for two previous yearly intervals.

Cases

Age Group (year)	1 Jan 98–31 Dec 98		1 Jan 99–31 Dec 99		Cumulative to 31 Dec 99			
	Male	Female	Male	Female	Male	Female	Total	%
0–2	*1*	*0*	*0*	*0*	*9*	*7*	*16*	*0.2*
3–12	*1*	*0*	*0*	*0*	*20*	*9*	*29*	*0.3*
0–12	2	0	0	0	29	16	45	0.5
13–19	0	0	1	0	26	4	30	0.4
20–29	34	4	13	4	1319	95	1427	17.2
30–39	108	7	57	7	3330	126	3463	41.8
40–49	80	7	34	2	2210	59	2271	27.4
50–59	37	0	22	1	752	29	782	9.4
60+	18	1	4	2	242	32	274	3.3
TOTAL†	**279**	**19**	**131**	**16**	**7908**	**361**	**8292**	**100.0**

Deaths

Age Group (year)	1 Jan 98–31 Dec 98		1 Jan 99–31 Dec 99		Cumulative to 31 Dec 99			
	Male	Female	Male	Female	Male	Female	Total	%
0–2	*0*	*0*	*0*	*0*	*5*	*5*	*10*	*0.2*
3–12	*0*	*1*	*0*	*0*	*16*	*6*	*22*	*0.4*
0–12	0	1	0	0	21	11	32	0.6
13–19	0	0	0	0	13	3	16	0.3
20–29	14	0	7	0	657	41	708	12.1
30–39	51	3	36	1	2249	81	2335	40.1
40–49	39	4	30	2	1772	42	1816	31.1
50–59	27	0	15	0	661	22	683	11.7
60+	15	0	3	0	212	27	239	4.1
TOTAL†	**146**	**8**	**91**	**3**	**5585**	**227**	**5829**	**100.0**

1 Cases are classified by age at diagnosis.
2 Deaths are classified by age at death.

Table 3.4 Cases of AIDS by sex and exposure category, cumulative to 31 December 1999, and for two previous yearly intervals.

Adults/adolescents (13 years and older at diagnosis of AIDS)

Exposure Category	1 Jan 98–31 Dec 98		1 Jan 99–31 Dec 99		Cumulative to 31 Dec 99			
	Male	Female	Male	Female	Male	Female	Total	%
Male homosexual/ bisexual contact	187	–	86	–	6616	–	6616	82.7
Male homosexual/bisexual contact and injecting drug use	9	–	7	–	358	–	358	4.5
Injecting drug use	18	5	5	3	166	85	251	3.1
Heterosexual	*9*	*4*	*2*	*3*	*109*	*66*	*175*	
Not further specified	*9*	*1*	*3*	*0*	*57*	*19*	*76*	
Heterosexual contact:	41	11	22	11	294	180	474	5.9
Sex with injecting drug user	*0*	*2*	*0*	*1*	*7*	*18*	*25*	
Sex with bisexual male	*–*	*0*	*–*	*1*	*–*	*38*	*38*	
From high prevalence country	*9*	*5*	*8*	*6*	*52*	*34*	*86*	
Sex with person from high prevalence country	*6*	*0*	*1*	*0*	*39*	*13*	*52*	
Sex with person with medically acquired HIV	*0*	*0*	*0*	*0*	*2*	*9*	*11*	
Sex with HIV–infected person, exposure not specified	*1*	*1*	*0*	*0*	*27*	*21*	*48*	
Not further specified	*25*	*3*	*13*	*3*	*167*	*47*	*214*	
Haemophilia/coagulation disorder	1	0	0	0	111	3	114	1.4
Receipt of blood/tissue	2	2	0	1	78	61	139	1.7
Health care setting	0	0	0	0	1	3	4	0.1
Total Adults/Adolescents	**258**	**18**	**120**	**15**	**7624**	**332**	**7956**	**99.4**
Children (under 13 years at diagnosis of AIDS)								
Mother with/at risk for HIV infection	2	0	0	0	13	13	26	0.3
Haemophilia/coagulation disorder	0	0	0	0	5	0	5	0.1
Receipt of blood/tissue	0	0	0	0	11	3	14	0.2
Total Children	**2**	**0**	**0**	**0**	**29**	**16**	**45**	**0.6**
Sub–total	**260**	**18**	**120**	**15**	**7653**	**348**	**8001**	**100.0**
Other/undetermined[1]	19	1	11	1	255	13	291	
TOTAL	**279**	**19**	**131**	**16**	**7908**	**361**	**8292**	

1 The 'Other/undetermined' category includes 23 AIDS cases in people whose sex was reported as transgender. The category was excluded from the calculation of the percentage of cases attributed to each exposure category.

Table 3.5 Deaths following AIDS by sex and exposure category, cumulative to 31 December 1999, and for two previous yearly intervals.

Adults/adolescents (13 years and older at diagnosis of AIDS)

Exposure Category	1 Jan 98–31 Dec 98		1 Jan 99–31 Dec 99		Cumulative to 31 Dec 99			
	Male	Female	Male	Female	Male	Female	Total	%
Male homosexual/bisexual contact	114	–	67	–	4766	–	4766	84.4
Male homosexual/bisexual contact and injecting drug use	8	–	4	–	249	–	249	4.4
Injecting drug use	5	0	6	0	96	49	145	2.6
Heterosexual	*1*	*0*	*3*	*0*	*72*	*42*	*114*	
Not further specified	*4*	*0*	*3*	*0*	*24*	*7*	*31*	
Heterosexual contact:	7	5	6	2	140	104	244	4.3
Sex with injecting drug user	*0*	*1*	*0*	*0*	*2*	*8*	*10*	
Sex with bisexual male	*–*	*1*	*–*	*0*	*–*	*26*	*26*	
From high prevalence country	*0*	*1*	*2*	*1*	*11*	*12*	*23*	
Sex with person from high prevalence country	*3*	*1*	*1*	*0*	*16*	*10*	*26*	
Sex with person with medically acquired HIV	*0*	*0*	*0*	*1*	*2*	*7*	*9*	
Sex with HIV–infected person, exposure not specified	*0*	*0*	*0*	*0*	*22*	*15*	*37*	
Not further specified	*4*	*1*	*3*	*0*	*87*	*26*	*113*	
Haemophilia/coagulation disorder	0	0	3	0	87	3	90	1.6
Receipt of blood/tissue	0	1	0	1	67	51	118	2.1
Health care setting	0	0	0	0	1	2	3	0.1
Total Adults/Adolescents	**134**	**6**	**86**	**3**	**5406**	**209**	**5615**	**99.4**
Children (under 13 years at diagnosis of AIDS)								
Mother with/at risk for HIV infection	0	1	0	0	7	9	16	0.3
Haemophilia/coagulation disorder	0	0	0	0	3	0	3	0.1
Receipt of blood/tissue	0	0	0	0	11	2	13	0.2
Total Children	**0**	**1**	**0**	**0**	**21**	**11**	**32**	**0.6**
Sub–total	**134**	**7**	**86**	**3**	**5427**	**220**	**5647**	**100.0**
Other/undetermined[1]	12	1	5	0	158	7	182	
TOTAL	**146**	**8**	**91**	**3**	**5585**	**227**	**5829**	

1 The 'Other/undetermined' category includes 17 deaths following AIDS in people whose sex was reported as transgender. The category was excluded from the calculation of the percentage of cases attributed to each exposure category.

The National HIV Database

Table 4.1 Number of new diagnoses of HIV infection by sex[1] and State/Territory, cumulative to 31 December 1999, and for two previous yearly intervals.

	1 Jan 98–31 Dec 98		1 Jan 99–31 Dec 99		Cumulative to 31 Dec 99			
State/Territory	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**	**Rate[2]**
ACT[3]	8	2	5	3	218	26	244	78.7
NSW[4]	324	40	318	29	10796	604	11674	182.1
NT	11	1	4	3	108	11	119	61.7
QLD	91	13	104	17	1965	148	2120	60.4
SA	28	6	19	3	672	61	733	49.1
TAS	2	1	2	1	79	6	85	18.1
VIC[5]	131	9	126	12	3872	212	4121	87.5
WA	28	19	31	7	907	113	1023	55.0
TOTAL[6]	**623**	**91**	**609**	**75**	**18617**	**1181**	**20119[7]**	**106.1**

1 Forty two people (19 NSW, 7 QLD, 13 VIC and 3 WA) whose sex was reported as transgender are included in the total columns of Tables 4.1 - 4.3.

2 Rate per one hundred thousand current population. Population estimates by sex, State/Territory and calendar interval from *Australian Demographic Statistics* (Australian Bureau of Statistics).

3 Number of new diagnoses of HIV infection in the ACT revised following inclusion of diagnoses not previously notified.

4 Cumulative total for NSW includes 255 people whose sex was not reported.

5 Cumulative total for VIC includes 24 people whose sex was not reported.

6 Cumulative total for Australia includes 279 people whose sex was not reported.

7 Estimated number of new diagnoses of HIV infection, adjusted for multiple reports, was 17,430 (range 17,000 to 17,850). Reference: Law MG, McDonald AM and Kaldor JM. Estimation of cumulative HIV incidence in Australia, based on national case reporting. *Aust NZ J Public Health* 1996; 20: 215 - 217.

Table 4.2 Number of new diagnoses of HIV infection for which exposure category was reported, by sex and exposure category, cumulative to 31 December 1999, and for two previous yearly intervals.

	1 Jan 98–31 Dec 98		1 Jan 99–31 Dec 99		Cumulative to 31 Dec 99			
Exposure Category	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total[1]**	**%**
Male homosexual/bisexual contact	404	–	349	–	12718	–	12718	78.3
Male homosexual/bisexual contact and injecting drug use	31	–	31	–	616	–	616	3.8
Injecting drug use	14	7	28	3	545	174	726	4.5
Heterosexual	*11*	*6*	*13*	*2*	*190*	*120*	*311*	
Not further specified	*3*	*1*	*15*	*1*	*355*	*54*	*415*	
Heterosexual contact:	88	74	76	60	879	702	1585	9.8
Sex with injecting drug user	*4*	*4*	*2*	*4*	*29*	*83*	*113*	
Sex with bisexual male	*–*	*6*	*–*	*7*	*–*	*104*	*104*	
From high prevalence country	*26*	*29*	*20*	*18*	*134*	*142*	*277*	
Sex with person from high prevalence country	*19*	*6*	*16*	*11*	*131*	*72*	*203*	
Sex with person with medically acquired HIV	*1*	*0*	*2*	*0*	*7*	*13*	*20*	
Sex with HIV–infected person, exposure not specified	*8*	*16*	*5*	*9*	*51*	*106*	*158*	
Not further specified	*30*	*13*	*31*	*11*	*527*	*182*	*710*	
Haemophilia/coagulation disorder	1	0	2	0	228	4	232	1.4
Receipt of blood/tissue	1	3	0	1	104	102	206	1.3
Health care setting[2]	0	0	0	0	3	8	11	0.0
Total Adults/Adolescents	**539**	**84**	**486**	**64**	**15093**	**990**	**16094**	**99.1**
Children (under 13 years at diagnosis of AIDS)								
Mother with/at risk for HIV infection	3	0	0	1	37	26	63	0.4
Haemophilia/coagulation disorder	0	0	1	0	67	0	67	0.4
Receipt of blood/tissue	0	0	0	1	13	8	21	0.1
Total Children	**3**	**0**	**1**	**2**	**117**	**34**	**151**	**0.9**
Sub–total	**542**	**84**	**487**	**66**	**15210**	**1024**	**16245**	**100.0**
Other/undetermined[3]	81	7	122	9	3407	157	3874	
TOTAL	**623**	**91**	**609**	**75**	**18617**	**1181**	**20119[4]**	

1 Total column includes people whose sex was not reported.

2 'Health care setting' includes 5 cases of occupationally acquired HIV infection and 4 cases of HIV transmission in surgical rooms.

3 The 'Other/undetermined' category includes 3856 adults/adolescents and 18 children. Forty two people whose sex was reported as transgender were included in the 'Other/undetermined' category. The 'Other/undetermined' category was excluded from the calculation of the percentage of cases attributed to each exposure category.

4 See footnotes Table 4.1.

Table 4.3 Number of new diagnoses of HIV infection by sex and age group, cumulative to 31 December 1999, and for two previous yearly intervals.

	1 Jan 98–31 Dec 98		1 Jan 99–31 Dec 99		Cumulative to 31 Dec 99			
Age Group (years)	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**	**%**
0–2	*2*	*0*	*0*	*1*	*42*	*17*	*60*	*0.3*
3–12	*1*	*0*	*3*	*1*	*90*	*19*	*109*	*0.5*
0–12	3	0	3	2	132	36	169	0.8
13–19	8	8	6	7	406	81	496	2.5
20–29	159	34	157	26	6411	484	7013	34.9
30–39	222	34	245	26	6834	320	7261	36.1
40–49	143	12	108	9	3222	125	3395	16.9
50–59	62	0	63	2	1071	49	1132	5.6
60+	25	3	22	2	353	55	410	2.0
Unknown	1	0	5	1	188	31	243	1.2
TOTAL	**623**	**91**	**609**	**75**	**18617**	**1181**	**20119**	**100.0**

Table 4.4 Number of new diagnoses of HIV infection in the year 1 January 1999 to 31 December 1999 for which an HIV seroconversion illness was diagnosed or the date of a prior negative test was within one year of diagnosis of HIV infection, by sex and State/Territory and for two six months intervals of HIV diagnosis.

	1 Jan 99–30 Jun 99		1 Jul 99–31 Dec 99		1 Jan 99–31 Dec 99		
State/Territory	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
ACT	0	0	1	0	1	0	1
NSW	28	0	36	2	64	2	66
NT	0	0	1	0	1	0	1
QLD	12	1	14	1	26	2	28
SA	3	0	3	0	6	0	6
TAS	1	0	0	0	1	0	1
VIC	17	2	12	0	29	2	31
WA	0	1	2	0	2	1	3
TOTAL	**61**	**4**	**69**	**3**	**130**	**7**	**137**

Table 4.5 Number of new diagnoses of HIV infection in the year 1 January 1999 to 31 December 1999 for which an HIV seroconversion illness was diagnosed or the date of a prior negative test was within one year of diagnosis of HIV infection, by sex and exposure category and for two six months intervals of HIV diagnosis.

	1 Jan 99–30 Jun 99		1 Jul 99–31 Dec 99		1 Jan 99–31 Dec 99		
Exposure Category	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
Male homosexual/bisexual contact	49	–	53	–	102	–	102
Male homosexual/bisexual contact and injecting drug use	4	–	5	–	9	–	9
Injecting drug use (female and heterosexual male)	3	1	2	0	5	1	6
Heterosexual contact	4	3	6	3	10	6	16
Health care setting	0	0	0	0	0	0	0
Other/undetermined	1	0	3	0	4	0	4
TOTAL	**61**	**4**	**69**	**3**	**130**	**7**	**137**

Table 4.6 Number of new diagnoses of HIV infection in the year 1 January 1999 to 31 December 1999 for which an HIV seroconversion illness was diagnosed or the date of a prior negative test was within one year of diagnosis of HIV infection, by sex and age group and for two six months intervals of HIV diagnosis.

	1 Jan 99–30 Jun 99		1 Jul 99–31 Dec 99		1 Jan 99–31 Dec 99		
Age Group (years)	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
13–19	2	0	2	0	4	0	4
20–29	26	2	17	1	43	3	46
30–39	20	2	35	2	55	4	59
40–49	8	0	6	0	14	0	14
50–59	3	0	7	0	10	0	10
60+	2	0	2	0	4	0	4
TOTAL	**61**	**4**	**69**	**3**	**130**	**7**	**137**

Sentinel surveillance of HIV infection in sexual health clinics

Table 5.1 Number of people seen, number of people tested for HIV antibody and number of people newly diagnosed with HIV infection by sex and sexual health clinic, during the quarter 1 October to 31 December 1999.

	Seen at Clinic		Tested for HIV antibody		Newly diagnosed with HIV infection		
Sexual Health Clinic	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
Sydney Sexual Health Centre, NSW	1079	670	387	211	4	1	5
Livingstone Rd Sexual Health Clinic, NSW	287	331	120	127	0	0	0
Brisbane Sexual Health Clinic, QLD	887	592	285	170	1	0	1
Gold Coast Sexual Health Clinic, QLD	390	469	111	173	1	0	1
Clinic 275, Adelaide, SA	956	671	663	454	2	0	2
Melbourne Sexual Health Centre, VIC	1907	1440	1143	984	0	0	0
TOTAL	**5506**	**4173**	**2709**	**2119**	**8**	**1**	**9**

Table 5.2 Number of people seen who had a *previous negative HIV antibody test*, percent retested for HIV antibody and number (percent) newly diagnosed with HIV infection by sex and exposure category, during the quarter 1 October to 31 December 1999.

	Previous negative HIV antibody test		% Retested for HIV antibody		Newly diagnosed with with HIV infection			
Exposure Category	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**	**%**
Homosexual/bisexual contact	742	–	68.3	–	5	–	5	1.0
Homosexual/bisexual contact and injecting drug use	77	–	53.2	–	0	–	0	0.0
Injecting drug use (female and heterosexual male)	175	132	56.6	54.5	0	0	0	0.0
Heterosexual contact	1681	1544	54.2	56.0	0	0	0	0.0
outside Australia	*231*	*171*	*53.7*	*47.4*	*0*	*0*	*0*	*0.0*
within Australia only	*1450*	*1373*	*54.3*	*57.1*	*0*	*0*	*0*	*0.0*
Sex worker	–	268	–	79.1	–	0	0	0.0
Sex worker and injecting drug use	–	34	–	50.0	–	0	0	0.0
Other/undetermined	98	119	89.8	79.0	0	0	0	0.0
TOTAL	**2773**	**2097**	**59.4**	**60.1**	**5**	**0**	**5**	**0.3**

Table 5.3 Number of people seen with *no previous HIV antibody test*, percent tested for HIV antibody for the first time, and number (percent) newly diagnosed with HIV infection, by sex and exposure category, during the quarter 1 October to 31 December 1999.

	No previous HIV antibody test		% Tested for HIV antibody		Newly diagnosed with with HIV infection			
Exposure Category	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**	**%**
Homosexual/bisexual contact	385	–	44.7	–	3	–	3	1.7
Homosexual/bisexual contact and injecting drug use	26	–	46.2	–	0	–	0	0.0
Injecting drug use (female and heterosexual male)	78	77	78.2	51.9	0	0	0	0.0
Heterosexual contact	1534	1564	47.6	42.8	0	1	1	0.1
outside Australia	*145*	*113*	*55.9*	*34.5*	*0*	*1*	*1*	*0.8*
within Australia only	*1389*	*1451*	*46.7*	*43.4*	*0*	*0*	*0*	*0.0*
Sex worker	–	64	–	64.4	–	0	0	0.0
Sex worker and injecting drug use	–	12	–	75.0	–	0	0	0.0
Other/undetermined	410	332	21.5	30.1	0	0	0	0.0
TOTAL	**2433**	**2049**	**43.7**	**41.9**	**3**	**1**	**4**	**0.2**

Table 5.4 Number of people seen, number of people tested for HIV antibody and number of people newly diagnosed with HIV infection, by sex and age group, during the quarter 1 October to 31 December 1999.

	Seen at Clinic		Tested for HIV antibody		Newly diagnosed with with HIV infection		
Age Group (Years)	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total**
13–19	177	430	106	194	0	0	0
20–29	2132	2238	1144	1135	3	0	3
30–39	1812	978	849	518	4	1	5
40–49	845	404	384	219	0	0	0
50–59	358	92	153	43	0	0	0
60+	181	29	73	9	1	0	1
Not reported	1	2	0	1	0	0	0
TOTAL	**5506**	**4173**	**2709**	**2119**	**8**	**1**	**9**

Table 5.5 Number of people diagnosed with specific sexually transmissible infections[1] other than HIV, by sex, exposure category and whether or not they were tested for HIV antibody[2] during the quarter 1 October to 31 December 1999.

	Tested for HIV antibody		Not tested for HIV antibody	
Exposure Category	**Male**	**Female**	**Male**	**Female**
Homosexual/bisexual contact	40	–	36	–
Homosexual/bisexual contact and injecting drug use	2	–	6	–
Injecting drug use (female and heterosexual male)	7	1	2	0
Heterosexual contact	41	27	34	27
outside Australia	*6*	*2*	*10*	*5*
within Australia only	*35*	*25*	*24*	*22*
Sex worker	–	2	–	1
Sex worker and injecting drug use	–	0	–	0
Other/undetermined	2	1	4	1
TOTAL	**92**	**31**	**82**	**29**

1 Specific sexually transmissible infections are gonorrhoea, syphilis and chlamydia.

2 Includes people who may have been previously tested for HIV antibody and excludes people previously known to have HIV infection.

Report from WHO Western Pacific Region

Dr G Poumerol, Regional Advisor, WHO Regional Office, Manilla.

Table 6.1 AIDS and HIV in the WHO Western Pacific Region by country, based on reports available at 31 December 1999.

	CUMULATIVE AIDS CASES					
Country/Area	**Male**	**Female**	**Children <13 Years**	**Total**	**AIDS Rate[1]**	**Cumulative HIV Diagnoses**
American Samoa	0	0	0	0	0.0	0
Australia[1]	7908	361	45	8292	43.7	20119
Brunei	11	1	0	12	3.1	498
Cambodia	108	23	333	4834	4.2	24028
China	269	18	1	417	0.0	12639
Cook Islands	0	0	0	0	0.0	0
Fed. S. Micronesia	2	0	0	2	1.8	2
Fiji	2	1	0	8	1.0	43
French Polynesia	4	0	0	54	24.9	174
Guam	45	4	0	60	29.6	129
Hong Kong	314	35	5	409	4.2	1255
Japan	1007	162	12	2065	1.2	6019
Kiribati	3	1	0	10	2.6	25
Laos	42	29	2	105	0.7	367
Macao	11	2	0	17	2.2	197
Malaysia	1696	108	34	2894	3.0	30593
Marshall Islands	1	1	0	2	3.8	9
Mongolia	0	0	0	1	0.0	2
Nauru	0	0	0	0	0.0	1
New Caledonia	52	14	2	67	26.9	189
New Zealand	665	37	5	702	18.9	1407
Niue	0	0	0	0	0.0	0
N. Mariana Islands	4	1	0	8	10.4	15
Palau	1	0	0	1	5.8	1
Papua New Guinea	215	196	21	618	5.4	1741
Philippines	219	123	7	404	0.5	1259
Rep. of Korea	104	11	0	145	0.1	964
Samoa	4	2	2	6	3.7	10
Singapore	389	30	4	484	9.2	930
Solomon Islands	0	0	0	0	0.0	2
Tokelau	0	0	0	0	0.0	0
Tonga	7	1	0	8	6.1	11
Tuvalu	0	0	0	0	0.0	1
Vanuatu	0	0	0	0	0.0	0
Vietnam	1008	157	8	2736	1.0	14509
Wallis and Futuna	1	0	0	1	7.1	2
TOTAL[†]	**14092**	**1318**	**481**	**24362**	**0.8**	**117141**

1 AIDS cases per 100,000 total current population.

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Australian HIV Surveillance Report

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NOTES

The National AIDS Registry is maintained by NCHECR on behalf of the National HIV Surveillance Committee, which consists of representatives from NCHECR, and the Health Departments of each State and Territory and the Commonwealth of Australia. The Registry is based on reports from doctors who diagnose AIDS, made to the Health Department in the State/Territory of diagnosis. Date of birth and a name code (first two letters of first and last name) are used to minimise duplicate registration, while maintaining confidentiality.

The National HIV Database is maintained by NCHECR on behalf of the National HIV Surveillance Committee. It is based on reports of new diagnoses of HIV infection from HIV Reference Laboratories (ACT, NSW, TAS, VIC), or from a combination of Reference Laboratory and diagnosing doctors (NT, QLD, SA, WA). In order to avoid counting the same case more than once, only diagnoses which are determined to be new by the diagnosing laboratory or doctor are reported for the purposes of national surveillance.

Sentinel surveillance is carried out by six sexual health clinics in five Australian cities, which send quarterly reports on HIV antibody testing to NCHECR. Tabulations from the National AIDS Registry, the National HIV Database and Sentinel HIV Surveillance in sexual health clinics are based on data available three months after the end of the reporting interval indicated, to allow for reporting delay and to incorporate newly available information.

Abbreviations: HIV is the human immunodeficiency virus, and unless otherwise specified, refers to HIV–1 only. AIDS is the acquired immunodeficiency syndrome and STI stands for sexually transmissible infection. High prevalence countries are those of sub–Saharan Africa and the Caribbean, where transmission of HIV is believed to be predominantly heterosexual. The Australian States and Territories are: Australian Capital Territory (ACT), New South Wales (NSW), Northern Territory (NT), Queensland (QLD), South Australia (SA), Tasmania (TAS), Victoria (VIC) and Western Australia (WA). NCHECR is the National Centre in HIV Epidemiology and Clinical Research.

All data in this report are provisional and subject to future revision.

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State/Territory publications of surveillance data, available through the Internet, are listed below:

NSW Public Health Bulletin	www.health.nsw.gov.au/public-health/phb/phb.html
The Northern Territory Disease Control Bulletin	www.nt.gov.au/nths/publich/bulletin.htm
Sexually Transmitted Diseases in South Australia	www.stdservices.on.net/publications
Victorian Infectious Diseases Bulletin	www.dhs.vic.gov.au/phd/vidb/
Disease WAtch	www.public.health.wa.gov.au/

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