

Australian Surveillance HIV Report

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A collaborative approach to STD and HIV control in central Australia: A report from the Tri-State STD/HIV Project

Central Australia has among the highest rates of sexually transmissible diseases (STDs) in Australia and indeed the world (National Notifiable Diseases Surveillance System 1990 - 1995, State/Territory Health Department reports). Chlamydia, donovanosis, gonorrhoea and syphilis are common infections. To date, there has been no known transmission of HIV infection among Aboriginal people in central Australia.

Health services in central Australia have had limited success in reducing STD incidence over the last ten years. A number of factors have been identified which contribute to this (Scrimgeour and Rowse 1992). The area is serviced by three state health departments and seven different primary health care agencies providing services with very little coordination and, at times, communication between them. These agencies consist of Aboriginal community controlled and government services and vary enormously in their size and resources, from the state health departments

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ANNOUNCEMENTS

National meetings

The 8th Annual Conference of the Australasian Society for HIV Medicine will be held in Randwick, New South Wales, on 14 – 17 November 1996.
Telephone: 02 382 1656, Facsimile: 02 382 3699

The First Australasian Conference on Hepatitis C will be held in Sydney, New South Wales, on 16 – 18 March 1997.
Telephone: 03 9328 3111, Facsimile: 03 9328 3008, E-mail: vadf@ilanet.slnsw.gov.au

International meetings

The 4th Conference on Retroviruses and Opportunistic Infections will be held in Washington DC, United States, on 22 – 26 January 1997.
Telephone: 703 299 0200, Facsimile: 703 299 0204, E-mail: info@idsociety.org,
Homepage: <http://www.idsociety.org>

The 8th International Conference on the reduction of drug related harm will be held on 23 – 27 March 1997 in Paris, France.
Telephone: 44 (0)151 227 4423, Facsimile: 44 (0)151 227 4023,
E-mail: hrc@hit1.demon.co.uk

The 3rd AIDS Impact Conference will be held in Melbourne, Victoria, on 22 – 25 June 1997.
Telephone: 61 3 9819 3700, Facsimile: 61 3 9819 5978, E-mail: meeting@iaccess.com.au

The 4th International Congress on AIDS in Asia and the Pacific will be held in Manila, Philippines, on 25 – 29 October 1997. Further information may be obtained from the Secretariat, 2/F Physicians' Tower, 533 United Nations Avenue, Manila, Philippines. Telephone: 632 521 4884 and 632 522 1081, Facsimile: 632 521 2831

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to single community health services staffed by one or two Aboriginal Health Workers and a nurse. Most non-Aboriginal staff have very little prior experience of the endemic STDs in the region. Morbidity and mortality from many causes is high and STDs are just another one of several priority areas. The people are highly mobile and, given grossly inadequate health service resources (Warchivker 1996, McDermott and Beaver 1996), provision of adequate treatment, follow-up and preventive education is very difficult.

A meeting of the Australian health ministers in 1990 recognised the need to address these difficulties. As a result the Tri-State STD/HIV Project (TSP) was created. It is a pilot project jointly financed by the governments of the Northern Territory, Western Australia, South Australia and the Commonwealth, with a funding commitment to mid-1996. Its brief is to support existing health services to develop and implement coordinated programs to reduce STD rates and prevent HIV transmission in the region. The project team consists of a project coordinator and a medical officer, and began work at the beginning of 1994. The TSP services an area of approximately 500,000 km² in central Australia. The population size is 45,000–50,000 people, of whom about half are Aboriginal. Aboriginal people are the main focus of TSP activities.

The philosophy and processes by which a public health agency such as the TSP works are crucial to its success. Public health agencies can only function through and with the support of the primary health care agencies. It is the primary health care sector that has the direct links with the community and it is their staff who do the work on the ground. The role of the TSP is to provide technical, logistic and strategic support to assist the primary health care agencies in their program delivery.

The TSP has generally focussed rather more on STDs other than HIV, on the grounds that while HIV infection is of concern, it is not yet a reality in the region. The other STDs are already associated with considerable morbidity and mortality (miscarriage, stillbirth, congenital syphilis, pelvic inflammatory disease, infertility, ectopic pregnancy), and are recognised as such by community members and primary health care staff. We took the view that there was an existing problem that needed addressing and that anything that reduced the level of STD occurrence now would also reduce the risk of future HIV transmission. Activities that conferred an immediate benefit to people would be more likely to receive support than those focussed on future, theoretical ones.

After initial consultations with both community and government services, the TSP developed a comprehensive operational plan covering clinical care, health care provider education, STD information systems, community based education and coordination and information sharing.

Syndromic management

A syndromic approach to management of STDs had been adopted in the region. Protocols are contained in the CARPA Standard Treatment Manual (Central Australian Rural Practitioners Association 1992) and the Women's Business Manual (Nganampa Health Council and Congress Alukura 1994). The TSP played a major role in revision of the STD protocols.

Urine testing for gonorrhoea and chlamydia

The advent of urine tests for gonorrhoea and chlamydia based on the polymerase chain reaction has opened up many new possibilities to make clinical services more acceptable and accessible to clients, and for more active case-finding and treatment by health services. In cooperation with the local pathology service, the TSP has established the routine availability of these tests throughout the region as well as sentinel systems for the culture of gonorrhoea.

Prior to the TSP, notifications of gonorrhoea and chlamydia resulting from routine clinic activities (clients presenting to clinics, and screening carried out at antenatal and well-women clinics) revealed very high rates of disease (National Notifiable Diseases Surveillance System 1990 - 1995). In the Northern Territory, notification rates for gonorrhoea and chlamydia in 1994 were 430 and 422 per 100,000 population, respectively. Similar rates were observed in the central Australian areas of South Australia and Western Australia (State/Territory Health Department reports). However, in 1995 the Nganampa Health Council, assisted by the TSP, carried out community urine screening programs (Skov *et al* 1994, 1996), and found a prevalence of gonorrhoea or chlamydia infection of 19% in men. Infection rates were highest in the 15-29 year age group (around 25%) and then declined with age but were still about 10% in 39-49 year olds. Similar prevalences have been measured in both men and women elsewhere in central Australia (Skov 1996). This work also demonstrated a significant association between infection with either organism and leucocytes on urinalysis. We have calculated predictive values to assist practitioners in offering clients further testing or immediate treatment. Case-finding surveys done with several primary health care agencies throughout central Australia have resulted in treatment of over 450 people with either gonorrhoea or chlamydia.

This work has shown a far higher burden of disease than was previously suspected. The majority of people with these infections did not present to clinics for treatment. As a result of these findings and client acceptability of urine testing, health services are now examining and implementing a broad range of more active case-finding strategies.

Azithromycin as a treatment for donovanosis

A randomised trial in the "Top End" of the Northern Territory (Bowden *et al* 1996) suggested that treatment with azithromycin once a week was very effective in the treatment of donovanosis. A field trial in central Australia confirmed this and identified problems in the diagnosis, management and follow-up of clients with donovanosis. Use of azithromycin, along with a support system for primary health care practitioners in diagnosis and management of donovanosis, now offers the very real possibility of eliminating, or at least drastically reducing, the incidence of this STD in the region.

Education for primary health care practitioners

The TSP has been very active in producing educational resource materials for practitioners and in conducting education programs in cooperation with other local agencies. The educational material covers clinical management as well as train the trainer programs for community education programs.

Information system

The only information currently routinely available to health services about the occurrence of STDs in central Australia comes from routine notifications of chlamydia, donovanosis, gonorrhoea and syphilis. While these reports provide the age, sex and location of cases, there is no information readily available about the proportion of clients with STDs who receive treatment or about delays that occur in treatment, nor is there information as to the proportion of pregnant women who receive full antenatal care (which includes investigations for STDs) or of babies who require investigation (for example serology, lumbar puncture, X-rays) to exclude congenital syphilis. Improving the quality of information at a local level and centrally should assist health services to better monitor, evaluate or refine their STD programs.

Due to the unfamiliarity of many primary health care practitioners with STDs, the multiplicity of primary health care agencies and the high mobility of people, there are often difficulties with the diagnosis of syphilis and donovanosis and the follow-up of clients and their partners. An STD advisory and follow up system has been established to assist health services in this respect.

In order to oversee the system and give primary health care agencies greater confidence in it, a legal agreement is planned between each health service and the Northern Territory Department of Health Services (who would administer the system). This agreement would define issues of confidentiality, reporting of information, ownership of and access to aggregate information and sanctions for breaches of the agreement.

Community education

Considerable work was done in developing a workshop methodology for community education and train the trainer programs. The value of this methodology was acknowledged, but it did generate controversy and debate about the philosophy of community education delivery. As a result there was an acceptance by the TSP and other public health agencies that resources and personnel for health education and promotion must be based in the community. The role of public health agencies would be to provide training and on-going support for these people.

Public relations

In the early stages of the TSP, consultation and negotiation and general attention to public relations were required to establish the project. The project was under-resourced and there had been a year's delay between the final decision to implement the project and the project staff starting work. Four health departments had to be reminded of the project, courted and persuaded to come up with extra funding. The TSP has always viewed marketing as an important and legitimate strategy in public health. This is not only to attract resources but also to publicise and promote the principles and programs which contribute to the successes of the project. It is also a facet of the project which can be put at the disposal of primary health care agencies to assist them in promoting themselves and gaining resources.

A regional collaborative approach

The high rates of infectious conditions, in combination with the high mobility of the people and the multiplicity of service providers, suggested the need for health services to agree to common and coordinated programs. To this end the TSP convened two workshops involving most of the health services in the region, which have resulted in agreement on a regional strategy. A minimum core set of activities has been defined for all health services that will form the basis of the regional strategy. The TSP will be working with all health services to assist them to formulate their own plans and to seek additional resources as required.

Seeking greater primary health care agency direction

Trying to consult and coordinate with ten different agencies and gain their cooperation has been challenging for the TSP in spite of the two staff members combined fifteen years of experience in this region: it would have been much more so for new people. This aspect of the TSP's experience reinforces what some Aboriginal community controlled services have been advocating for some time: the need for structures that allow regional planning by primary health care

agencies, assist them to act in a coordinated fashion and permit them to direct the actions of public health agencies such as the TSP.

To address this for itself, the TSP management committee has sought expanded representation from primary health care agencies. On a broader level, the Central Australian Aboriginal Congress proposed the establishment of a Regional Indigenous Health Planning Authority (RIHPA) (Central Australian Aboriginal Congress 1995). RIHPA would be composed largely of Aboriginal representatives from primary health care agencies and health departments whose role would be to determine regional priorities, policies and programs. Public health agencies would take direction from and put proposals to this body. When initiatives are endorsed by the RIHPA, its member bodies would then have a responsibility to support and work with public health agencies in their implementation.

The future

The TSP has had some preliminary successes in defining promising STD prevention strategies. These strategies now need broad implementation. The serious under-resourcing of primary health care services must be addressed if such public health strategies are to be effectively delivered. In addition, structures such as the RIHPA are crucial to continued development and refining of coordinated regional programs. If effective resourcing does not occur, the promising start made by the TSP toward reducing STD incidence and minimising the incursion of HIV into central Australia may well be wasted.

Reported by:

Dr Steven Skov and Ms Kerry Arabena
Tri-State STD/HIV Project

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Skov S, Miller P *et al.* Urine screening for gonorrhoea and chlamydia in central Australia. *Central Australian Rural Practitioners Association Newsletter* 1994; 22: 61-65.

Skov S, Miller P *et al.* Urinary diagnosis of gonorrhoea and chlamydia in men in remote Aboriginal communities. *Med J Aust* 1996; (In press).

Warchivker I. Variations in health care expenditure in the Alice Springs Rural District in 1993-94. *Aust NZ J Public Health* 1996; 20 (1): 11-13.

National surveillance for occupational exposure to blood borne viruses in health care workers: Second report

Information on the characteristics of occupational exposures to blood or body fluid was received from 29 sites (28 hospitals and 1 community care agency) for the reporting period 1 January 1996 to 30 June 1996. Reported cases of occupational exposure to blood or body fluids were those exposures classified as possible or definite parenteral and massive exposures, according to the Australian National Council on AIDS classification (ANCA Bulletin No 16).

There were 9.6 percutaneous exposures per 100 daily occupied beds reported from 28 hospitals and 2.1 non percutaneous exposures per 100 daily occupied beds from 1 January to 30 June 1996 (Table 1.1). For the 29 sites, the percutaneous exposure rate was 2.2 per 100 full time equivalent staff (FTE) and the non-percutaneous exposure rate was 0.5 per 100 FTE.

Table 1.1
Number of cases of occupational exposure to blood or body fluids¹ in health care workers reported by participating sites² during the six months 1 January to 30 June 1996 and number of cases of occupational exposure per 100 occupied beds by type of exposure³.

| Type of exposure | Number of exposures | Exposures per 100 occupied beds |
|--|---------------------|---------------------------------|
| Percutaneous exposure | 831 | 9.6 |
| <i>Hollow bore sharps</i> | 493 | 5.7 |
| <i>Non hollow bore, non glass sharps</i> | 307 | 3.6 |
| <i>Glass objects</i> | 10 | 0.1 |
| <i>Unknown sharp objects</i> | 21 | 0.2 |
| Non percutaneous exposure | 185 | 2.1 |

For almost half the exposures, the source was tested for HIV, hepatitis C or hepatitis B. Prevalence of HIV, hepatitis C and hepatitis B surface antigen were each 3% among source patients tested following a percutaneous exposure (Table 1.2).

Follow up information was reported for almost 50% of exposures and serology results at three months were reported for almost one third. No health care worker was reported to have acquired HIV infection. One HCW had hepatitis C antibody detected at three months post exposure, but no baseline healthcare worker or source serology was reported. Three HCWs were positive for hepatitis B surface antibody at three months post exposure but it was not possible to rule out past exposure or vaccination (Table 1.3).

Table 1.2
Number of cases of occupational exposure to blood or body fluids¹ in health care workers reported by participating sites² during the six months 1 January to 30 June 1996 for which the source was tested for specific blood borne viruses, and number with infection, by type of exposure³ and viral test.

| Viral test | Percutaneous | | Non-percutaneous | |
|--------------|---------------|-----------------------|------------------|-----------------------|
| | Number tested | Number with infection | Number tested | Number with infection |
| HIV antibody | 412 | 13 | 93 | 6 |
| HCV antibody | 398 | 12 | 87 | 7 |
| HBsantigen | 413 | 12 | 93 | 5 |
| HBe antigen | 47 | 1 | 8 | 0 |

Table 1.3
Number of health care workers (HCWs) exposed to blood or body fluids in the six months 1 January to 30 June 1996 with at least 3 months post exposure followup, number tested for specific blood borne viruses, and number with occupationally acquired infection, by type of exposure and viral test.

| Viral test | Percutaneous (Number of HCW = 831) | | Non-percutaneous (Number of HCW = 185) | |
|---------------------------|---------------------------------------|-----------------------|---|-----------------------|
| | Number tested | Number with infection | Number tested | Number with infection |
| HIV antibody | 95 | 0 | 45 | 0 |
| HCV antibody ⁴ | 152 | 1 | 25 | 0 |
| HBsantigen | 52 | 0 | 8 | 0 |
| HBs antibody ⁵ | 26 | 3 | 9 | 0 |
| HBc antibody | 22 | 0 | 6 | 0 |

This study documents ongoing exposure to blood borne viruses in health care settings in Australia. The completeness of the information presented in the tables is limited by the three month reporting delay in obtaining follow up serology for health care workers. As the network of hospitals expands it will provide a basis for assessing risk factors for exposure.

Footnotes

1. Reported cases of occupational exposures to blood and body fluids were exposures classified as possible or definite parenteral and massive exposures according to the Australian National Council on AIDS classification (ANCA Bulletin No 16).
2. Participating sites (29 sites, 28 hospitals): Bankstown/Lidcombe NSW, Beleura Private VIC, Bloomfield NSW, Box Hill VIC, Calvary ACT, Goulburn Base NSW, Holy Spirit QLD, Ipswich QLD, John James Memorial ACT, Logan Hospital QLD, Lyell McEwin Health Service SA, Mount Hospital WA, Mount Druitt NSW, Nowra NSW, Royal Adelaide SA, Royal Brisbane QLD, Royal Women's NSW, St. Vincent's VIC, St. Vincent's Public NSW, St Vincent's Private NSW, St John of God VIC, St John of God Murdoch WA, Silver Chain Community Health Care WA, Sir Charles Gardiner WA, Strathfield Private NSW, Tamworth NSW, West Gippsland VIC, Westmead NSW, Woden Valley ACT.
3. The type of injuries were either percutaneous (a skin penetration caused by a sharp object) or non percutaneous exposures (mucous membrane or conjunctival contact with blood and non intact skin contact with blood or body fluid).
4. No HCW baseline serology or source serology was available for the case of hepatitis C infection.
5. No information was available on HCW vaccination status or past exposure for the cases with hepatitis B surface antibody.

Reference

ANCA Bulletin No 16. Needlestick and blood accidents. Canberra 1996

Reported by Margaret MacDonald

National Centre in HIV Epidemiology and Clinical Research, Sydney, NSW on behalf of:

Participating sites:

Calvary, John James Memorial, and Woden Valley hospitals, ACT; Bankstown/Lidcombe, Blacktown, Bloomfield, Goulburn Base, Mount Druitt, Nowra, Royal Women's, St. Vincent's Public, St Vincent's Private, Strathfield Private, Tamworth and Westmead hospitals, NSW; Cairns Base, Holy Spirit, Ipswich, Logan Hospital and Royal Brisbane QLD; Lyell McEwin Health Service and Royal Adelaide SA; Beleura Private, Box Hill, Mildura, St John of God, St. Vincent's and West Gippsland hospitals VIC; Mount, St John of God, Murdoch, Silver Chain Community Health Care and Sir Charles Gardiner hospitals, WA.

State and Territory co-ordinators:

Helen Bedford, Public Health Division, ACT Health, ACT; Ann Arthur and Frank Bowden, Communicable Diseases Centre, Royal Darwin Hospital, NT; Lizzie Griggs and John Brown, AIDS/Infectious Diseases Branch, NSW Department of Health, NSW; Jo Murray and Hugo Ree, Queensland Health, QLD; Tess Davey, STD Control Branch, SA; David Coleman, Community Health Services, Tasmania; Genevieve Ryan, John McBride and Geoff Hogg, Microbiological Diagnostic Unit, University of Melbourne, Victoria; Jag Atrie and Margherita Veroni, Communicable Diseases Control Unit, WA.

THE NATIONAL AIDS REGISTRY

Table 2.1
Cases of AIDS and deaths following AIDS by sex and State/Territory in which diagnosis of AIDS was made, cumulative to 30 June 1996, and for two previous yearly intervals.

Cases

| STATE/ TERRITORY | 1Jul94 – 30Jun95 | | 1Jul95 – 30Jun96 | | Cumulative to 30 Jun 96 | | | |
|---------------------|------------------|-----------|------------------|-----------|-------------------------|------------|-------------|--------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| ACT | 12 | 2 | 6 | 0 | 76 | 5 | 81 | 1.1 |
| NSW | 470 | 17 | 284 | 10 | 3859 | 137 | 4006 | 58.3 |
| NT | 4 | 0 | 1 | 0 | 26 | 0 | 26 | 0.4 |
| QLD | 94 | 4 | 76 | 3 | 662 | 29 | 693 | 10.1 |
| SA | 37 | 5 | 34 | 0 | 284 | 18 | 302 | 4.4 |
| TAS | 2 | 0 | 0 | 0 | 32 | 2 | 34 | 0.5 |
| VIC | 175 | 13 | 104 | 3 | 1368 | 48 | 1423 | 20.7 |
| W A | 30 | 2 | 24 | 1 | 293 | 17 | 312 | 4.5 |
| TOTAL† | 824 | 43 | 529 | 17 | 6600 | 256 | 6877 | 100.0 |

Deaths

| | | | | | | | | |
|---------------|------------|-----------|------------|-----------|-------------|------------|-------------|--------------|
| ACT | 8 | 0 | 2 | 0 | 50 | 2 | 52 | 1.0 |
| NSW | 353 | 19 | 208 | 7 | 2714 | 101 | 2821 | 56.9 |
| NT | 2 | 0 | 2 | 0 | 20 | 0 | 20 | 0.4 |
| QLD | 78 | 4 | 58 | 5 | 462 | 24 | 488 | 9.8 |
| SA | 34 | 4 | 31 | 0 | 194 | 13 | 207 | 4.2 |
| TAS | 1 | 0 | 0 | 0 | 21 | 2 | 23 | 0.5 |
| VIC | 145 | 10 | 116 | 12 | 1080 | 37 | 1123 | 22.6 |
| W A | 27 | 2 | 15 | 2 | 216 | 11 | 228 | 4.6 |
| TOTAL† | 648 | 39 | 432 | 26 | 4757 | 190 | 4962 | 100.0 |

†. Total columns of Tables 2.1 - 2.5 and 5.1 include 21 cases and 15 AIDS deaths in people whose sex was reported as transsexual.

Table 2.2

Incidence of AIDS per million current population by sex and State/Territory of diagnosis, from 1 January 1981 to 30 June 1996, and for two previous yearly intervals.

| STATE/ TERRITORY | 1Jul94 – 30Jun95 | | 1Jul95 – 30Jun96 | | Cumulative to 30 Jun 96 | | |
|--------------------------|------------------|------------|------------------|------------|-------------------------|-------------|--------------|
| | Male | Female | Male | Female | Male | Female | Total |
| ACT | 78.5 | 13.3 | 38.8 | 0.0 | 491.6 | 32.9 | 264.4 |
| NSW | 155.2 | 5.5 | 92.6 | 3.2 | 1258.8 | 44.1 | 649.0 |
| NT | 44.7 | 0.0 | 11.0 | 0.0 | 284.8 | 0.0 | 146.5 |
| QLD | 57.6 | 2.5 | 45.4 | 1.8 | 395.4 | 17.4 | 207.5 |
| SA | 50.6 | 6.7 | 46.3 | 0.0 | 387.1 | 24.2 | 204.4 |
| TAS | 8.5 | 0.0 | 0.0 | 0.0 | 136.3 | 8.4 | 71.9 |
| VIC | 78.6 | 5.7 | 46.4 | 1.3 | 609.7 | 21.0 | 313.9 |
| W A | 34.7 | 2.3 | 27.2 | 1.1 | 332.5 | 19.4 | 177.7 |
| TOTAL[†] | 92.0 | 4.8 | 59.7 | 1.9 | 726.8 | 28.0 | 377.1 |

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

Table 2.3
Cases of AIDS and deaths following AIDS by sex and age group, cumulative to 30 June 1996, and for two previous yearly intervals.

Cases¹

| AGE GROUP (years) | 1Jul94 – 30Jun95 | | 1Jul95 – 30Jun96 | | Cumulative to 30 Jun 96 | | | |
|----------------------|------------------|-----------|------------------|-----------|-------------------------|------------|-------------|--------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| 0 – 2 | 2 | 2 | 0 | 0 | 8 | 6 | 14 | 0.2 |
| 3 – 12 | 2 | 4 | 0 | 1 | 19 | 9 | 28 | 0.4 |
| 0 – 12 | 4 | 6 | 0 | 1 | 27 | 15 | 42 | 0.6 |
| 13 – 19 | 3 | 0 | 1 | 0 | 22 | 3 | 25 | 0.4 |
| 20 – 29 | 106 | 12 | 75 | 5 | 1141 | 68 | 1221 | 17.7 |
| 30 – 39 | 384 | 15 | 249 | 7 | 2796 | 80 | 2882 | 41.9 |
| 40 – 49 | 233 | 7 | 132 | 2 | 1854 | 41 | 1897 | 27.6 |
| 50 – 59 | 68 | 2 | 54 | 1 | 581 | 22 | 604 | 8.8 |
| 60 + | 26 | 1 | 18 | 1 | 179 | 27 | 206 | 3.0 |
| TOTAL† | 824 | 43 | 529 | 17 | 6600 | 256 | 6877 | 100.0 |

Deaths²

| AGE GROUP (years) | 1Jul94 – 30Jun95 | | 1Jul95 – 30Jun96 | | Cumulative to 30 Jun 96 | | | |
|----------------------|------------------|-----------|------------------|-----------|-------------------------|------------|-------------|--------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| 0 – 2 | 1 | 2 | 0 | 0 | 5 | 5 | 10 | 0.2 |
| 3 – 12 | 1 | 1 | 0 | 0 | 16 | 4 | 20 | 0.4 |
| 0 – 12 | 2 | 3 | 0 | 0 | 21 | 9 | 30 | 0.6 |
| 13 – 19 | 1 | 1 | 0 | 0 | 13 | 3 | 16 | 0.3 |
| 20 – 29 | 51 | 7 | 42 | 7 | 591 | 35 | 635 | 12.8 |
| 30 – 39 | 279 | 15 | 181 | 12 | 1921 | 63 | 1988 | 40.1 |
| 40 – 49 | 216 | 9 | 127 | 4 | 1506 | 33 | 1541 | 31.1 |
| 50 – 59 | 73 | 3 | 63 | 2 | 536 | 21 | 557 | 11.2 |
| 60 + | 26 | 1 | 19 | 1 | 169 | 26 | 195 | 3.9 |
| TOTAL† | 648 | 39 | 432 | 26 | 4757 | 190 | 4962 | 100.0 |

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

Table 2.4

Cases of AIDS by sex and exposure category, cumulative to 30 June 1996, and for two previous yearly intervals.

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

| EXPOSURE CATEGORY | 1 Jul 94 – 30 Jun 95 | | 1 Jul 95 – 30 Jun 96 | | Cumulative to 30 Jun 96 | | | |
|---|-------------------------|-----------|-------------------------|-----------|-------------------------|------------|-------------|-------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| Male homosexual/bisexual contact | 693 | - | 432 | - | 5642 | - | 5642 | 82.1 |
| Male homosexual/bisexual contact and ID use | 29 | - | 27 | - | 280 | - | 280 | 4.1 |
| ID use | 18 | 8 | 15 | 3 | 111 | 59 | 170 | 2.5 |
| <i>Heterosexual</i> | 13 | 8 | 6 | 2 | 89 | 50 | 139 | |
| <i>Not further specified</i> | 5 | 0 | 9 | 1 | 22 | 9 | 31 | |
| Heterosexual contact: | 30 | 24 | 20 | 10 | 179 | 113 | 292 | 4.2 |
| <i>Sex with ID user</i> | 2 | 1 | 0 | 3 | 3 | 8 | 11 | |
| <i>Sex with bisexual male</i> | - | 2 | - | 2 | - | 26 | 26 | |
| <i>From specified country</i> | 6 | 3 | 3 | 3 | 22 | 17 | 39 | |
| <i>Sex with person from specified country</i> | 5 | 3 | 4 | 0 | 22 | 10 | 32 | |
| <i>Sex with person with medically acquired HIV</i> | 1 | 1 | 0 | 2 | 3 | 8 | 11 | |
| <i>Sex with HIV-infected person, exposure not specified</i> | 1 | 4 | 1 | 0 | 27 | 15 | 42 | |
| <i>Not further specified</i> | 15 | 10 | 12 | 0 | 102 | 29 | 131 | |
| Haemophilia/coagulation disorder | 11 | 0 | 7 | 0 | 96 | 2 | 98 | 1.4 |
| Receipt of blood components/tissue | 6 | 4 | 1 | 3 | 75 | 56 | 131 | 1.9 |
| Health care setting | 1 | 1 | 0 | 0 | 2 | 3 | 5 | 0.0 |
| Other/undetermined† | 32 | 0 | 27 | 0 | 188 | 8 | 217 | 3.2 |
| Total Adults/ Adolescents† | 820 | 37 | 529 | 16 | 6573 | 241 | 6835 | 99.4 |

Children (under 13 years at diagnosis of AIDS)

| | | | | | | | | |
|--|------------|-----------|------------|-----------|-------------|------------|-------------|--------------|
| Mother with/at risk for HIV infection | 4 | 5 | 0 | 1 | 11 | 12 | 23 | 0.3 |
| Haemophilia/coagulation disorder | 0 | 0 | 0 | 0 | 5 | 0 | 5 | 0.1 |
| Receipt of blood components/tissue | 0 | 1 | 0 | 0 | 11 | 3 | 14 | 0.2 |
| Total Children | 4 | 6 | 0 | 1 | 27 | 15 | 42 | 0.6 |
| TOTAL† | 824 | 43 | 529 | 17 | 6600 | 256 | 6877 | 100.0 |

Table 2.5
Deaths following AIDS by sex and exposure category, cumulative to 30 June 1996,
and for two previous yearly intervals.

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

| EXPOSURE CATEGORY | 1 Jul 94 – 30 Jun 95 | | 1 Jul 95 – 30 Jun 96 | | Cumulative to 30 Jun 96 | | | |
|---|-------------------------|-----------|-------------------------|-----------|-------------------------|------------|-------------|-------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| Male homosexual/bisexual contact | 542 | - | 352 | - | 4109 | - | 4109 | 82.8 |
| Male homosexual/bisexual contact and ID use | 35 | - | 26 | - | 194 | - | 194 | 3.9 |
| ID use | 18 | 7 | 10 | 6 | 69 | 44 | 113 | 2.3 |
| <i>Heterosexual</i> | 14 | 7 | 9 | 5 | 61 | 38 | 99 | |
| <i>Not further specified</i> | 4 | 0 | 1 | 1 | 8 | 6 | 14 | |
| Heterosexual contact: | 18 | 20 | 17 | 20 | 109 | 81 | 190 | 3.8 |
| <i>Sex with ID user</i> | 0 | 1 | 0 | 3 | 0 | 6 | 6 | |
| <i>Sex with bisexual male</i> | - | 2 | - | 2 | - | 20 | 20 | |
| <i>From specified country</i> | 3 | 4 | 2 | 3 | 8 | 11 | 19 | |
| <i>Sex with person from specified country</i> | 0 | 3 | 3 | 1 | 11 | 8 | 19 | |
| <i>Sex with person with medically acquired HIV</i> | 1 | 1 | 0 | 1 | 2 | 5 | 7 | |
| <i>Sex with HIV-infected person, exposure not specified</i> | 3 | 3 | 0 | 1 | 22 | 10 | 32 | |
| <i>Not further specified</i> | 11 | 6 | 12 | 9 | 66 | 21 | 87 | |
| Haemophilia/coagulation disorder | 11 | 1 | 8 | 0 | 73 | 2 | 75 | 1.5 |
| Receipt of blood components/tissue | 3 | 7 | 2 | 0 | 64 | 48 | 112 | 2.3 |
| Health care setting | 0 | 0 | 1 | 0 | 1 | 1 | 2 | 0.0 |
| Other/undetermined† | 19 | 0 | 16 | 0 | 115 | 4 | 134 | 2.7 |
| Total Adults/ Adolescents† | 646 | 35 | 432 | 26 | 4734 | 180 | 4929 | 99.3 |

Children (under 13 years at diagnosis of AIDS)

| | | | | | | | | |
|--|------------|-----------|------------|-----------|-------------|------------|-------------|--------------|
| Mother with/at risk for HIV infection | 2 | 2 | 0 | 0 | 7 | 7 | 14 | 0.3 |
| Haemophilia/coagulation disorder | 0 | 0 | 0 | 0 | 5 | 0 | 5 | 0.1 |
| Receipt of blood components/tissue | 0 | 2 | 0 | 0 | 11 | 3 | 14 | 0.3 |
| Total Children | 2 | 4 | 0 | 0 | 23 | 10 | 33 | 0.7 |
| TOTAL† | 648 | 39 | 432 | 26 | 4757 | 190 | 4962 | 100.0 |

THE NATIONAL HIV DATABASE

Table 3.1

Number of new diagnoses of HIV infection by sex¹ and State/Territory, cumulative to 30 June 1996, and for two previous yearly intervals.

| STATE/ TERRITORY | 1 Jul 94 – 30 Jun 95 | | 1 Jul 95 – 30 Jun 96 | | Cumulative to 30 Jun 96 | | | |
|--------------------------|----------------------|-----------|----------------------|-----------|-------------------------|------------|--------------------------|-------------------|
| | Male | Female | Male | Female | Male | Female | Total | Rate ² |
| ACT | 13 | 3 | 12 | 1 | 170 | 16 | 186 | 60.7 |
| NSW ³ | 396 | 43 | 370 | 29 | 10097 | 567 | 12721 | 206.1 |
| NT | 6 | 0 | 4 | 0 | 84 | 3 | 87 | 49.0 |
| QLD ⁴ | 132 | 13 | 121 | 7 | 1618 | 98 | 1722 | 51.6 |
| SA | 36 | 4 | 29 | 0 | 575 | 44 | 619 | 41.9 |
| TAS | 3 | 0 | 0 | 0 | 70 | 4 | 74 | 15.6 |
| VIC ⁵ | 185 | 13 | 167 | 14 | 3411 | 167 | 3629 | 80.1 |
| WA | 39 | 14 | 35 | 6 | 760 | 73 | 835 | 47.6 |
| TOTAL⁶ | 810 | 90 | 738 | 57 | 16785 | 972 | 19873⁷ | 109.0 |

1. Twenty three people (7 NSW, 5 QLD, 9 VIC and 2 WA) whose sex was reported as transsexual are included in the total columns of Tables 3.1 – 3.6.
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. Cumulative total for NSW includes 2050 people whose sex was not reported.
4. Cumulative total for QLD includes 1 person whose sex was not reported.
5. Cumulative total for VIC includes 42 people whose sex was not reported.
6. Cumulative total for Australia includes 2093 people whose sex was not reported.
7. Estimated number of new diagnoses of HIV infection, adjusted for multiple reports, was 15,600 (range 14,700 to 16,500). 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 3.2

Number of new diagnoses of HIV infection for which exposure category was reported, by sex and exposure category, cumulative to 30 June 1996 and for two previous yearly intervals.

| EXPOSURE CATEGORY | 1 Jul 94 – 30 Jun 95 | | 1 Jul 95 – 30 Jun 96 | | Cumulative to 30 Jun 96 | | | |
|---|-------------------------|-----------|-------------------------|-----------|-------------------------|------------|--------------|-------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| Male homosexual/bisexual contact | 612 | - | 534 | - | 10582 | - | 10582 | 80.3 |
| Male homosexual/bisexual contact and ID use | 40 | - | 25 | - | 410 | - | 410 | 3.1 |
| ID use | 23 | 7 | 23 | 6 | 477 | 155 | 653 | 5.0 |
| <i>Heterosexual</i> | 17 | 3 | 9 | 5 | 130 | 58 | 191 | |
| <i>Not further specified</i> | 6 | 4 | 14 | 1 | 347 | 97 | 462 | |
| Heterosexual contact: | 79 | 67 | 63 | 45 | 606 | 425 | 1035 | 7.9 |
| <i>Sex with ID user</i> | 3 | 6 | 1 | 2 | 15 | 30 | 45 | |
| <i>Sex with bisexual male</i> | - | 5 | - | 4 | - | 29 | 29 | |
| <i>From specified country</i> | 15 | 15 | 11 | 8 | 55 | 43 | 99 | |
| <i>Sex with person from specified country</i> | 8 | 10 | 19 | 7 | 66 | 38 | 104 | |
| <i>Sex with person with medically acquired HIV</i> | 0 | 2 | 0 | 0 | 3 | 6 | 9 | |
| <i>Sex with HIV-infected person, exposure not specified</i> | 7 | 8 | 7 | 6 | 34 | 33 | 67 | |
| <i>Not further specified</i> | 46 | 21 | 25 | 18 | 433 | 246 | 682 | |
| Haemophilia/coagulation disorder | 1 | 0 | 0 | 0 | 186 | 2 | 188 | 1.4 |
| Receipt of blood/tissue | 4 | 2 | 1 | 1 | 108 | 65 | 173 | 1.3 |
| Health care setting¹ | 0 | 1 | 0 | 0 | 3 | 7 | 10 | 0.1 |
| Total Adults/ Adolescents² | 759 | 77 | 646 | 52 | 12372 | 654 | 13051 | 99.1 |

Children (under 13 years at diagnosis of HIV infection)

| | | | | | | | | |
|--|------------|-----------|------------|-----------|--------------|------------|--------------------------|--------------|
| Mother with/at risk for HIV infection | 3 | 7 | 3 | 1 | 26 | 20 | 46 | 0.4 |
| Haemophilia/coagulation disorder | 0 | 0 | 0 | 0 | 55 | 0 | 55 | 0.4 |
| Receipt of blood/tissue | 0 | 0 | 0 | 0 | 12 | 5 | 17 | 0.1 |
| Total Children | 3 | 7 | 3 | 1 | 93 | 25 | 118 | 0.9 |
| Sub-total | 762 | 84 | 649 | 53 | 12465 | 679 | 13169 | 100.0 |
| Other/undetermined ³ | 48 | 6 | 89 | 4 | 4320 | 293 | 6704 | |
| TOTAL | 810 | 90 | 738 | 57 | 16785 | 972 | 19873⁴ | |

1. The category 'Health care setting' includes 5 cases of occupationally acquired HIV infection and 4 cases of transmission in surgical rooms.
2. Total column includes cases for which sex was not reported.
3. The 'Other/undetermined' category includes 6686 adults/adolescents and 18 children. Twenty three people whose sex was reported as transsexual are 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 footnote Table 3.1.

Table 3.3
Number of new diagnoses of HIV infection by sex and age group, cumulative to 30 June 1996, and for two previous yearly intervals.

| AGE GROUP (YEARS) | 1 Jul 94 – 30 Jun 95 | | 1 Jul 95 – 30 Jun 96 | | Cumulative to 30 Jun 96 | | | |
|--------------------------|----------------------|-----------|----------------------|-----------|-------------------------|------------|--------------|--------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| 0 – 2 | 2 | 4 | 3 | 0 | 32 | 13 | 46 | 0.2 |
| 3 – 12 | 1 | 4 | 0 | 1 | 75 | 15 | 90 | 0.5 |
| 0 – 12 | 3 | 8 | 3 | 1 | 107 | 28 | 136 | 0.7 |
| 13 – 19 | 10 | 11 | 8 | 5 | 359 | 59 | 426 | 2.1 |
| 20 – 29 | 257 | 29 | 211 | 27 | 5435 | 381 | 5930 | 29.8 |
| 30 – 39 | 314 | 30 | 298 | 16 | 5499 | 229 | 5842 | 29.4 |
| 40 – 49 | 144 | 8 | 138 | 4 | 2457 | 75 | 2573 | 13.0 |
| 50 – 59 | 53 | 3 | 59 | 3 | 752 | 34 | 794 | 4.0 |
| 60 + | 27 | 1 | 18 | 0 | 239 | 38 | 278 | 1.4 |
| Unknown | 2 | 0 | 3 | 1 | 1937 | 128 | 3894 | 19.6 |
| TOTAL¹ | 810 | 90 | 738 | 57 | 16785 | 972 | 19873 | 100.0 |

1. See footnotes Table 3.1.

Table 3.4
Number of new diagnoses of HIV infection in the year 1 July 1995 to 30 June 1996 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 month intervals of HIV diagnosis.

| STATE/ TERRITORY | 1 Jul 95 – 31 Dec 95 | | 1 Jan 96 – 30 Jun 96 | | 1 Jul 95 – 30 Jun 96 | | |
|--------------------------|----------------------|----------|----------------------|----------|----------------------|----------|------------|
| | Male | Female | Male | Female | Male | Female | Total |
| ACT | 5 | 0 | 1 | 0 | 6 | 0 | 6 |
| NSW ¹ | 43 | 1 | 37 | 0 | 80 | 1 | 82 |
| NT | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| QLD | 10 | 0 | 6 | 2 | 16 | 2 | 18 |
| SA | 5 | 0 | 3 | 0 | 8 | 0 | 8 |
| TAS | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| VIC | 15 | 1 | 13 | 1 | 28 | 2 | 30 |
| W A | 3 | 1 | 3 | 2 | 6 | 3 | 9 |
| TOTAL¹ | 81 | 3 | 63 | 5 | 144 | 8 | 153 |

1. Total column for Tables 3.4 – 3.6 includes 1 person whose sex was not reported.

Table 3.5

Number of new diagnoses of HIV infection in the year 1 July 1995 to 30 June 1996 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 month intervals of HIV diagnosis.

| EXPOSURE CATEGORY | 1 Jul 95 – 31 Dec 95 | | 1 Jan 96 – 30 Jun 96 | | 1 Jul 95 – 30 Jun 96 | | |
|---|----------------------|----------|----------------------|----------|----------------------|----------|------------|
| | Male | Female | Male | Female | Male | Female | Total |
| Male homosexual/bisexual contact | 67 | - | 53 | - | 120 | - | 120 |
| Male homosexual/bisexual contact and ID use | 5 | - | 1 | - | 6 | - | 6 |
| ID use (female and heterosexual male) | 0 | 1 | 1 | 2 | 1 | 3 | 4 |
| Heterosexual contact | 5 | 2 | 4 | 3 | 9 | 5 | 14 |
| Health care setting | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other/undetermined ¹ | 4 | 0 | 4 | 0 | 8 | 0 | 9 |
| TOTAL¹ | 81 | 3 | 63 | 5 | 144 | 8 | 153 |

1. See footnote Table 3.4.

Table 3.6

Number of new diagnoses of HIV infection in the year 1 July 1995 to 30 June 1996 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 month intervals of HIV diagnosis.

| AGE GROUP (YEARS) | 1 Jul 95 – 31 Dec 95 | | 1 Jan 96 – 30 Jun 96 | | 1 Jul 95 – 30 Jun 96 | | |
|--------------------------|----------------------|----------|----------------------|----------|----------------------|----------|------------|
| | Male | Female | Male | Female | Male | Female | Total |
| 13 – 19 | 2 | 1 | 2 | 2 | 4 | 3 | 8 |
| 20 – 29 | 34 | 2 | 25 | 0 | 59 | 2 | 61 |
| 30 – 39 | 32 | 0 | 26 | 3 | 58 | 3 | 61 |
| 40 – 49 | 11 | 0 | 7 | 0 | 18 | 0 | 18 |
| 50 – 59 | 2 | 0 | 2 | 0 | 4 | 0 | 4 |
| 60 + | 0 | 0 | 1 | 0 | 1 | 0 | 1 |
| TOTAL¹ | 81 | 3 | 63 | 5 | 144 | 8 | 153 |

1. See footnote Table 3.4.

SENTINEL SURVEILLANCE OF HIV INFECTION IN SEXUALLY TRANSMISSIBLE DISEASE CLINICS

Table 4.1

Number of people seen, number of people tested for HIV antibody and number of people newly diagnosed with HIV infection by sex and STD clinic¹, during the quarter 1 April 1996 to 30 June 1996.

| STD CLINIC | Seen at Clinic | | Tested for HIV antibody | | Newly diagnosed with HIV infection | | |
|-------------------------------------|----------------|-------------|-------------------------|-------------|------------------------------------|----------|-----------|
| | Male | Female | Male | Female | Male | Female | Total |
| Sydney Sexual Health Centre, NSW | 1536 | 1065 | 552 | 448 | 4 | 1 | 5 |
| Clinic 34, Darwin, NT | 263 | 145 | 125 | 81 | 1 | 0 | 1 |
| Brisbane Sexual Health Clinic, QLD | 837 | 538 | 312 | 175 | 0 | 0 | 0 |
| Clinic 275, Adelaide, SA | 968 | 658 | 721 | 481 | 0 | 0 | 0 |
| Melbourne Sexual Health Centre, VIC | 1846 | 1270 | 1297 | 1083 | 6 | 0 | 6 |
| TOTAL | 5450 | 3676 | 3007 | 2268 | 11 | 1 | 12 |

1. Data not available for Parramatta Sexual Health Clinic, NSW.

Table 4.2

Number of people seen¹ 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 April 1996 to 30 June 1996.

| EXPOSURE CATEGORY | Previous negative HIV antibody test | | % Retested for HIV antibody | | Newly diagnosed with HIV infection | | | |
|--|-------------------------------------|-------------|-----------------------------|-------------|------------------------------------|----------|----------|------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| Homosexual/bisexual contact | 642 | - | 63.4 | - | 1 | - | 1 | 0.2 |
| Homosexual/bisexual contact and ID use | 80 | - | 68.8 | - | 0 | - | 0 | 0.0 |
| ID use (female and heterosexual male) | 223 | 116 | 64.6 | 60.3 | 1 | 0 | 1 | 0.5 |
| Heterosexual contact | 1897 | 1453 | 55.4 | 58.9 | 0 | 1 | 1 | 0.1 |
| <i>outside Australia</i> ² | 238 | 140 | 48.7 | 41.4 | 0 | 1 | 1 | 0.6 |
| <i>within Australia only</i> | 1569 | 1313 | 59.7 | 60.8 | 0 | 0 | 0 | 0.0 |
| Sex worker | - | 419 | - | 77.8 | - | 0 | 0 | 0.0 |
| Sex worker and ID use | - | 30 | - | 60.0 | - | 0 | 0 | 0.0 |
| Other/undetermined | 91 | 128 | 83.5 | 76.6 | 0 | 0 | 0 | 0.0 |
| TOTAL | 2933 | 2146 | 59.1 | 63.7 | 2 | 1 | 3 | 0.1 |

1. At clinics other than Clinic 34, Darwin, NT.
2. Within 3 months for Clinic 275 and one year for other clinics.

Table 4.3

Number of people seen¹ 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 April 1996 to 30 June 1996.

| EXPOSURE CATEGORY | No previous HIV antibody test | | % Tested for HIV antibody | | Newly diagnosed with HIV infection | | | |
|---|-------------------------------|-------------|---------------------------|-------------|------------------------------------|----------|----------|------------|
| | Male | Female | Male | Female | Male | Female | Total | % |
| Homosexual/bisexual contact | 206 | - | 55.3 | - | 3 | - | 3 | 2.6 |
| Homosexual/bisexual contact and ID use | 5 | - | 80.0 | - | 0 | - | 0 | 0.0 |
| ID use (female and heterosexual male) | 81 | 31 | 79.0 | 71.0 | 0 | 0 | 0 | 0.0 |
| Heterosexual contact outside Australia ² | 1435 | 1085 | 59.5 | 61.6 | 1 | 0 | 1 | 0.1 |
| <i>within Australia only</i> | 113 | 56 | 63.7 | 50.0 | 0 | 0 | 0 | 0.0 |
| Sex worker | 1322 | 1029 | 59.2 | 62.2 | 1 | 0 | 1 | 0.1 |
| Sex worker and ID use | - | 61 | - | 86.9 | - | 0 | 0 | 0.0 |
| Other/undetermined | - | 4 | - | 100.0 | - | 0 | 0 | 0.0 |
| TOTAL | 319 | 194 | 35.1 | 37.1 | 4 | 0 | 4 | 2.2 |
| TOTAL | 2046 | 1375 | 56.1 | 59.6 | 8 | 0 | 8 | 0.4 |

1. At clinics other than Clinic 34, Darwin, NT.

2. Within 3 months for Clinic 275 and one year for other clinics.

Table 4.4

Number of people seen¹, 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 April 1996 to 30 June 1996.

| AGE GROUP (YEARS) | Seen at Clinic | | Tested for HIV antibody | | Newly diagnosed with HIV infection | | |
|-------------------|----------------|-------------|-------------------------|-------------|------------------------------------|----------|-----------|
| | Male | Female | Male | Female | Male | Female | Total |
| 13 - 19 | 175 | 445 | 113 | 237 | 0 | 0 | 0 |
| 20 - 29 | 2327 | 1954 | 1355 | 1219 | 4 | 1 | 5 |
| 30 - 39 | 1600 | 745 | 841 | 469 | 5 | 0 | 5 |
| 40 - 49 | 709 | 287 | 394 | 195 | 1 | 0 | 1 |
| 50 - 59 | 252 | 77 | 117 | 54 | 0 | 0 | 0 |
| 60 + | 124 | 20 | 62 | 13 | 0 | 0 | 0 |
| Unknown | 0 | 3 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 5187 | 3531 | 2882 | 2187 | 10 | 1 | 11 |

1. At clinics other than Clinic 34, Darwin, NT.

Table 4.5

Number of people diagnosed with specific STD¹, other than HIV, by sex, exposure category and whether or not they were tested for HIV antibody² during the quarter 1 April 1996 to 30 June 1996.

| EXPOSURE CATEGORY | Tested for HIV antibody | | Not tested for HIV antibody | |
|--|-------------------------|-----------|-----------------------------|-----------|
| | Male | Female | Male | Female |
| Homosexual/bisexual contact | 16 | - | 27 | - |
| Homosexual/bisexual contact and ID use | 0 | - | 3 | - |
| ID use (female and heterosexual male) | 10 | 2 | 3 | 0 |
| Heterosexual contact | 34 | 26 | 38 | 18 |
| <i>outside Australia³</i> | 5 | 0 | 9 | 3 |
| <i>within Australia only</i> | 29 | 26 | 29 | 15 |
| Sex worker | - | 7 | - | 3 |
| Sex worker and ID use | - | 0 | - | 0 |
| Other/undetermined | 2 | 0 | 1 | 0 |
| TOTAL | 62 | 35 | 72 | 21 |

1. Specific STD 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.
3. Within three months for Clinic 275 and one year for other clinics.

REPORT FROM WHO WESTERN PACIFIC REGION

Dr G Pomerol, Acting Regional Advisor, WHO Regional Office, Manila.

Table 5.1
AIDS and HIV in the WHO Western Pacific Region by country; based on reports available at 30 June 1996.

| COUNTRY/ AREA | CUMULATIVE AIDS CASES | | | | AIDS Rate ¹ | Cumulative Diagnoses HIV |
|--------------------------|-----------------------|------------|-----------------------|--------------|---------------------------|--------------------------------|
| | Male | Female | Children <13 Years | Total | | |
| American Samoa | 0 | 0 | 0 | 0 | 0.0 | 0 |
| Australia [†] | 6600 | 256 | 42 | 6877 | 37.7 | 19873 |
| Brunei | 5 | 0 | 0 | 8 | 2.7 | 350 |
| Cambodia | 20 | 10 | 27 | 235 | 2.5 | 6829 |
| China ² | 109 | 8 | 0 | 117 | 0.0 | 3341 |
| 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 | 24 |
| French Polynesia | 3 | 2 | 0 | 50 | 23.1 | 156 |
| Guam | 21 | 2 | 0 | 37 | 26.1 | 93 |
| Hong Kong | 165 | 49 | 0 | 214 | 3.7 | 702 |
| Japan | 691 | 83 | 0 | 1312 | 1.1 | 3758 |
| Kiribati | 2 | 0 | 0 | 2 | 2.6 | 12 |
| Laos | 10 | 3 | 1 | 17 | 0.4 | 131 |
| Macao | 4 | 0 | 0 | 8 | 1.9 | 133 |
| Malaysia | 443 | 33 | 7 | 476 | 2.4 | 16963 |
| Marshall Islands | 1 | 1 | 0 | 2 | 3.8 | 9 |
| Nauru | 0 | 0 | 0 | 0 | 0.0 | 1 |
| New Caledonia | 12 | 4 | 0 | 56 | 30.2 | 135 |
| New Zealand | 533 | 24 | 4 | 557 | 15.7 | 1131 |
| Niue | 0 | 0 | 0 | 0 | 0.0 | 0 |
| N. Mariana Islands | 2 | 0 | 0 | 6 | 10.4 | 10 |
| Palau | 1 | 0 | 0 | 1 | 5.8 | 1 |
| Papua New Guinea | 49 | 53 | 5 | 177 | 4.3 | 453 |
| Philippines | 162 | 85 | 7 | 247 | 0.4 | 732 |
| Rep. of Korea | 42 | 3 | 0 | 55 | 0.1 | 582 |
| Samoa | 3 | 1 | 1 | 6 | 3.7 | 9 |
| Singapore | 208 | 14 | 1 | 222 | 7.6 | 477 |
| Solomon Islands | 0 | 0 | 0 | 0 | 0.0 | 2 |
| Tokelau | 0 | 0 | 0 | 0 | 0.0 | 0 |
| Tonga | 1 | 0 | 0 | 7 | 7.1 | 11 |
| Tuvalu | 0 | 0 | 0 | 0 | 0.0 | 0 |
| Vanuatu | 0 | 0 | 0 | 0 | 0.0 | 0 |
| Vietnam | 408 | 44 | 1 | 500 | 0.7 | 4153 |
| Wallis and Futuna | 1 | 0 | 0 | 1 | 7.1 | 2 |
| TOTAL[†] | 9500 | 676 | 96 | 11200 | 0.6 | 60075 |

1. AIDS cases per 100,000 total current population.

2. For Taiwan 45 AIDS cases in males, 3 in females and 300 diagnosis of HIV infection were reported to 30 June 1996.

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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 STD 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 STD 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.

HIV antibody testing is carried out at Public Health Laboratories and Blood Transfusion Services, and summary information on testing is sent on a four-weekly basis to the National HIV Reference Laboratory, which produces quarterly tabulations for publication in the Australian HIV Surveillance Report.

Abbreviations: HIV is the human immunodeficiency virus, and unless otherwise specified, refers to HIV-1 only. AIDS is the acquired immunodeficiency syndrome, ID stands for injecting drug, and STD for sexually transmissible disease. Specified 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.

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