

NSW HIV Strategy 2016 – 2020

Quarter 2

2016

Data Report



Executive Summary

The *NSW HIV Strategy 2016-2020* continues the NSW Government's commitment to achieving the virtual elimination of HIV transmission in NSW by 2020, and sustaining the virtual elimination of HIV transmission in people who inject drugs, sex workers and from mother to child. The Strategy refines our efforts across prevention, testing and treatment, building on the actions that have proven successful in implementing the *NSW HIV Strategy 2012-2015* and prioritising the additional activities needed to end HIV transmission in NSW, including expanding access to PrEP for people at a high risk of HIV and the rapid initiation of HIV treatment.

To achieve this goal the Strategy focuses on:

- Sustaining the central role of condoms in preventing the transmission of HIV
- Reducing sharing of injecting equipment among people who inject drugs by 25%
- Assessing all people attending public sexual health services and high caseload general practices for PrEP eligibility
- Facilitating testing of all recent sexual and injecting partners of people newly diagnosed with HIV
- Increasing the frequency of HIV testing in priority populations in accordance with risk
- Strengthening service integration and models of care to deliver HIV testing in our priority settings
- Strengthening systems and service integration for HIV prevention, diagnosis and management for Aboriginal people at risk
- Increasing the proportion of people with diagnosed HIV on ART to 95%
- Ensuring 90% of people newly diagnosed with HIV are on ART within 6 weeks of diagnosis in 2016 and to further reduce this timeframe over the life of the Strategy
- Further strengthening systems for timely collection and reporting of data to monitor progress, report outcomes and determine additional focus

The Strategy identifies the range of key settings needed for action including publically funded sexual health services, general practice and primary care, Aboriginal Community Controlled Health Services, NSW needles and syringe program outlets, antenatal care services, drug and alcohol services, mental health services and emergency departments.

The activities NSW Health is engaged in to meet the Strategy goals and targets is summarised in the [NSW HIV Snapshot](#). To monitor progress against the Strategy goals and targets, a range of data sources are monitored and reported against via this quarterly data report. Detailed information on NSW residents newly diagnosed with HIV up to 2013 is available in the [NSW HIV 2013 Epidemiological Report](#).

Key data to 30 June 2016:

- From April to June (quarter 2) 2016, 86 NSW residents were notified with newly diagnosed HIV infection, four per cent (%) greater than the average count for quarter 2 2010-2015 (n=83). Of 86 new diagnoses, 83% (n=71) reported being men who have sex with men (MSM), 4% greater than the average count for MSM for quarter 2 2010-2015 (n=68). Of 71 MSM newly diagnosed in quarter 2 2016, 8% (n=6) had been tested as part of eligibility screening for pre-exposure prophylaxis (PrEP). Of six MSM newly diagnosed in quarter 2 2016 through screening for PrEP all had a past negative HIV test a median of 84 days prior to diagnosis.
- From January to June 2016, 170 people were newly diagnosed, 3% less than the average count for January to June 2010-2015 (n=175). Of these 170, 82% (n=139) were MSM, 3% less than the average count for MSM for January to June 2010-2015 (n=143). Of 139 MSM newly diagnosed January to June 2016, 5% (n=7) been tested as part of eligibility screening for PrEP. Screening for PrEP as reason for HIV test was added in 2016 to the HIV notification.
- Of 170 new diagnoses January to June 2016 38% (n=65) had a CD4 count at diagnosis of less than 350 cells/ μ L, indicative of late diagnosis, compared with 34% in the same period in 2010-2015.
- Of 139 MSM newly diagnosed January to June 2016, 49% (n=68) had early stage infection compared with 53% of MSM newly diagnosed in the same period in 2010-2015, while 17% (n=24) had advanced stage infection, compared with 12% in the same period in 2010-2015.
- Between 1 March and 30 June 2016, 1993 people at high risk of HIV infection were provided with PrEP for the prevention of HIV infection through EPIC-NSW.
- From April to June 2016, 135,164 HIV serology tests were performed in NSW; 15% more than same period in 2015, 19% more than same period in of 2014 and 2013 and 30% greater than same period in 2012.
- From April to June 2016, 13,523 HIV tests were performed across NSW public sexual health clinics; 20% greater than the same period in 2015. Among MSM, there was a 39% increase in HIV tests compared with the same period in 2015.
- The number of new diagnoses in 2016 should be considered in the context of: 1) a marked and continued increase in HIV testing (see Section 3); 2) commencement of enrolment on 1 March 2016 of people at high risk of acquiring HIV into a population level PrEP impact study ([EPIC-NSW](#)) with almost 2000 participants enrolled to 30 June 2016 and likely bringing forward in time screening of many of those at the highest risk of HIV acquisition; and 3) a greater proportion of people newly diagnosed in the first half of 2016 had evidence of late or advanced stage diagnosis compared with the previous six years. The fact that the number of early diagnoses has not increased despite the large increase in testing suggests that the rate of HIV transmission has not increased, and the higher proportion of late diagnoses indicates that people living with HIV for some years but previously undiagnosed have been tested with little overall change in the rate of HIV diagnosis.
- Data from public sexual health and HIV clinics indicate 91% - 95% of people living with HIV who attended these services were on antiretroviral therapy (ART).
- Of 103 NSW residents newly diagnosed October to December 2015, 57% (n=51) had commenced ART within six weeks, 75% (n=77) within three months and 83% (n=85) within six months of diagnosis.

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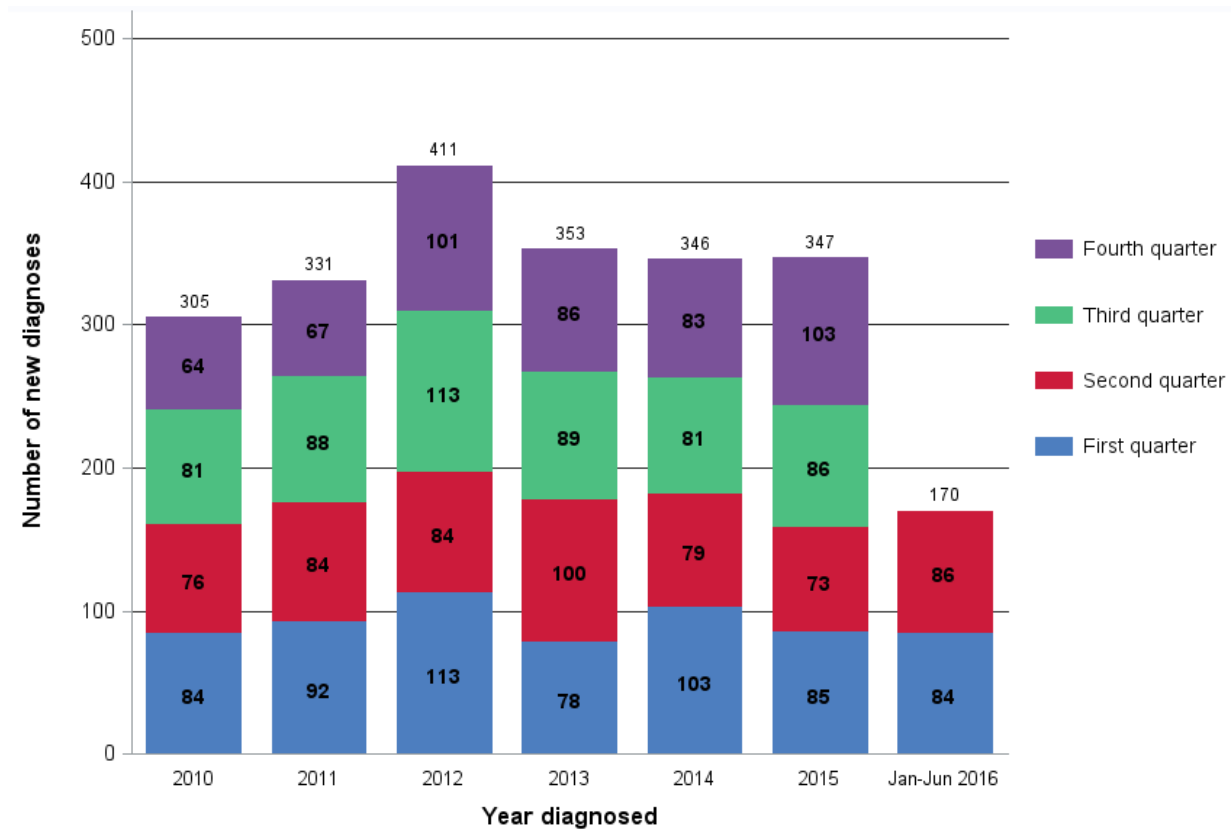
Glossary of Terms

ART	Antiretroviral therapy
CAIC	Condomless anal intercourse with casual partners
HIV	Human Immunodeficiency Virus
LHD	Local Health District
MSM	Men who have sex with men
NSP	Needle and syringe program
NSW	New South Wales
NSWPHS	New South Wales Population Health Survey
PWID	People who inject drugs
PFSHC	Publicly Funded Sexual Health Clinic
PrEP	Pre-exposure prophylaxis
SGCPS	Sydney Gay Community Periodic Survey

1. Reduce HIV transmission

1.1 How many cases are notified?

Figure 1: Number of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016



Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

From April to June (quarter 2) 2016, 86 NSW residents were notified with newly diagnosed HIV infection, four per cent (%) greater than the average count for quarter 2 2010-2015 (n=83). Of 86 new diagnoses, 83% (n=71) reported being men who have sex with men (MSM), 4% greater than the average count for MSM for quarter 2 2010-2015 (n=68). Of 71 MSM newly diagnosed in quarter 2 2016, 8% (n=6) had been tested as part of eligibility screening for pre-exposure prophylaxis (PrEP). Of 6 MSM newly diagnosed in quarter 2 2016 through screening for PrEP the median age was 29 years and all had a past negative HIV test a median of 84 days prior to diagnosis.

From January to June 2016, 170 people were newly diagnosed, 3% less than the average count from January to June 2010-2015 (n=175). Of these 170, 82% (n=139) were MSM, 3% less than the average count for MSM for January to June 2010-2015 (n=143).

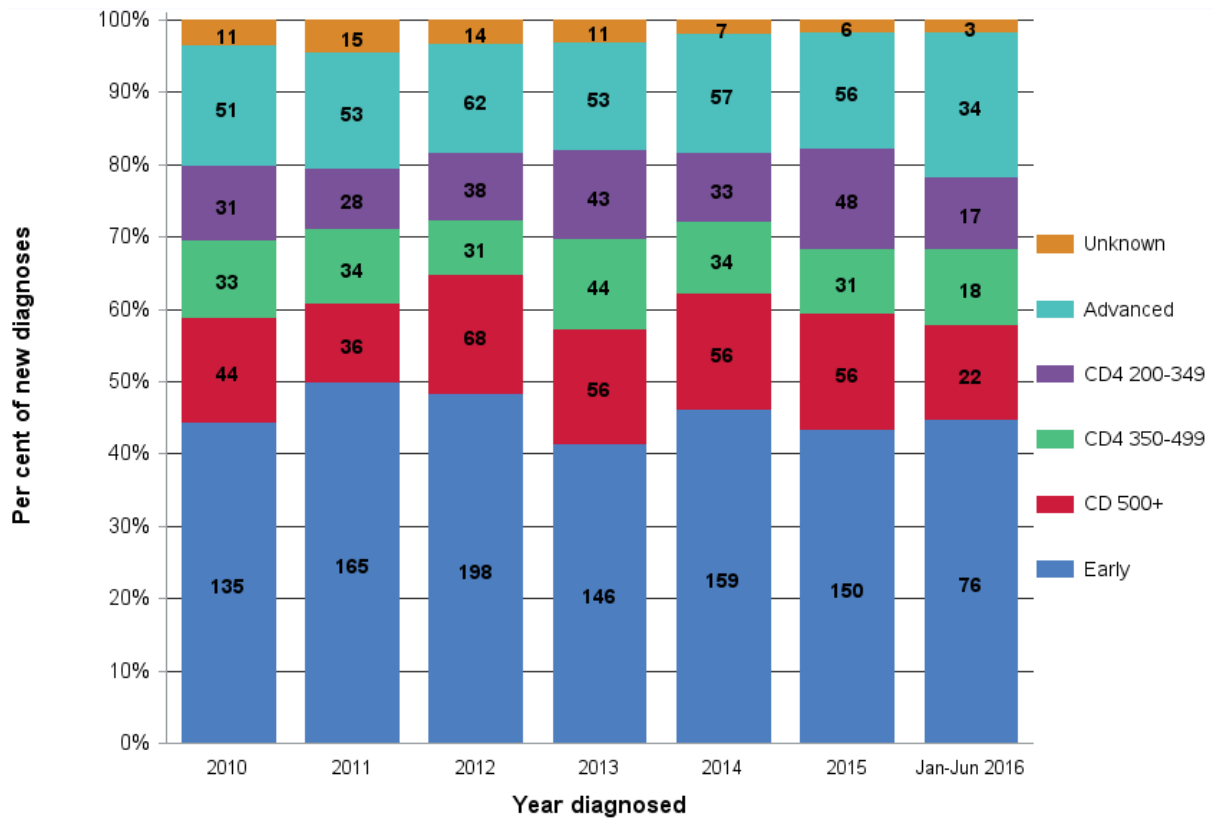
The number of new diagnoses in 2016 should be considered in the context of: 1) a marked and continued increase in HIV testing (see Section 3); 2) commencement of enrolment on 1 March 2016 of people at high risk of acquiring HIV into a population level PrEP impact study ([EPIC-NSW](#)) with almost 2000 participants enrolled to 30 June 2016 and likely bringing forward in time screening of many of those at the highest risk of HIV acquisition; and 3) a greater proportion of people newly diagnosed in the first half of 2016 had evidence of late or advanced stage diagnosis compared with

the previous six years. The fact that the number of early diagnoses has not increased despite the large increase in testing suggests that the rate of HIV transmission has not increased, and the higher proportion of late diagnoses indicates that people living with HIV for some years but previously undiagnosed have been tested with little overall change in the rate of HIV diagnosis.

1.2 What proportion of HIV notifications are newly acquired infections?

Trends in the stage of infection at which people are diagnosed with HIV provide an indication as to the timeliness of diagnosis over time. Figure 2a (all new diagnoses) and 2b (new diagnoses reporting to be MSM) draws on a combination of notification data including clinical symptoms at diagnosis (sero-conversion like illness, AIDS), HIV testing history and CD4 count at diagnosis to describe 'stage of infection'¹ at the time of diagnosis. Figure 3 (all new diagnoses) utilises CD4 count at diagnosis only.

Figure 2a: Per cent of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 by stage of infection at diagnosis¹



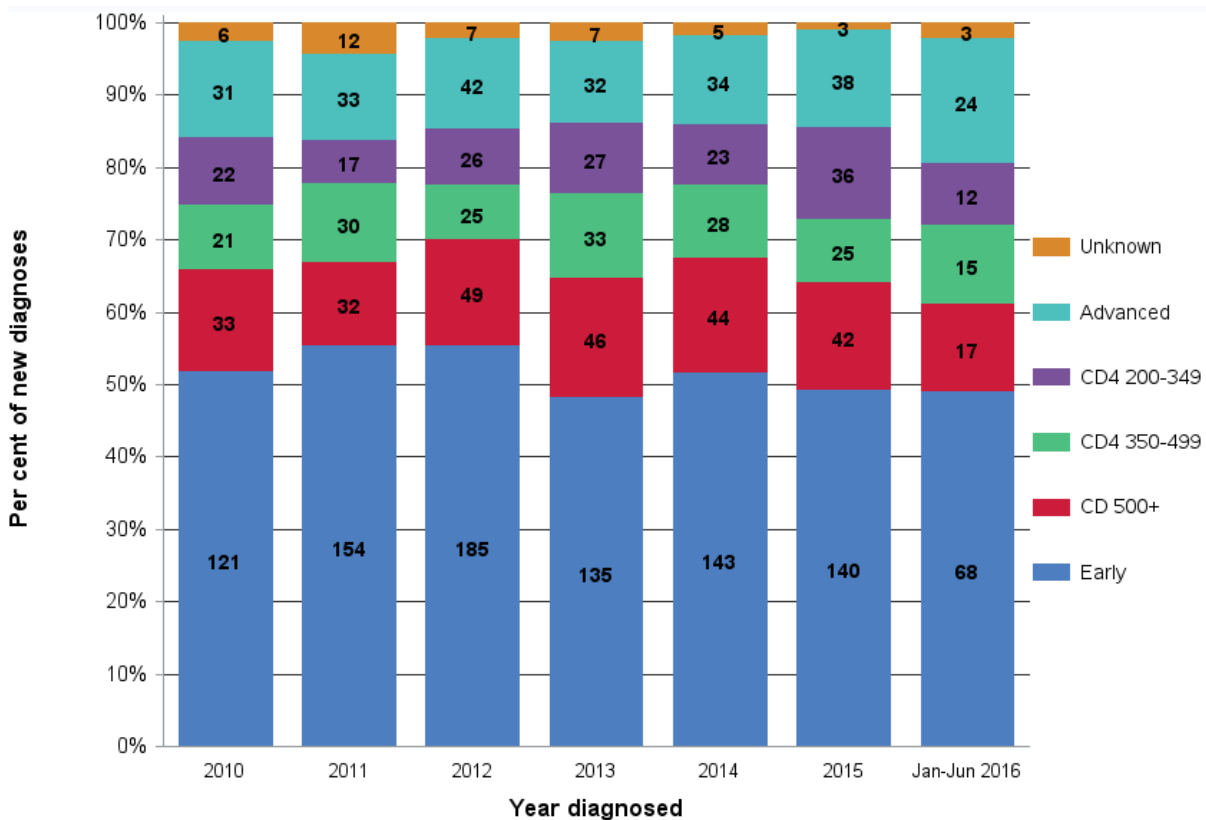
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

¹Stage of infection at diagnosis: Early = Evidence of HIV infection acquired within 12 months of diagnosis, which was defined as notification of a sero-conversion like illness or negative or indeterminate HIV test within 12 months of diagnosis, irrespective of CD4 or presentation with an AIDS defining illness at diagnosis. CD4 500+, CD4 350 to 499, CD4 200 to 349 each excludes early and advanced categories. Advanced = CD4 count less than 200 or AIDS defining illness in absence of evidence of 'Early' diagnosis

Comment

Of 86 NSW residents notified with newly diagnosed HIV infection in quarter 2 2016, 47% (n=40) had evidence of early stage infection at diagnosis compared with 45% of new diagnoses in quarter 2 of 2010-2015, while 22% (n=19) had evidence of advanced stage infection, compared with 15% of new diagnoses in quarter 2 of 2010-2015. Of 170 new diagnoses in January to June 2016, 45% (n=76) had evidence of early stage infection at diagnosis compared with 46% of new diagnoses in the same period in 2010-2015, while 20% (n=34) had evidence of advanced stage infection, compared with 15% of new diagnoses in the same period in 2010-2015.

Figure 2b: Per cent of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 reporting to be men who have sex with men (MSM) by stage of infection at diagnosis¹

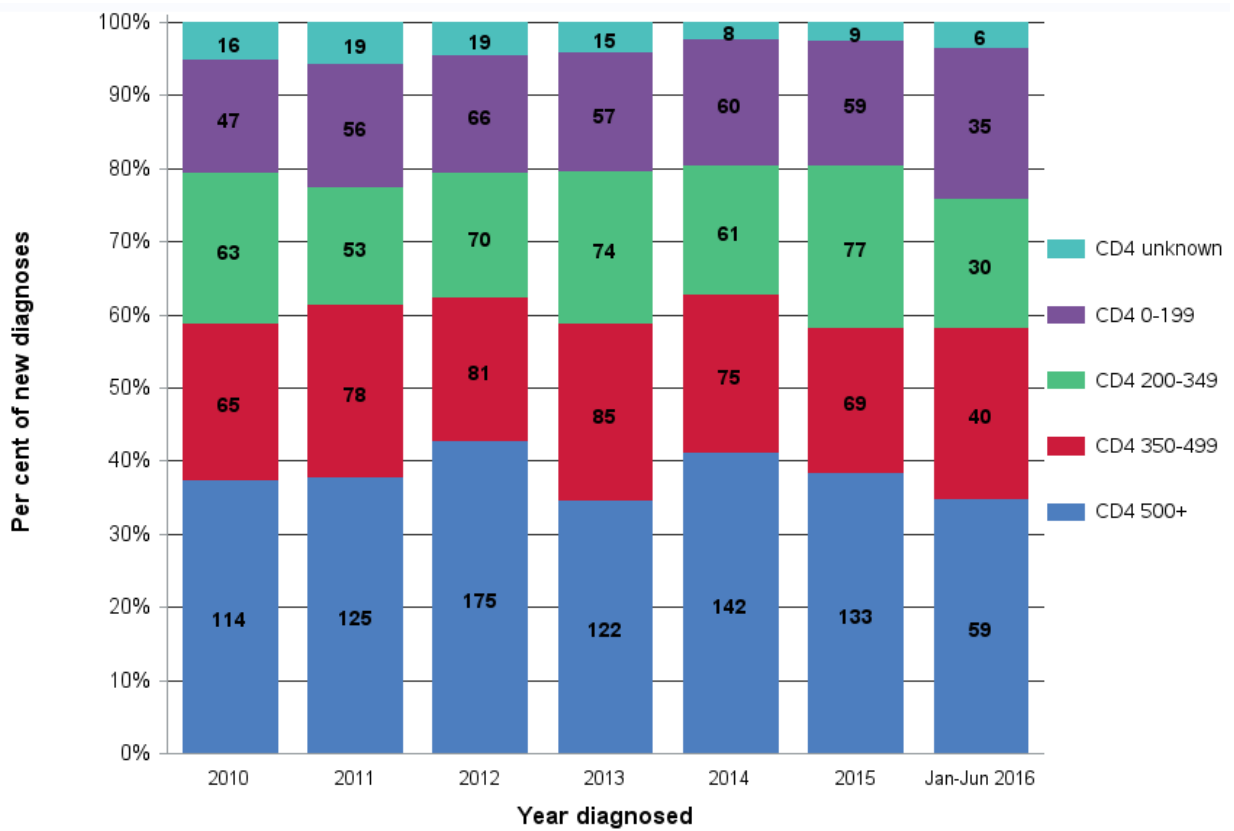


Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

Of 71 NSW residents notified with newly diagnosed HIV infection in quarter 2 2016 reported to be MSM, 49% (n=35) had evidence of early stage infection, compared with 51% of new diagnoses in quarter 2 of 2010-2015; 20% (n=14) had evidence of advanced stage infection at diagnosis compared with 13% of new diagnoses in quarter 2 of 2010-2015. Of 139 MSM newly diagnosed in January to June 2016, 49% (n=68) had evidence of early stage infection at diagnosis compared with 53% of MSM newly diagnosed in the same period in 2010-2015, while 17% (n=24) had evidence of advanced stage infection, compared with 12% of MSM newly diagnosed in the same period in 2010-2015.

Figure 3: Per cent of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 by CD4 count at diagnosis



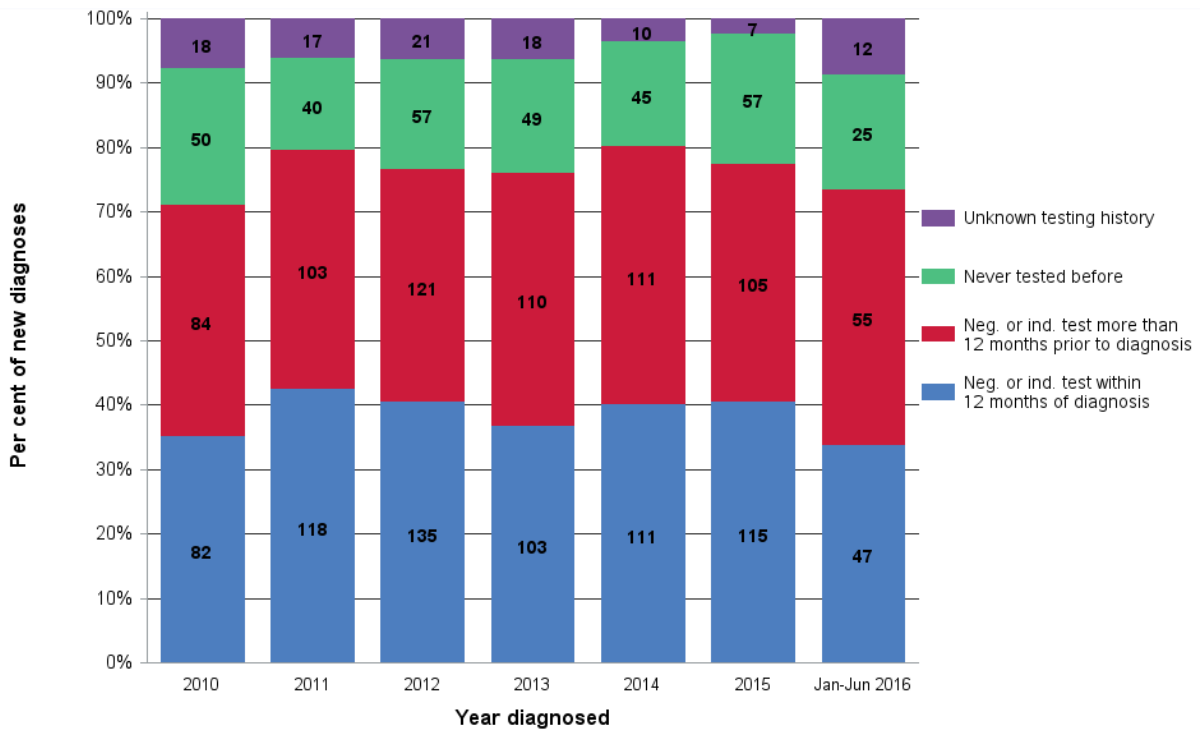
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

Of 86 NSW residents notified with newly diagnosed HIV infection in quarter 2 2016, 33% (n=28) had a CD4 count (in cells/ μ L) at diagnosis of 500 or over, 27% (n=23) of 350 to 499, 16% (n=14) of 200 to 349, 22% (n=19) of 0 to 199 and 2% (n=2) were unknown. Of those newly diagnosed in the same period in 2010-2015, a greater proportion had a CD4 count of 500 or over (40%) and a lesser proportion had a CD4 count of 0-199 (15%). Of 86 NSW residents notified with newly diagnosed HIV infection in quarter 2 2016, 38% (n=33) had a CD4 count at diagnosis of less than 350 cells/ μ L, indicative of late diagnosis, compared with 33% of those diagnosed in quarter 2 in 2010-2015.

Of 170 new diagnoses in January to June 2016, 35% (n=59) had a CD4 count at diagnosis of 500 or over, 24% (n=40) of 350 to 499, 18% (n=30) of 200 to 349, 21% (n=35) of 0 to 199 and 4% (n=6) were unknown. Of those newly diagnosed in the same period 2010-2015, a greater proportion had a CD4 count of 500 or over (39%) and a lesser proportion had a CD4 count of 0-199 (15%). Of 170 new diagnoses in January to June 2016, 38% (n=65) had a CD4 count at diagnosis of less than 350 cells/ μ L, indicative of late diagnosis, compared with 34% of those diagnosed in the same period in 2010-2015.

Figure 4: Per cent of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 reporting to be MSM by HIV testing history



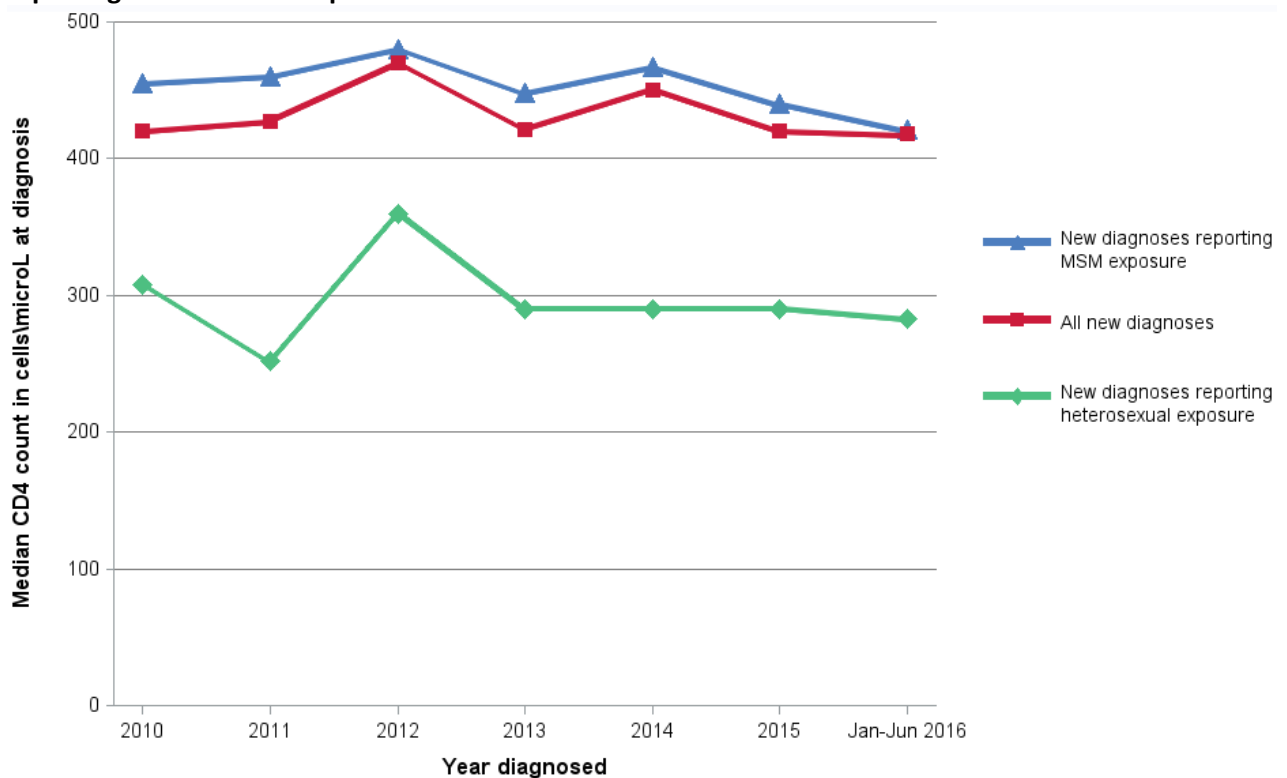
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

Of 71 NSW residents notified with newly diagnosed HIV infection in quarter 2 2016 reported to be MSM, 37% (n=26) were reported to have had a negative or indeterminate HIV test within 12 months of diagnosis, compared with 41% of MSM newly diagnosed in quarter 2 in 2010-2015. Of the 71 new diagnoses in MSM in quarter 2 2016, 17% (n=12) reported not ever having had an HIV test prior to diagnosis, compared with 20% of MSM newly diagnosed in quarter 2 2010-2015.

Of 139 MSM newly diagnosed in January to June 2016, 34% (n=47) were reported to have had a negative or indeterminate HIV test within 12 months of diagnosis, compared with 39% of MSM newly diagnosed in the same period in 2010-2015. Of 139 MSM newly diagnosed in January to June 2016, 18% (n=25) reported not ever having had an HIV test prior to diagnosis, compared with 19% in the same period in 2010-2015. However 9% (n=12) did not have past testing history reported, compared with 5% in the same period in 2010-2015.

Figure 5: Median CD4 count at diagnosis of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 for all, for those reporting to be MSM and for those reporting heterosexual acquisition of HIV¹



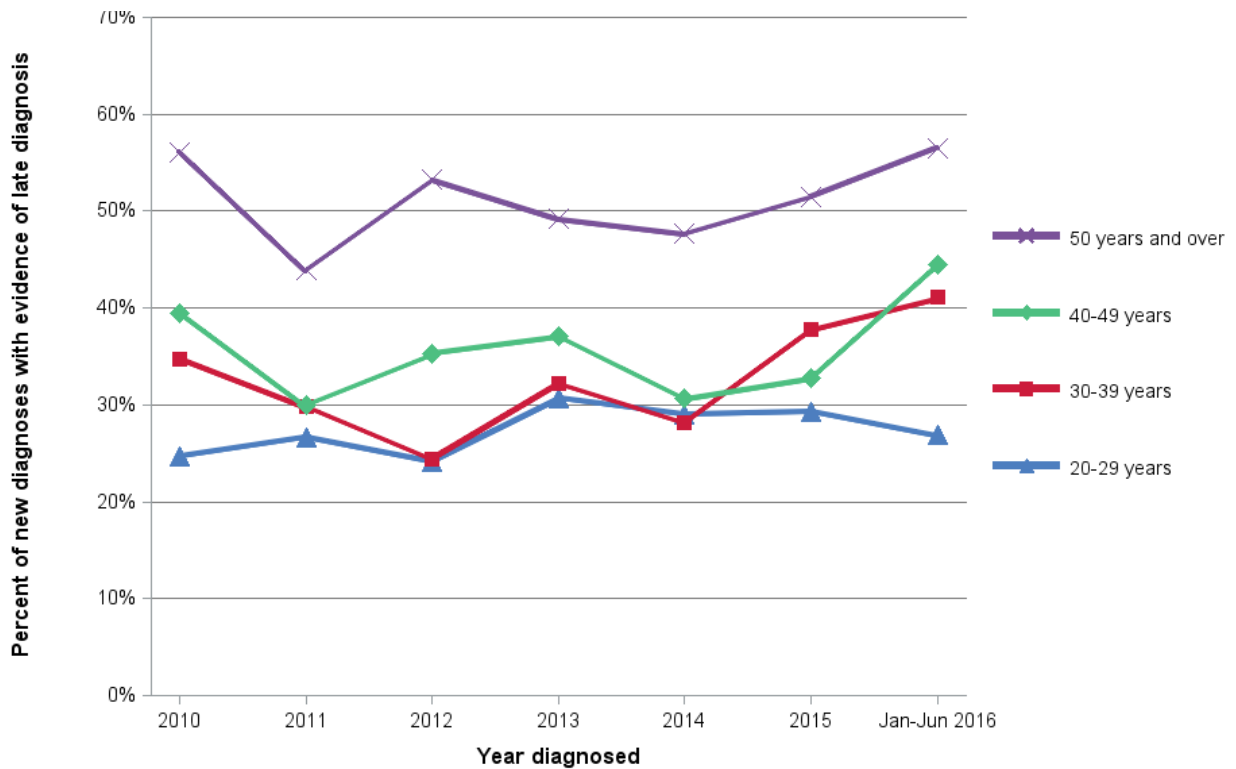
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

¹The median CD4 count at diagnosis for other HIV risk exposure groups such as being a person who injected drugs (PWID) are not reported separately due to very low number of cases.

Comment

The median CD4 count at diagnosis for all 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016 was 418. For 139 reporting to be MSM the median CD4 count at diagnosis was 421 and for the 25 cases reporting heterosexual exposure to HIV it was 283. The median CD4 counts at diagnosis for all, MSM only and heterosexual only new diagnoses in January to June 2016 were lower than the median CD4 counts of their counterparts diagnosed each year from 2010-2015.

Figure 6: Within each age group at diagnosis of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 the per cent with evidence of late diagnosis¹



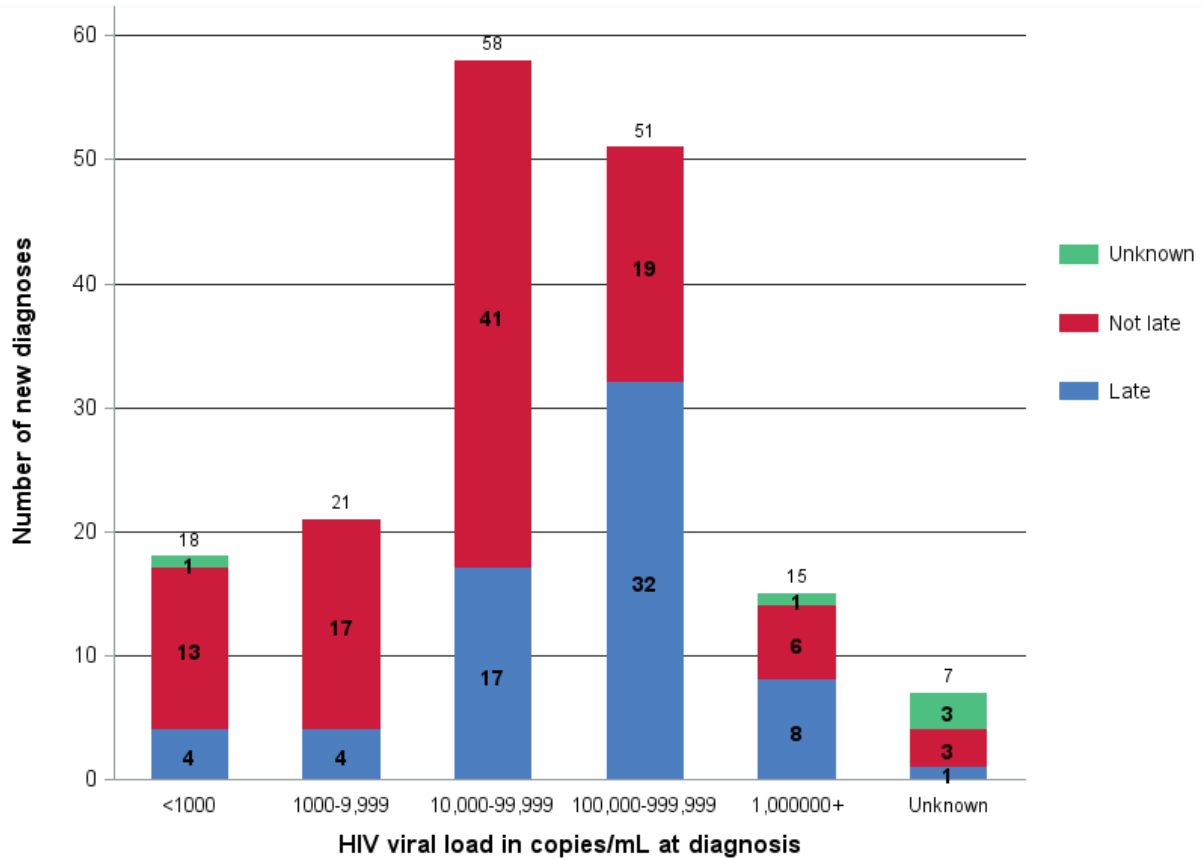
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

¹Evidence of a late diagnosis = a CD4 count less than 350 or an AIDS defining illness or AIDS death within three months of diagnosis, in the absence of a laboratory confirmed negative HIV test in the 12 months prior to diagnosis.

Comment

Of 170 NSW residents newly diagnosed with HIV infection from January to June 2016, 39% (n=66) had evidence of late diagnosis. Evidence of late diagnosis was more common as age at diagnosis increased. Of 23 who were aged 50 years or over at diagnosis, 57% had evidence of late diagnosis. Of 36 aged 40 to 49 years at diagnosis, 44% had evidence of late diagnosis. Of 56 aged 30 to 39 years at diagnosis, 41% had evidence of late diagnosis. Of 52 aged 20 to 29 years at diagnosis, 27% had evidence of late diagnosis. None of the 3 people newly diagnosed aged less than 20 years of age had evidence of late diagnosis.

Figure 7: Number of NSW residents notified with newly diagnosed HIV infection from January to June 2016 by HIV viral load at diagnosis and evidence of late diagnosis¹



Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

¹Evidence of a late diagnosis = a CD4 count less than 350 or an AIDS defining illness or AIDS death within three months of diagnosis, in the absence of a laboratory confirmed negative HIV test in the 12 months prior to diagnosis.

Comment

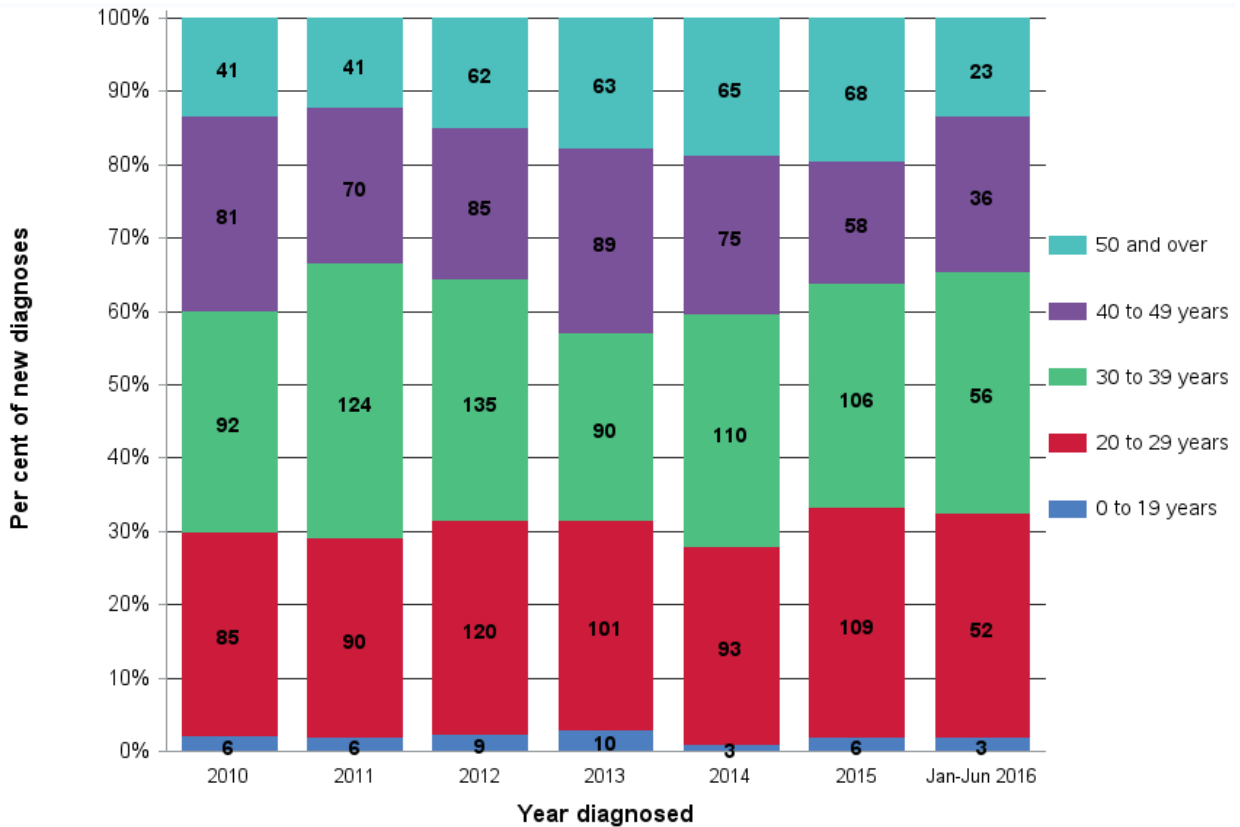
Of 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016, 23% (n=39) had an HIV viral load (HIV VL) 0-9,999 copies/mL, 34% (n=58) had an HIV VL of 10,000-99,999, 39% (n=66) had an HIV VL of 100,000 or more and 4% (n=7) had an unknown HIV VL at diagnosis. Of 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016, 39% (n=66) had evidence of late diagnosis and of those 61% (n=40) had an HIV VL of 100,000 copies/mL or more.

For the HIV-infected individual, unchecked viral replication is associated with negative clinical outcomes and is a factor in disease progression and death, independent of CD4 count. Higher viral loads (for example 100,000 copies/mL or more) are associated with a higher risk of transmission of HIV and lower viral loads are associated with a lower risk of transmission of HIV.

1.3 Which groups are being notified?

Of 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016, 92% (n=156) were male, 8% (n=13) were female and less than 1% were transgender (n=1), similar to previous years (Appendix A). Of 170 people newly diagnosed January to June 2016, 4% (n=7) were reported to be Aboriginal or Torres Strait Islander people; this is a slightly higher proportion than previous years and is being monitored closely. A lesser proportion of new diagnoses in January to June 2016 resided in South-Eastern Sydney Local Health District, while a greater proportion resided in Central Coast, Murrumbidgee-Albury, Southern NSW and Illawarra-Shoalhaven LHDs, compared with the geographical distribution of new diagnoses in 2010-2015 (though absolute counts in these regional and rural LHDs remain small) (Appendix A).

Figure 8: Per cent of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 by age at diagnosis

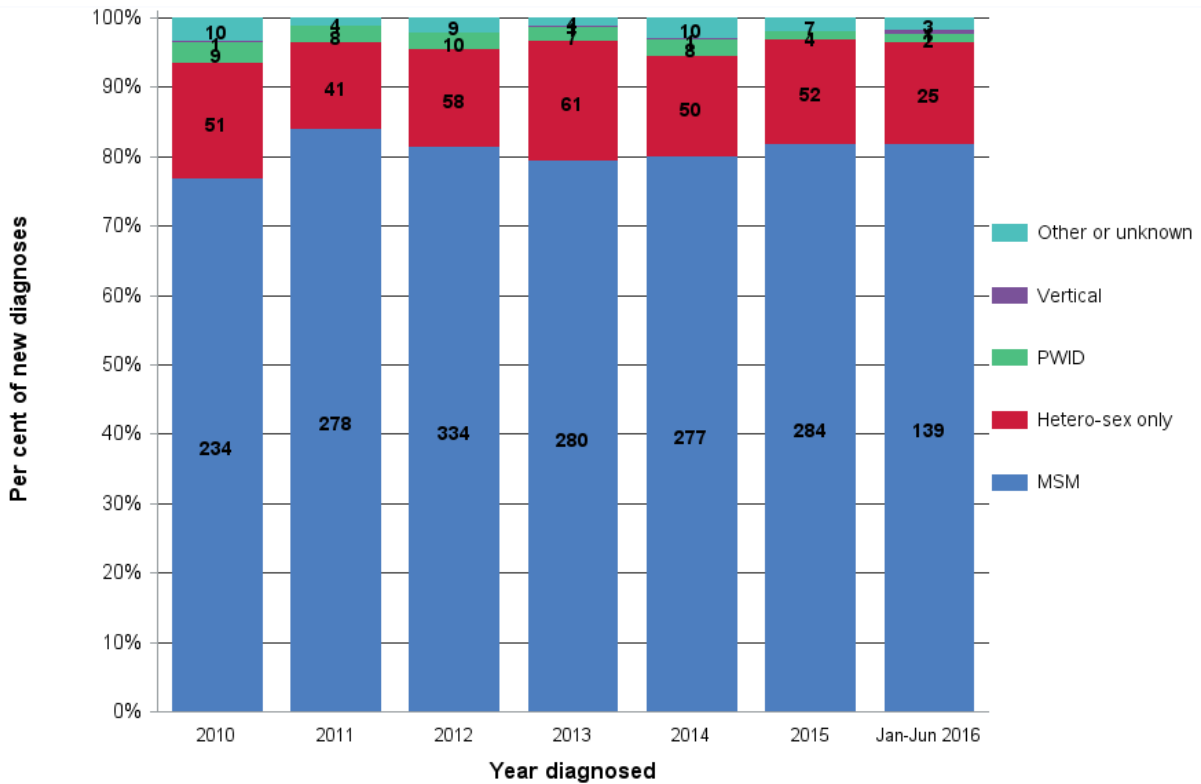


Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

Of 86 NSW residents notified with newly diagnosed HIV infection in quarter 2 2016, 1% (n=1) were less than 20 years of age at diagnosis, 26% (n=22) were 20 to 29 years, 41% (n=35) were 30 to 39 years, 22% (n=19) were 40 to 49 years and 10% (n=9) were 50 years of age or over. Of 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016, 2% (n=3) were less than 20 years of age at diagnosis, 31% (n=52) were 20 to 29 years, 33% (n=56) were 30 to 39 years, 21% (n=36) were 40 to 49 years and 14% (n=23) were 50 years or over. This is a similar age breakdown for new diagnoses in the same period in 2010-2015.

Figure 9: Per cent of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 by reported HIV risk exposure



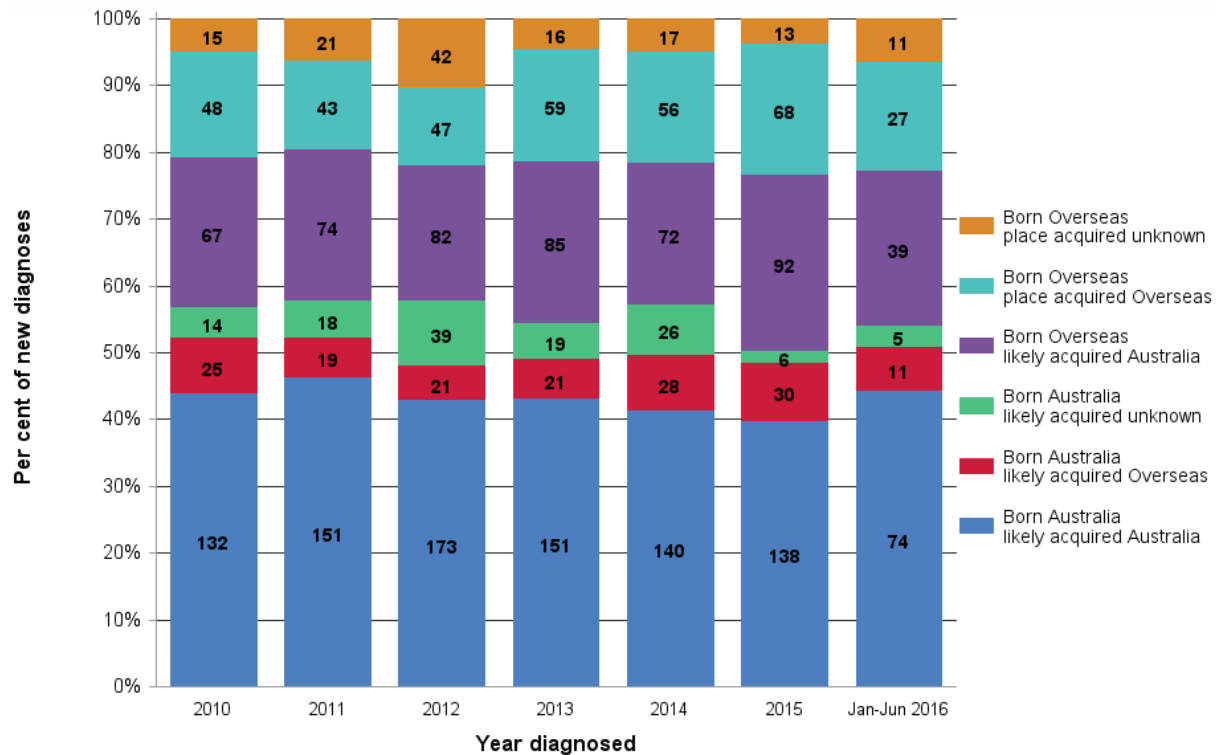
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

Of 86 NSW residents notified with newly diagnosed HIV infection in quarter 2 2016, HIV risk exposure was reported as male to male sex for 83% (n=71), heterosexual sex for 15% (n=13), injecting drug use (PWID) for 1% (n=1) and another type or unknown exposure for 1% (n=1). This was a similar breakdown of HIV risk exposures as was reported for people newly diagnosed in quarter 2 2010-2015.

Of 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016, HIV risk exposure was reported as male to male sex for 82% (n=139), heterosexual sex for 15% (n=25), another type or unknown exposure for 2% (n=3), injecting drug use (PWID) for 1% (n=2) and vertical transmission for <1% (n=1; occurred outside of Australia). This was a similar breakdown of HIV risk exposures as was reported for people newly diagnosed in the same period in 2010-2015.

Figure 10: Number of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 by place of birth and place most likely acquired HIV*



Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

* Excluded were 27 new diagnoses in 2010 to 31 March 2016 with unknown country of birth.

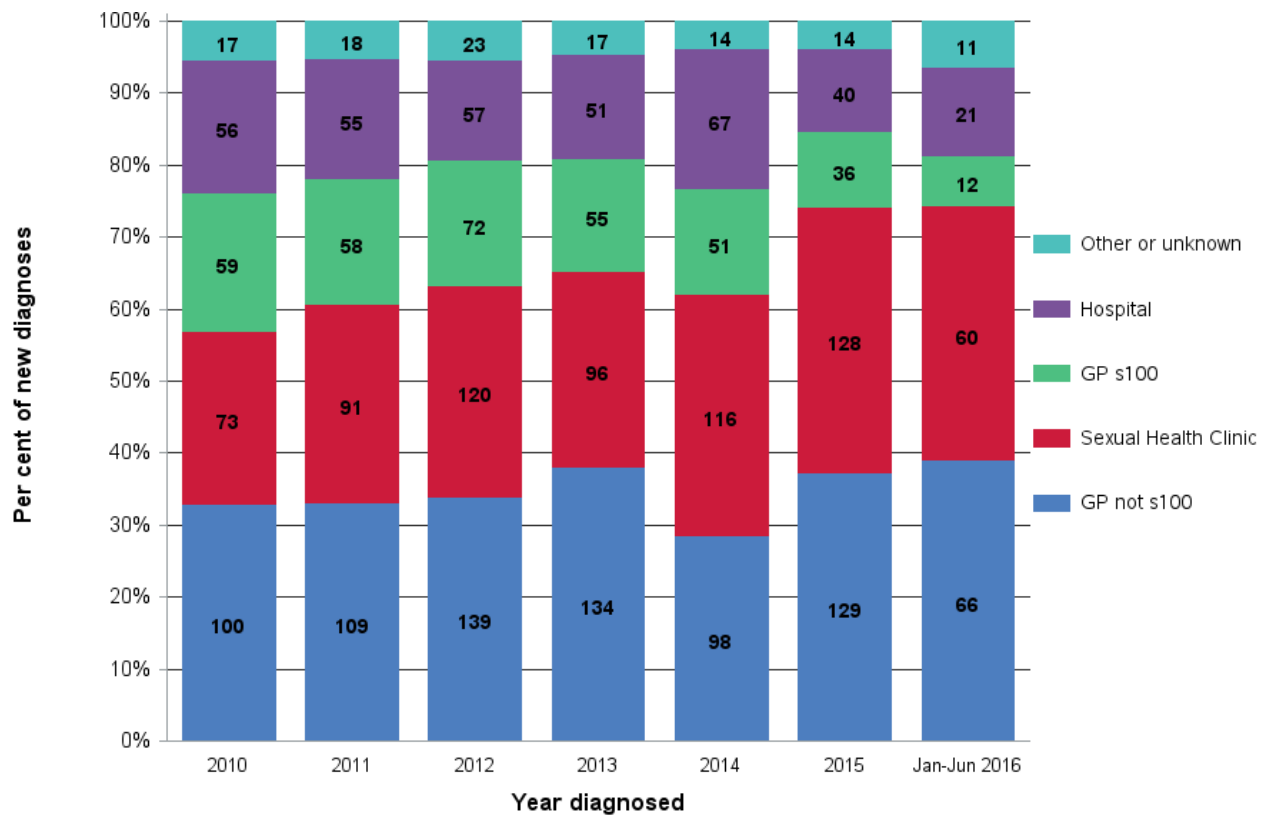
Comment

Of 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016, 53% (n=90) were born in Australia and 45% (n=77) were born overseas, similar to the same period in 2010-2015 (54% born in Australia, 45% born overseas). Of 139 MSM newly diagnosed HIV infection from January to June 2016, 55% (n=77) were born in Australia and 43% (n=60) born overseas, compared with 58% born in Australia and 42% born overseas for the same period in 2010-2015.

Of 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016:

- 43% (n=74) were born in and likely acquired HIV in Australia, same as in the same period in 2010-2015;
- 6% (n=11) were born in Australia but likely acquired HIV overseas, same as in the same period in 2010-2015;
- 3% (n=5) were born in Australia with the place they likely acquired their infection unknown, compared with 6% for January to June in 2010-2015;
- 23% (n=39) were born overseas but likely acquired in Australia, compared with 24% of new diagnoses in the same period in 2010-2015;
- 16% (n=27) were born overseas and likely acquired HIV overseas, compared with 14% of new diagnoses in the same period in 2010-2015, and;
- 6% (n=11) were born overseas with the place they likely acquired their infection unknown, compared with 7% for January to June 2010-2015.

Figure 11: Number of NSW residents notified with newly diagnosed HIV infection from 1 January 2010 to 30 June 2016 by type of diagnosing doctor



Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

Of 170 NSW residents notified with newly diagnosed HIV infection from January to June 2016:

- 39% (n=66) were diagnosed by medical general practitioners (GPs) not accredited to prescribe antiretroviral therapy (ART) (GP not-s100), compared with 32% of the new diagnoses in the same period in 2010-2015;
- 35% (n=60) were diagnosed by sexual health clinics (SHC) (includes linked community testing sites), compared with 31% of the new diagnoses in the same period in 2010-2015;
- 12% (n=21) were diagnosed by hospital located doctors, compared with 16% of the new diagnoses in the same period in 2010-2015;
- 7% (n=12) were diagnosed by GP s100 doctors (HIV specialised and accredited to prescribe ART), compared with 16% of the new diagnoses in the same period in 2010-2015, and;
- 6% (n=11) were diagnosed by other doctor types such as immigration services, compared with 5% of the new diagnoses in the same period in 2010-2015.

Figure 12: Number of NSW residents notified with newly diagnosed HIV infection from January to June 2016 by type of diagnosing doctor and self-reported HIV risk exposure

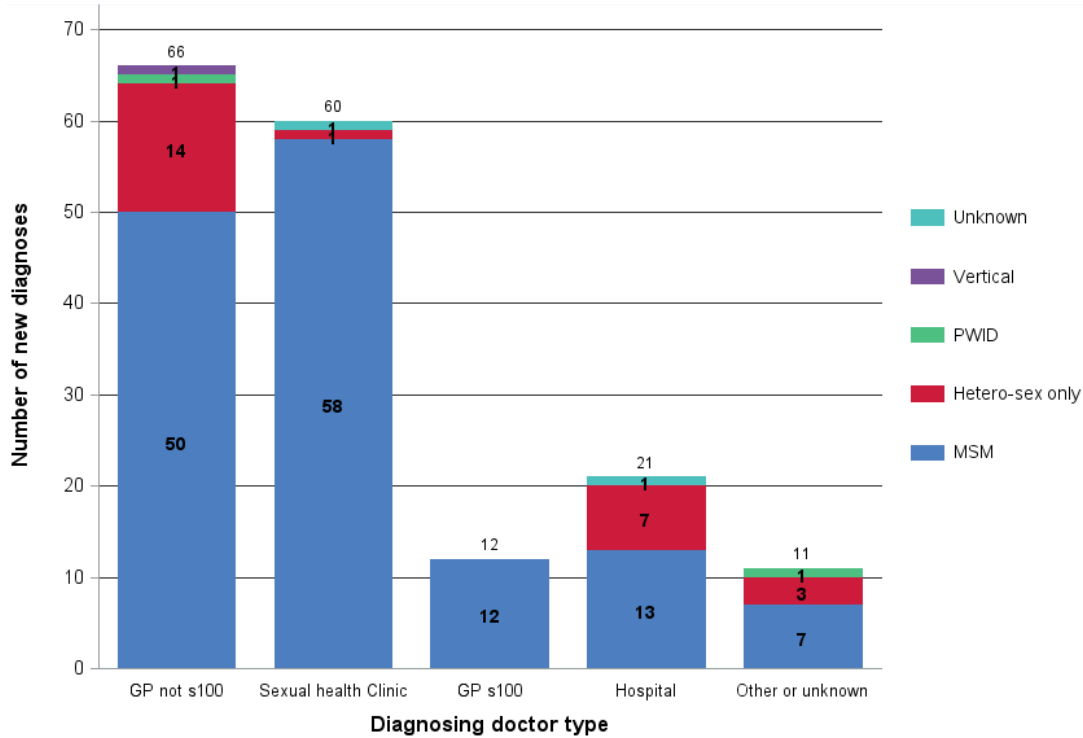
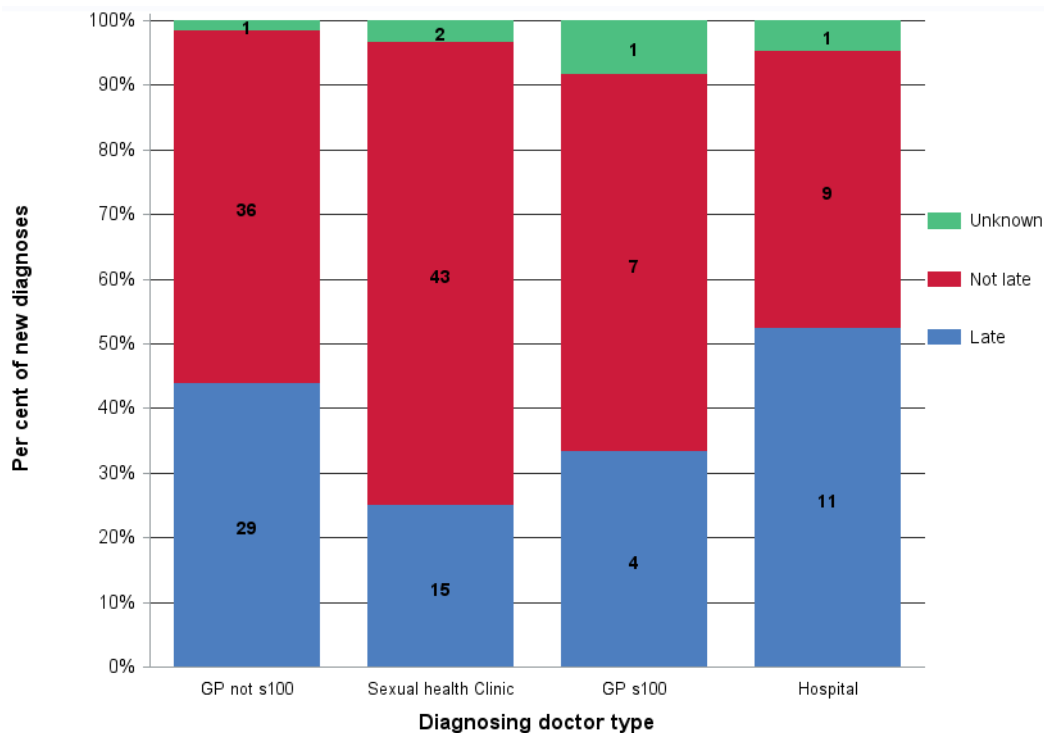


Figure 13: NSW residents notified with newly diagnosed HIV infection from January to June 2016 by type of diagnosing doctor* and evidence of late diagnosis



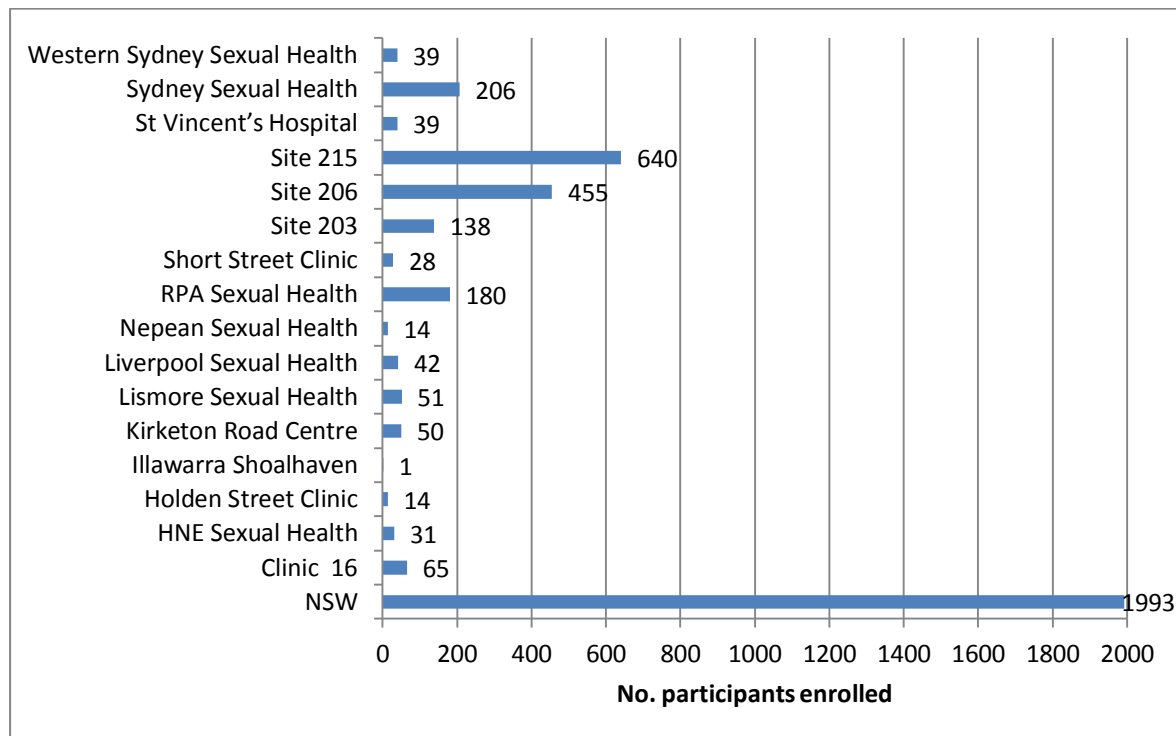
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016. *11 new diagnoses with other or unknown doctor type excluded.

2. Expand HIV Prevention

2.1 Who is accessing PrEP through EPIC-NSW?

Pre-exposure prophylaxis (PrEP) is the next critical tool for HIV prevention. EPIC-NSW: Expanded PrEP Implementation in Communities in NSW was launched on 1 March 2016 to provide PrEP to 3700 people at a high risk of HIV infection in NSW for 2 years.

Figure 14: Participants enrolled in EPIC-NSW by clinic between 1 March and 30 June 2016^{1,2}



Comment

Between 1 March and 30 June 2016, 1993 participants were enrolled at sixteen clinics (East Sydney Doctors, Holdsworth House, Taylor Square Private Clinic, Clinic 16, Hunter New England Sexual Health, Holden Street Clinic, Illawarra Shoalhaven Sexual Health, Kirketon Road Centre, Lismore Sexual Health Clinic, Liverpool Sexual Health, Nepean Sexual Health and HIV Clinics, RPA Sexual Health, Short Street Clinic, St Vincent's Hospital, Sydney Sexual Health Centre, Western Sydney Sexual Health) (Figure 14). Enrolment into EPIC-NSW is occurring rapidly, with full enrolment expected to occur before 31 December 2016 (Figure 15).

In addition, approximately 300 participants are enrolled in the PrELUDE PrEP demonstration trial, which provides PrEP to people at a high risk infection for up to 2.5 years. The PrELUDE study will be closed and eligible participants enrolled in EPIC-NSW by late November 2016.

¹ Private practices have been de-identified. As each clinic began enrolling participants at a different date, the activity of clinics should not be directly compared.

² EPIC-NSW study data was extracted on 9 August 2016.

Figure 15: Projected and actual enrolment of participants in EPIC-NSW, by study week, from 1 March to 30 June 2016

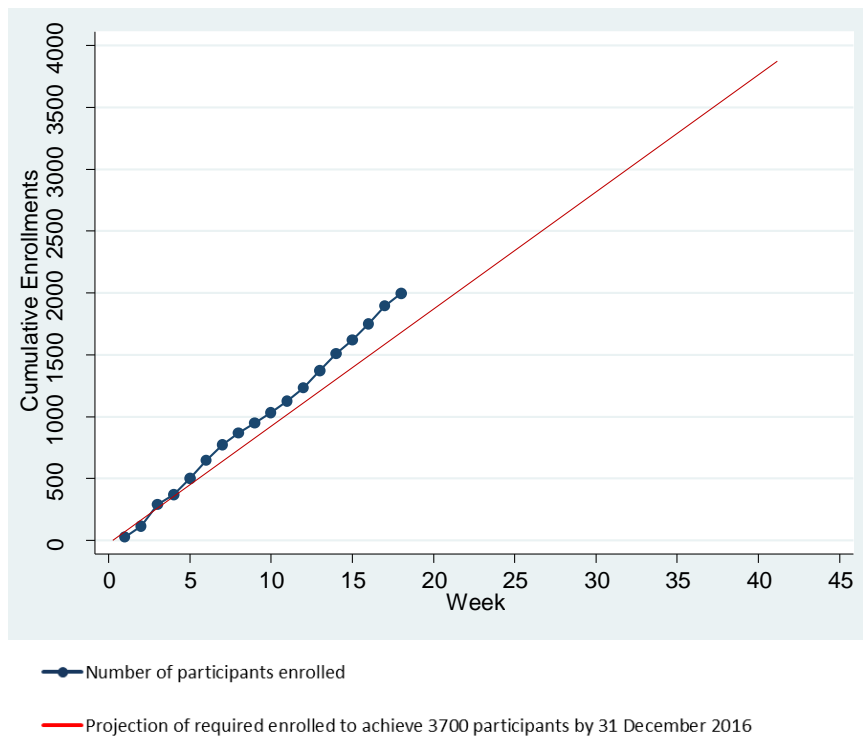


Table 1: Demographic data for EPIC-NSW participants enrolled between 1 March and 30 June 2016³

Characteristic	N	%
Sex*		
Male	1,979	99.3
Female	2	0.1
Transgender, male-to-female	8	0.4
Transgender, female-to-male	4	0.2
Sexual identity*		
Gay/Homosexual	1,918	96.2
Bisexual	57	2.9
Heterosexual	4	0.2
Other	14	0.7
Age**		
<20 years	6	0.38
20 – 29 years	350	22
30 – 39 years	590	37
40 – 49 years	399	25.1
50+ years	248	15.6

³ Postcode of residence was not available for this report.

Region of birth***		
Australia	923	63.3
Oceania	63	4.3
Asia	164	11.2
Northern America	45	3.1
South America, Central America & the Caribbean	44	3.0
Europe	170	11.7
Middle East	13	0.9
Africa	37	2.5
Aboriginal or Torres Strait Islander***		
No	1,447	99.2
Aboriginal or Torres Strait Islander	12	0.8

Note: *reported for all enrolled participants (n=1993); ** only reported for people who consented to data linkage (n=1593), only participants aged 18 years and older are eligible for enrolment in EPIC-NSW; ***only reported by people who have completed the behavioural questionnaire (n=1459)

Comment

Of all 1993 participants enrolled in EPIC-NSW between 1 March and 30 June 2016, 99.3% were male and 96.2% were gay/homosexual. While sex and sexual identity were collected for all participants enrolled in EPIC-NSW, the age, region of birth and Aboriginal or Torres Strait Islander status was only available for a subset of individuals who consented to data linkage and/or completed the behavioural questionnaire. Of the 1593 participants consenting to data linkage, the majority were aged 30-39 years (37.0%), with 22.0% aged 20-29 years, 25.1% aged 40-49 years, 15.6% aged 50+ years and only 0.38% aged <20 years. Of the 1459 participants completing the behavioural questionnaire, 63.3% were born in Australia, with 11.2% born in Asia and 11.7% born in Europe. In addition, 0.9% of the 1459 participants completing the behavioural questionnaire identified as Aboriginal or Torres Strait Islander.

Table 2: Reasons for withdrawal from EPIC-NSW

Reason	No. participants
Tired of taking pills every day	1
Other	1
Total	2

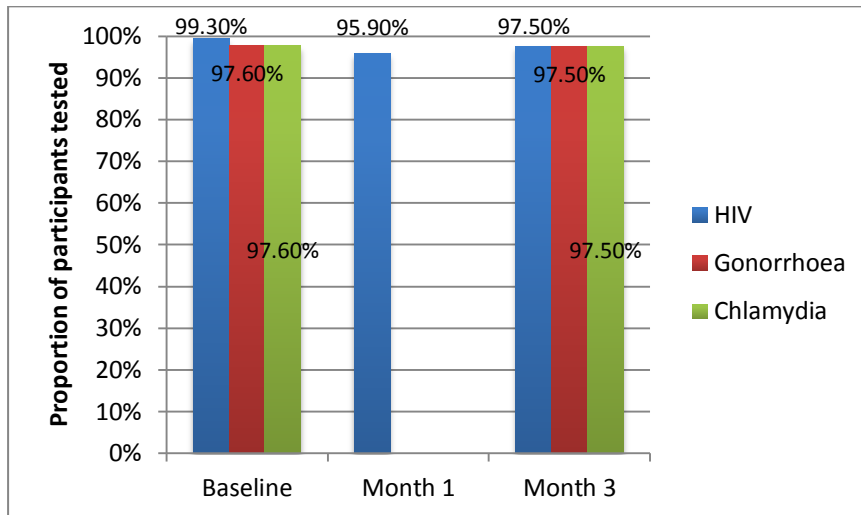
Comment

Between 1 March and 30 June 2016, two participants have withdrawn from EPIC-NSW.

2.2 What is the prevalence of STIs among EPIC-NSW participants?

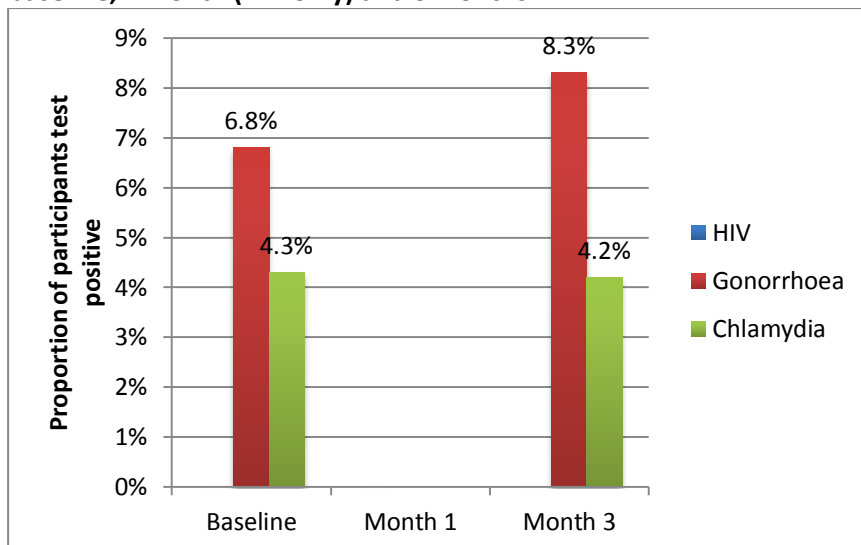
HIV and sexually transmissible infection (STI) testing is recommended for all EPIC-NSW participants at baseline (enrolment), 1 month (HIV only) and every three months, in accordance with the NSW Health Guidelines on the Pre-Exposure Prophylaxis of HIV with Antiretroviral Medications. For Quarter 2 2016, data are only available for HIV, gonorrhoea and chlamydia testing for participants enrolled at clinic 206. Data from other participating clinics and for hepatitis C, syphilis, attendance and scripts will be available for future reports.

Figure 16: Proportion of EPIC-NSW participants at clinic 206 receiving an HIV test at baseline, 1 month and 3 months or STI test at baseline and 3-months⁴



Note: Visit windows for baseline, 1 month and 3 months are mutually exclusive and adjacent. Windows begin and end at the midpoint between baseline and month 1, month 1 and month 3, and month 3 and month 6 or close of data. Chlamydia and Gonorrhoea testing are not required at 1 month visit.

Figure 17: Proportion of EPIC-NSW participants testing positive for an HIV or STI at clinic 206 at baseline, 1 month (HIV only) and 3 months.



⁴ All participants enrolled at site 206 between 1 March and 30 June 2016 were matched on the ACCESS database (n=455); three participants did not have any HIV or STI testing data currently available. Clinical data was extracted from the ACCESS database on 15 July 2016.

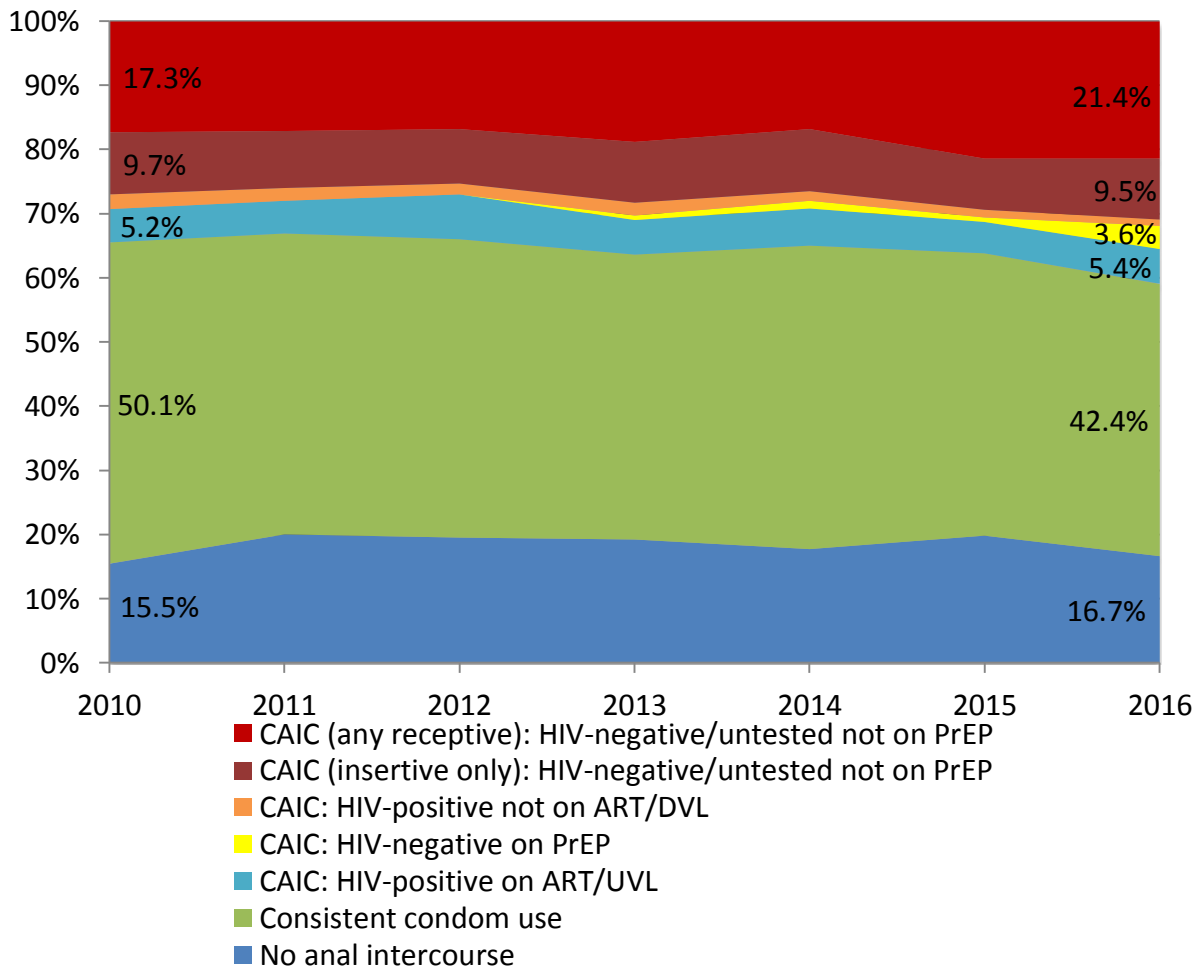
Comment

Of the 452 participants from clinic 206 with HIV and STI testing information available, 449 (99.3%) had an HIV test, 441 (97.6%) a gonorrhoea test and 441 (97.6%) a chlamydia test at baseline. Of the 198 participants expected to have had a visit at 3 months post enrolment in EPIC-NSW, 193 (97.5%) had an HIV test, 193 (97.5%) a gonorrhoea test, and 193 (97.5%) a chlamydia test at 3 months. No participants tested positive for HIV at baseline, 1 month or 3 months. Of the 441 EPIC-NSW participants tested for an STI at baseline, 6.8% (n=30) tested positive for gonorrhoea and 4.3% (n=19) for chlamydia. Of the 193 participants tested for an STI to 30 June 2016 at 3 months post enrolment in EPIC-NSW, 8.3% (n=16) tested positive for gonorrhoea and 4.2% (n=8) for chlamydia.

2.3 How many men who have sex with men use condoms and other HIV risk reduction practices?

Condom use and other HIV risk reduction strategies used by gay and bisexual men are measured through the annual Sydney Gay Community Periodic Survey (SGCPS), conducted each year during February. Given the introduction of pre-exposure prophylaxis (PrEP) in NSW and the focus on the preventative benefits of HIV treatment in the current Strategy, reporting of condomless anal intercourse with casual partners (CAIC) in the SGCPS has been modified, distinguishing between HIV-positive men who are virally suppressed or not and HIV-negative men who are protected by PrEP or not. These subcategories can be seen in Figure 18.

Figure 18: Anal intercourse, condom use and antiretroviral protection with casual male partners in the six months prior to survey, Sydney Gay Community Periodic Survey



Note: CAIC = condomless anal intercourse with casual male partners. Denominator varies from 1408 to 1996 gay men with casual partners per year.

Comment

Among gay men with casual male partners, the proportion avoiding anal intercourse has remained relatively stable since 2010, while the proportion reporting consistent condom use has declined slightly over time (reaching 42.4% in 2016). The proportion reporting any condomless anal intercourse with casual partners (CAIC) has increased over time, reaching 40.9% in 2016. The proportion of HIV-positive men not on treatment or with a detectable viral load who report CAIC has fallen since 2010 (to 1.0% of men with casual partners in 2016). During 2013–2015 there were very

few HIV-negative men on PrEP in the SGCPs. At the beginning of 2016 (the survey is conducted in February) we saw an increase in PrEP users reporting CAIC in the survey (to 3.6% of casual partners). The majority of men who report CAIC remain HIV-negative and untested men *not* using PrEP. Between 2015 and 2016 the group of HIV-negative men not using PrEP who reported receptive CAIC (the highest risk practice for HIV) remained unchanged at 21.4% of casual partners.

2.4 Community mobilisation “Ending HIV”

Since 2013, ACON has monitored the knowledge and attitudes of gay men in regards to key messages relating to the NSW ‘Ending HIV’ campaign. Key findings and a description of the evaluation is provided in Appendix B.

2.5 How accessible is the Needle and Syringe Program in NSW?

In the year ending 31 December 2015, a total of 13,202,904 units of injecting equipment were distributed in NSW. This figure includes injecting equipment distributed by pharmacies participating in the Pharmacy NSP Fitpack[®] scheme and by the Public NSP. This represents an increase of 770,022 additional units (6.2%) compared with the previous 12 months.

During the same period to 31 December 2015, the number of units of injecting equipment distributed by the Public NSP increased by 777,252 units (7.1%), while the number of units of injecting equipment distributed by the Pharmacy NSP Fitpack[®] scheme remained stable, with a decrease of 7,230 units (0.5% decrease).

(NSW Health NSP Minimum Data Set)

As of 31 December 2015, under the public NSP there were a total of 27 primary and 306 secondary outlets, 254 ADMs and IDCs located across NSW. In addition, there were 518 Pharmacies participating in the Pharmacy NSW Fitpack Scheme, making a total of 1,105 NSP outlets located across NSW as at 31 December 2015. This represents an increase of 56 additional outlets (5.3%) compared with same period in 2014.

(NSW NSP Data Collection)

2.6 What proportion of people reuse other people’s needles and syringes (receptive syringe sharing) in NSW?

Among respondents in the NSW NSP Enhanced Data Collection (NNEDC), reports of receptive syringe sharing (RSS) in the previous month declined from 22% in 2013 to 14% in 2014^[1]. In 2015, the proportion who reported receptive sharing of needles and syringes was 16%, which is stable compared with 2014 ($p=0.067$).^{[2] [3]}

^[1] In 2013, the first of three consecutive annual NNEDC was conducted. The purpose of the data collection is to report NSP client demographic, behavioural and drug use data on an annual basis to strengthen the state-wide prevention approach, and also inform LHDs in planning for NSP service delivery at the local level. Methodology: Clients are surveyed over a 2 week period in February. A total of 2938 individual NSW NSP clients were surveyed in 2013; 3029 people were surveyed in 2014; and 2,453 in 2015. The majority of NSPs (n=50 NSPs) participated in the study in both 2013 and 2014; and 49 NSPs participated in 2015. Refer to Appendix 1, Table 1.

^[2] Geddes, L, Iversen J, Maher L NSW Needle and Syringe Program Enhanced Data Collection 2015. A report for the Ministry of Health by the Kirby Institute, UNSW Australia, 2015.

These results are broadly comparable to NSW results from the Australian NSP Survey (ANSPS). In the ANSPS, which is conducted at selected NSW NSP services, the proportion of NSW respondents who reported receptive sharing of needles and syringes in the previous month was 13% in 2013 and 16% in 2014.^[4]

Findings from the upcoming 2015 NSW NSP Enhanced Data Collection will indicate whether the reduction between 2013 and 2014 identified in that survey is a continuing trend or an expected fluctuation.

^[3] Note 2013 and 2014 RSS in this Data Report has been calculated using a revised methodology compared with the NSW HIV Strategy 2012-2015 Data Report (<http://www.health.nsw.gov.au/endinghiv/Pages/tools-and-data.aspx>). The 2013 and 2014 HIV Data reports present RSS as a proportion of all NSP survey respondents. The revised methodology used in this Data Report for Hepatitis C and B presents RSS as a proportion of PWID respondents who reported injection in the last month. The revised methodology is consistent with the ANSPS, and enables the results of the surveys to be compared.

^[4] Iversen J, and Maher L. Australian Needle and Syringe Program Survey National Data Report 1995-2014. The Kirby Institute, UNSW Australia, 2015. In 2014, 646 people in NSW were surveyed in 19 primary NSPs. Refer to Appendix 1, Table 2.

3. Increase HIV testing frequency

Table 4: HIV testing data sources

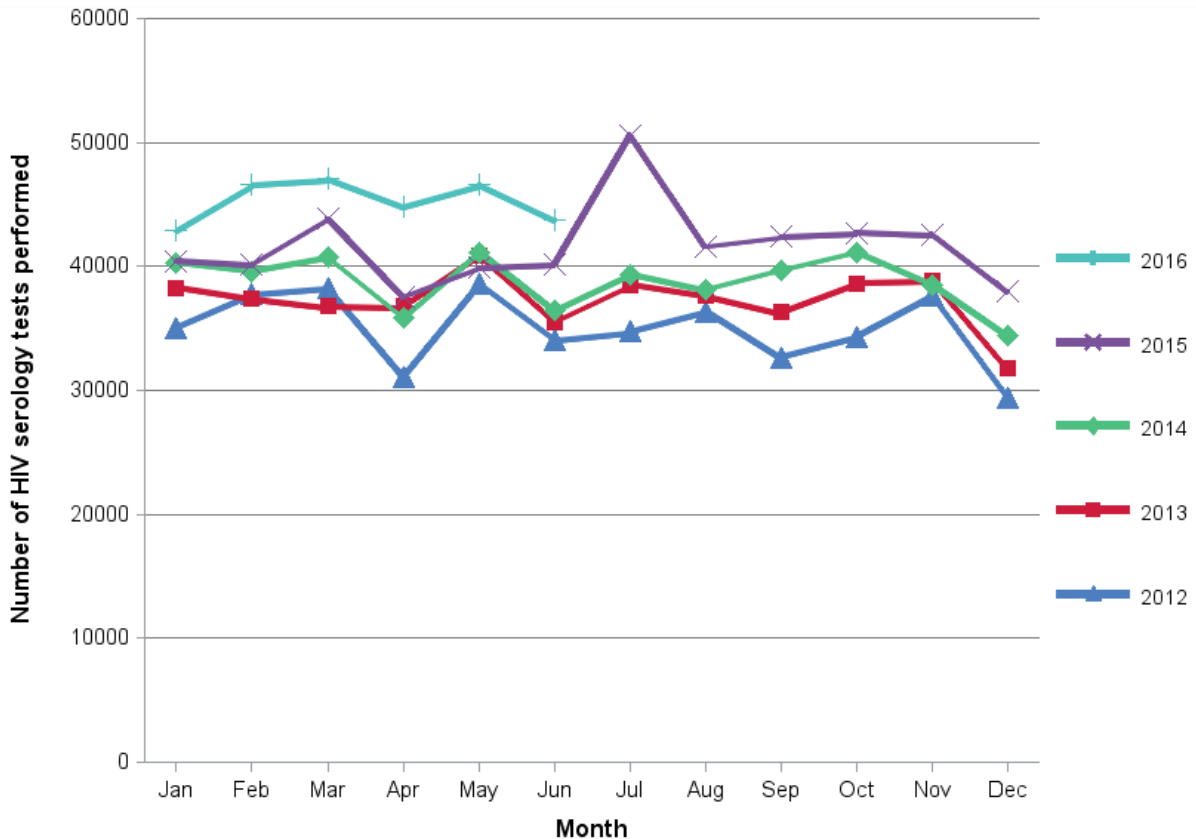
Name	Custodian	Availability	Coverage
NSW Health denominator data project	Health Protection NSW, NSW Health	Quarterly - ongoing	Number of tests in NSW
NSW Health HIV Strategy Monitoring Database	NSW Ministry of Health, NSW Health	Quarterly - ongoing	Congregated testing data for public sexual health clinics by priority populations
ACCESS Study	The Kirby Institute	Quarterly	Unique testing data for public sexual health clinics by priority populations, and for select GP practices with high and medium case load of GBM in Sydney
Sydney Gay Community Periodic Survey	Centre for Social Research in Health	Annually (collected in February and reported in August)	Data on sexual, drug use and testing practices related to the transmission of HIV and other STIs among gay men in Sydney (self-reported)

3.1 Is HIV testing increasing in NSW?

3.1.1 NSW overall

In 2012, NSW Health commenced collection of testing data for selected notifiable conditions, including HIV, from 15 NSW laboratories. These laboratories represent about 95% of the laboratory testing for HIV in NSW residents. Information from laboratories does not provide any indication on the purpose of testing (screening of high risk individuals, routine antenatal, post-exposure testing), nor whether there are repeat tests on the same individual.

Figure 19: Number of HIV serology tests performed in 15 NSW labs January 2012 to June 2016



Data source: NSW Health denominator data project, extracted 8 August 2016.

Comment

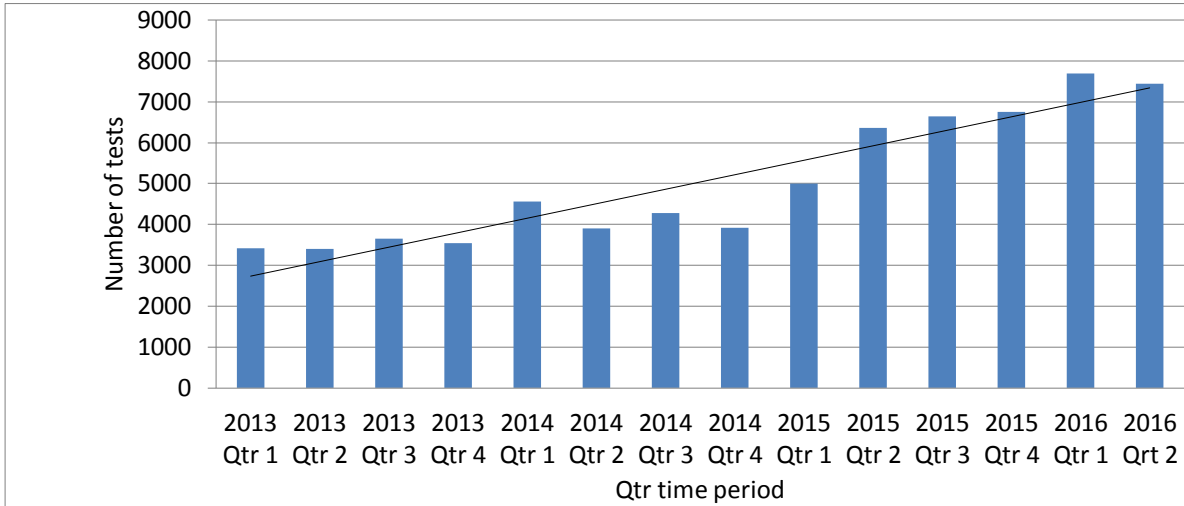
In quarter 2 2016 135,164 HIV serology tests were performed in 15 laboratories in NSW, which was 15% greater than in quarter 2 2015 (n=117,628), 19% greater than in both quarter 2 2014 (n=113,512) and quarter 2 2013 (n=113,174) and 30% greater than quarter 2 2012 (n=103,737). From March to June 2016 almost 2000 people at high risk of acquiring HIV were tested (and found HIV negative) prior to enrolment in EPIC-NSW, a population level PrEP impact study. The spike in HIV serology test count in July 2015 coincided with an HIV testing awareness initiative (“NSW HIV Testing Week”) and also a public health intervention, when a letter was sent to select dental patients in early July recommending testing for HIV and hepatitis B and C.

3.1.2 Local Health Districts

HIV testing data in Publicly Funded Sexual Health Clinics (PFSHCs) has been available for all LHDs since July 2013; however the type of data is not uniform due to different data management systems.

Figure 20 displays the number of HIV tests done in PFSHC between 1 January 2013 and 30 June 2016 in South Eastern Sydney LHD. Both rapid HIV testing and HIV serology are included.

Figure 20: Number of HIV serology tests performed in South Eastern Sydney Local Health District Publicly Funded Sexual Health Clinics per quarter 2013 to June 2016



Data source: South Eastern Sydney Local Health District

Comment

From January to June, testing in South Eastern Sydney LHD (Figures 20) increased by 33% (n=15,140) compared with the same period in 2015 (n=11,354).

A comparison in the number of HIV tests done between 1 January and 30 June 2016 for metropolitan PFSHCs is displayed in Figure 21 and for regional and rural PFSHCs in Figure 22. Both rapid HIV testing and HIV serology are included.

Figure 21: Number of HIV tests performed in Sydney metropolitan Local Health District Publicly Funded Sexual Health Clinics January to June 2016

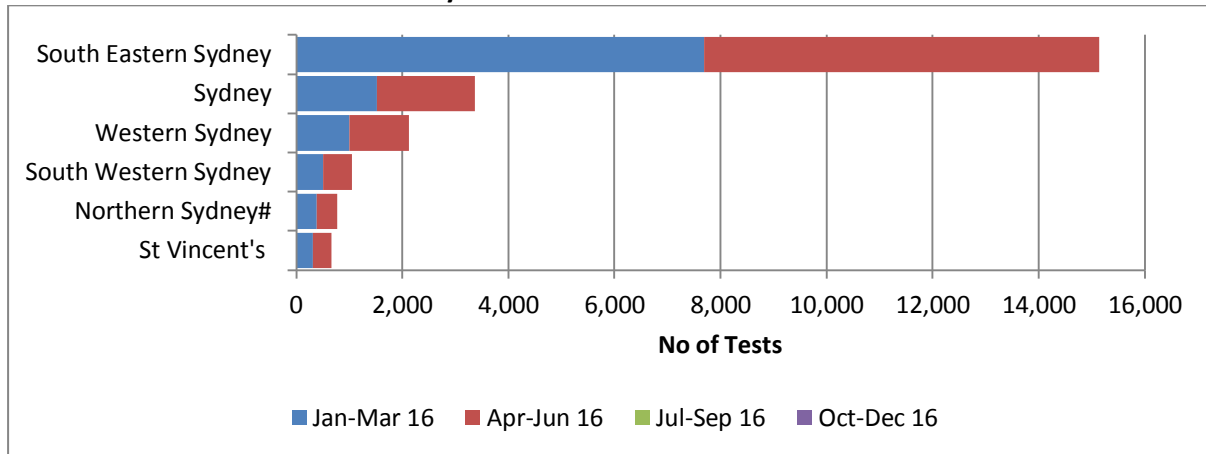
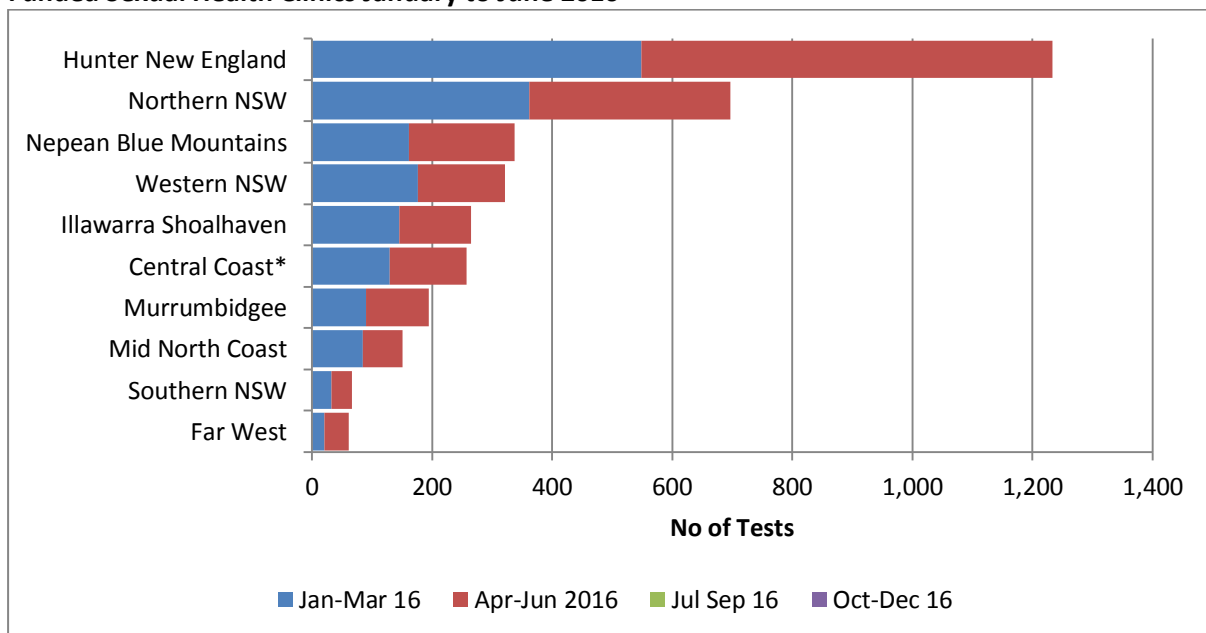


figure is an underestimate as actual activity data is not available from Dec 2015

Data source: NSW Health HIV Strategy Monitoring Database

Figure 22: Number of HIV tests performed in regional and rural Local Health District Publicly Funded Sexual Health Clinics January to June 2016



*Central Coast figure is an underestimate as actual activity data is not available from Dec 2013

Data source: NSW Health HIV Strategy Monitoring Database

Comment

From April to June 2016, 13,523 HIV tests were done in all PFSHCs in NSW; 20% greater than the same period in 2015 (n=11,268). From April to June 2016, testing increased particularly in some local health districts; HIV testing in Sydney LHD increased by 62% (n=1,138) compared with the same period in 2015, and Northern NSW LHD increased by 65% (n=335) compared to the same period in 2015.

3.2 Where is HIV testing being done?

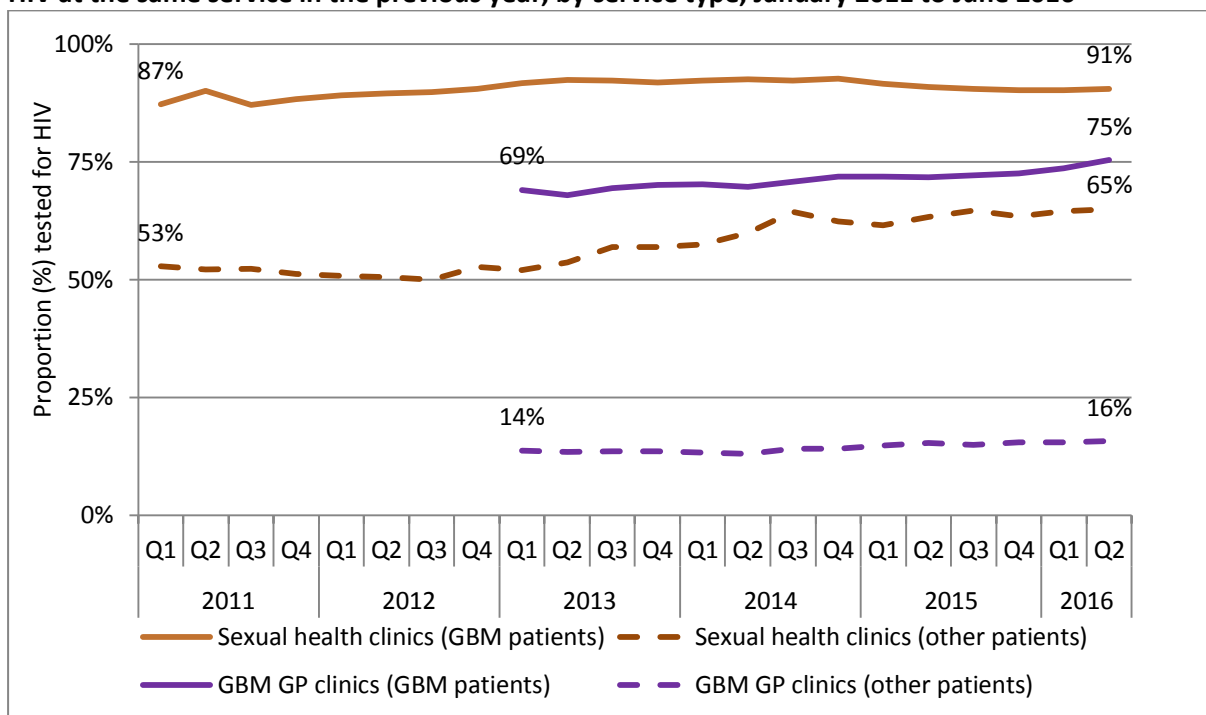
Apart from PFSHCs, HIV testing takes place in a range of other clinical and community settings. A large proportion of testing occurs in the private sector, especially in general practice.

3.2.1 General practice with high caseload of gay and bisexual men (GBM GP clinics) and PFSHCs

Data from the ACCESS project data base (managed by the Kirby Institute) has been added to the monitoring and evaluation framework for the NSW HIV Strategy to strengthen NSW's systems for monitoring progress and reporting outcomes against the NSW HIV Strategy 2016-2020.

Figure 23 displays HIV testing uptake in both PFSHCs and GBM GP clinics from the ACCESS database.

Figure 23: Proportion of patients⁵ attending PFSHCs and GBM GP clinics⁶ tested at least once for HIV at the same service in the previous year, by service type, January 2011 to June 2016^{7,8}



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

Comment

Testing uptake for HIV increased steadily among patients attending PFSHCs and GBM GP clinics. The greatest increase from 2011 to June 2016 was among patients other than GBM at PFSHCs. Although testing among patients other than GBM was much lower in GP clinics, given that people attend such clinics for a range of reasons unrelated to sexual health, testing may not be appropriate or they may have received sexual health testing elsewhere.

⁵ Excludes patients known to be HIV positive

⁶ GBM clinics defined as general practice clinics serving at least 50 GBM patients annually; attendance data for patients not tested for HIV was unavailable for at GP clinics prior to 2013 and has been excluded

⁷ Patients were uniquely identified within a health service only; if a patient moved between services they were counted multiple times

⁸ The testing period is retrospective; the proportion represents those who attended in a quarter and had at least one HIV test in the previous 12 months

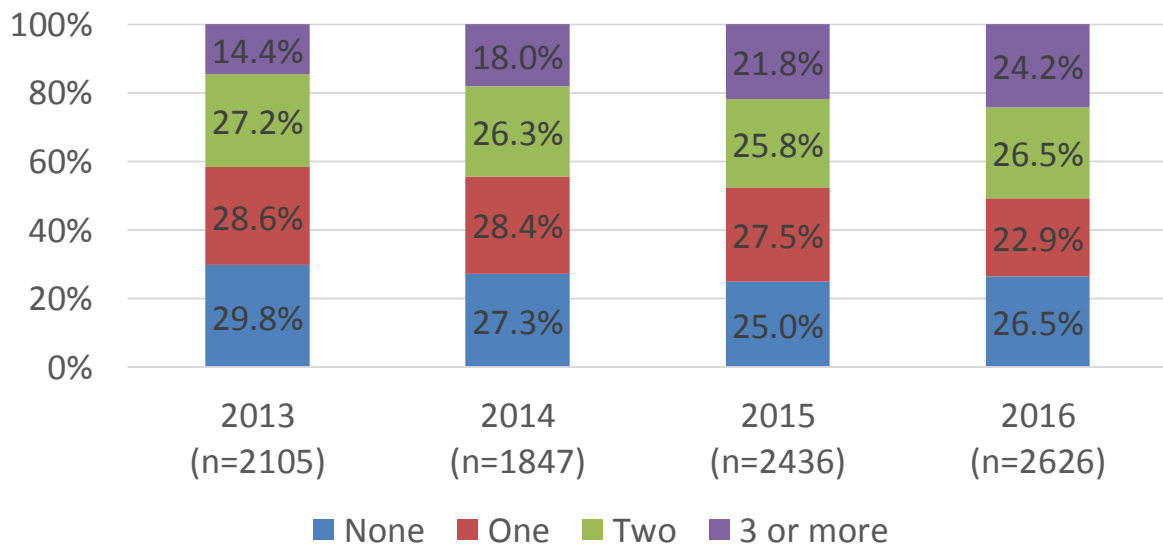
3.3 Who are being tested and testing patterns for HIV?

To reduce the pool of undiagnosed HIV infection, testing should be targeted to high risk populations.

3.3.1 Survey data

HIV testing in MSM is measured regularly through the SGCPs (conducted annually in February).

Figure 24: Number of HIV tests in the previous 12 months reported by non-HIV-positive men⁹



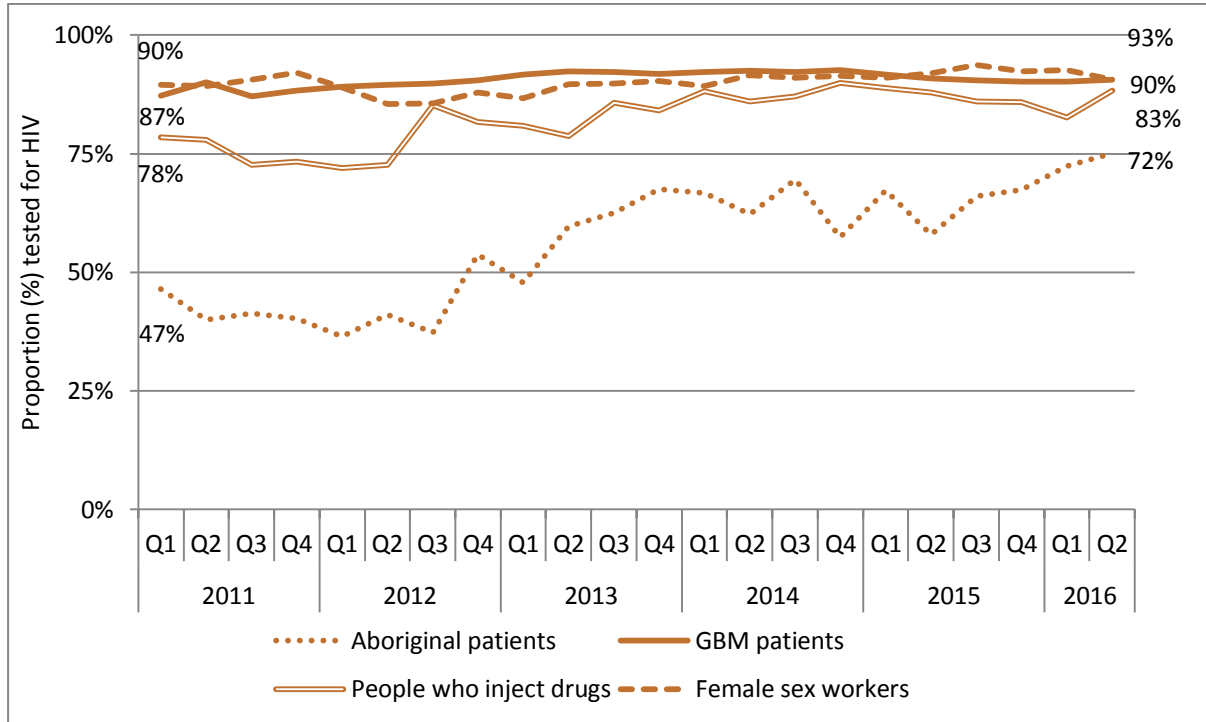
Data source: Sydney Gay Community Periodic Survey (February 2016)

Comment:

In the Sydney Gay Community Periodic Survey (conducted annually in February), the proportion of men having multiple HIV tests within a year has gradually increased, with over half of non-HIV-positive men in 2016 reporting two or more HIV tests in the previous 12 months (Figure 24).

Figure 25 and Table 5 summarises the available data from PFSHCs on HIV testing in priority population groups.

Figure 25: Proportion of patients⁹ attending PFSHCs and tested at least once for HIV at the same service in the previous year, by priority population¹⁰, January 2011 to June 2016^{11,12}



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

Comment

Among priority populations, HIV testing uptake at PFSHCs was highest among female sex workers and GBM. Although lower overall, the greatest increases in testing uptake over time were among patients reporting injecting drug use and Aboriginal men and women (excluding GBM). Notably, testing uptake among Aboriginal patients increased 25% from 2011 to June 2016.

⁹ Excludes patients known to be HIV positive

¹⁰ Priority populations other than GBM exclude GBM-identified patients; priority populations are not mutually exclusive

¹¹ Patients were uniquely identified within a health service only; if a patient moved between services they were counted multiple times

¹² The testing period is retrospective; the proportion represents those who attended in a quarter and had at least one HIV test in the previous 12 months

Table 5: HIV testing in priority populations, Publicly Funded Sexual Health Clinics, NSW

Priority Population	% of HIV tests in all PFSHCs, Q2 2016*	Number of HIV tests in all PFSHCs, Q2 2016*	% increase in HIV tests compared with Q2 2015 in all PFSHCs [#]
GBM	45%	8,884	39%
Sex workers [^]	12%	1,537	21%
People who inject drugs (PWID) [^]	7%	932	33%
Aboriginal people	2%	311	7%

*Excludes Central Coast and Northern Sydney LHD who was unable to provide testing data by priority population.

[#]Excludes LHDs without testing data by priority population in Q2 2016 (St Vincent's Hospital Network, Northern Sydney LHD and Central Coast LHD).

[^]Includes people who *ever* were sex workers or who *ever* injected drugs.

Data source: NSW Health HIV Strategy Monitoring Database¹³

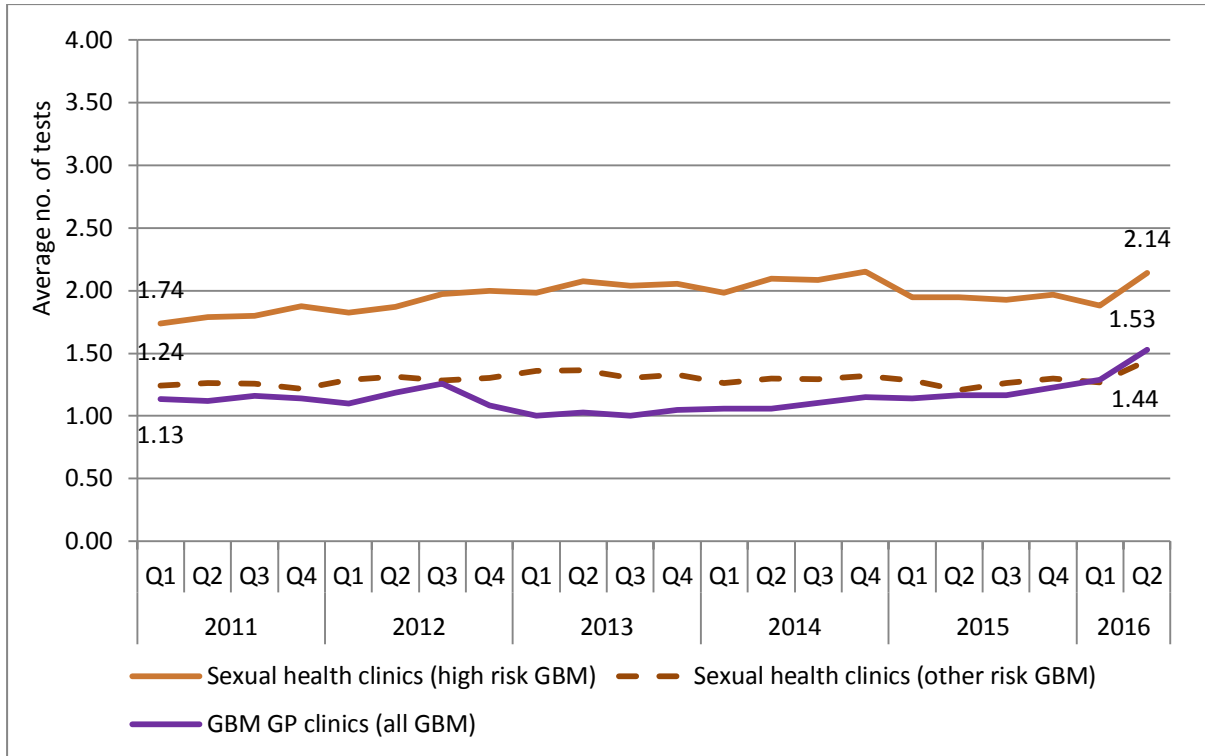
Comment

In summary, data from PFSHCs indicates that testing remains high and well-targeted towards priority populations. Achieving further increases in testing frequency, particularly in high risk GBM, is important to identify and link HIV infected individuals to care; and to reduce the number of people living with HIV in NSW who are undiagnosed.

¹³ Public sexual health and HIV services data provided by Local Health Districts for the purpose of monitoring the implementation of the NSW HIV Strategy.

3.4 Testing patterns for HIV?

Figure 26: Average number of HIV tests annually at the same service¹⁴ per GBM patient¹⁵ attending PFSHCs and GBM GP clinics¹⁶, by service type and quarter, January 2011 to June 2016



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

Risk categorisation is available only for sexual health clinics, defined as:

- **High risk:** >5 sexual partners in the three months prior to consultation AND/OR >20 sexual partners in the 12 months prior to consultation AND/OR a diagnosis for chlamydia, gonorrhoea, and/or infectious syphilis in the 24 months prior to consultation
- **Other risk:** Any person not otherwise meeting the criteria of ‘high risk’

Comment

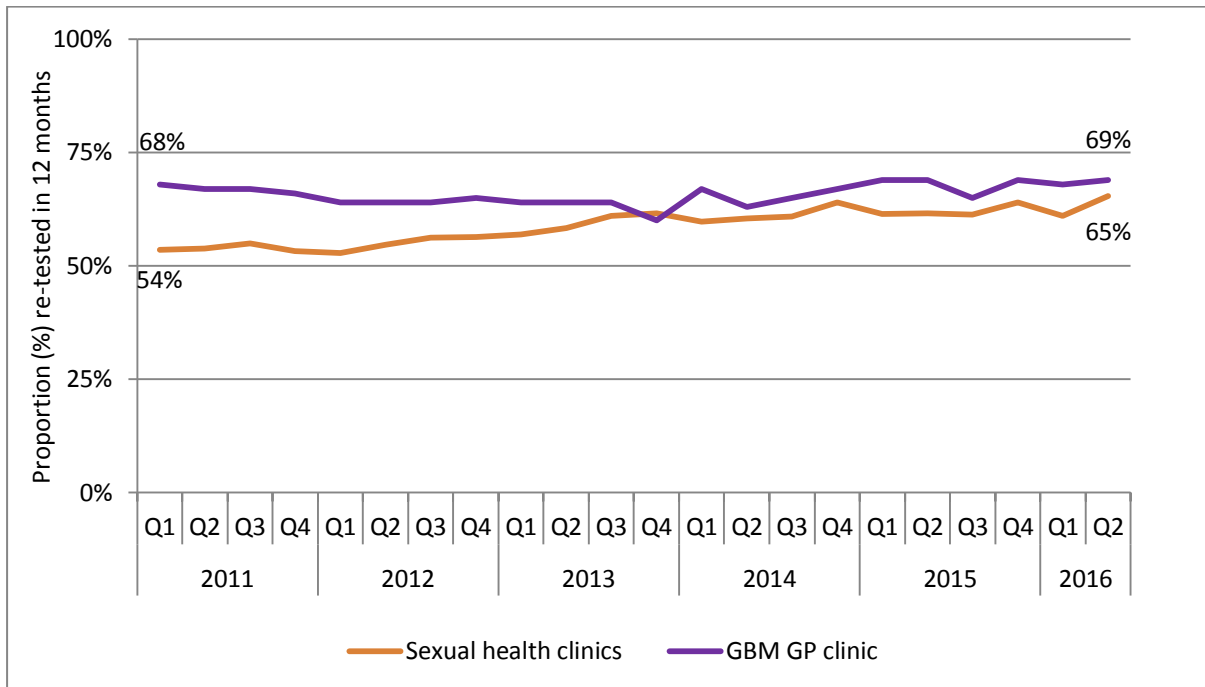
Since 2011, the average number of HIV tests per patient has increased among patients attending both PFSHCs and GBM GP clinics. These increases suggest more tests per year among individual patients. In high risk GBM, the average number of tests increased from 1.74 in the year prior to quarter 1 2011 to 2.14 in the 12 months prior to quarter 2 2016 while during the same period the average number of tests increased from 1.24 to 1.44 among men of other risk profiles.

¹⁴ Average test numbers only include tests at the same service; tests at multiple services were not counted

¹⁵ Excludes patients known to be HIV positive

¹⁶ GBM clinics defined as general practice clinics serving at least 50 GBM patients annually; attendance data for patients not tested for HIV was unavailable for at GP clinics prior to 2013 and has been excluded

Figure 27: Proportion of GBM patients¹⁷ tested for HIV at PFSCs and GBM GP clinics¹⁸ with a previous HIV test at the same clinic in the previous year^{19,20}, by service type, risk classification and quarter, January 2011 to June 2016



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

Comment

Annual re-testing at the same service among GBM increased over time in PFSCs but remained generally stable in GBM GP clinics.

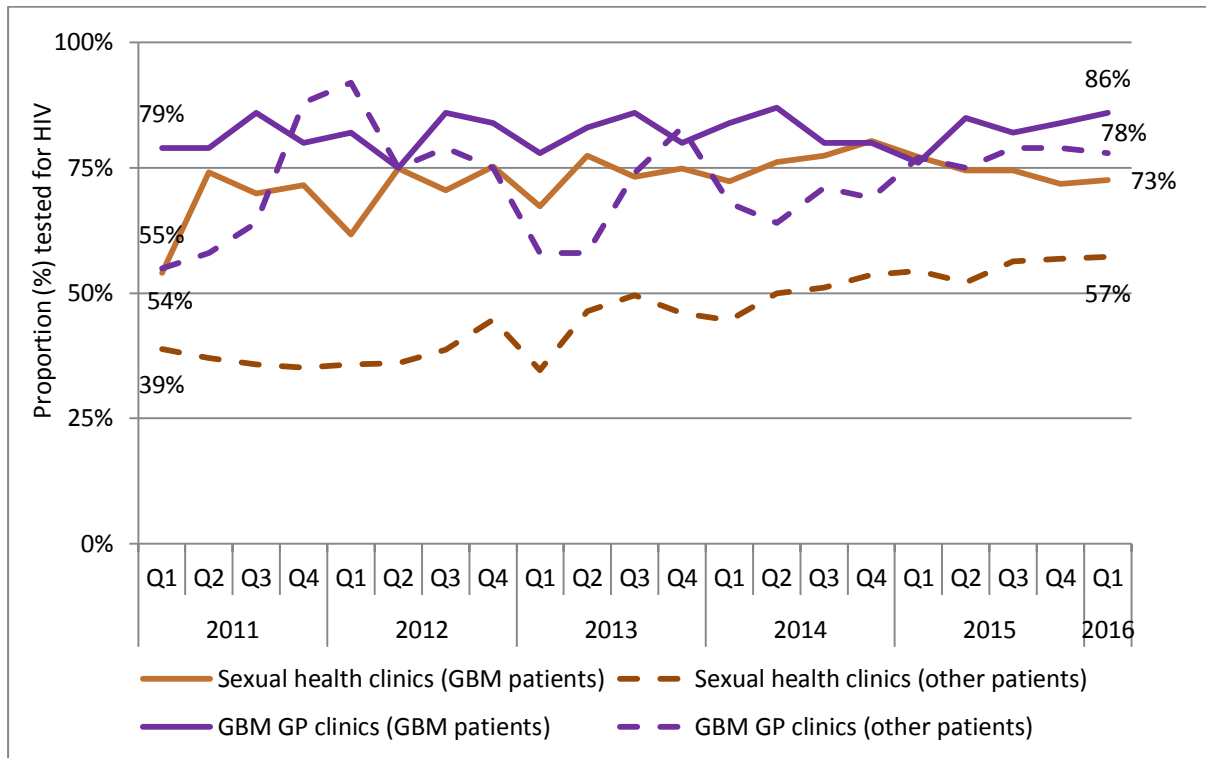
¹⁷ Excludes patients known to be HIV positive

¹⁸ GBM clinics defined as general practice clinics serving at least 50 GBM patients annually

¹⁹ Re-testing only calculated at the same service as initial test; patients may have been tested elsewhere

²⁰ The testing period is retrospective; the proportion represents those tested for HIV in a quarter who had at least one other test in the previous 12 months

Figure 28: Proportion of patients²¹ attending PFSHCs and GBM GP clinics²² who received an HIV test within one month of an STI diagnosis^{23,24}, by service type and quarter, January 2011 to March 2016²⁵



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

Comment

The majority of STI diagnoses among GBM at PFSHCs and GBM GP clinics were accompanied by an HIV test within 30 days. Of the HIV tests conducted in GBM in quarter 1 2016, 96% were on the same day as the STI test and the remaining 4% were within 1-30 days. Among ‘other patients’ attending PFSHCs a lower proportion of STI diagnoses were accompanied by an HIV test, but there was a steady increase over time from 39% in quarter 1 of 2011 to 57% in quarter 1 of 2016.

²¹ Excludes patients known to be HIV positive

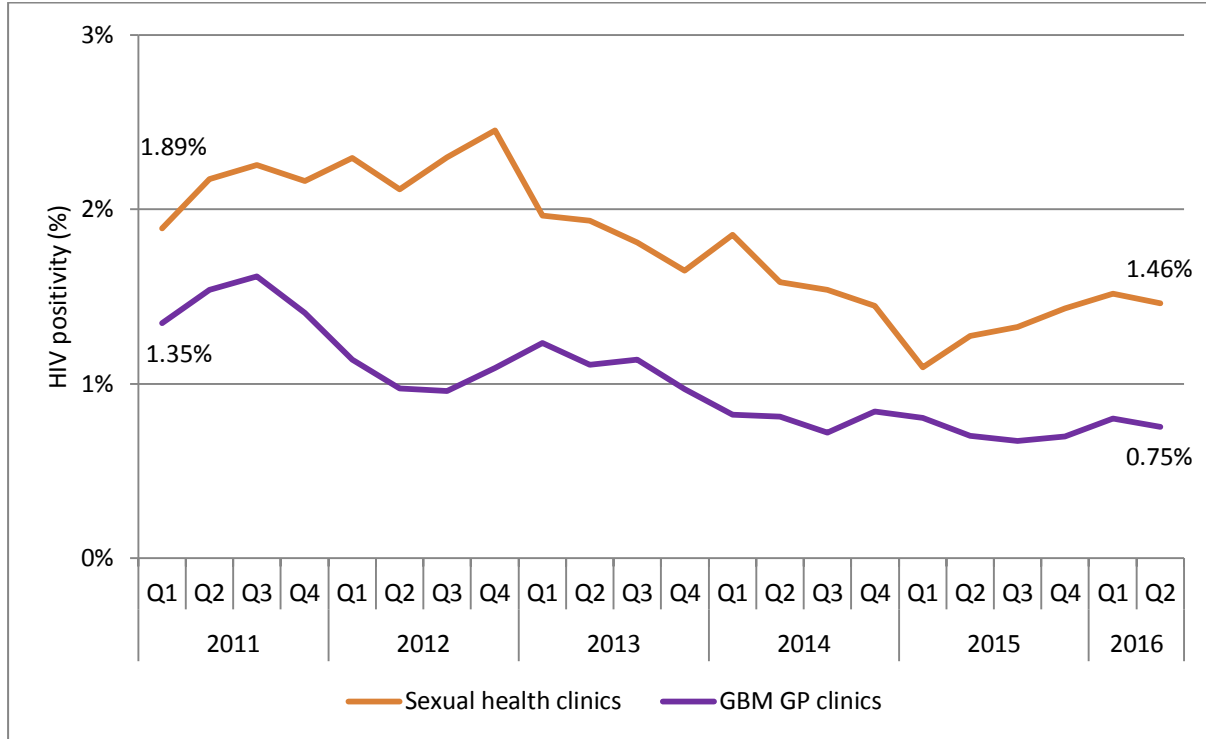
²² GBM clinics defined as general practice clinics serving at least 50 GBM patients annually

²³ Only includes HIV tests at the same health service as the STI diagnosis

²⁴ Diagnosis for chlamydia, gonorrhoea and/or infectious syphilis

²⁵ The period for HIV testing is one month before or after an STI diagnosis; due to this timeframe data from quarter 2 2016 have been excluded

Figure 29: Proportion of individual GBM patients²⁶ attending sexual health and GBM GP clinics²⁷ tested for HIV with a positive result (*HIV positivity*²⁸), by service type and quarter, January 2011 to June 2016



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

Comment

HIV positivity declined over time since 2011 in both PFSHCs and GBM GP clinics. With increased HIV testing overall and testing targeting priority populations, it is anticipated that HIV positivity in PFSHCs and GBM GP clinics will decrease over time. This is an important indicator and should not deter services from continuing to increase testing in accordance with current guidelines.

²⁶ Excludes patients known to be HIV positive; patients only uniquely identified within a service

²⁷ GBM clinics defined as general practice clinics serving at least 50 GBM patients annually

²⁸ HIV positivity is calculated as the proportion of individuals tested in a retrospective year period (discounting repeat tests among individuals) with an HIV diagnosis or confirmed pathology (positive p24 antigen or western blot test)

3.5 How is testing being made more accessible?

3.5.1 Rapid testing

Rapid HIV testing has been embedded into the mix of the testing options in NSW, with a focus on community based testing services. Table 6 displays the number of rapid HIV tests done and the proportion of clients with high risk behaviours and infrequent testing history in community-based and other non-traditional clinical testing sites in NSW.

Table 6: Number of rapid HIV tests in non-traditional testing sites and proportion of clients with high risk behaviour and infrequent testing history from January to June 2016

Non-traditional Settings	Number of RHT Q2 2016 and (unique)	% Unique Positive	% never previously tested	% tested more than 12 months ago	% with > 5 sexual partners in last 3 months
Community-based					
<i>aTEST Surry Hills (7 hours/week)</i>	255 (252)	1.6%	15%	17%	28%
<i>aTEST Oxford ST (40 hours/week)</i>	1,758 (1,669)	0.5%	12%	13%	31%
<i>aTEST Kings Cross (3 hours/week)</i>	102 (102)	1.0%	-	18%	20%
<i>aTEST Newtown (6 hours/week)</i>	195 (195)	0.0%	-	9%	22%

Data sources: NSW Health HIV Strategy Monitoring Database²⁹

Comment

Though the number of clients tested in community sites is relatively small, NSW data suggests it is an effective testing model for engaging GBM, a high proportion of whom reported high risk behaviours, or infrequent testing for HIV.

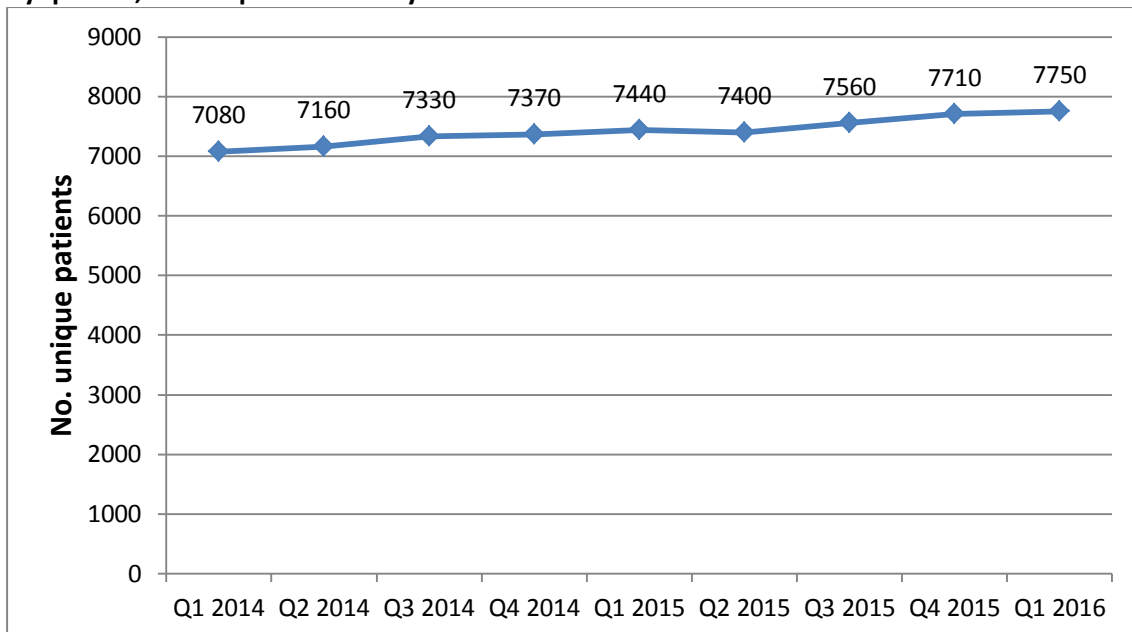
²⁹ Public sexual health and HIV services data provided by Local Health Districts for the purpose of monitoring the implementation of the NSW HIV Strategy.

4 Increase HIV treatment

4.1 How many people in NSW are on antiretroviral treatment?

With the introduction of community pharmacy dispensing of HIV antiretroviral therapy (ART) on 1 July 2015, public hospital dispensing data no longer captures all HIV ART dispensing in NSW and will no longer be presented in this report. As almost all HIV ART dispensed in NSW is billed against the Pharmaceutical Benefits Scheme (PBS), the Commonwealth hold a complete dataset for dispensing occurring through both public hospital and community pharmacies. The NSW Ministry of Health is working with the Commonwealth Department of Health to obtain HIV ART dispensing data for both public hospital and community pharmacies on an ongoing basis. This data set will also allow more comprehensive analysis of HIV ART dispensing in NSW, including information on ART initiations, the LHD of patient’s residence, prescriber location and drug combinations. The data presented below for the number of people dispensed ART has been obtained on a one-off basis and is estimated based on a 10% sample of the PBS.

Figure 30: Estimated number of patients dispensed ART in NSW by the PBS in previous 12 months, by quarter, for the period January 2014 to March 2016



Data source: Pharmaceutical Benefits Scheme 10% sample, Department of Human Services. Tabulated by the Kirby Institute using Pharmdash.

Comment

In the 12 months between 1 July 2015 to 30 June 2016, it is estimated that 7,750 people diagnosed with HIV and in care in NSW were dispensed ART through the PBS from a public hospital or community pharmacy at least once. It does not include non-PBS dispensing by public hospitals, or people who may be accessing ART through other sources, including those who purchase HIV treatment from overseas, receive ART through clinical trials or are dispensed ART for pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP).

4.2 What are the current antiretroviral treatment prescribing patterns?

Data on the treatment status of clients who received HIV care in NSW public sexual health and HIV services in the year ending 30 June 2016 is summarised at Table 7³⁰.

Table 7: Clients who received HIV care in NSW public sexual health and HIV services from 1 April 2015 and 31 March 2016

Number (%) of patients for whom treatment information was available	3173*
Number (%) on ART	2895 (91%)

Data sources: NSW Health HIV Strategy Monitoring Database³¹

*No data submitted by the Albion Centre and Central Coast

Comment

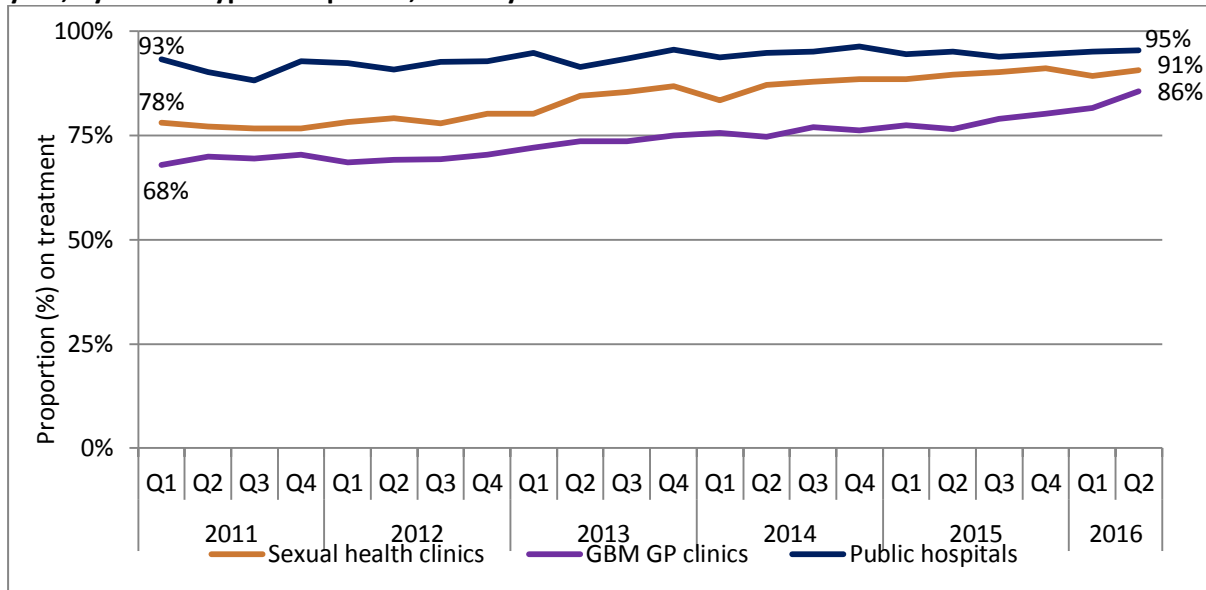
In the year ending 30 June 2016, treatment information was available for 3,173 clients with HIV who received care in public HIV and sexual health clinics in NSW. The available data indicates that treatment coverage in public clinics is high at 91%.

Figures 31, 32 and 33 display data from the ACCESS program database on the proportion of HIV positive patients attending PFSHCs and GBM GP clinics who received HIV treatment, by age group and 'undetectable' viral load.

³⁰ Data is representative of all clients who has received HIV care in NSW public HIV and sexual health services in the last 12 months where treatment information is available.

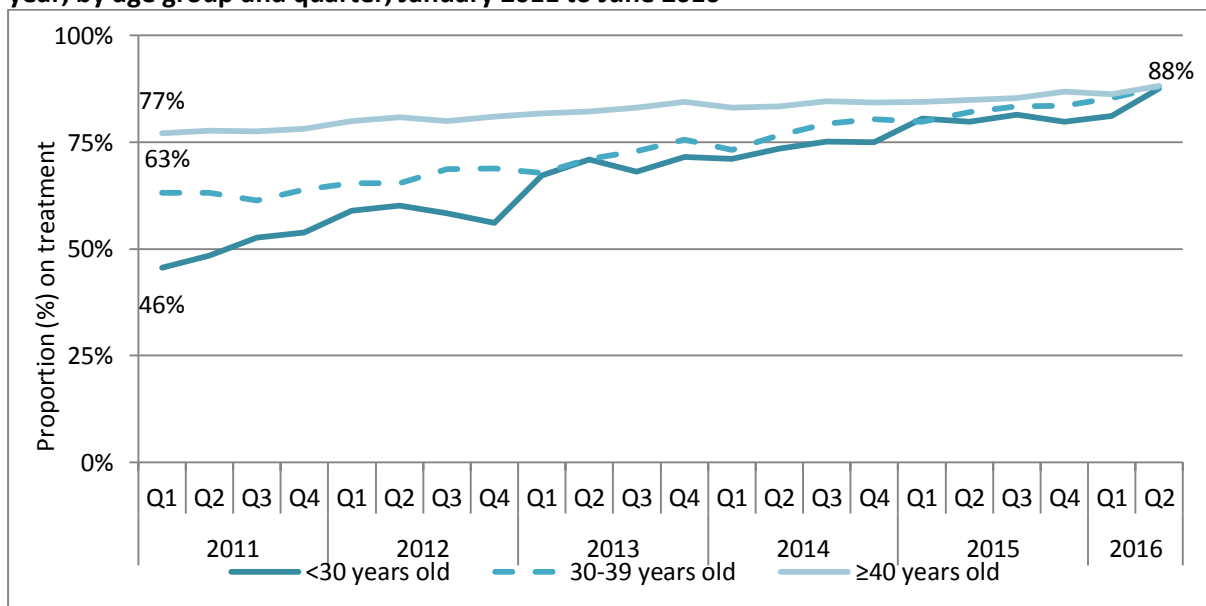
³¹ Public sexual health and HIV services data provided by Local Health Districts for the purpose of monitoring the implementation of the NSW HIV Strategy.

Figure 31: Proportion of HIV positive patients³² attending PFSHCs, public hospital outpatient clinics and GBM GP clinics³³ who received treatment or were recorded as on treatment in the previous year, by service type and quarter, January 2011 to June 2016



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

Figure 32: Proportion of HIV positive patients attending PFSHCs, public hospital outpatient clinics and GBM GP clinics who received treatment or were recorded as on treatment in the previous year, by age group and quarter, January 2011 to June 2016



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

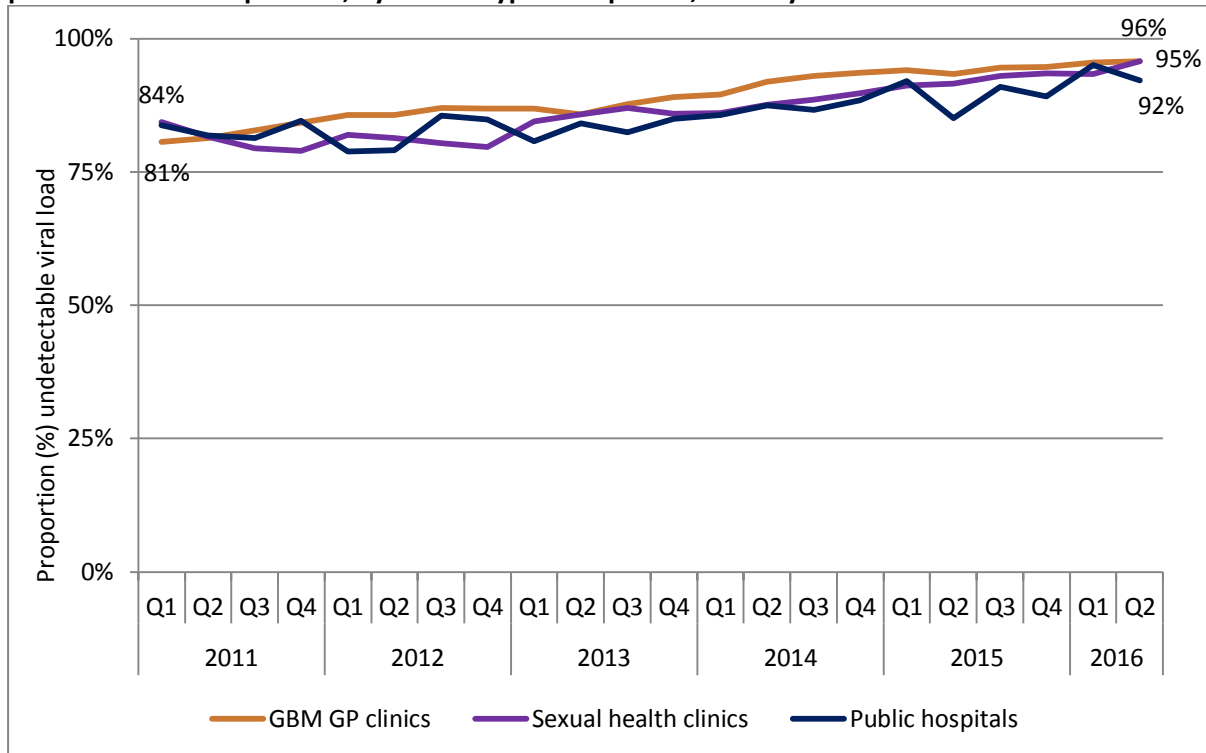
Comment

HIV treatment uptake in NSW was highest overall among patients attending public hospitals but from 2011 onward uptake increased across all service types. Treatment uptake also increased across patients of all ages but the greatest increase over time was, by far, among those aged 30 years and younger. In quarter 2 2016, 88% of patients of all age groups had accessed HIV treatment in the previous year.

³² Excludes patients for whom HIV care was recorded as managed elsewhere

³³ GBM clinics defined as general practice clinics serving at least 50 GBM patients annually

Figure 33: Proportion of HIV positive patients on treatment at PFSHCs, public hospital outpatient clinics and GBM GP clinics³⁴ with an ‘undetectable’³⁵ viral load at their most recent test in the previous 12 month period³⁶, by service type and quarter, January 2011 to June 2016



Data source: ACCESS Database, The Kirby Institute and the Burnet Institute

Comment

Differences in undetectable viral load among HIV positive patients on treatment were minor between service types. The proportion of HIV positive patients on treatment whose viral load was undetectable increased over time.

³⁴ GBM clinics defined as general practice clinics serving at least 50 GBM patients annually

³⁵ ‘Undetectable’ defined as <200 RNA copies/mm³ of blood

³⁶ Excludes patients for whom viral load test information was not available

4.2.2 Retention in care, ART commencement and HIV viral load suppression among NSW residents newly diagnosed with HIV from 2013 to 2015, measured at six months post diagnosis follow up

Since 2013, HIV surveillance in NSW was enhanced to:

- a) at the time of diagnosis, collect from doctors additional information on the patient's HIV viral load, antiretroviral therapy (ART) commencement or deferral, and;
- b) at six months post diagnosis, follow up on the patient via their doctor to collect information on retention in care, ART commencement, pre-ART and latest HIV viral load and CD4 count.

In each quarterly report, the cases reported on with respect to six months post diagnosis follow up data, will have been diagnosed at least six months prior to each report period. In this quarter 2 2016 report, six months post diagnosis follow up data is reported on 1046 NSW residents newly diagnosed with HIV infection from 1 January 2013 to 31 December 2015. Six month post diagnosis follow up data were available for 94% (n=983) of the people newly diagnosed in 2013-2015; this comprised follow up data on 97% (342/353) of the new diagnoses in 2013, 92% (316/344) of the new diagnoses in 2014 and 94% (325/347) of the new diagnoses in 2015.

ART uptake at six weeks, three months and by six months post diagnosis among NSW residents newly diagnosed with HIV from 2013 to 2015

Data on commencement of ART by six months post diagnosis was drawn from six months post diagnosis follow up form (FUF) data and HIV notification form data and combined for analysis. All new diagnoses were included irrespective of care outcome reported at the six months post diagnosis follow up (i.e., retained in care, moved out of NSW, lost to follow up, died, unknown). In mid-2015 strong evidence emerged that starting ART as early as possible after diagnosis irrespective of CD4 count maximised individual health gain (START study). A key indicator to monitor against the NSW HIV Strategy 2016-2020 is the proportion of NSW residents newly diagnosed who commence ART within six weeks of diagnosis. The impact of the START study results may start to be observed in the six months post diagnosis follow up data on people newly diagnosed in the third or the fourth quarter 2015 onwards, while the impact of policy and program work under the NSW HIV Strategy 2016-2020 may start to be observed in the follow up data on people newly diagnosed in quarter 1 2016 onwards.

Figure 34 and Table 8: ART commencement status at six weeks, three and six months post diagnosis, among 1046 NSW residents newly diagnosed from January 2013 to December 2015

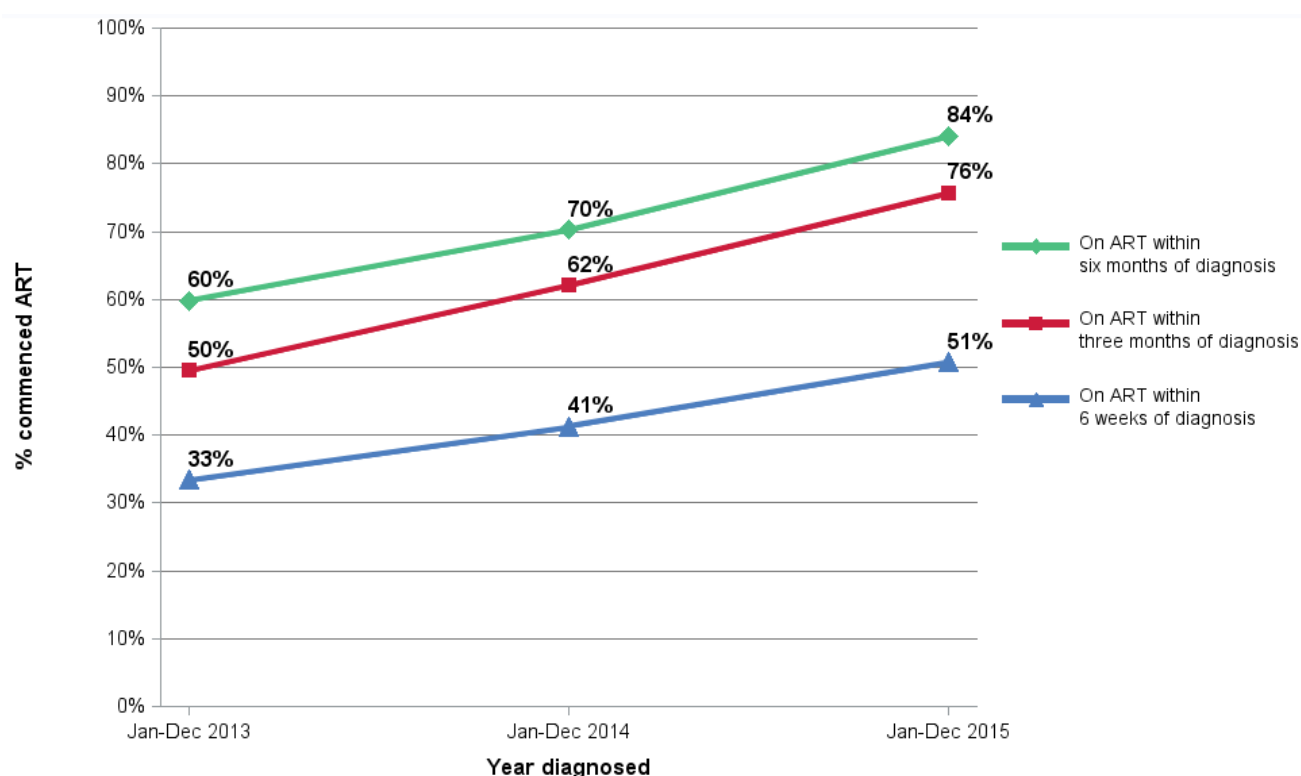


Table 8: ART commencement status reported at six months post diagnosis follow up on 1046 NSW residents newly diagnosed from 1 January 2013 to 31 December 2015

ART status at six months post diagnosis	Diagnosed 2013	Diagnosed 2014	Diagnosed 2015	Total
On ART within 6 weeks of diagnosis	118 (33%)	143 (41%)	176 (51%)	437 (42%)
On ART > 6 weeks but <=3 months of diagnosis	57 (16%)	72 (21%)	87 (25%)	216 (21%)
On ART > 3 months but <=6 months of diagnosis	36 (10%)	28 (8%)	29 (8%)	93 (9%)
No ART by six months post diagnosis	103 (29%)	78 (23%)	36 (10%)	217 (21%)
ART status unknown	39 (11%)	25 (7%)	19 (5%)	83 (8%)
Total	353	346	347	1046

Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

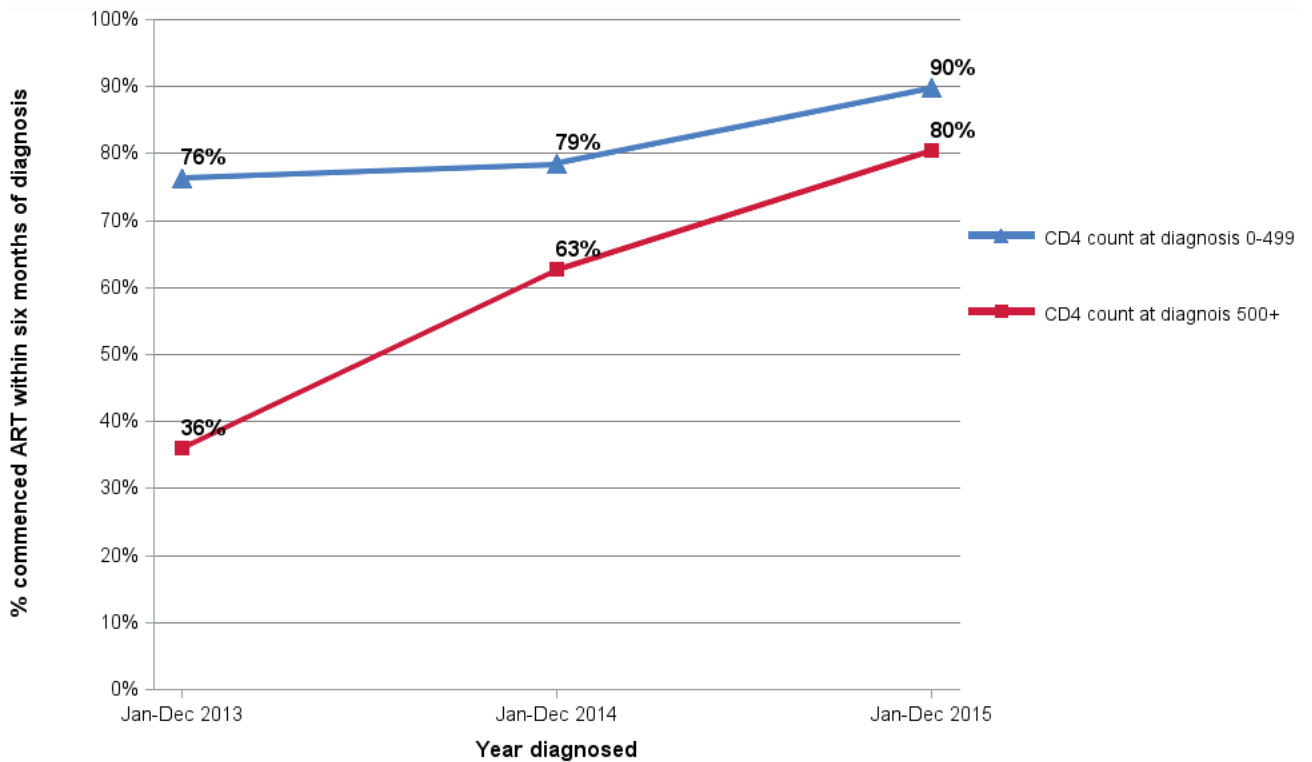
The latest available six months follow up data are for those newly diagnosed in quarter 4 2015. Of the 103 new diagnoses in October to December 2015, 57% (n=51) had commenced ART within six weeks, 75% (n=77) within three months and 83% (n=85) within six months of diagnosis. Of the 103 new diagnoses in October to December 2015, 69% (n=71) were known to have achieved viral suppression (VL < 400 copies/mL) by the time of six months post diagnosis follow up.

Since 2013, increasing proportions of people newly diagnosed in NSW have commenced ART within 6 weeks of diagnosis. Of 1046 NSW residents newly diagnosed with HIV infection from 1 January 2013 to 31 December 2015, 42% (n=437) had commenced ART within six weeks of diagnosis. This comprises 33% (118/353) of people newly diagnosed in 2013, 41% (143/346) of those diagnosed in 2014 and 51% (176/347) of those diagnosed in 2015.

Of 1046 NSW residents newly diagnosed with HIV infection from 2013 to 2015, 62% (n=653) had commenced ART within three months of diagnosis. This comprises 50% (175/353) of people newly diagnosed in 2013, 62% (215/346) of people newly diagnosed in 2014 and 76% (263/347) of people newly diagnosed in 2015.

Of 1046 NSW residents newly diagnosed with HIV infection from 2013 to 2015, 71% (n=746) had commenced ART within six months of diagnosis. This comprises 60% (211/353) of people newly diagnosed in 2013, 70% (243/346) of people newly diagnosed in 2014 and 84% (292/347) of people newly diagnosed in 2015.

Figure 35: Per cent of NSW residents notified with newly diagnosed HIV infection in 2013, 2014 and 2015 which had commenced ART within six months by CD4 count at diagnosis



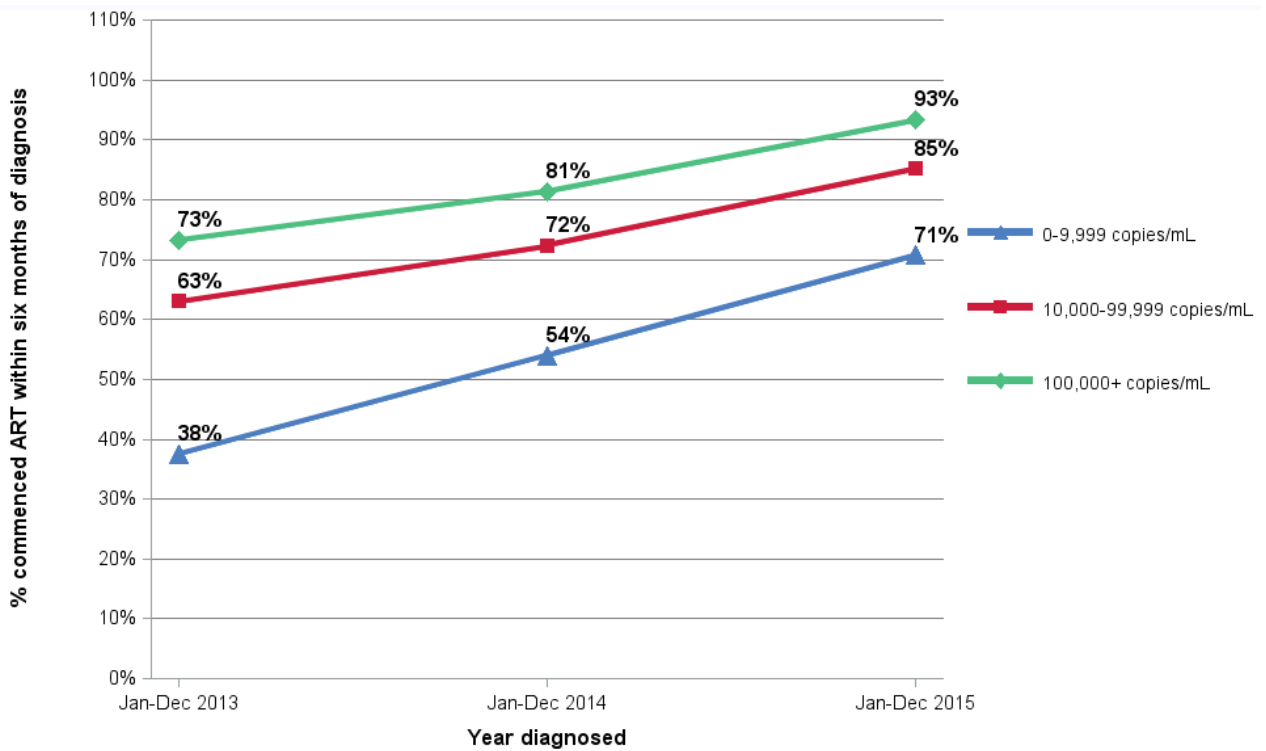
Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

The proportion of people newly diagnosed with a CD4 count of 0-499 cells/ μ L who commenced ART within six months of diagnosis was 76% of the 2013, 79% of the 2014 and 90% of the 2015 new diagnoses cohorts.

The proportion of people newly diagnosed with a CD4 count of 500 or over who commenced ART within six months of diagnosis was 36% of the 2013, 63% of the 2014 and 80% of the 2015 new diagnoses cohorts.

Figure 36: Per cent of NSW residents notified with newly diagnosed HIV infection in 2013, 2014 and 2015 which had commenced ART within six months by HIV VL at diagnosis



Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

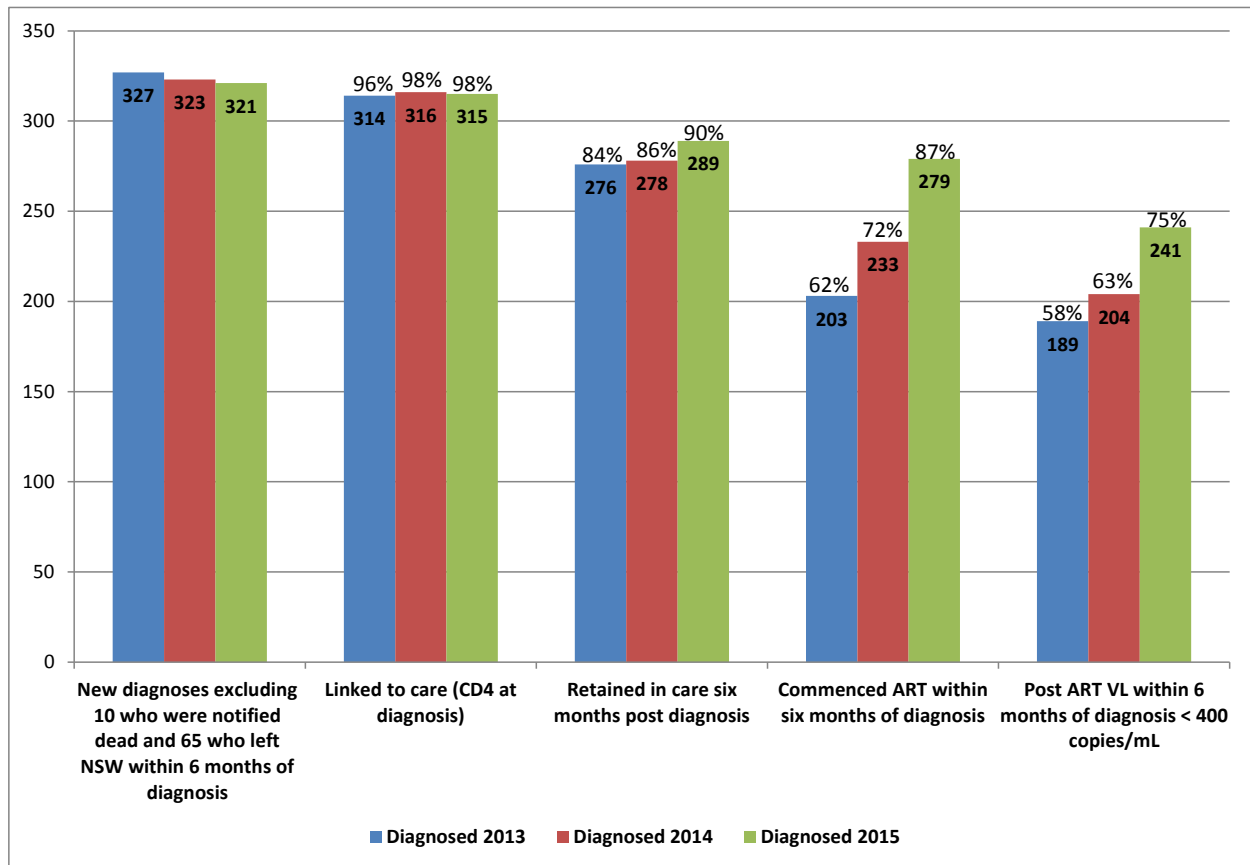
Comment

The proportion of people newly diagnosed with a HIV VL of 0-9,999 copies/mL who commenced ART within six months of diagnosis was 38% of the 2013, 54% of the 2014 and 71% of the 2015 new diagnoses cohorts.

The proportion of people newly diagnosed with a HIV VL of 10,000-99,999 who commenced ART within six months of diagnosis was 63% of the 2013, 72% of the 2014 and 86% of the 2015 new diagnoses cohorts.

The proportion of people newly diagnosed with a HIV VL of 100,000 or over who commenced ART within six months of diagnosis was 73% of the 2013, 81% of the 2014 and 93% of the 2015 new diagnoses cohorts.

Figure 37: HIV care cascade indicators measured six months post diagnosis on 971 of 1046 NSW residents newly diagnosed with HIV infection in 2013, 2014 and 2015



Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016

Comment

Notification and six months post diagnosis follow up data on NSW residents newly diagnosed 2013-2015 was used to construct an HIV care cascade. The HIV care cascade reflects their linkage to HIV services, retention in care, early uptake of treatment and subsequent HIV viral load suppression.

Of 1046 NSW residents newly diagnosed HIV infection from 1 January 2013 to 31 December 2015, 10 were reported dead and 65 reported to have permanently left NSW (for overseas or interstate) prior to the six months post diagnosis follow up period. These 75 were excluded from cascade. In total 93% (n=971) of the 1046 new diagnoses 2013-2015 were included in the cascade, comprising 327 diagnosed in 2013, 323 in 2014 and 321 in 2015.

Since 2013, increasing proportions of people newly diagnosed in NSW have been linked to HIV services, retained in care, commenced ART and achieved viral load suppression within six months of diagnosis. The respective proportions of the 2013, 2014 and 2015 new diagnoses cohorts which were: linked to care was 96%, 98% and 98%; retained in care six months post diagnosis was 84%, 86% and 90%; commencing ART within six months of diagnosis was 62%, 72% and 87%, and; on ART and with viral suppression within six months of diagnosis was 58%, 63% and 75%.

Overall of 971 NSW residents newly diagnosed with HIV infection 2013-2015 not known to have left NSW or died within six months of diagnosis, 97% (n=945) were linked to care (CD4 count at diagnosis used as proxy measure); 87% (n=843) were reported to be retained in care six months post diagnosis; 74% (n=715) had commenced ART within six months of diagnosis, and; 65% (n=634) of those on ART had achieved viral suppression (VL < 400 copies/mL) by six months post diagnosis.

5. Sustain the virtual elimination of HIV related deaths

5.1 What is the number of deaths for which HIV/AIDS was reported as underlying cause?

Ascertaining the number of deaths due to HIV is complex in an era when people with HIV have access to effective treatment giving them a long life expectancy. People with HIV are subject to the same causes of morbidity and mortality as are people without HIV. Methods to better estimate deaths attributable to HIV are being investigated.

Appendix A: Characteristics of NSW residents notified with newly diagnosed HIV infection 1981 to 30/06/2016

Demographics	1981- 2007	%	2008	%	2009	%	2010	%	2011	%	2012	%	2013	%	2014	%	2015	%	Q1-2 2016	%	1981-30/6/16	%
Gender	14838	100	326	100	336	100	305	100	331	100	411	100	353	100	346	100	347	100	170	100	17763	100
Male	13663	92.1	294	90.2	295	87.8	280	91.8	310	93.7	374	91.0	323	91.5	321	92.8	318	91.6	156	91.8	16334	92.0
Female	898	6.1	32	9.8	38	11.3	23	7.5	21	6.3	36	8.8	27	7.6	24	6.9	28	8.1	13	7.6	1140	6.4
Transgender	30	0.2	0	0.0	2	0.6	2	0.7	0	0.0	1	0.2	3	0.8	1	0.3	1	0.3	1	0.6	41	0.2
Unknown	247	1.7	0	0.0	1	0.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	248	1.4
Aboriginal person status																						
Aboriginal person	113	0.8	8	2.5	9	2.7	7	2.3	5	1.5	12	2.9	8	2.3	7	2.0	6	1.7	6	3.5	180	1.0
Torres Strait Islander person	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.6	2	0.0
Non-Aboriginal person	7875	53.1	302	92.6	315	93.8	293	96.1	324	97.9	393	95.6	343	97.2	331	95.7	338	97.4	162	95.3	10676	60.1
Not stated	6850	46.2	16	4.9	12	3.6	5	1.6	2	0.6	6	1.5	2	0.6	8	2.3	3	0.9	1	0.6	6905	38.9
Age in years																						
0-4	37	0.2	0	0.0	1	0.3	1	0.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	39	0.2
5-9	21	0.1	0	0.0	1	0.3	0	0.0	0	0.0	0	0.0	1	0.3	0	0.0	0	0.0	1	0.6	24	0.1
10-14	35	0.2	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.3	0	0.0	0	0.0	36	0.2
15-19	265	1.8	3	0.9	3	0.9	5	1.6	6	1.8	9	2.2	9	2.5	2	0.6	6	1.7	2	1.2	310	1.7
20-24	1835	12.4	39	12.0	34	10.1	29	9.5	35	10.6	44	10.7	37	10.5	41	11.8	45	13.0	16	9.4	2155	12.1
25-29	2989	20.1	58	17.8	58	17.3	56	18.4	55	16.6	76	18.5	64	18.1	52	15.0	64	18.4	36	21.2	3508	19.7
30-34	3060	20.6	44	13.5	42	12.5	49	16.1	65	19.6	71	17.3	48	13.6	65	18.8	61	17.6	32	18.8	3537	19.9
35-39	2502	16.9	64	19.6	59	17.6	43	14.1	59	17.8	64	15.6	42	11.9	45	13.0	45	13.0	24	14.1	2947	16.6
40-44	1769	11.9	52	16.0	58	17.3	51	16.7	44	13.3	47	11.4	44	12.5	46	13.3	32	9.2	19	11.2	2162	12.2
45-49	1005	6.8	32	9.8	30	8.9	30	9.8	26	7.9	38	9.2	45	12.7	29	8.4	26	7.5	17	10.0	1278	7.2
50-54	593	4.0	14	4.3	28	8.3	7	2.3	25	7.6	28	6.8	24	6.8	26	7.5	28	8.1	8	4.7	781	4.4
55-59	317	2.1	10	3.1	12	3.6	22	7.2	10	3.0	14	3.4	22	6.2	15	4.3	12	3.5	8	4.7	442	2.5
60-64	176	1.2	6	1.8	1	0.3	5	1.6	2	0.6	13	3.2	6	1.7	14	4.0	15	4.3	4	2.4	242	1.4
65-69	92	0.6	0	0.0	4	1.2	6	2.0	2	0.6	4	1.0	9	2.5	7	2.0	7	2.0	3	1.8	134	0.8
70 or over	54	0.4	4	1.2	5	1.5	1	0.3	2	0.6	3	0.7	2	0.6	3	0.9	6	1.7	0	0.0	80	0.5
Unknown	88	0.6	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	88	0.5

Reported HIV risk	1981- 2007	%	2008	%	2009	%	2010	%	2011	%	2012	%	2013	%	2014	%	2015	%	Q1-2 2016	%	1981-30/6/16	%
Men who have sex with men	9016	60.8	236	72.4	221	65.8	226	74.1	267	80.7	320	77.9	264	74.8	258	74.6	263	75.8	129	75.9	11200	63.1
MSM & injects drugs	401	2.7	11	3.4	17	5.1	8	2.6	11	3.3	14	3.4	16	4.5	19	5.5	21	6.1	10	5.9	528	3.0
Hetero-sex only	1152	7.8	64	19.6	75	22.3	51	16.7	41	12.4	58	14.1	61	17.3	50	14.5	52	15.0	25	14.7	1629	9.2
Person who has injected drugs	489	3.3	12	3.7	12	3.6	9	3.0	8	2.4	10	2.4	7	2.0	8	2.3	4	1.2	2	1.2	561	3.2
Blood disorder, blood or tissue recipient	275	1.9	0	0.0	1	0.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.3	0	0.0	277	1.6
Mother to child	45	0.3	0	0.0	2	0.6	1	0.3	0	0.0	0	0.0	1	0.3	1	0.3	0	0.0	1	0.6	51	0.3
Other	34	0.2	0	0.0	2	0.6	1	0.3	1	0.3	2	0.5	1	0.3	4	1.2	3	0.9	1	0.6	49	0.3
Unknown	3426	23.1	3	0.9	6	1.8	9	3.0	3	0.9	7	1.7	3	0.8	6	1.7	3	0.9	2	1.2	3468	19.5
LHD of residence																						
SES	4540	30.6	118	36.2	106	31.5	109	35.7	124	37.5	150	36.5	124	35.1	112	32.4	128	36.9	49	28.8	5560	31.3
Sydney	2231	15.0	77	23.6	92	27.4	76	24.9	88	26.6	113	27.5	87	24.6	82	23.7	84	24.2	42	24.7	2972	16.7
Northern Sydney	782	5.3	25	7.7	39	11.6	19	6.2	24	7.3	23	5.6	25	7.1	18	5.2	24	6.9	11	6.5	990	5.6
Western Sydney	525	3.5	26	8.0	21	6.3	20	6.6	31	9.4	25	6.1	27	7.6	27	7.8	21	6.1	12	7.1	735	4.1
SWS	484	3.3	16	4.9	21	6.3	25	8.2	18	5.4	30	7.3	33	9.3	31	9.0	32	9.2	15	8.8	705	4.0
HNE	352	2.4	14	4.3	16	4.8	16	5.2	10	3.0	14	3.4	17	4.8	27	7.8	17	4.9	7	4.1	490	2.8
NBM	222	1.5	7	2.1	3	0.9	3	1.0	4	1.2	5	1.2	3	0.8	7	2.0	6	1.7	2	1.2	262	1.5
Illawarra-Shoal	173	1.2	3	0.9	5	1.5	8	2.6	5	1.5	9	2.2	7	2.0	6	1.7	7	2.0	6	3.5	229	1.3
Central Coast	148	1.0	6	1.8	5	1.5	5	1.6	4	1.2	10	2.4	5	1.4	8	2.3	5	1.4	8	4.7	204	1.1
Northern NSW	146	1.0	4	1.2	5	1.5	8	2.6	11	3.3	5	1.2	5	1.4	7	2.0	7	2.0	3	1.8	201	1.1
Mid North Coast	102	0.7	8	2.5	6	1.8	3	1.0	4	1.2	3	0.7	6	1.7	7	2.0	6	1.7	0	0.0	145	0.8
Western NSW	91	0.6	3	0.9	3	0.9	4	1.3	3	0.9	7	1.7	5	1.4	2	0.6	2	0.6	2	1.2	122	0.7
Murrumb-Albury	60	0.4	3	0.9	2	0.6	7	2.3	2	0.6	5	1.2	3	0.8	3	0.9	4	1.2	7	4.1	96	0.5
Southern NSW	29	0.2	3	0.9	6	1.8	1	0.3	2	0.6	8	1.9	4	1.1	4	1.2	2	0.6	3	1.8	62	0.3
Far West	4	0.0	0	0.0	2	0.6	0	0.0	0	0.0	2	0.5	0	0.0	0	0.0	0	0.0	0	0.0	8	0.0
Other or unknown	4949	33.4	13	4.0	4	1.2	1	0.3	1	0.3	2	0.5	2	0.6	5	1.4	2	0.6	3	1.8	4982	28.0
Total (ALL)	14838	100	326	100	336	100	305	100	331	100	411	100	353	100	346	100	347	100	170	100	17763	100

Data source: Notifiable Conditions Information Management System, Health Protection NSW, extracted 8 August 2016.

Appendix B: Ending HIV Seven Statements Evaluation, ACON 2015

The table below shows the figures over the five separate surveys.

Percentage of respondents who strongly agree or agree with the statements below.							
Answer Options	FEB 2013 (n=233)	MAY 2013 (n=517)	NOV 2013 (n=553)	APRIL 2014 (n=530)	DEC 2014 (n=549)	APR 2015 (n=602)	+/-
Everything has changed, we can now dramatically reduce HIV transmission	48%	59%	59%	67%	61%	71%	+23
Now more than ever, gay men need to know their HIV status	81%	85%	86%	90%	89%	91%	+10
Sexually active gay men should take an HIV test at least twice a year	88%	87%	92%	93%	89%	92%	+4
HIV treatments now offer increased health benefits and fewer side effects	65%	66%	67%	73%	69%	75%	+10
HIV treatments significantly reduce the risk of passing on HIV	33%	42%	50%	64%	59%	69%	+36
Early HIV treatment is better for your health and can help protect your sex partners	74%	80%	89%	91%	92%	93%	+19
Condoms continue to be the most effective way of preventing HIV transmission	95%	92%	92%	91%	91%	85%	-10

Survey methodology:

Each of the five online evaluation surveys was developed and analysed by an independent consultant using the Survey Monkey online tool. Each survey was run over a one to three week period. In addition to 30 to 40 mainly multiple choice questions, with a few opportunities for respondents to provide comments, respondents were provided with a set of seven statements and asked to indicate whether they agree or disagree with the statements (using a five point scale)

Recruitment methodology:

Respondents were mainly recruited through the placement of survey advertisements on Facebook undertaken by ACON.

Survey objectives:

The online evaluation survey focussed on measuring a) advertisement awareness, b) engagement with campaign components, and c) self-reported impact and getting answers to seven statements.