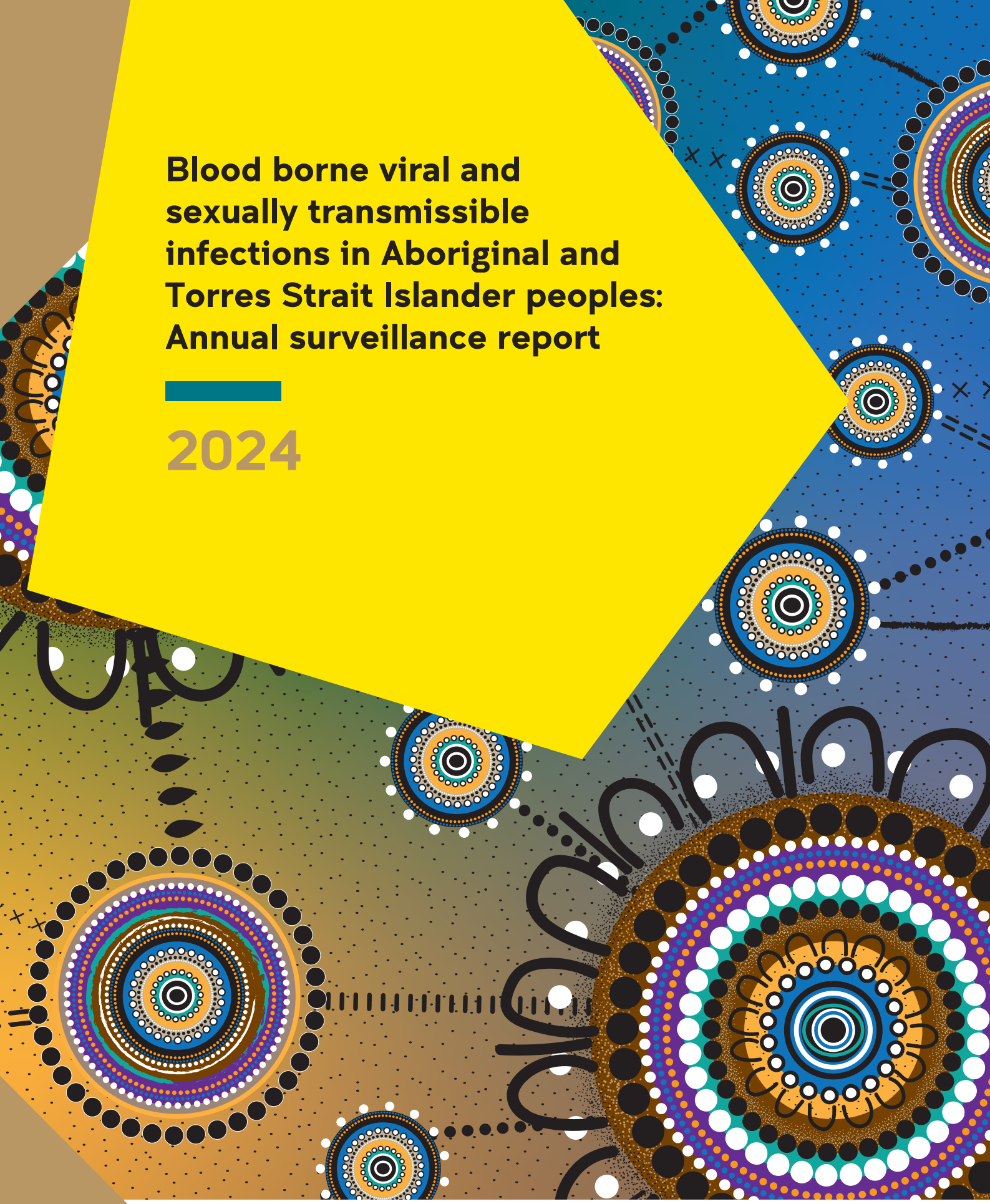
Blood borne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander peoples: Annual surveillance report

2024



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Cover Artwork

The cover artwork was created by Jasmine Sarin. Jasmine is a proud Kamilaroi and Jerrinja woman from NSW. Born and raised in Dharawal Country (Wollongong) as well as Jerrinja and Yuin Country (Nowra) and has family connections in Kamilaroi Country (Coonabarabran). Jasmine is also a Rescue Qualified Firefighter with Fire and Rescue NSW, a lover of good coffee, rugby league and a self-taught Aboriginal artist and graphic designer.

The narrative for this artwork can be found on the inside back cover of this report.

"My artwork predominantly features bright and bold colours. The narratives behind my artworks are often linked to the way we connect, the way we come together, and how we grow as community. These concepts are illustrated in my work as concentric circles, connection lines, floral emblems, and textured patterns symbolic of landscape. All of which reflect the cultural connection of country. We stand in footsteps millennia old, may we acknowledge all traditional owners of this great land… past, present and emerging."

Jasmine Sarin

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Blood borne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander peoples:
Annual surveillance report 2024

The Kirby Institute

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Special thank you to the Aboriginal and Torres Strait Islander people who have given their yarns in the report. Names may have been changed to protect their privacy. The yarns were added on extensive consultation with the Kirby Aboriginal Reference group members, to help provide valuable context, about challenges faced by individuals and better understand stigma, and foster empathy.

Table of Contents

Tables List

Figures List

Preface

This report provides information on the occurrence of blood borne viruses (BBVs) and sexually transmissible infections (STIs) among Aboriginal and Torres Strait Islander peoples in Australia. The report is published by the Kirby Institute, UNSW Sydney for the purposes of stimulating and supporting discussion on ways to minimise the risk of transmission of these infections as well as the personal and social impacts within Aboriginal and Torres Strait Islander communities.

This report is published annually as an accompanying document to the HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report [1] and is overseen by the National Blood Borne Virus and Sexually Transmissible infections Surveillance Sub-Committee (NBBVSTI SSC) and the Annual Surveillance Report Advisory Committee with input provided by the National Aboriginal Community Controlled Health Organisation (NACCHO).

The report is produced for use by a wide range of health service providers and consumers, and particularly Aboriginal and Torres Strait Islander health services and communities. Tables, graphs, and infographics are also available online at the Kirby Institute website.

Unless specifically stated otherwise, all data provided in this report are to the end of 2023. Data in this report are provisional and subject to future revision.

The Kirby Institute acknowledges Traditional Custodians of Country throughout Australia and recognises the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander Elders past and present. We acknowledge the unique position of Aboriginal and Torres Strait Islander peoples' culture, history and as the original inhabitants of the land. We extend our gratitude to the Kirby Institute Aboriginal and Torres Strait Islander Surveillance Reference Group, for providing expert insight, advice, and Aboriginal and Torres Strait Islander perspective, without whose input this report would not be possible. We also acknowledge Jasmine Sarin, a proud Kamilaroi and Jerrinja women who created the beautiful artwork for this report.

Abbreviations

ABS	Australian Bureau of Statistics
ACCESS	Australian Collaboration for Coordinated Enhanced Sentinel Surveillance
ANSPS	Australian Needle Syringe Program Survey
BBV	blood borne virus
HIV	human immunodeficiency virus
HPV	human papillomavirus
PBS	Pharmaceutical benefit scheme
PrEP	Pre-Exposure Prophylaxis
STI	sexually transmissible infection

Voices from the community...

"You can have something serious happening inside your body without even knowing it on the outside – that's what it means to be asymptomatic. Now, think of your body like the 'deadly' car you've always dreamed of owning. Just like you dress to impress with popular clothing brands, and style your hair, apply makeup, or choose the perfect accessories, you want your car to look its best too. Consider all the effort you put into making your car look amazing – the flawless paintwork, the shiny mag wheels, the luxurious leather seats, the powerful engine, and the booming 'doof-doof' speakers in the boot. But here's the catch: what happens to that stunning car if you never lift the bonnet and do any maintenance? It might look 'schmiko' on the outside, but without regular check-ups, it will eventually 'chug-chug' and break down. The same goes for your body. You can keep it looking great on the outside, but if you don't 'lift the bonnet' and get regular health checks, your body might break down with illnesses you never knew you had. Regular Well Person's Health Checks are essential to keep everything running smoothly inside and out. "

Annette's yarn
(talking to the community to explain the importance of health checks)

"As a woman being diagnosed with HIV in the early 90's then having a baby, and not knowing if I passed on the virus was scary, luckily she was ok. Many things have changed since the 90's, such as new medication, taking PrEP which can prevent HIV or using condoms. If you get tested for HIV and the result is that you are now HIV Positive, you can start medication straight away so that you can now live a long life. Taking your HIV medication every day stops you from passing it on. Life does not stop if your test comes back HIV+, you can still work, you can still play sport, Women can still have babies and we can drink from the same cup. It is important to talk to your doctor if you have other health conditions that might cause problems with your HIV medication. Yarning with Mob who are living with HIV can help you get through the tough times, so you are not alone."

Michelle's yarn

"As a gay man, the prospect of HIV has always been daunting for me, often leading to anxiety when it comes to sex. I made sure to use condoms consistently, which helped alleviate some of that fear. However, there was one time when a condom broke without my knowledge, and that left me feeling anxious about the possibility of HIV. Thankfully, I was able to get PEP (Post-Exposure Prophylaxis) quickly after the potential exposure, which gave me peace of mind. Afterward, I talked with my doctor about starting PrEP (Pre-Exposure Prophylaxis), and we both felt it was a wise decision. Now, I approach sex with much less anxiety and greater confidence, knowing I'm protected and actively managing my sexual health."

Jayden's* yarn
*name changed to protect privacy

Summary

We recognise the devastating impacts colonisation and the social systems that continue to uphold social inequalities have on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. This report provides high-quality and important data about persistent and emerging public health threats and inequities to inform public health responses and to address these issues. We also acknowledge the importance of the cultural determinants for Aboriginal and Torres Strait Islander health, and support principles of empowerment, community ownership, co-design, and partnership.

The years for comparison in this report are from 2019 to 2023 and 2014 to 2023, dependent on data availability, unless focus is given to the impact of the COVID-19 pandemic, where the changes up to 2019, and from 2019 to 2022, are highlighted.

Please note, the 2021-2023 rates are impacted by a larger than expected increase in counts of people who identified as being of Aboriginal and/or Torres Strait Islander origin in the 2021 Census, hence should be interpreted with caution.

Sexually transmissible infections

Infectious Syphilis

- There were 6390 infectious syphilis notifications in Australia in 2023, of which 1022 (16%) were among Aboriginal and Torres Strait Islander peoples, 4766 (75%) were among non-Indigenous people, and 602 (9%) were among people whose Aboriginal and Torres Strait Islander status was not reported.
- Infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples are based on data from all jurisdictions, as Aboriginal and Torres Strait Islander status was at least ≥80% complete in all jurisdictions for infectious syphilis notifications for each of the ten years from between 2014 to 2023.
- The age-standardised infectious syphilis notification rate among Aboriginal and Torres Strait Islander peoples increased more than three-fold in the 10-year period from 31 per 100 000 in 2014 to 101.6 per 100 000 population in 2023.
- Infectious syphilis notification rates among both Aboriginal and Torres Strait Islander males and females were nearly three times and 17 times as high as their non-Indigenous sex equivalent, respectively.
- There were 20 cases of congenital syphilis recorded in 2023, of which 13 (65%) were among Aboriginal and Torres Strait Islander infants, seven were among non-Indigenous infants and none had Aboriginal and Torres Strait Islander status missing.

Chlamydia

- Chlamydia is the most frequently diagnosed sexually transmissible infection in Australia. In 2023, there was a total of 109 451 chlamydia notifications in Australia, of which 8557 (8%) were among Aboriginal and Torres Strait Islander peoples, 49 414 (45%) were among non-Indigenous people, and Aboriginal and Torres Strait Islander status was not reported for 51 480 (47%) notifications.
- Chlamydia notification rates among Aboriginal and Torres Strait Islander peoples were based on data from six jurisdictions (the Australian Capital Territory, the Northern Territory, South Australia, New South Wales, Queensland and Western Australia). Jurisdictions were included where Aboriginal and Torres Strait Islander status was ≥50% complete for all chlamydia notifications for each of the five years from 2019 to 2023.
- In 2023, the age standardised chlamydia notification rate for Aboriginal and Torres Strait Islander peoples (820.0 per 100 000 population) was twice as high as that among non-Indigenous people (411.8 per 100 000 population).
- Between 2019 and 2023, the chlamydia age-standardised notification rate in Aboriginal and Torres Strait Islander peoples and non-Indigenous people fluctuated with declines between 2019 and 2022 likely related to impacts of the COVID-19 pandemic.

Gonorrhoea

- There were 40 029 gonorrhoea notifications in Australia in 2023. Of these, 5631 (14%) were among Aboriginal and Torres Strait Islander peoples, 26 283 (66%) were among non-Indigenous people, and 8155 (20%) were among people for whom Aboriginal and Torres Strait Islander status was not reported.
- Gonorrhoea notification rates among Aboriginal and Torres Strait Islander peoples are based on data from all jurisdictions except Victoria, as Aboriginal and Torres Strait Islander status was ≥50% complete for gonorrhoea notifications for these jurisdictions for each of the five years from 2019 to 2023.
- In 2023, the age standardised gonorrhoea notification rate in Aboriginal and Torres Strait Islander peoples was more than four times that of non-Indigenous people (541.0 per 100 000 vs. 134.9 per 100 000 population).

Donovanosis

- Australia is on track to eliminate donovanosis, which was once a frequently diagnosed sexually transmissible infection among remote Aboriginal populations. Since 2014 there has only been one case, notified in 2014.

Human papillomavirus

- In Australia, the national vaccination program for human papillomavirus (HPV) was introduced for girls aged 12 to 13 years in 2007 and was extended to include boys of the same age in 2013. Since 2007 there have been considerable reductions in the proportions diagnosed with genital warts among Aboriginal and Torres Strait Islander males and females aged 21 years or younger attending 54 sexual health clinics included in the Genital Warts Surveillance Network for their first visit.

HIV

- In 2023, there were 24 HIV notifications among Aboriginal and Torres Strait Islander peoples, accounting for 3% of all HIV notifications (722 notifications overall).
- In 2023, the age-standardised HIV notification rate was 2.9 per 100 000 population among Aboriginal and Torres Strait Islander peoples compared with 2.7 per 100 000 population among non-Indigenous people.
- In 2023, among Aboriginal and Torres Strait Islander peoples, the HIV notification rate was 3.6 per 100 000 population for those aged 35 or older and was 2.0 per 100 000 population for those aged under 35 years. Among non-Indigenous people, the HIV notification rate was 2.3 per 100 000 population for those aged 35 and older and was 1.8 per 100 000 population for those aged under 35 years.
- In the five-year period from 2019 to 2023, the proportion of HIV notifications attributed to injection drug use was 13% among Aboriginal and Torres Strait Islander peoples compared with 2% among non-Indigenous people. The proportion of HIV notifications attributed to male-to-male sex was 42% among Aboriginal and Torres Strait Islander peoples, compared with 57% among non-Indigenous people.
- Based on mathematical modelling, there were an estimated 620 (range of 540-680) Aboriginal and Torres Strait Islander people living with HIV in Australia in 2023 which corresponds to an estimated HIV prevalence of 0.09% (range 0.08% to 0.10%).
- Based on the test for immune function (CD4+ cell count), 30% of HIV notifications among Aboriginal and Torres Strait Islander peoples in 2023 were classified as late diagnoses (CD4+ cell count of less than 350 cells/μL) compared with 35% among non-Indigenous people. These notifications are likely to have been in people who had acquired HIV at least four years prior to diagnosis.
- According to the Australian Needle Syringe Program Survey (ANSPS), a similar proportion of Aboriginal and Torres Strait Islander and non-Indigenous women and men reported having been tested for HIV in the last 12 months (41% vs 40% females in 2023, respectively and 44% vs 43% males respectively in 2023).
- In 2023, among participants of the ANSPS, 76% of Aboriginal and Torres Strait Islander women reported inconsistent condom use with casual partners compared to 84% of Aboriginal and Torres Strait Islander men. This proportion was 75% for both non-Indigenous women and men.

Hepatitis C

- In 2023, there were 1499 hepatitis C notifications among Aboriginal and Torres Strait Islander peoples, accounting for 20% of all hepatitis C notifications (7602 notifications overall). There were a further 2310 (38%) notifications among people for whom Aboriginal and Torres Strait Islander status was not reported.
- Hepatitis C notification rates among Aboriginal and Torres Strait Islander peoples were based on data from five jurisdictions (the Northern Territory, Queensland, South Australia, Tasmania and Western Australia). Jurisdictions were included where Aboriginal and Torres Strait Islander status was ≥50% complete for all hepatitis C notifications for each of the five years from 2019 to 2023.
- In 2023, the age-standardised hepatitis C notification rate for Aboriginal and Torres Strait Islander peoples was more than six times as high as compared to non-Indigenous people (165.5 vs 25.7 per 100 000 populations).
- Among Aboriginal and Torres Strait Islander men and women who were hepatitis C antibody negative participating in the (ANSPS), the proportion who reported a hepatitis C antibody test in the past 12 months declined over the period from 2014 to 2023 from 60% to 41% among males, and from 60% to 44% among females.
- In 2023, 27% of Aboriginal and Torres Strait Islander respondents to the ANSPS reported receptive syringe sharing in the previous month, a key risk factor for hepatitis C transmission, compared with 15% among non-Indigenous survey respondents.
- Among Aboriginal and Torres Strait Islander respondents to the ANSPS in 2023, two thirds (68%) of those who self-reported having ever lived with chronic hepatitis C had received treatment in their lifetime. This proportion was over six times higher than at the end of 2015 (10%) when PBS-subsidised interferon-free direct-acting antiviral regimens becoming available. In 2023, Aboriginal and Torres Strait Islander respondents had lower uptake of treatment in the last 12 months (29%) compared to non-Indigenous participants (42%).

Hepatitis B

- There were 5390 notifications of hepatitis B infection in Australia in 2023, of which 135 (2.5%) were among Aboriginal and Torres Strait Islander peoples and 3213 (60%) were among non-Indigenous people. For 2042 notifications (38%), Aboriginal and Torres Strait Islander status was not reported.
- Hepatitis B notification rates among Aboriginal and Torres Strait Islander peoples were based on data from six jurisdictions (the Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania and Western Australia). Jurisdictions were included where Aboriginal and Torres Strait Islander status was ≥50% complete for all hepatitis C notifications for each of the five years 2019–2023.
- The hepatitis B age standardised notification rate among Aboriginal and Torres Strait Islander peoples decreased between 2019 and 2023 (from 25.1 to 20.5 per 100 000 population). In 2023, the age-standardised notification rate of hepatitis B for Aboriginal and Torres Strait Islander peoples was higher compared to non-Indigenous people (20.5 vs. 17.2 per 100 000 population).
- From 2019 to 2023, hepatitis B vaccination coverage rates for Aboriginal and Torres Strait Islander children were consistently at or above 90% however coverage declined since 2019. In 2023, the coverage rate was 90% for children aged 12 months and 95% for children aged 24 months.

1 Interpretation

The increases in infectious syphilis among Aboriginal and Torres Strait Islander peoples along with a considerable increase in the number of congenital syphilis cases, emphasise the need to enhance culturally appropriate health promotion, testing and treatment strategies in partnership with Aboriginal and Torres Strait Islander stakeholders and communities. In particular, antenatal care needs to be more accessible with enhanced syphilis screening for pregnant women, regardless of the healthcare setting.

There has been some success in controlling a limited number of STIs among Aboriginal and Torres Strait Islander peoples. Donovanosis, once an STI diagnosed among remote Aboriginal populations, is now virtually eliminated. Significant declines in the number of genital warts diagnoses have been observed after previously being recorded as the most common STI managed at sexual health clinics among Aboriginal and Torres Strait Islander peoples. These declines reflect the success of the National Immunisation Program (NIP) for HPV, introduced in 2007 for girls and in 2013 for boys. Also, declines in the number of hepatitis B notifications among younger Aboriginal and Torres Strait Islander people reflect the success of the NIP which provides free HBV vaccinations for Australian infants, along with better antenatal care. Maintaining high vaccine coverage for both HPV and hepatitis B are crucial to maintain and extend these gains.

In 2023, age-standardised STI notification rates remained higher among Aboriginal and Torres Strait Islander peoples than among non-Indigenous people: infectious syphilis was almost 5 times as high, chlamydia was almost twice as high, and gonorrhoea was four times as high. The age standardised HIV notification rate in Aboriginal and Torres Strait Islander peoples fluctuated between 2014 and 2023, and remained higher as compared to all non-Indigenous people. Trends in HIV notification rates among Aboriginal and Torres Strait Islander peoples are based on small numbers (24 notifications in 2023) and may reflect localised occurrences rather than national patterns.

At the end of 2023, there were an estimated 620 (range: 540-680), Aboriginal and Torres Strait Islander people living with HIV in Australia. Australia is yet to meet the first UNAIDS 2025 target of 95% of people living with HIV being diagnosed (94% (580) had been diagnosed). Of those diagnosed at the end of 2023, an estimated 97% (560) were retained in care, meeting the UNAIDS target, which shows strong engagement with healthcare services, which is crucial for managing HIV. 97% (540) of those diagnosed were receiving antiretroviral therapy, and 100% (540) of those on antiretroviral therapy had a suppressed viral load, meeting the 95% target and highlights success of treatment programs.

Hepatitis C notification rates remain more than six times as high among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people, suggesting an increase in the at-risk population and/or less effective implementation of harm reduction. Further, there is hyper-incarceration of Aboriginal and Torres Strait Islander peoples where access to evidence-based harm-reduction strategies is substantially limited. Given the high proportion of hepatitis C notifications without a reported Aboriginal and Torres Strait Islander status, the actual hepatitis C-related burden of disease among Aboriginal and Torres Strait Islander peoples may be even higher. Better capture of Aboriginal and Torres Strait Islander status among notifications data is required to better measure the true impact of hepatitis C on Aboriginal and Torres Strait Islander communities. According to the Australian Needle Syringe Program Survey, a lower proportion of Aboriginal and Torres Strait Islander peoples reported hepatitis C treatment uptake than non-Indigenous people. This suggests that there is inequity in the availability of direct acting antiviral therapy as well as resources directed toward harm reduction and linkage to care. This inequity may be limiting the decline in the rate of hepatitis C infections among Aboriginal and Torres Strait Islander peoples.

The declining trend in hepatitis B notifications in Aboriginal and Torres Strait Islander peoples younger than 40 years suggests that immunisation programs for hepatitis B have had a clear benefit and have reduced the gap in hepatitis B notification rates between Aboriginal and Torres Strait Islander peoples and non-Indigenous people. However, hepatitis B notification rates in Aboriginal and Torres Strait Islander peoples in older age groups remained high compared to non-Indigenous people, highlighting the need for a continued focus on hepatitis B testing, immunisation, and engagement in care among Aboriginal and Torres Strait Islander peoples.

Wider determinants of health, such as access to health care, education, unemployment, poverty, discrimination and racism, can also influence risk factors for blood borne viruses and sexually transmissible infections [(2)]. These social determinants must be acknowledged in the development of strategies to address the concerning trends in blood borne viruses and sexually transmissible infection transmission rates and the associated burden of disease. A significant proportion of HIV diagnosis resulted from the screening process, highlighting the effectiveness of HIV testing program. This success also contributes to the lower estimates of undiagnosed cases (6%) within the Aboriginal and Torres Strait Islander population.

2 Overview

Aboriginal and Torres Strait Islander status completeness

Incomplete information on Aboriginal and Torres Strait Islander identification has the potential to misrepresent the true extent of blood borne viruses and sexually transmissible infections in Aboriginal and Torres Strait Islander peoples. The National Notifiable Diseases Surveillance System uses 'Indigenous status' to indicate Aboriginal and Torres Strait Islander identity. For the purposes of reporting, when discussing data sourced from the National Notifiable Diseases Surveillance System, 'Aboriginal and Torres Strait Islander status' will be used in place of 'Indigenous status'.

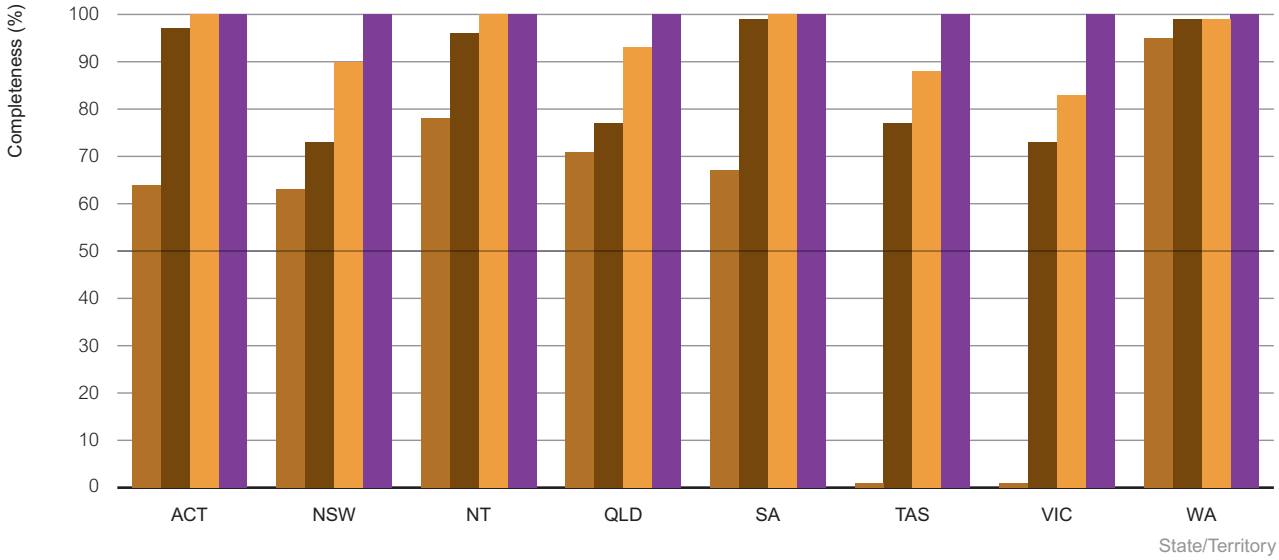
In 2023, all jurisdictions reported Aboriginal and Torres Strait Islander status for at least 50% of HIV, infectious syphilis and newly acquired hepatitis B notifications (infections acquired within the last two years). However, Aboriginal and Torres Strait Islander status was reported for less than 50% of notifications in the following jurisdictions for the following infections (Figure 1, Figure 2):

- Chlamydia: Tasmania and Victoria
- Gonorrhoea: Victoria
- Hepatitis C: the Australian Capital Territory, New South Wales and Victoria.
- Hepatitis B: New South Wales and Victoria

Due to the potential misrepresentation and misinterpretation of Hepatitis B (newly acquired) and Hepatitis C (newly acquired) notifications data due to low numbers, separate analyses of these infections are not included in this report. Time trends of notification rates for specific infections by jurisdiction were included in this report if information on Aboriginal and Torres Strait Islander status was available for at least 50% of notifications of the infection in each of the five years, 2019-2023. Jurisdictions which met the 50% threshold in 2023 (Figure 1 and Figure 2) but not in other years were not included in this report, unless otherwise mentioned. Caution should be taken interpreting the data, as even at least 50% Aboriginal and Torres Strait Islander status reporting is a low threshold.

Multiple enhanced surveillance and health force education activities are being undertaken at the jurisdictional and national level to improve completeness of Aboriginal and Torres Strait Islander status. This includes consideration of the addition of Aboriginal and Torres Strait Islander status to pathology forms, continuing education of health care providers, and enhanced data review processes to improve the completion rate. Continued focus on this area is essential to improve completion of data relating to Aboriginal and Torres Strait Islander peoples as stated in national strategies [3].

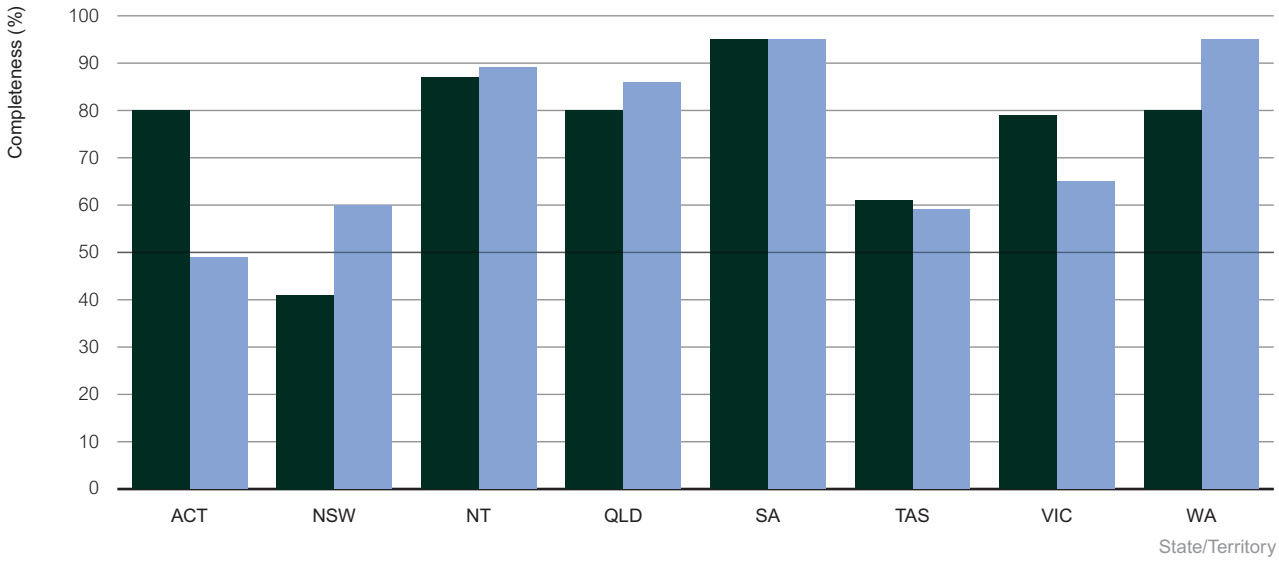
Figure 1 Reporting of Aboriginal and Torres Strait Islander status at notification of chlamydia, gonorrhoea, infectious syphilis and HIV by State/Territory, 2023



	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Chlamydia (%)	64	63	78	71	67	1	1	95
Gonorrhoea (%)	97	73	96	77	99	77	73	99
Infectious syphilis (%)	100	90	100	93	100	88	83	99
HIV (%)	100	100	100	100	100	100	100	100

Source: National Notifiable Diseases Surveillance System; see Methodology for details.

Figure 2 Reporting of Aboriginal and Torres Strait Islander status at notification of viral hepatitis by state/territory, 2023



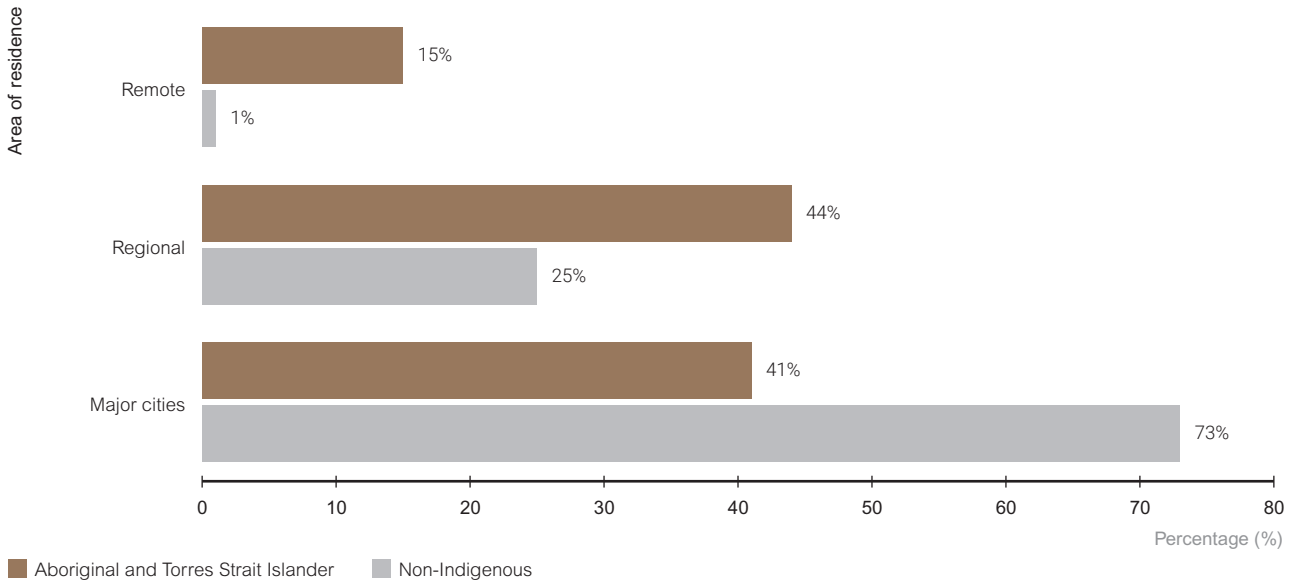
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Hepatitis B (%)	80	41	87	80	95	61	79	80
Hepatitis C (%)	49	60	89	86	95	59	65	95

Source: National Notifiable Diseases Surveillance System; see Methodology for details.

Area of residence

Based on ABS population projections, it is estimated that in 2023, 15% of Aboriginal and Torres Strait Islander peoples lived in remote areas, 44% in regional areas and 41% in major cities, compared with 1%, 25%, and 73% of non-Indigenous people, respectively (Figure 3). See Methodology for further information.

Figure 3 Area of residence by Aboriginal and Torres Strait Islander status, 2023



Source: Australian Bureau of Statistics, March, 2024 see Methodology for details.

Aboriginal and Torres Strait Islander peoples in Australia

Aboriginal and Torres Strait Islander peoples make up 3.8% of the Australian population, with the greatest proportions living in New South Wales (35%) and Queensland (28%) (Table 1).

Table 1 Number and proportion of Aboriginal and Torres Strait Islander peoples living in each state and territory, 2023

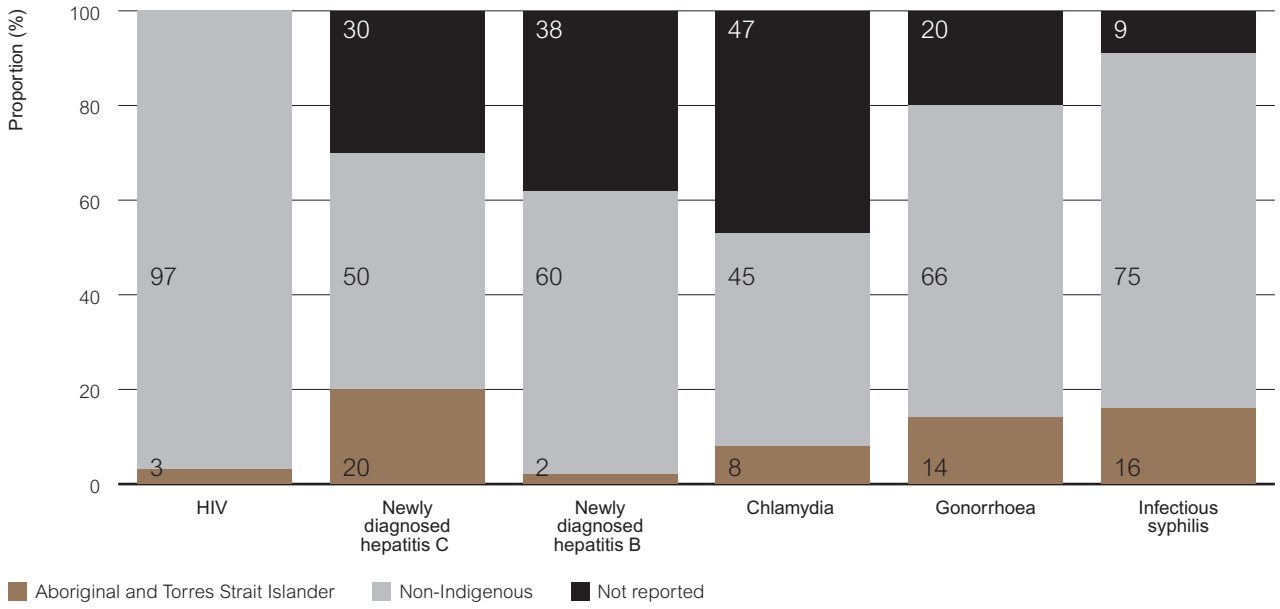
State/Territory	Estimated resident Aboriginal and Torres Strait Islander population	Proportion of total Australian Aboriginal and Torres Strait Islander population
Australian Capital Territory	9 525	1%
New South Wales	339 710	35%
Northern Territory	76 487	8%
Queensland	273 119	28%
South Australia	52 069	5%
Tasmania	33 857	3%
Victoria	78 696	8%
Western Australia	120 006	12%
Total	**983 709**	**100%**

Source: Estimates of Aboriginal and Torres Strait Islander Australians, March, 2024 , Australian Bureau of Statistics.

Number of notifications and notification rates in Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples make up 3.8% of the Australian population but accounted for a disproportionate level (2% to 19%) of most notifications of STIs and BBVs in 2023, with the exception of HIV (Figure 4). For many infections, this proportion may not be truly representative due to the incomplete reporting of Aboriginal and Torres Strait Islander status.

Figure 4 Proportion of all notifications by Aboriginal and Torres Strait Islander status, 2023



Source: National Notifiable Diseases Surveillance System; see Methodology for details.

To allow a more appropriate comparison between Aboriginal and Torres Strait Islander peoples and non-Indigenous people, age-standardised notification rates per 100 000 population were calculated, by taking into consideration the differences in the distribution of age within these populations. In 2023, age standardised notification rates of STIs and blood borne viruses in Aboriginal and Torres Strait Islander peoples were more than non-Indigenous people. (Table 2).

Table 2 Number and notification rate of sexually transmissible infections and blood borne viruses in Australia by Aboriginal and Torres Strait Islander status, 2023

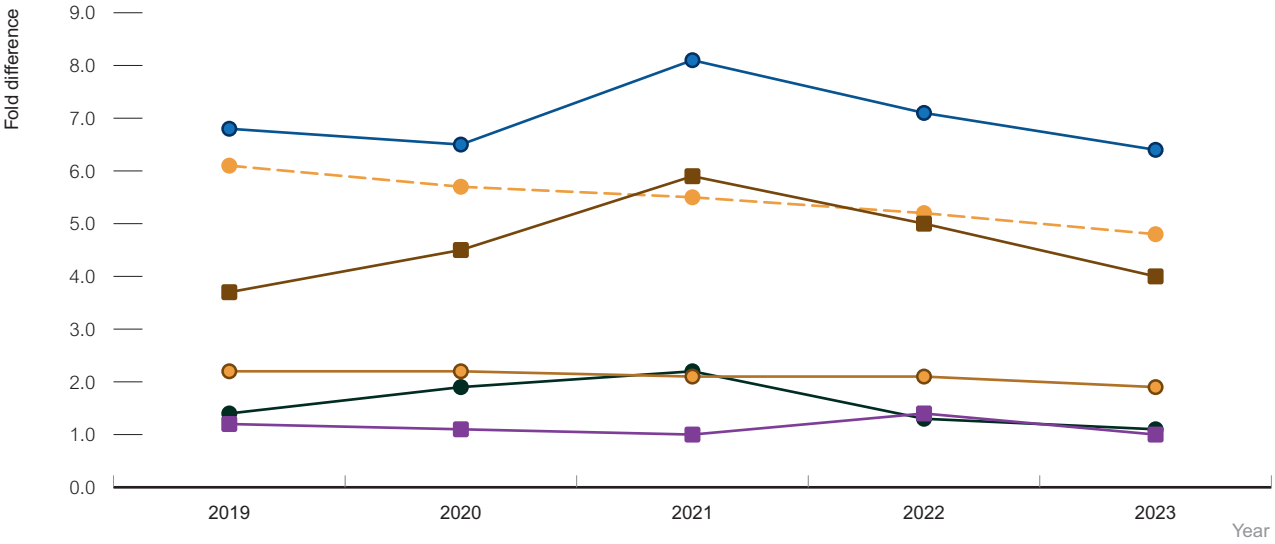
	Aboriginal and Torres Strait Islander		Non-Indigenous		Fold difference	Excluded jurisdictions[d]
Notifications of sexually transmissible infections and viral hepatitis	Number[a]	Rate[b]	Number[c]	Rate[b]		
Chlamydia	8 557	820.0	49 414	411.8	2.0	Tasmania, Victoria
Gonorrhoea	5 631	541.0	26 283	134.9	4.0	Victoria
Infectious syphilis	1 022	101.6	4 766	21.1	4.8	None
HIV	24	2.9	722	2.7	1.1	None
Newly diagnosed hepatitis B (ALL)	135	20.5	3 213	17.2	1.2	Victoria, New South Wales
Newly diagnosed hepatitis C (ALL)	1 499	165.5	3 793	25.7	6.4	Australian Capital Territory, Victoria, New South Wales

a Jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications in each of the past five years.
b Age-standardised rate per 100 000 population.
c All jurisdictions
d Jurisdictions in which Aboriginal and Torres Strait Islander status was reported for less than 50% of notifications.

Source: National Notifiable Diseases Surveillance System; National HIV Registry; see Methodology for details.

Between 2019 and 2023 the difference between the age-standardised notification rates of Aboriginal and Torres Strait Islander peoples and non-Indigenous people, expressed as a ratio, declined gradually for infectious syphilis, hepatitis B and chlamydia, remained stable for HIV and increases after slightly declining for gonorrhoea and hepatitis C (Figure 5).

Figure 5 Notification rates ratio by Aboriginal and Torres Strait Islander status and disease, 2019–2023



	2019	2020	2021	2022	2023
Chlamydia	2.2	2.2	2.1	2.1	1.9
Gonorrhoea	3.7	4.5	5.9	5.0	4.0
Infectious syphilis	6.1	5.7	5.5	5.2	4.8
HIV	1.2	1.1	1.0	1.4	1.0
Hepatitis B	1.4	1.9	2.2	1.3	1.1
Hepatitis C	6.8	6.5	8.1	7.1	6.4

Source: National Notifiable Diseases Surveillance System; see Methodology for details.

3 Sexually transmissible infections

Please see p. 7 for summary.

Syphilis

Infectious syphilis

Syphilis is a sexually transmissible infection caused by the bacterium *Treponema pallidum*. An expanded infectious syphilis national case definition was implemented in July 2015 in all jurisdictions except for New South Wales, where it was implemented in July 2016. The expanded case definition includes a subcategory of 'probable' infectious syphilis to capture infectious syphilis cases in people without a prior testing history, particularly young people aged 15–19 years. The probable infectious syphilis cases are included in the number of infectious syphilis notifications for the years 2015–2023.

At least 80% of all infectious syphilis notifications in all jurisdictions had Aboriginal and Torres Strait Islander status complete for every year from 2014 to 2023. For this reason, infectious syphilis data are presented for the 10-year period 2014 to 2023.

There were 6390 infectious syphilis notifications in Australia in 2023. Of these, 1022 (16%) notifications were among Aboriginal and Torres Strait Islander peoples, 4766 (75%) were among non-Indigenous people, and 602 (9%) were among people for whom Aboriginal and Torres Strait Islander status was not reported [(1)] (Table 3). Between 2014 and 2023, over half (53) of the 94 congenital syphilis notifications were among Aboriginal and Torres Strait Islander infants, with 12 notifications in 2023 (Table 3).

The male to female ratio of infectious syphilis notifications in Aboriginal and Torres Strait Islander peoples in 2023 was almost 1:1 compared with 4:1 in non-Indigenous people (data not shown). This may indicate greater transmission occurring through heterosexual contact among Aboriginal and Torres Strait Islander peoples than among non-Indigenous people compared with greater transmission occurring through male-to-male sex among non-Indigenous people

Table 3 Infectious syphilis notifications in Aboriginal and Torres Strait peoples, by characteristic, 2014–2023

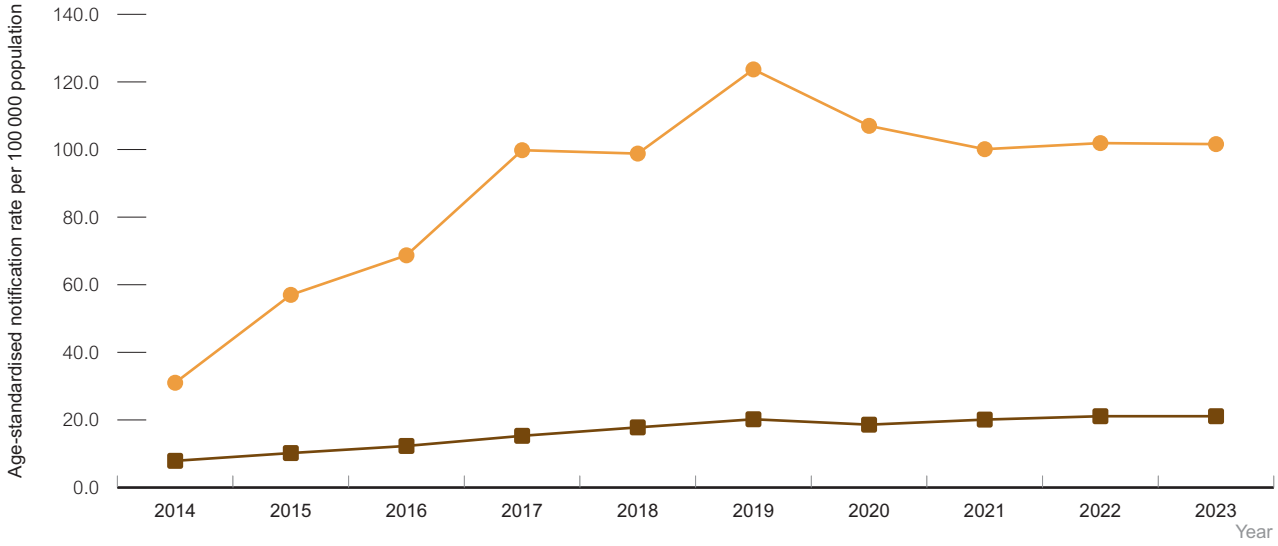
Characteristic	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total cases	254	466	552	804	814	1051	919	990	1003	1022
Gender[a]										
Male	141	267	305	410	422	528	462	481	513	478
Female	113	199	247	394	392	523	457	509	490	544
Median age in years	29	28	22	23	23	23	26	27	27	26
Age group										
0-14	11	16	17	23	7	30	17	12	8	11
15-19	86	142	140	173	170	271	239	240	200	203
20-24	49	108	92	158	175	170	149	207	201	205
25-29	36	68	102	129	138	175	132	161	182	176
30-39	39	77	118	178	182	224	215	211	250	257
≥40	33	55	83	143	142	181	167	159	162	170
State/Territory										
Australian Capital Territory	3	<5	0	<5	<5	<5	<5	<5	<5	<5
New South Wales	32	25	30	49	50	86	98	106	137	138
Northern Territory	59	184	206	270	289	307	241	203	204	191
Queensland	136	177	221	355	292	326	225	221	250	270
South Australia	<5	17	12	28	38	34	34	27	22	42
Tasmania	0	0	0	0	0	0	0	<5	0	6
Victoria	8	16	31	31	40	49	23	49	44	63
Western Australia	13	46	52	70	102	245	293	383	346	310
Congenital syphilis	2	2	1	5	4	1	8	9	9	12

a Excludes 'Not reported'; The National Notifiable Diseases Surveillance System includes the variable 'Sex' to indicate Sex/Gender. For reporting purposes, 'Gender' is used in place of 'Sex'.

Source: National Notifiable Diseases Surveillance System.

In 2023, the age-standardised infectious syphilis notification rate in Aboriginal and Torres Strait Islander peoples was a little less than five times as high as among non-Indigenous people (101.6 vs. 21 per 100 000). Among Aboriginal and Torres Strait Islander peoples, the infectious syphilis notification rate increased more than four-fold between 2014 and 2019 from 31.0 to 123.7 per 100 000. Between 2019 and 2023, the age standardised infectious syphilis notification rate declined from 123.7 to 101.6 per 100 000(Figure 6). A similar trend over time was seen among Aboriginal and Torres Strait Islander males and females (Figure 7). Infectious syphilis notification rates among both Aboriginal and Torres Strait Islander males and females were three times and over 17 times as high as their non-Indigenous gender equivalent, respectively (Figure 7).

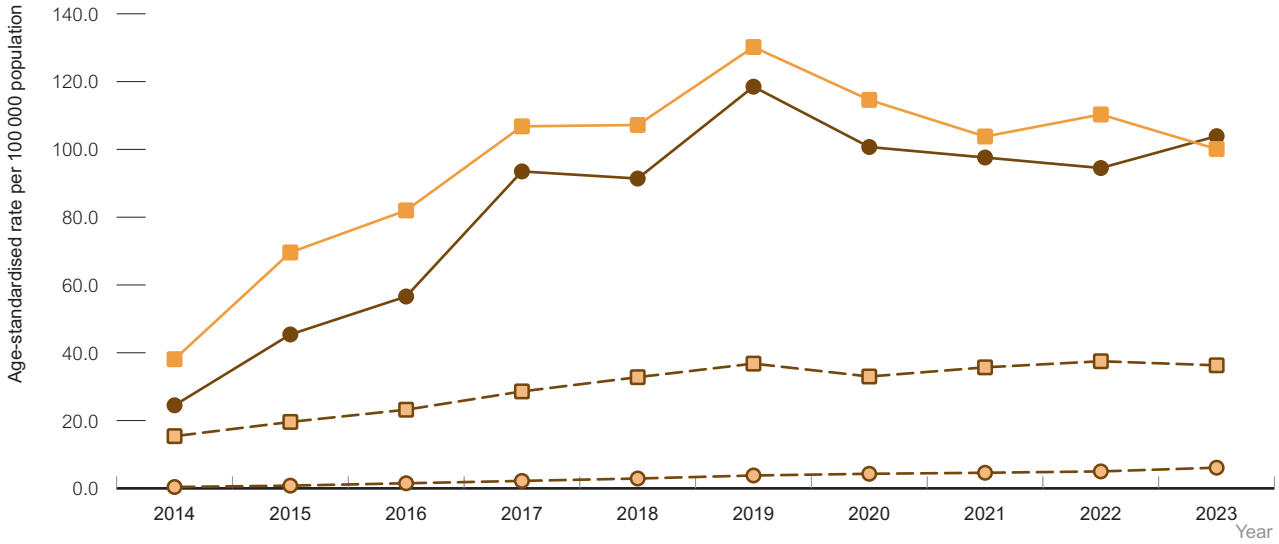
Figure 6 Age standardised Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2014-2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples	31.0	57.0	68.7	99.8	98.8	123.7	107.0	100.1	101.9	101.6
Non-Indigenous people	7.9	10.2	12.3	15.3	17.8	20.2	18.6	20.1	21.1	21.1

Source: Australian National Notifiable Diseases Surveillance System.

Figure 7 Age standardised Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and gender, 2014–2023

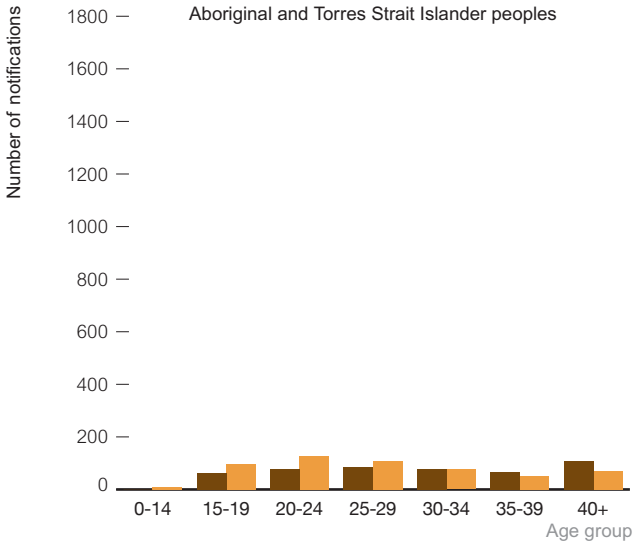


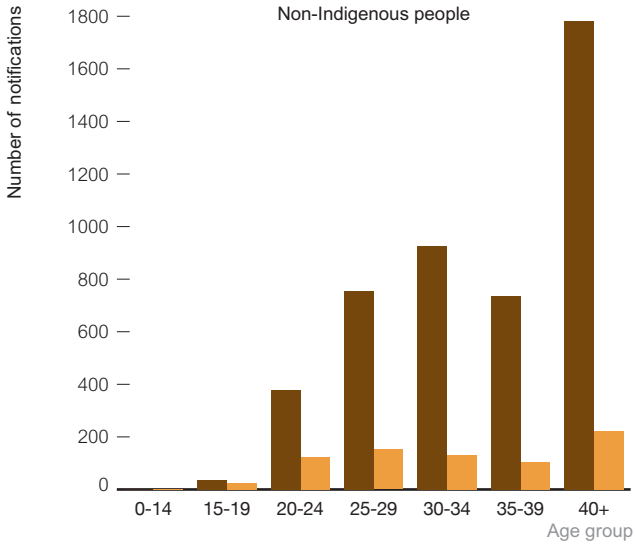
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander female	24.5	45.4	56.6	93.5	91.4	118.5	100.7	97.6	94.5	103.9
Aboriginal and Torres Strait Islander male	38.1	69.6	82.0	106.8	107.2	130.2	114.6	103.8	110.3	100.1
Non-Indigenous female	0.4	0.8	1.5	2.2	2.9	3.8	4.3	4.6	5.0	6.1
Non-Indigenous male	15.4	19.6	23.2	28.6	32.8	36.8	33.0	35.7	37.5	36.3

Source: Australian National Notifiable Diseases Surveillance System.

Differences in age at diagnosis exist between Aboriginal and Torres Strait Islander peoples and non-Indigenous people. In 2023, the greatest proportion of infectious syphilis notifications in Aboriginal and Torres Strait Islander peoples occurred among those aged 20 to 24 years (20%). By comparison the highest proportion of notifications in non-Indigenous people in 2023 occurred among those aged over 40 years (37%) with a much higher proportion of notifications occurring among males than among females (Figure 8).

Figure 8 Number of infectious syphilis notifications by Aboriginal and Torres Strait Islander status, gender, and age group, 2023





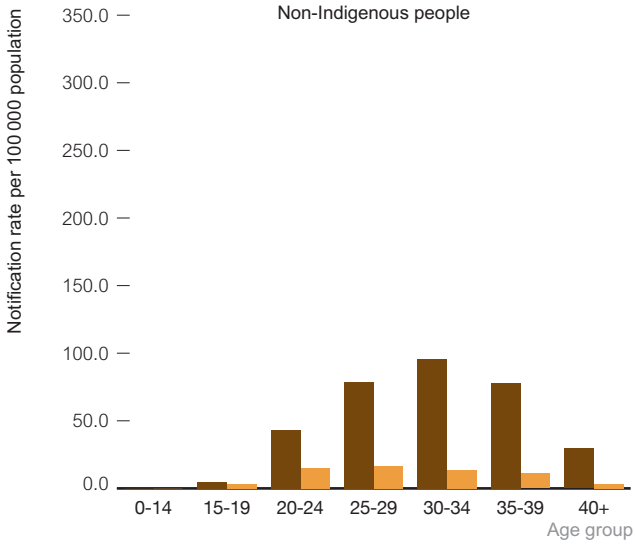
	0-14	15-19	20-24	25-29	30-34	35-39	40+
Male	0	64	77	84	78	66	109
Female	11	98	126	110	76	51	72

	0-14	15-19	20-24	25-29	30-34	35-39	40+
Male	0	37	377	755	925	735	1782
Female	1	24	122	152	131	106	221

Source: Australian National Notifiable Diseases Surveillance System.

In 2023, the infectious syphilis notification rate in males was highest in those aged 30 to 39 years for both Aboriginal and Torres Strait Islander and non-Indigenous males (436.3 per 100 000 and 173.6 per 100 000 respectively). Similarly for non-Indigenous females the notification rate was highest for those aged 30 to 39 years old (24.4 per 100 000). However, for Aboriginal and Torres Strait Islander females, the infectious syphilis notification rate was highest for those aged 20 to 24 years (289.8 per 100 000) (Figure 9).

Figure 9 Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and age group, 2023



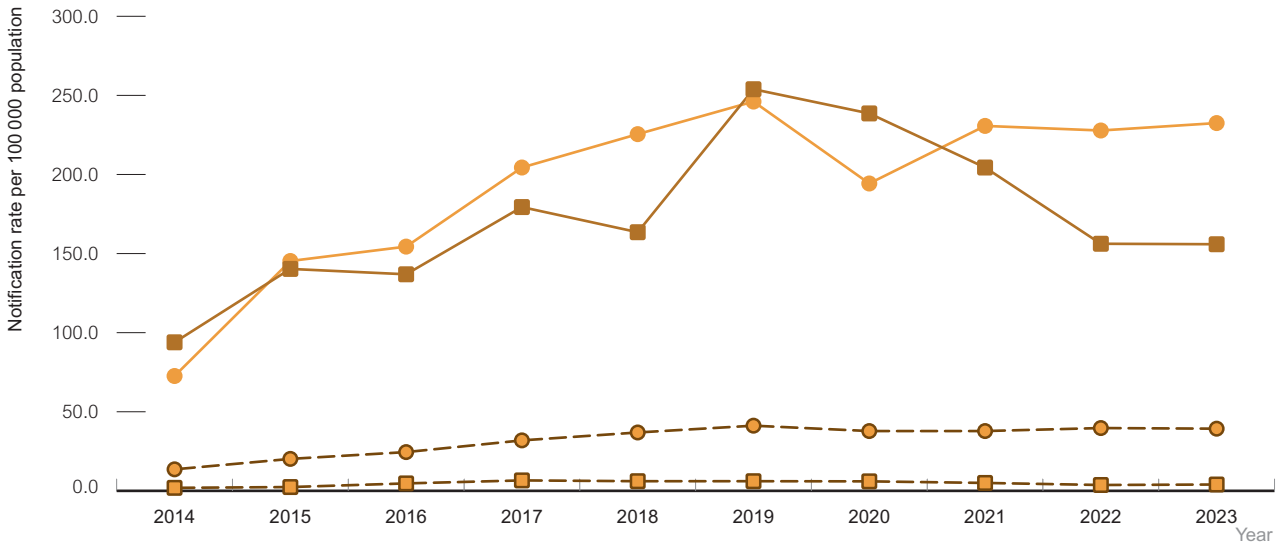
	0-14	15-19	20-24	25-29	30-34	35-39	40+
Males	0.0	120.5	168.4	202.1	214.0	222.3	79.8
Females	6.9	192.8	289.8	275.3	211.7	170.1	48.3

	0-14	15-19	20-24	25-29	30-34	35-39	40+
Males	0.0	4.7	43.2	78.8	95.8	77.8	29.5
Females	0.0	3.2	15.1	16.3	13.4	11.0	3.4

Source: Australian National Notifiable Diseases Surveillance System.

Between 2014 and 2023, infectious syphilis notification rates increased sharply in Aboriginal and Torres Strait Islander peoples aged 15 to 19 years and 20 to 29 years from 93.9 to 155.9 per 100 000 and from 72.6 to 232.5 per 100 000, respectively (Figure 10). Infectious syphilis notification rates declined between 2019 and 2022 and in 2023 were 155.9 per 100 000 among those aged 15 to 19 years. The rates were 232.5 per 100 000 among those aged 20 to 29 years. In all years and among both age groups, the infectious syphilis notification rate was higher in Aboriginal and Torres Strait Islander peoples than in non-Indigenous people.

Figure 10 Infectious syphilis notification rate per 100 000 population in Aboriginal and Torres Strait Islander peoples by age group, 2014–2023



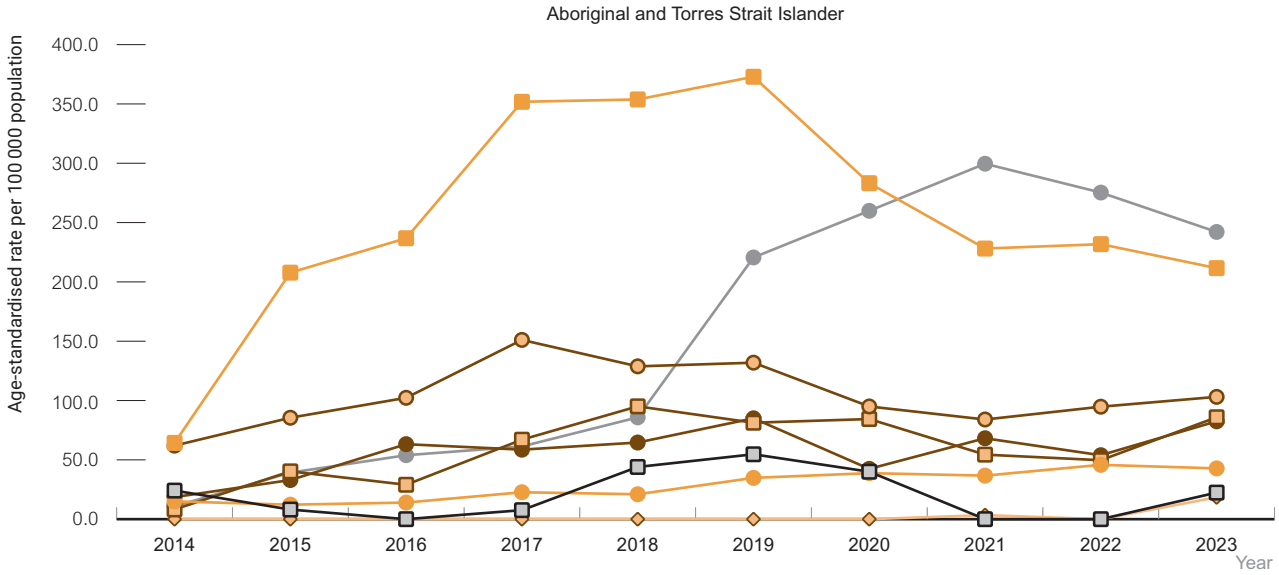
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander aged 15-19 years	93.9	140.3	136.9	179.4	163.5	253.9	238.6	204.4	156.2	155.9
Aboriginal and Torres Strait Islander aged 20-29 years	72.6	145.3	154.4	204.4	225.5	246.1	194.3	230.7	227.8	232.5
Non-Indigenous aged 15-19 years	1.9	2.4	4.7	6.6	6.1	6.1	6.0	5.0	3.7	4.0
Non-Indigenous aged 20-29 years	13.6	20.2	24.5	31.9	36.9	41.2	37.8	37.8	39.7	39.3

Source: Australian National Notifiable Diseases Surveillance System.

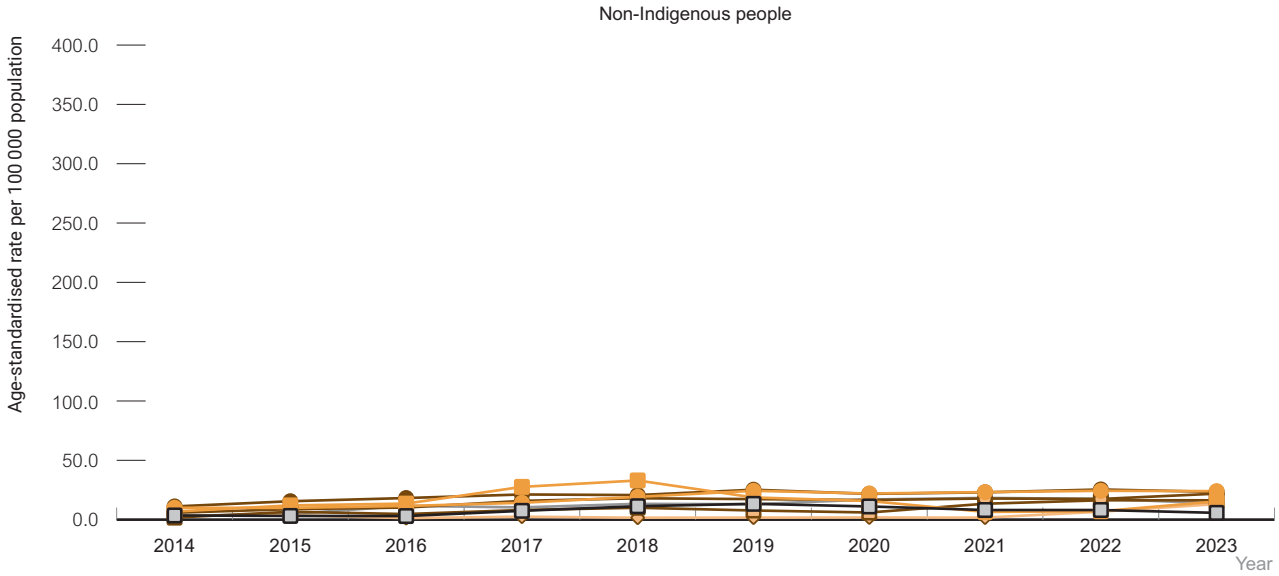
In 2023, infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples were highest in Western Australia (242.1 per 100 000), followed by the Northern Territory (211.6 per 100 000), and Queensland (103.1 per 100 000).

Between 2014 and 2021, infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples increased considerably in every state and territory apart from the Australian Capital Territory and Tasmania. In 2023, notification rates were at least twice as high among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous peoples in every state and territory apart from the Australian Capital Territory, Tasmania, and New South Wales. The Northern Territory had highest notification rates during 2014-2020 but Western Australia had highest rates from 2021-2023 (Figure 11).

Figure 11 Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status by jurisdiction, 2014–2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
ACT	24.1	8.1	0.0	7.6	44.0	54.7	40.0	0.0	0.0	22.4
NSW	15.0	12.2	14.0	22.7	21.0	34.8	38.8	36.7	45.8	42.8
NT	64.3	207.8	236.8	351.8	353.8	372.9	283.2	228.1	231.8	211.6
QLD	62.0	85.5	102.3	151.1	128.8	131.9	95.0	84.0	94.8	103.1
SA	8.2	40.3	29.0	67.0	95.1	81.3	84.4	54.4	49.7	85.9
TAS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	18.4
VIC	18.6	33.0	63.2	58.6	64.6	85.0	42.4	68.2	53.9	82.5
WA	10.8	39.2	53.9	61.3	85.8	220.6	259.9	299.6	275.3	242.1

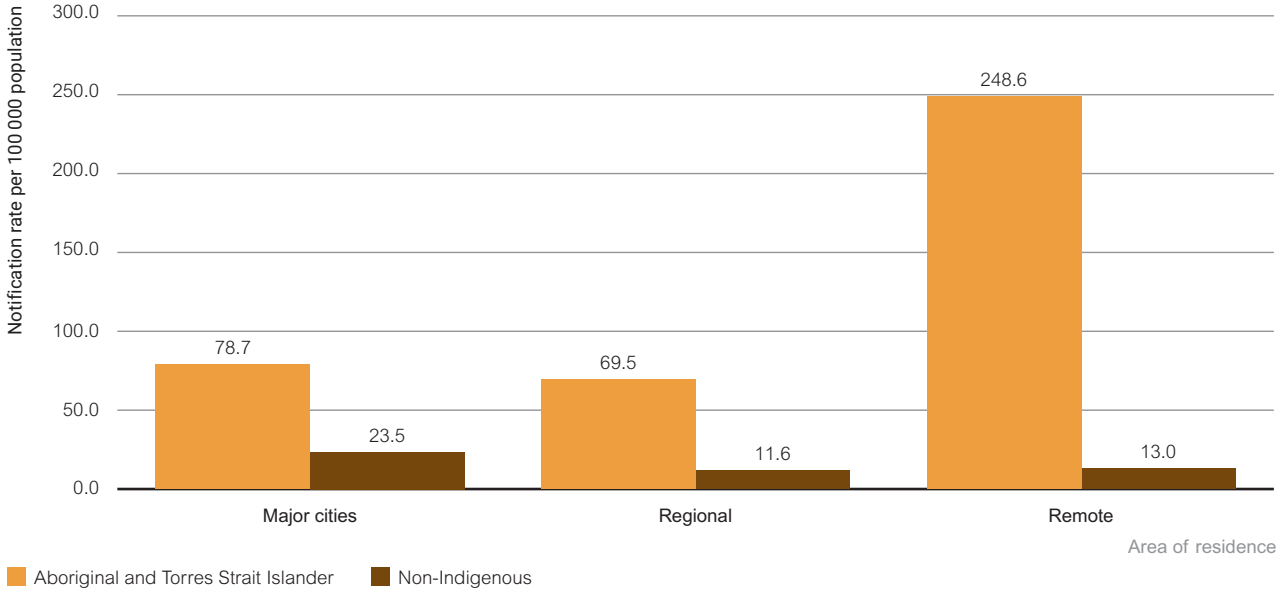


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
ACT	3.5	3.1	3.0	7.4	11.3	13.3	11.1	8.1	8.1	5.7
NSW	10.0	9.9	11.5	14.2	19.2	24.3	22.0	23.2	24.3	24.0
NT	6.8	12.0	13.5	27.6	33.0	18.7	15.7	6.5	7.1	15.3
QLD	5.8	8.8	10.2	15.8	18.0	17.3	16.5	17.8	17.4	21.9
SA	1.7	6.6	4.7	8.1	10.0	7.7	6.0	13.4	16.3	16.3
TAS	3.3	3.7	1.3	2.5	1.6	1.7	1.8	1.7	6.7	13.1
VIC	11.1	15.5	18.2	21.2	20.7	25.2	21.7	23.0	25.4	23.4
WA	3.2	4.7	11.6	10.3	13.3	13.0	17.0	18.3	17.5	13.7

Source: Australian National Notifiable Diseases Surveillance System.

In 2023, the infectious syphilis notification rate among Aboriginal and Torres Strait Islander peoples in major cities was nearly three times as high as among non-Indigenous people (78.7 vs. 23.5 per 100 000), increasing to six times in regional areas (69.5 vs. 11.6 per 100 000), and 19 times in remote areas (248.6 vs. 13 per 100 000) (Figure 12).

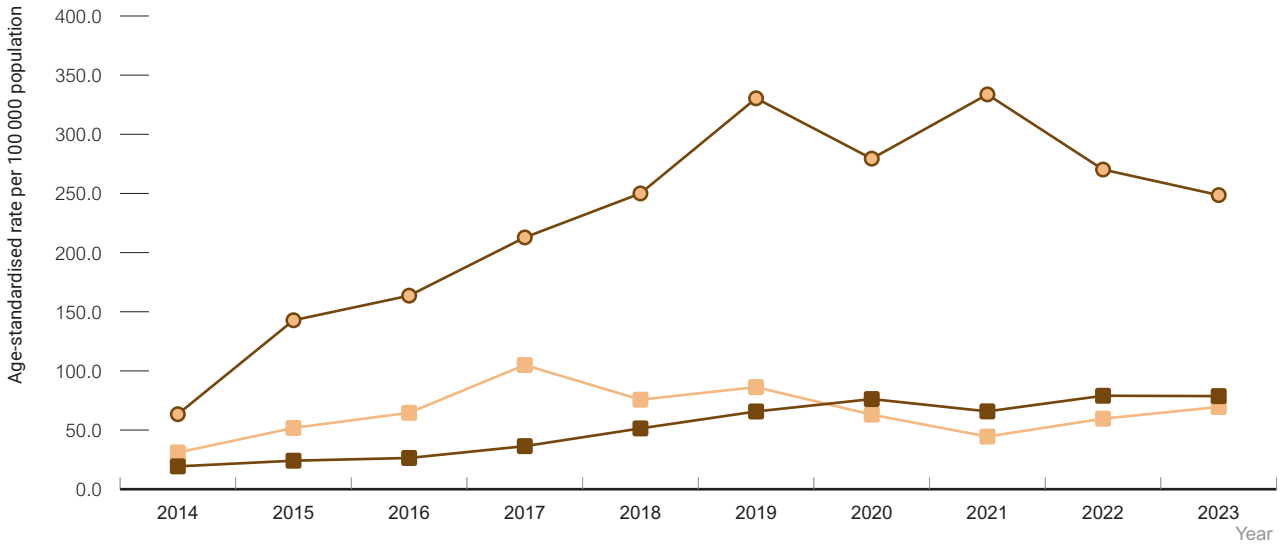
Figure 12 Infectious syphilis notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and area of residence, 2023



Source: Australian National Notifiable Diseases Surveillance System.

Between 2014 and 2023, age standardised infectious syphilis notification rates among Aboriginal and Torres Strait Islander peoples living in major cities and remote areas increased by 307% and 292%, respectively. In regional areas rates increased by nearly 238% between 2014 and 2017, then decreased by 33.8% to 2023 (Figure 13).

Figure 13 Infectious syphilis notification rate per 100 000 population by area of residence, 2014–2023



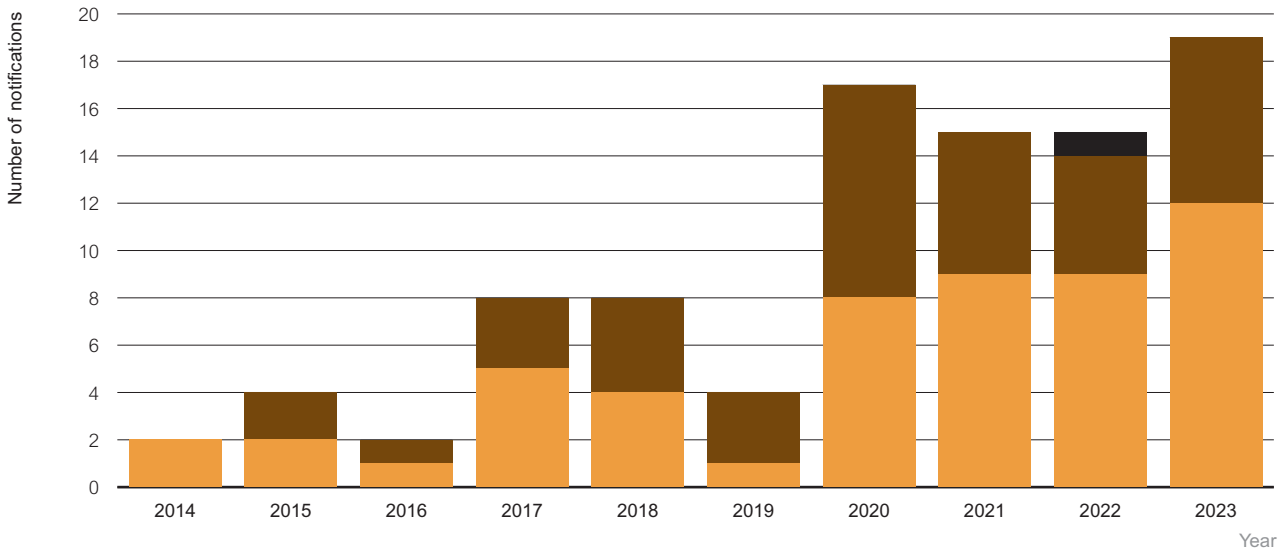
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Major cities	19.3	24.1	26.4	36.4	51.4	65.7	76.2	65.8	79.0	78.7
Regional	31.0	51.8	64.6	105.0	75.7	86.3	63.0	44.5	59.6	69.5
Remote	63.4	142.8	163.6	212.8	250.0	330.4	279.4	333.7	270.2	248.6

Source: Australian National Notifiable Diseases Surveillance System.

Congenital syphilis

Congenital syphilis occurs when syphilis is passed from pregnant person to child during foetal development or at birth. Between 2014 and 2023, almost half (54) of the 95 congenital syphilis notifications were among Aboriginal and Torres Strait Islander infants, with 13 notifications in 2023 (Figure 14), the highest in the 10-year reporting period. The congenital syphilis notification rate among Aboriginal and Torres Strait Islander infants was 27 times high as among non-Indigenous infants (53.3 per 100 000 live births in 2023 in comparison with 2.5 per 100 000 in non-Indigenous) (Figure 15).

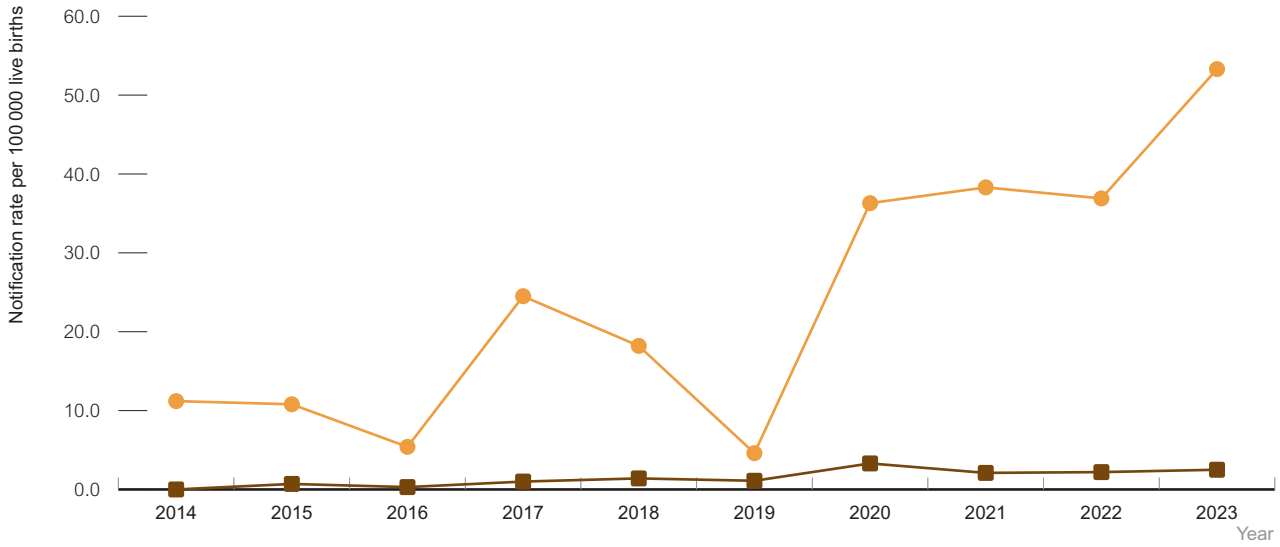
Figure 14 Number of congenital syphilis cases by Aboriginal and Torres Strait Islander status, 2014–2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Not reported	0	0	0	0	0	0	0	0	1	0
Non-Indigenous	0	2	1	3	4	3	9	6	5	7
Aboriginal and Torres Strait Islander	2	2	1	5	4	1	8	9	9	12

Source: Australian National Notifiable Diseases Surveillance System.

Figure 15 Congenital syphilis rate per 100 000 live births by Aboriginal and Torres Strait Islander status, 2014–2023



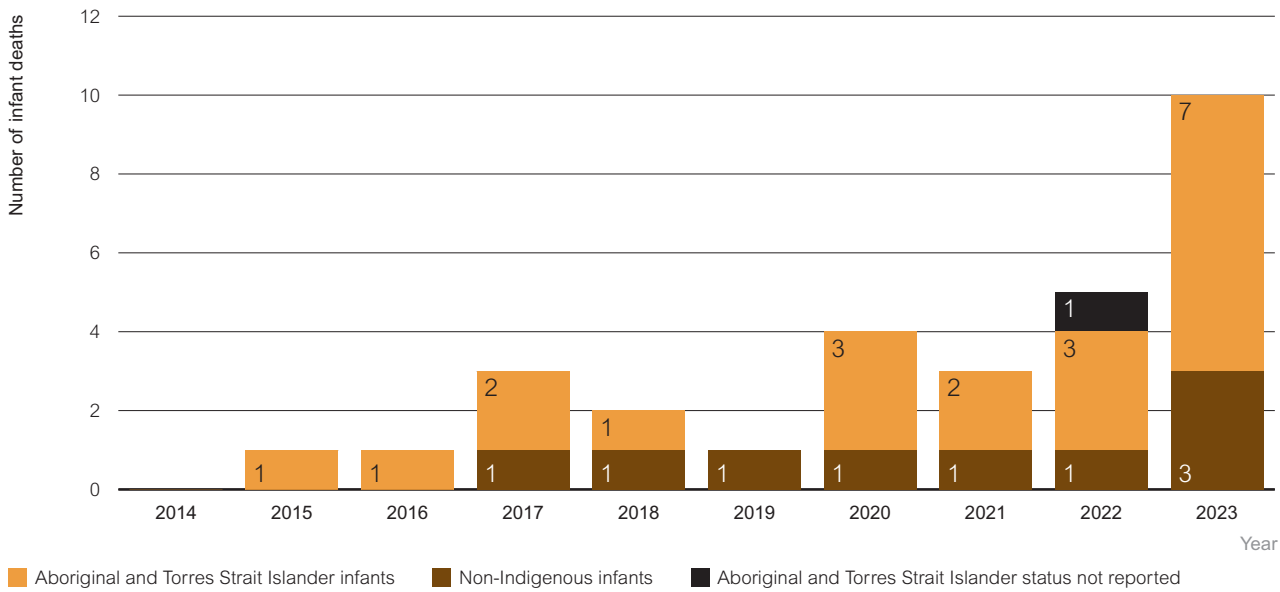
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander births	11.2	10.8	5.4	24.5	18.2	4.6	36.3	38.3	36.9	53.3
Non-Indigenous births	0	0.7	0.3	1	1.4	1.1	3.3	2.1	2.2	2.5

Includes notifications where Aboriginal and Torres Strait Islander status was not reported.

Source: Australian National Notifiable Diseases Surveillance System.

Of the 95 congenital cases notified between 2015 and 2023, 30 cases resulted in the death of the infant (including stillbirth). Of these, 20 were Aboriginal and Torres Strait Islander infants, nine were non-Indigenous infants and one was an infant without a reported Aboriginal and Torres Strait Islander status (Figure 16).

Figure 16 Number of deaths attributed to congenital syphilis by Aboriginal and Torres Strait Islander status, 2014–2023



Source: Australian National Notifiable Diseases Surveillance System.

Chlamydia

Chlamydia is a sexually transmissible infection caused by a specific strain of bacteria known as *Chlamydia trachomatis*. Chlamydia was the most frequently notified sexually transmissible infection in Australia in 2023, with a total of 109 451 notifications, of which 8557 (8%) were among Aboriginal and Torres Strait Islander peoples, 49 414 (45%) were among non-Indigenous people, and 51 480 (47%) were for people for whom Aboriginal and Torres Strait Islander status was not reported [(1)]. Details of Aboriginal and Torres Strait Islander chlamydia notifications for the 2019-2023 reporting period are provided in Table 4.

Table 4 Chlamydia notifications in Aboriginal and Torres Strait peoples, by characteristic, 2019–2023

Characteristic	2019	2020	2021	2022	2023
Total cases	8548	7854	7637	7810	8557
Gender[a]					
Male	2954	2740	2700	2829	3115
Female	5595	5113	4936	4977	5418
Median age in years	22	24	23	24	24
Age groups					
0-14	267	207	177	159	187
15-19	3282	2987	2965	3018	3088
20-24	2336	2144	2130	2071	2369
25-29	1302	1195	1155	1162	1298
30-39	978	944	909	1026	1187
≥40	383	377	301	374	428
State/Territory[b]					
Australian Capital Territory	67	61	48	48	56
New South Wales	1532	1348	1429	1509	1775
Northern Territory	1858	1697	1544	1588	1840
Queensland	3068	2865	2720	2615	2487
South Australia	384	395	425	378	455
Western Australia	1585	1484	1467	1657	1942
Tasmania	<5	<5	<5	12	0
Victoria	53	<5	<5	<5	<5

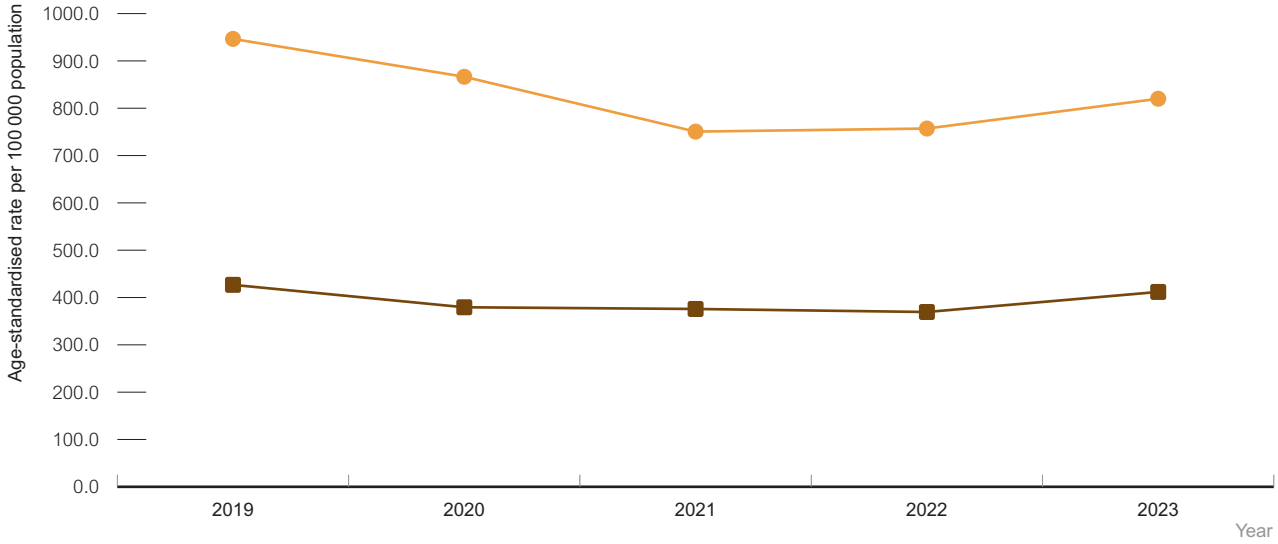
a Excludes 'Not reported'; The National Notifiable Diseases Surveillance System includes the variable 'Sex' to indicate Sex/Gender. For reporting purposes, 'Gender' is used in place of 'Sex'.
b Numbers of notifications in some jurisdictions may be strongly influenced by completeness of Aboriginal and Torres Strait Islander status.

Source: National Notifiable Diseases Surveillance System.

Notification rates are based on data from six jurisdictions (the Australian Capital Territory, the Northern Territory, South Australia, Queensland, Western Australia, New South Wales), where Aboriginal and Torres Strait Islander status was at least 50% complete for chlamydia notifications for each of the five years (2019–2023).

The chlamydia age standardised notification rate for Aboriginal and Torres Strait Islander peoples in 2023 of 820.0 per 100 000 population was twice that of non-Indigenous peoples at 411.8 per 100 000 population (Figure 17).

Figure 17 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2019–2023



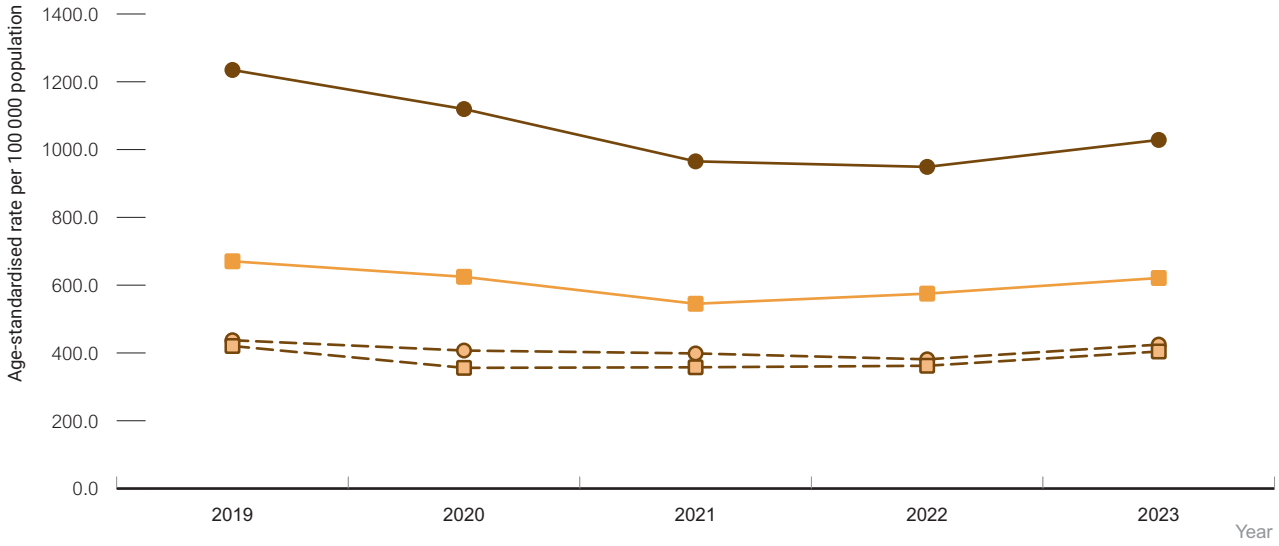
	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples	946.5	866.5	750.6	757.1	820.0
Non-Indigenous people	426.8	379.4	375.8	369.4	411.8

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

Between 2019 and 2023, chlamydia notification rates among Aboriginal and Torres Strait Islander males and females decreased by 7% (670.4 to 621.1 per 100 000) and 17% (1234.8 to 1028.4 per 100 000) respectively.

In 2023, the age standardised chlamydia notification rate was nearly two and a half times as high in Aboriginal and Torres Strait Islander females as in non-Indigenous females (1028.4 per 100 000 vs 424.7 per 100 000) and more than one and a half times as high in Aboriginal and Torres Strait Islander males as in non-Indigenous males (621.1 per 100 000 vs 404.3 per 100 000) (Figure 18).

Figure 18 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and sex, 2019–2023

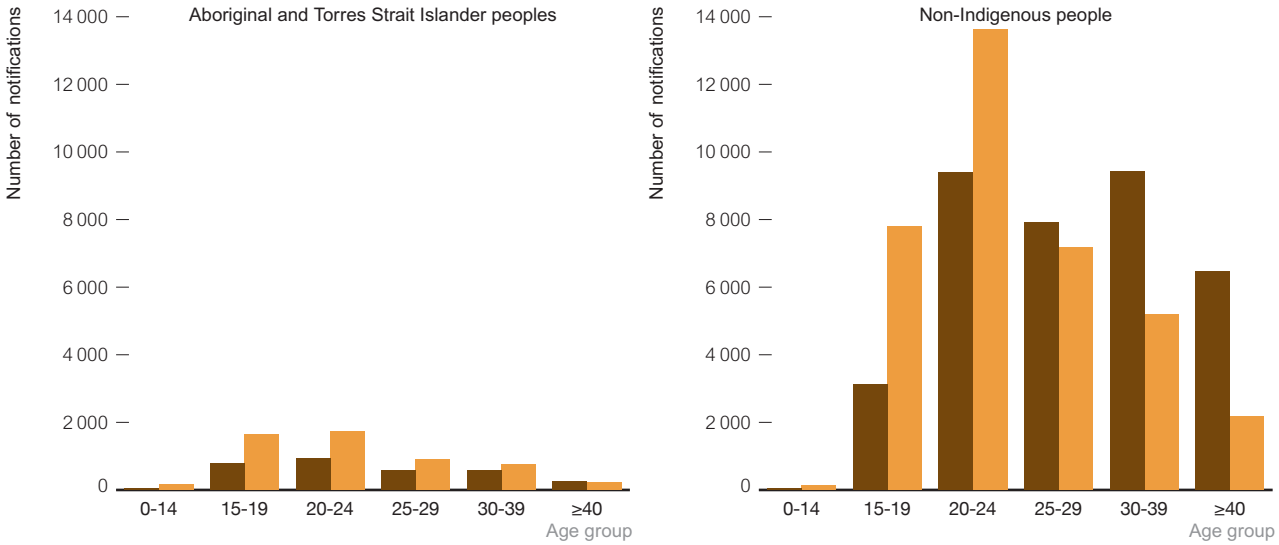


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander females	1234.8	1119.5	965.2	948.9	1028.4
Aboriginal and Torres Strait Islander males	670.4	624.6	545.1	575.0	621.1
Non-Indigenous females	437.5	407.1	398.6	381.2	424.7
Non-Indigenous males	420.5	356.0	357.7	362.2	404.3

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

Chlamydia is notified predominantly among young people. In 2023, 77% of chlamydia notifications among Aboriginal and Torres Strait Islander peoples were aged 15–29 years, with 68% in this age group among non-Indigenous people. In 2023, of the chlamydia notifications in Aboriginal and Torres Strait Islander peoples, 3139 were among males and 5416 among females, providing a male-to-female ratio of 0.58:1 compared to 1:1 among non-Indigenous people (Figure 19). This may reflect differences in health-seeking behaviour and suggests an under-identification of cases of chlamydia among men compared to women.

Figure 19 Number of chlamydia notifications by Aboriginal and Torres Strait Islander status, gender, and age group, 2023

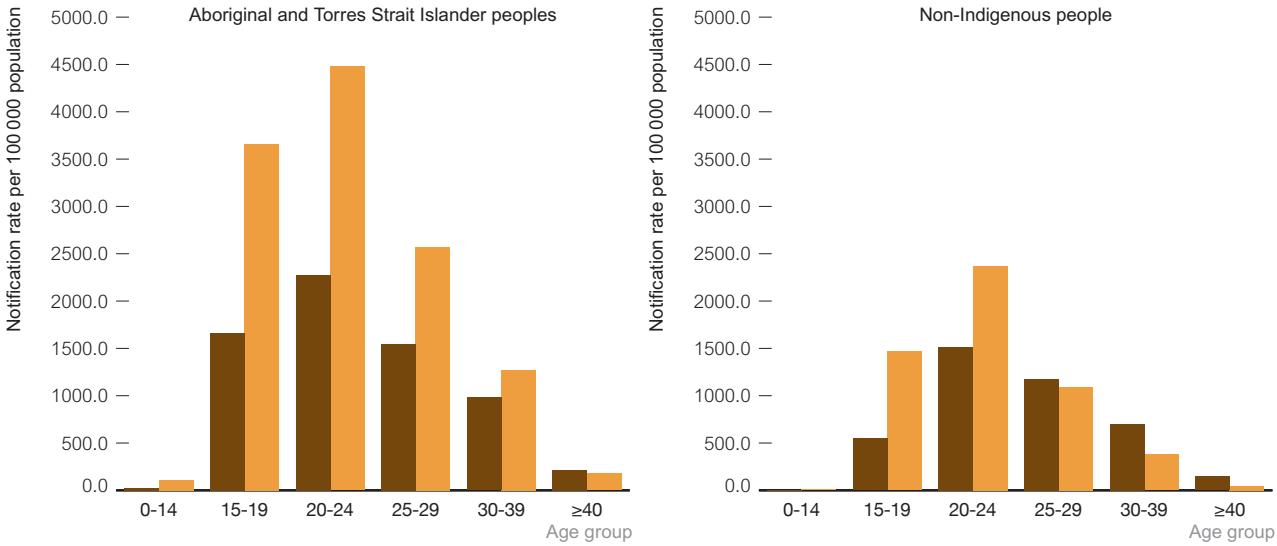


	Aboriginal and Torres Strait Islander peoples						Non-Indigenous people					
	0-14	15-19	20-24	25-29	30-39	≥40	0-14	15-19	20-24	25-29	30-39	≥40
Males	32	784	919	567	575	262	32	3 127	9 385	7 925	9 429	6 453
Females	155	1 651	1 724	908	743	235	147	7 807	13 629	7 184	5 203	2 177

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, New South Wales, Queensland).

By age group and gender, the chlamydia notification rate for males aged 15 to 19 years was three times as high among Aboriginal and Torres Strait Islander males as compared to non-Indigenous males (1662.6 per 100 000 vs 548.8 per 100 000) (Figure 20). The chlamydia notification rate for Aboriginal and Torres Strait Islander females aged 15 to 19 was two and a half times as high as the rate among non-Indigenous females in the same age group (3663 per 100 000 vs 1465.9 per 100 000). Among Aboriginal and Torres Strait Islander females aged 20 to 24 years old, the rate was nearly twice as high as the rate among non-Indigenous females in the same age group (4479.0 per 100 000 vs. 2371.9 per 100 000) (Figure 20). In 2023, notification rates were highest in Aboriginal and Torres Strait Islander females, aged 20 to 24 years (4479.0 per 100 000 population) followed by those aged 15 to 19 years (3663.0 per 100 000). In the absence of testing data, it is uncertain if the high rates in this age group are attributed solely to increased infections or due to increased testing.

Figure 20 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, gender, and age group, 2023

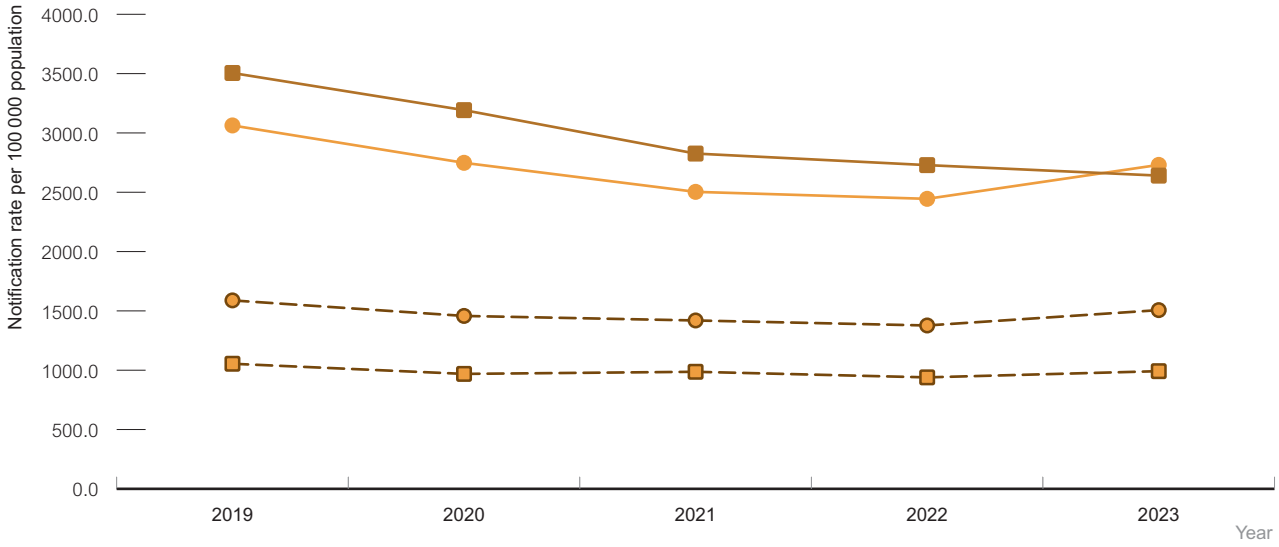


	Aboriginal and Torres Strait Islander peoples						Non-Indigenous people					
	0-14	15-19	20-24	25-29	30-39	≥40	0-14	15-19	20-24	25-29	30-39	≥40
Males	21.3	1662.6	2277.5	1545.2	982.4	217.3	1.9	548.8	1511.1	1173.4	699.7	147.5
Females	109.7	3663.0	4479.0	2574.0	1274.4	178.1	9.5	1465.9	2371.9	1089.3	380.3	46.7

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, New South Wales and Queensland).

The chlamydia notification rate among Aboriginal and Torres Strait Islander peoples aged 15 to 19 years declined by 24.6% from 3505.2 per 100 000 in 2019 to 2640.2 per 100 000 in 2023. Similarly, among Aboriginal and Torres Strait Islander peoples aged 20 to 29 years, notification rates decreased by 10.8% from 3063.1 per 100 000 in 2019 to 2730.6 per 100 000 in 2023 (Figure 21). Rates also declined by 5.9% in non-Indigenous people aged 15 to 19 years, from 1054.4 per 100 000 in 2018 to 991.9 per 100 000 in 2022. The chlamydia notification rate among non-Indigenous people aged 20 to 29 years remained steady and was 1506.5 per 100 000 in 2023.

Figure 21 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, by age group, 2019-2023

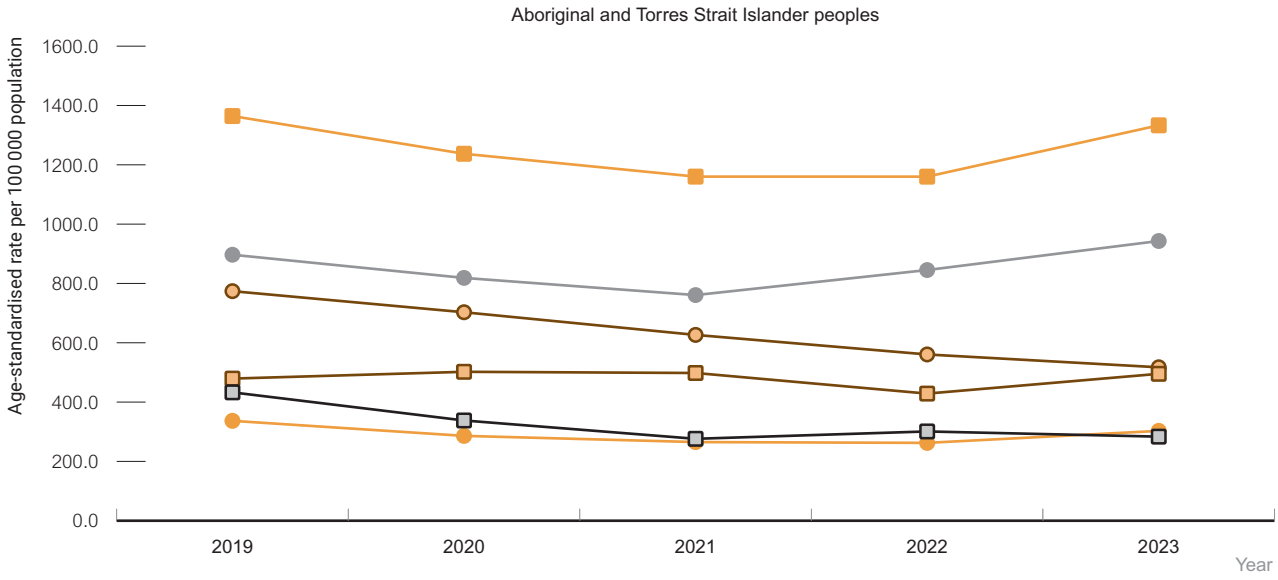


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander people aged 15-19 years	3505.2	3192.2	2826.1	2728.7	2640.2
Aboriginal and Torres Strait Islander aged 20-29 years	3063.1	2748.1	2503.3	2444.5	2730.6
Non-Indigenous people aged 15-19 years	1054.4	968.9	986.7	939.6	991.9
Non-Indigenous people aged 20-29 years	1588.4	1457.5	1419.3	1377.0	1506.5

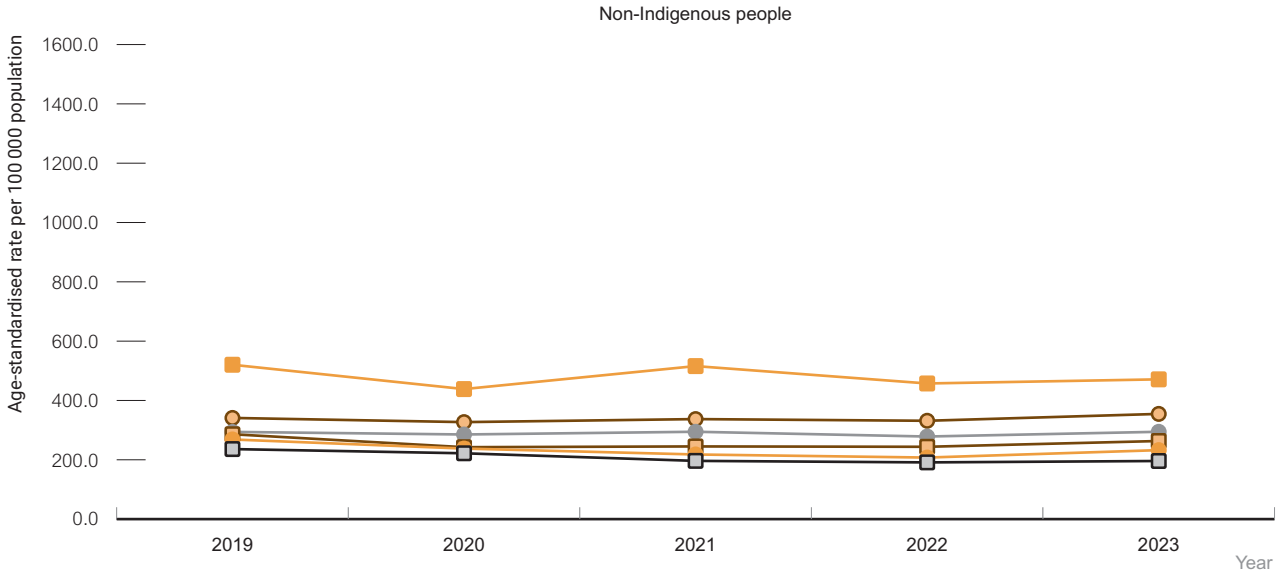
Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland and New South Wales).

In 2023, chlamydia notification rates among Aboriginal and Torres Strait Islander peoples were highest in the Northern Territory (1333.1 per 100 000), followed by Western Australia (943.1 per 100 000), and Queensland (517.3 per 100 000). Chlamydia notification rates among Aboriginal and Torres Strait Islander peoples declined between 2019 and 2022 and was likely related to the COVID-19, increasing in all states and territories except for the Australian Capital Territory and Queensland in 2023. In 2023, notification rates were higher among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people in every reported state and territory (Figure 22).

Figure 22 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and state/territory, 2019–2023



	2019	2020	2021	2022	2023
ACT	432.8	338.0	276.2	301.0	283.5
NSW	336.8	286.1	265.2	262.5	302.9
NT	1364.4	1237.2	1160.2	1160.1	1333.1
QLD	774.0	702.9	626.5	560.6	517.3
SA	479.2	502.1	498.1	428.6	495.3
WA	896.8	818.7	760.8	845.2	943.1

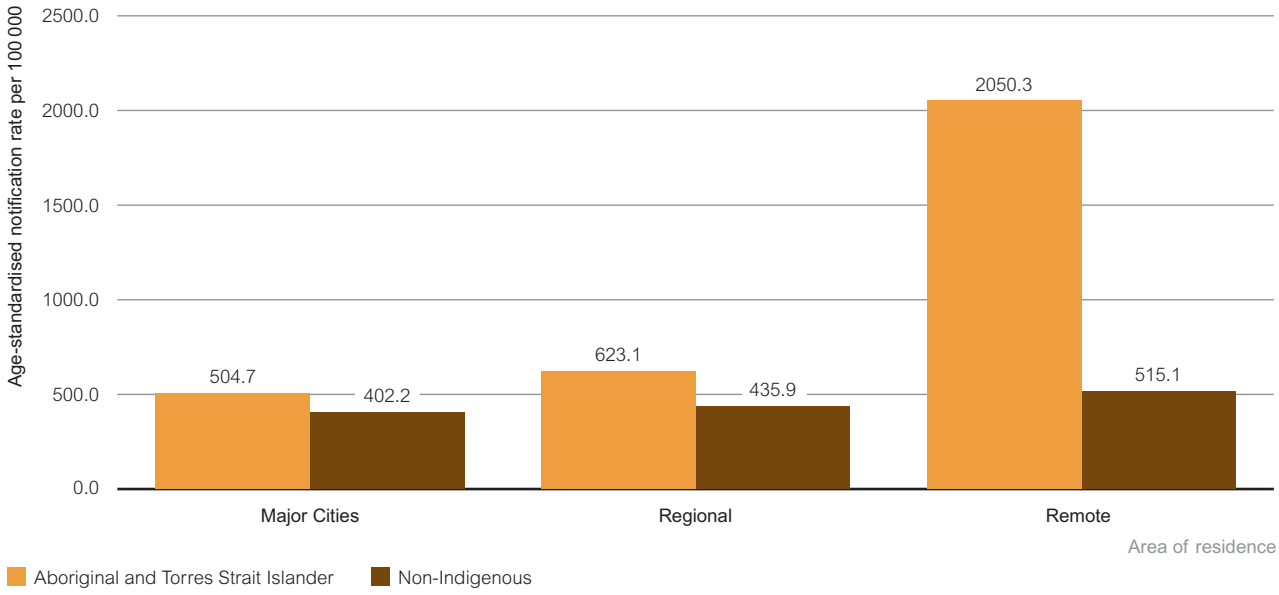


	2019	2020	2021	2022	2023
ACT	236.1	221.9	196.3	191.2	195.9
NSW	268.5	237.8	217.9	207.5	232.5
NT	520.4	438.4	515.9	457.3	471.2
QLD	341.1	327.0	337.2	331.5	354.7
SA	286.1	242.5	245.0	243.8	263.3
WA	294.0	285.3	294.5	278.4	294.4

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland and New South Wales).

In 2023, the chlamydia notification rate in Aboriginal and Torres Strait Islander peoples compared to non-Indigenous people was higher in all areas of residence. In regional areas the chlamydia notification rates were nearly 1.5 times as high increasing to four times as high in remote areas (Figure 23).

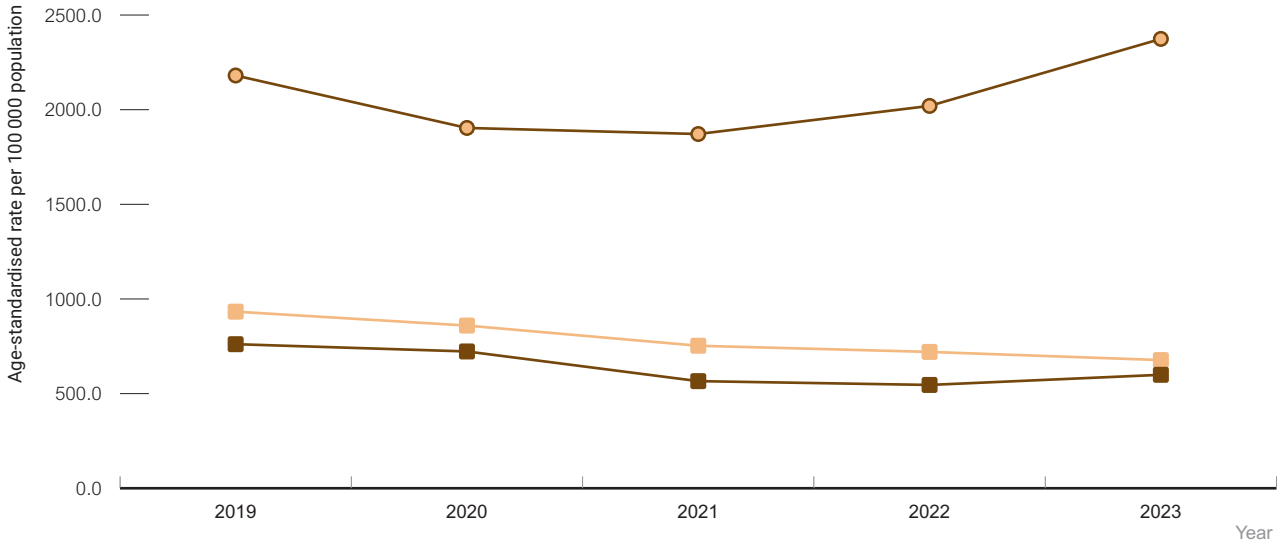
Figure 23 Chlamydia notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and area of residence, 2023



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, New South Wales).

Between 2019 and 2023, age standardised chlamydia notification rates in Aboriginal and Torres Strait Islander peoples living in major cities decreased by 21% from 761.1 per 100 000 to 599.4 per 100 000. Similarly, notification rates in Aboriginal and Torres Strait Islander peoples living in regional areas decreased by nearly 27% from 933 per 100 000 in 2019 to 677.1 per 100 000 in 2023. Among Aboriginal and Torres Strait Islander peoples living in remote areas notification rates fluctuated in last 5 years and increased by 8.8% since 2020 from 1903.5 per 100 000 to 2373.9 per 100 000, with fluctuations throughout this period (Figure 24).

Figure 24 Chlamydia notification rate in Aboriginal and Torres Strait Islander peoples per 100 000 population by area of residence, 2019–2023



	2019	2020	2021	2022	2023
Major cities	761.1	722.7	565.9	545.8	599.4
Regional	933.0	859.5	752.9	720.3	677.1
Remote	2180.6	1903.5	1871.4	2019.9	2373.9

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, New South Wales).

Gonorrhoea

Gonorrhoea is a sexually transmissible infection caused by the bacterium *Neisseria gonorrhoeae*. There were 40 029 gonorrhoea notifications in Australia in 2023. Of these, 5631 (14%) were among Aboriginal and Torres Strait Islander peoples, 26 283 (66%) were in non-Indigenous people, and 8115 (20%) were in people for whom Aboriginal and Torres Strait Islander status was not reported Table 5.

The ratio of male to female gonorrhoea notifications in Aboriginal and Torres Strait Islander peoples in 2023 was 0.8:1 compared with 2.3:1 in non-Indigenous people (data not shown). This may indicate greater transmission occurring through heterosexual sex among Aboriginal and Torres Strait Islander peoples than among non-Indigenous people.

Table 5 Gonorrhoea notifications in Aboriginal and Torres Strait Islander peoples, by characteristic, 2019–2023

Characteristic	2019	2020	2021	2022	2023
Total cases	4202	4451	4712	5098	5631
Gender[a]					
Male	1944	2060	2219	2366	2463
Female	2257	2391	2493	2730	3163
Median age in years	22	24	23	24	24
Age group					
0-14	149	126	137	91	149
15-19	1029	1296	1313	1432	1529
20-24	979	1005	1101	1164	1335
25-29	789	824	822	885	1005
30-39	742	879	999	1099	1148
≥40	304	321	340	427	465
State/Territory[b]					
Australian Capital Territory	11	12	21	27	36
New South Wales	430	426	394	475	567
Northern Territory	1190	1169	1486	1811	1985
Queensland	1040	1022	1123	1084	1108
South Australia	419	370	485	410	497
Tasmania	4	21	18	17	32
Victoria	118	78	74	81	167
Western Australia	990	1353	1111	1193	1239

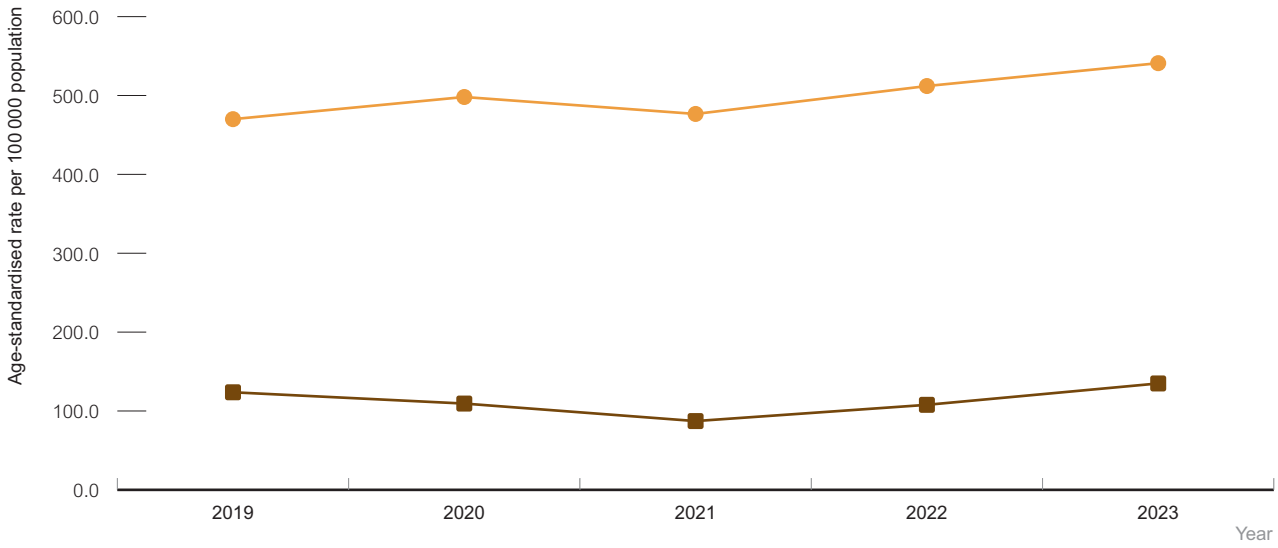
a The National Notifiable Diseases Surveillance System includes the variable 'Sex' to indicate Sex/Gender. For reporting purposes, 'Gender' is used in place of 'Sex'.
b Numbers of notifications in some jurisdictions may be strongly influenced by completeness of Aboriginal and Torres Strait Islander status.

Source: National Notifiable Diseases Surveillance System.

In the period 2019–2023, Aboriginal and Torres Strait Islander status was at least 50% complete in each year in all states and territories, except Victoria.

The gonorrhoea age-standardised notification rate for Aboriginal and Torres Strait Islander peoples in 2023 was four times that of non-Indigenous people (541.0 and 134.9 per 100 000 population, respectively). Between 2019 and 2023 the gonorrhoea notification rate in Aboriginal and Torres Strait Islander peoples increased by 15 percent (470.0 per 100 000 vs 541.0 per 100 000) (Figure 25). The increases in gonorrhoea rates each year from 2019 and 2022 are in the context of declines in other sexually transmissible infections and Blood borne viruses during the COVID-19 pandemic.

Figure 25 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2019–2023

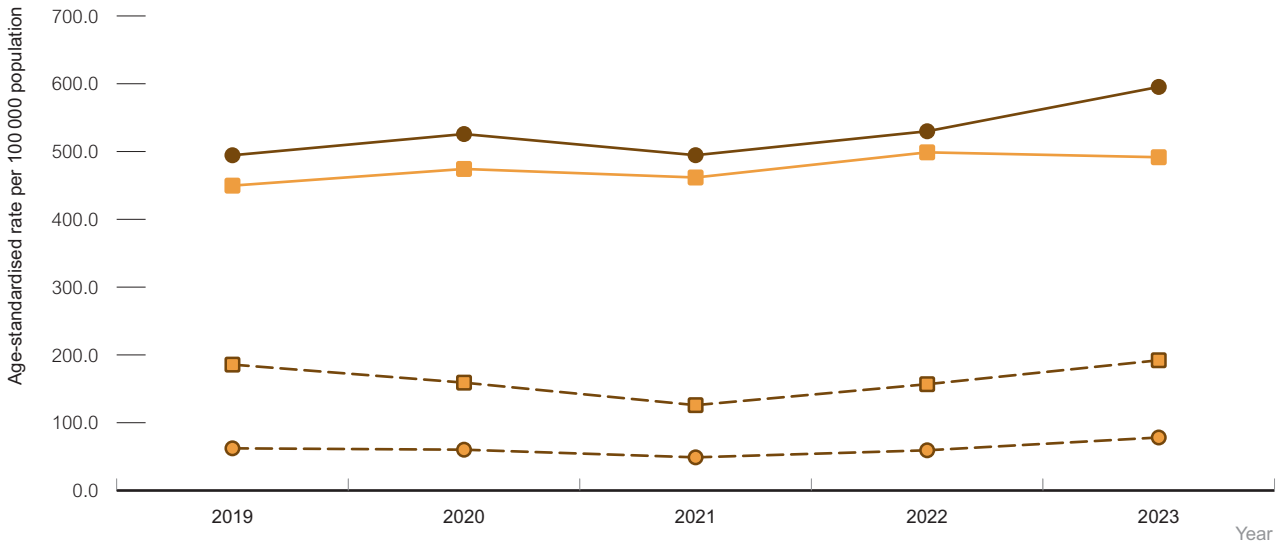


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples	470.0	498.1	476.6	512.0	541.0
Non-Indigenous people	123.7	109.4	87.2	107.8	134.9

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Indigenous status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

The age standardised gonorrhoea notification rate for Aboriginal and Torres Strait Islander females in 2023 was seven and a half times that of non-Indigenous females (595.3 and 78.2 per 100 000, respectively) (Figure 26). The gonorrhoea notification rate for Aboriginal and Torres Strait Islander males in 2023 was more than two and a half times that of non-Indigenous males (491.6 and 192.1 per 100 000, respectively). Gonorrhoea notification rates among Aboriginal and Torres Strait Islander males and females increased between 2019 and 2023 by 9 percent and 20 percent, respectively (Figure 26).

Figure 26 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and sex, 2019–2023

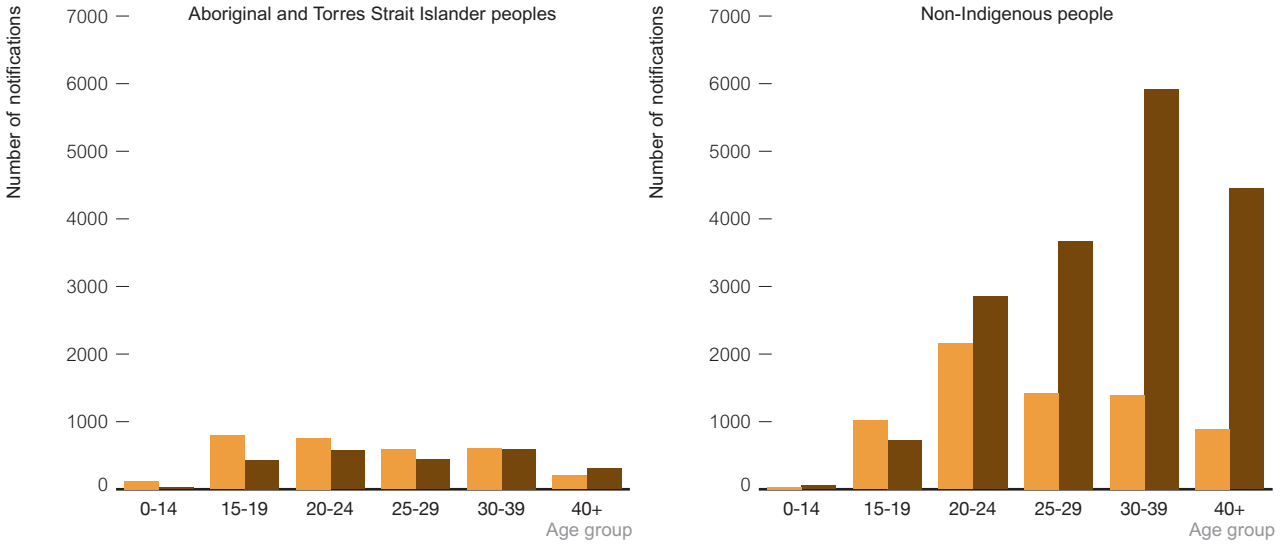


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander female	494.5	525.8	494.6	529.9	595.3
Aboriginal and Torres Strait Islander male	449.7	474.3	461.7	498.8	491.6
Non-Indigenous female	62.2	60.2	48.9	59.3	78.2
Non-Indigenous male	185.7	159.1	125.9	156.8	192.1

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Indigenous status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

Differences in age at notification exist between Aboriginal and Torres Strait Islander peoples and non-Indigenous people. In 2023, the greatest proportion of gonorrhoea notifications in Aboriginal and Torres Strait Islander peoples occurred among those aged 20 to 24 years (24%). By comparison the highest proportion of notifications in non-Indigenous people in 2023 occurred among those aged 30 to 39 years (28%) (Figure 27).

Figure 27 Number of gonorrhoea notifications by Aboriginal and Torres Strait Islander status, gender, and age group, 2023

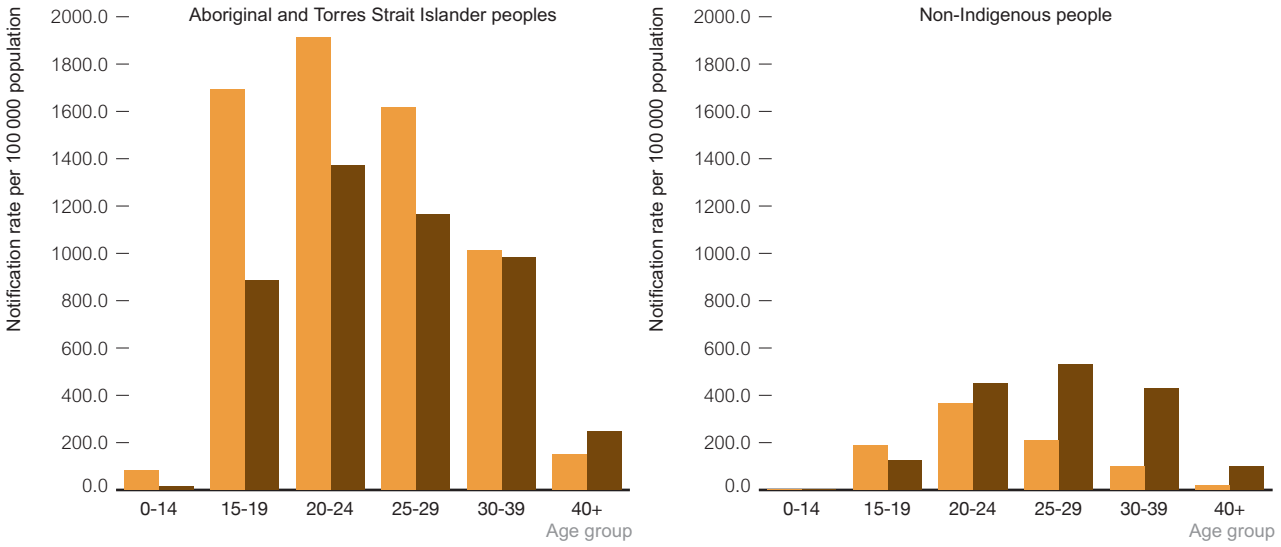


	Aboriginal and Torres Strait Islander peoples						Non-Indigenous people					
	0-14	15-19	20-24	25-29	30-39	40+	0-14	15-19	20-24	25-29	30-39	40+
Female	122	793	761	590	613	207	35	1017	2157	1424	1395	888
Male	25	435	574	441	594	309	55	729	2849	3674	5920	4451

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

Notification rates in Aboriginal and Torres Strait Islander peoples were significantly higher than in non-Indigenous people across all age groups for both males and females (Figure 28). Notification rates were more than nine times as high among Aboriginal and Torres Strait Islander females aged 15 to 19 years than among non-Indigenous females in the same age group (1692.3 and 186.0 per 100 000, respectively). In the same age group, the gonorrhoea notification rate was nearly seven times as high among Aboriginal and Torres Strait Islander males as compared to non-Indigenous males (886.3 and 124.6 per 100 000, respectively).

Figure 28 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, gender, and age group, 2023

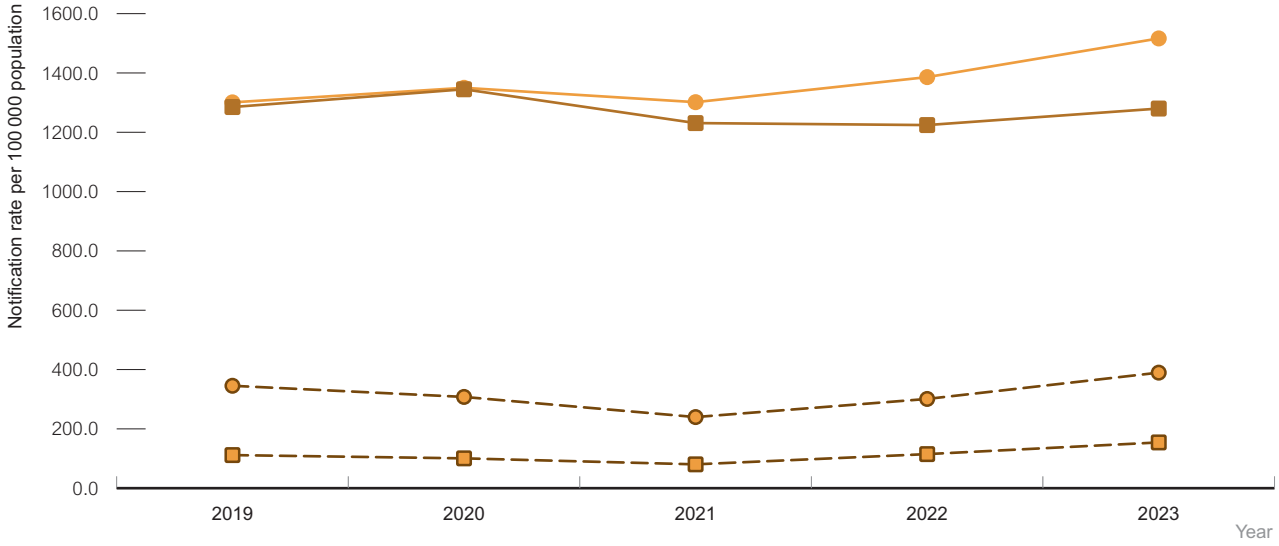


	Aboriginal and Torres Strait Islander peoples						Non-Indigenous people					
	0-14	15-19	20-24	25-29	30-39	40+	0-14	15-19	20-24	25-29	30-39	40+
Female	83.3	1692.3	1911.9	1616.7	1011	150.4	2.2	186	366.9	210.3	99.3	18.5
Male	16.1	886.3	1372.3	1163.6	980.8	245.8	3.3	124.6	448.5	530.2	427.4	98.6

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

The gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples aged 15 to 19 years was relatively unchanged between 2019 and 2023 and was 1280.0 per 100 000 in 2023 (Figure 29). Among Aboriginal and Torres Strait Islander peoples aged 20 to 29 years, the gonorrhoea notification rate increased by 17% from 1300.8 per 100 000 in 2019 to 1516.4 per 100 000 in 2023 (Figure 29). In 2023, among those aged 15 to 19 years, the gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples over eight times as high as compared to non-Indigenous people. Also in 2023, among those aged 20 to 29 years, the gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples was nearly four times as high as compared to non-Indigenous people (Figure 29).

Figure 29 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander and age group, 2019–2023

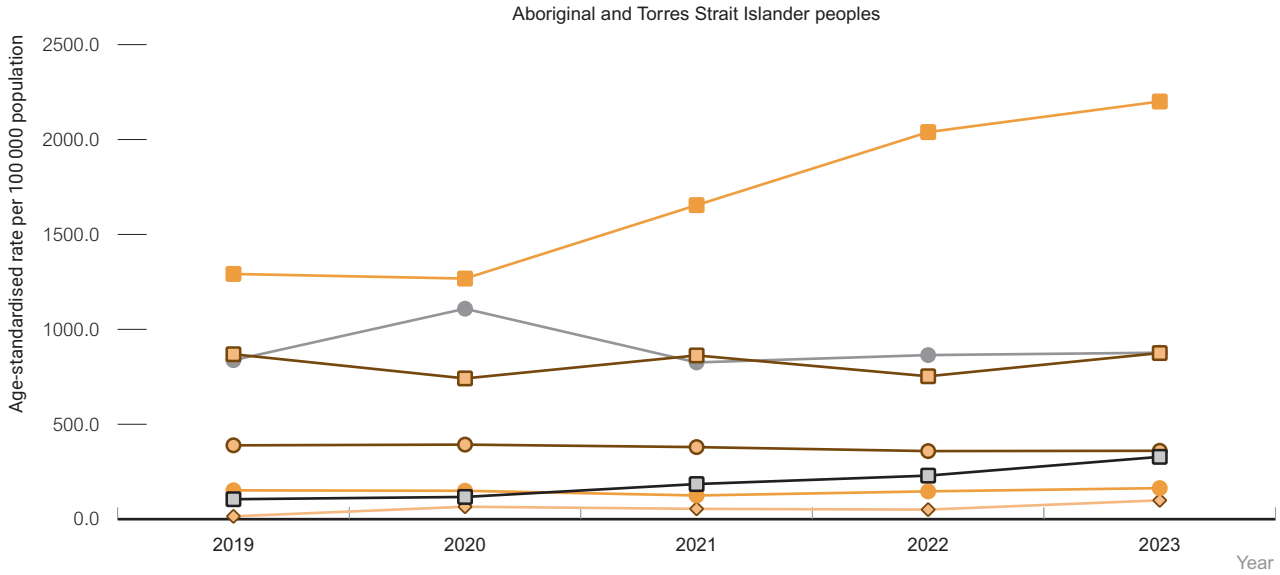


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander people aged 15-19 years	1285.1	1345.0	1231.0	1224.3	1280.0
Aboriginal and Torres Strait Islander people aged 20-29 years	1300.8	1349.9	1301.5	1386.0	1516.4
Non-Indigenous people aged 15-19 years	111.6	100.6	80.4	114.9	154.3
Non-Indigenous people aged 20-29 years	345.3	307.7	239.8	300.9	389.6

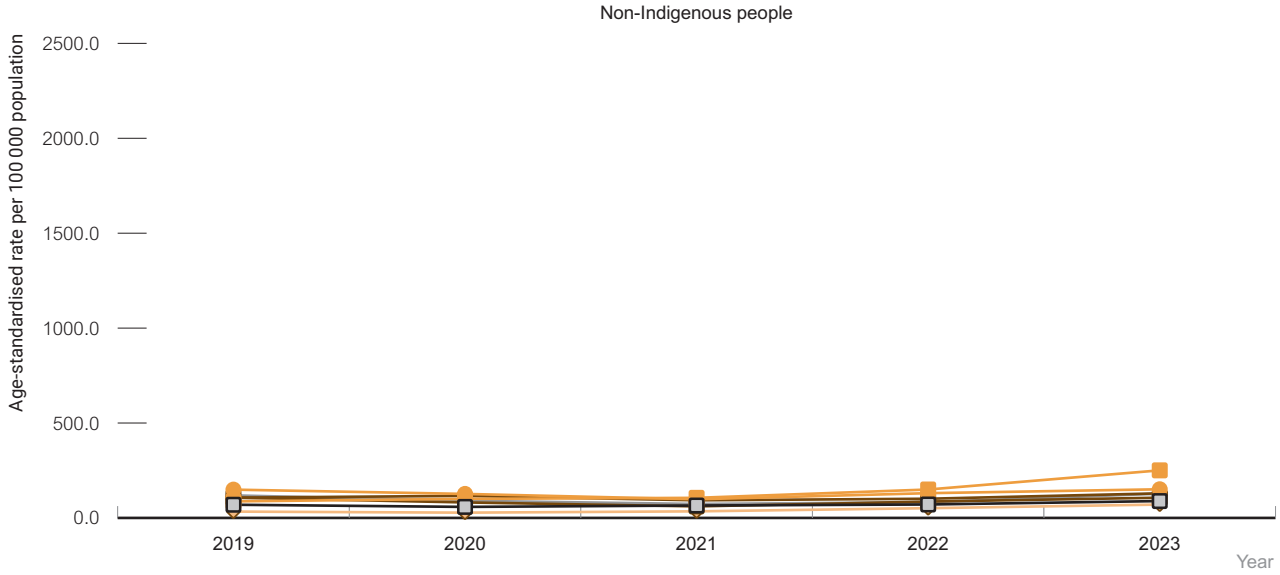
Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

In 2023, the age standardised gonorrhoea notification rates among Aboriginal and Torres Strait Islander peoples were highest in the Northern Territory (2200.3 per 100 000), followed by Western Australia (877.0 per 100 000), and South Australia (875.1 per 100 000). Despite declines in testing due to the COVID-19 pandemic, gonorrhoea notification rates among Aboriginal and Torres Strait Islander peoples increased in the Australian Capital Territory, Northern Territory and Tasmania between 2019 and 2023. In comparison, notification rates in New South Wales, Queensland, South Australia and Western Australia fluctuated. In 2023, notification rates were more than twice as high among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous peoples in the Australian Capital Territory, the Northern Territory, Queensland, South Australia, and Western Australia (Figure 30).

Figure 30 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander swtatus and state/territory, 2019–2023



	2019	2020	2021	2022	2023
ACT	105.1	117.1	185.0	229.5	328.4
NSW	151.8	149.6	124.8	146.5	163.6
NT	1291.9	1267.5	1654.3	2039.1	2200.3
QLD	389.0	392.8	379.7	358.6	360.2
SA	868.9	741.4	862.6	752.8	875.1
TAS	14.9	65.5	54.4	50.4	99.2
WA	837.6	1108.7	825.7	864.4	877.0

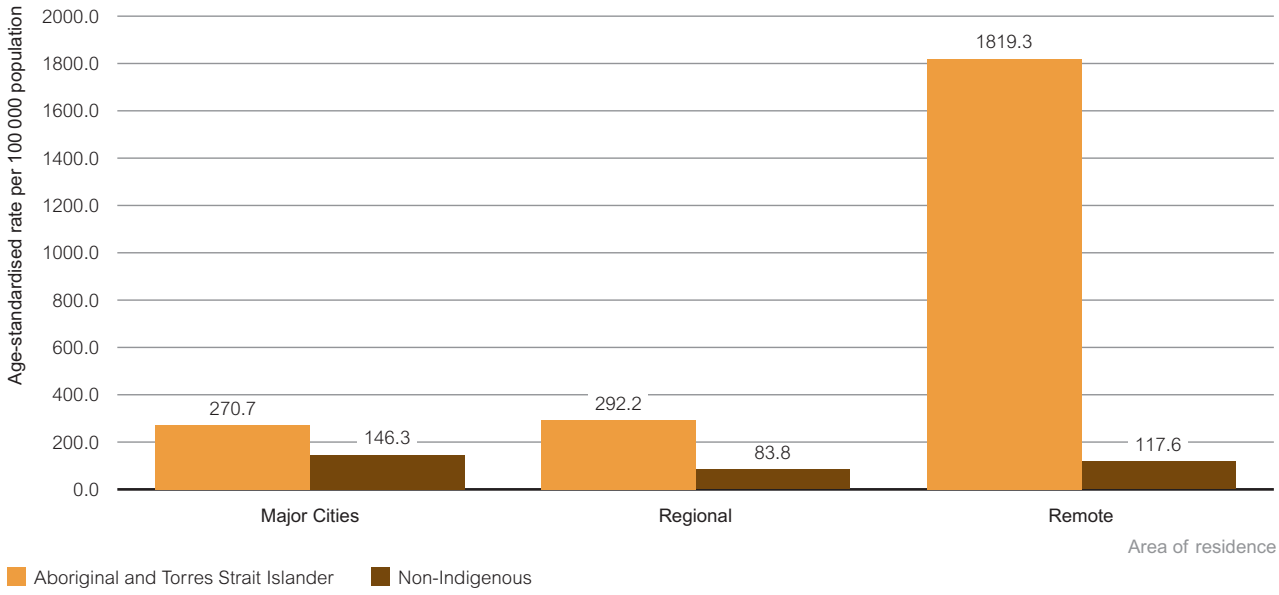


	2019	2020	2021	2022	2023
ACT	69.5	58.1	65.4	70.8	88.8
NSW	149.1	126.5	98.2	130.4	150.9
NT	87.2	100.4	105.8	149.7	250.6
QLD	106.9	116.1	92.9	101.1	129.5
SA	106.6	81.7	60.8	86.2	106.5
TAS	33.4	27.8	34.7	51.4	70.4
WA	118.7	90.4	73.5	83.0	127.7

Source: Australian National Notifiable Diseases Surveillance System. Includes all jurisdictions except Victoria, as Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year.

In 2023, the age standardised gonorrhoea notification rate among Aboriginal and Torres Strait Islander peoples living in major cities, was a little less than twice as high compared to non-Indigenous people (270.7 vs 146.3 per 100 000), 3.4 times as high in regional areas (292.2 vs. 83.8 per 100 000), and almost 15 times as high in remote areas (1819.3 vs. 117.6 per 100 000) (Figure 31).

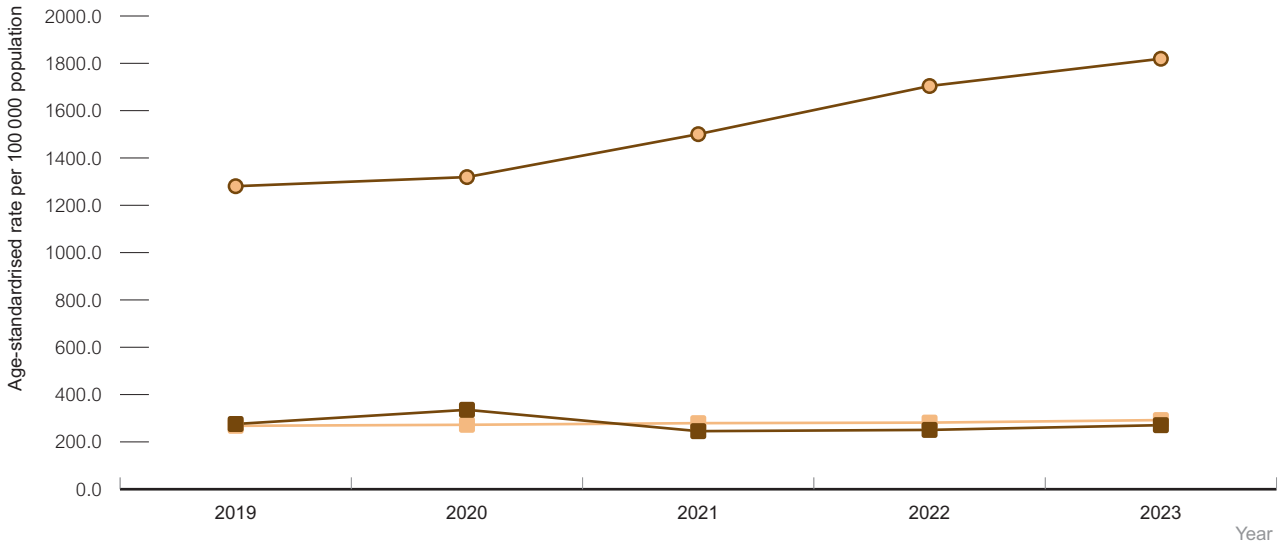
Figure 31 Gonorrhoea notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and area of residence, 2023



Source: Australian National Notifiable Diseases Surveillance System. Includes all jurisdictions except Victoria, as Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year.

Between 2019 and 2023, notification rates among Aboriginal and Torres Strait Islander peoples fluctuated for people living in major cities and regional areas. Amongst Aboriginal and Torres Strait Islander people living in remote areas, rates increased year on year between 2019 and 2023 (Figure 32).

Figure 32 Gonorrhoea notification rate in Aboriginal and Torres Strait Islander peoples per 100 000 population by area of residence, 2019–2023



	2019	2020	2021	2022	2023
Major cities	275.6	335.6	245.4	250.7	270.7
Regional	268.0	272.3	279.2	281.5	292.2
Remote	1280.6	1319.2	1500.6	1704.1	1819.3

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, South Australia, Western Australia, Queensland, Tasmania and New South Wales).

Donovanosis

The National Donovanosis Eradication (Elimination) Project was implemented in 2001–2004, following the introduction of improved methods of diagnosis and treatment of donovanosis. The project employed strategies such as targeted surveillance, high-quality education, and support of primary healthcare workers in their management of genital ulcerative disease, intermittent or short-course oral medication and new laboratory techniques.

Australia is on track to eliminate donovanosis, which was once a frequently diagnosed STI among remote Aboriginal populations. Since 2014 there has only been one case notified, in 2014.

Human papillomavirus

Human papillomavirus (HPV) types 16 and 18 cause 70% to 80% of cervical cancer and about half of high-grade cervical intraepithelial neoplasia (CIN grade 2 or 3) lesions, and genotypes 6 and 11 cause most cases of genital warts. In Australia, the nonavalent HPV vaccine (types 6, 11, 16, 18, 31, 33, 45, 52 and 58) is provided free in school to all students aged 12-13 years under the National HPV Vaccination Program, in a single dose schedule. The vaccine type and schedule has changed over time, however the program began in 2007 for females aged 12-13 years and was extended in 2013 to include males the same age.

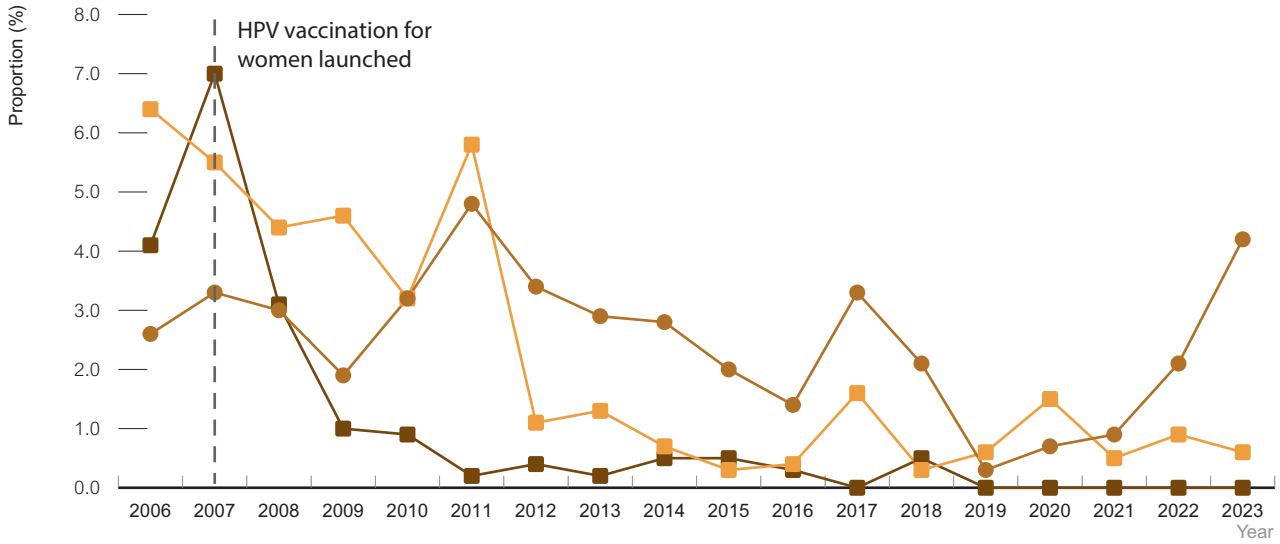
Catch-up programs through schools, general practices and community immunisation services were run from 2007 to 2009 for females aged 14–26 years, and from 2013 to 2015 for males aged 14–15 years [6]. Data on HPV vaccination coverage is currently not available by Aboriginal and Torres Strait Islander status but will be available in the future. The Genital Warts Surveillance Network is a sentinel surveillance system that includes over 50 sexual health clinics across Australia and provides evaluation of the population-level effects of the National HPV Vaccination Program. The network monitors epidemiological trends of genital wart diagnoses by collecting routinely collected de-identified electronic medical record data on demographics, sexual behaviours, and genital wart clinical diagnoses from the clinics.

Following the introduction of vaccination against HPV in 2007, a decline has been seen in the number of diagnoses of genital warts at first visit at sexual health clinics (see the HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2022 for further detail). Information available from sexual health clinics participating in the Genital Warts Surveillance Network within the ACCESS national sentinel surveillance system indicates a considerable reduction in the proportion of both Aboriginal and Torres Strait Islander males and females under 30 notified with genital warts at their first visit since 2007.

Among Aboriginal and Torres Strait Islander females aged under 21 years, the proportion diagnosed with genital warts at first visit declined from 4.1% in 2006 to 0.0% in 2023. Among women aged 21 to 29 years, the proportion diagnosed with genital warts reduced from 6.4% in 2006 to 0.6% in 2023. The proportion of Aboriginal and Torres Strait Islander women aged 30 years or older diagnosed with genital warts diagnoses increased from 2.6% in 2006 to 4.2% in 2023 (Figure 33).

Among Aboriginal and Torres Strait Islander males aged under 21 years, the proportion diagnosed with genital warts at first visit declined from 5.0% in 2006 to 0.0% in 2023. Among men aged 21 to 29 years the proportion diagnosed with genital warts reduced from 13.5% in 2007 to 0.5% in 2023. The proportion of Aboriginal and Torres Strait Islander men aged 30 years or older diagnosed with genital warts diagnoses declined from 7.0% in 2006 to 1.3% in 2023 (Figure 34).

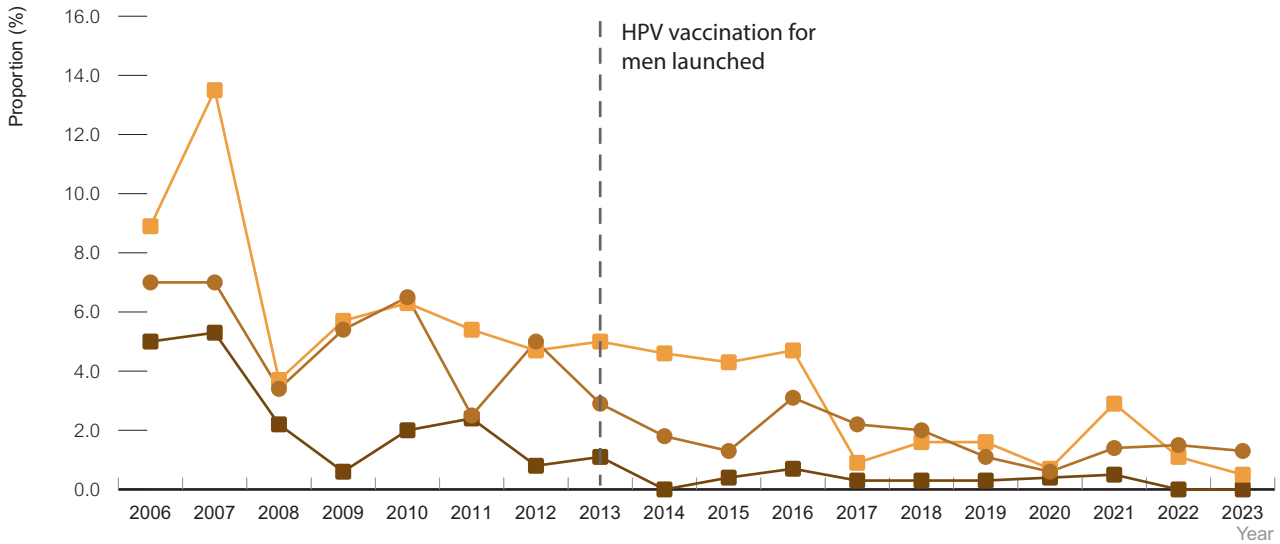
Figure 33 Proportion of Aboriginal and Torres Strait Islander females notified with genital warts at first visit at sexual health clinics by age group, 2006–2023



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
<21 years (%)	4.1	7.0	3.1	1.0	0.9	0.2	0.4	0.2	0.5	0.5	0.3	0.0	0.5	0.0	0.0	0.0	0.0	0.0
21-29 years (%)	6.4	5.5	4.4	4.6	3.2	5.8	1.1	1.3	0.7	0.3	0.4	1.6	0.3	0.6	1.5	0.5	0.9	0.6
≥30 years (%)	2.6	3.3	3.0	1.9	3.2	4.8	3.4	2.9	2.8	2.0	1.4	3.3	2.1	0.3	0.7	0.9	2.1	4.2

Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); Genital Wart Surveillance Network.

Figure 34 Proportion of Aboriginal and Torres Strait Islander males notified with genital warts at first visit at sexual health clinics, by age group 2006–2023



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
<21 years (%)	5.0	5.3	2.2	0.6	2.0	2.4	0.8	1.1	0.0	0.4	0.7	0.3	0.3	0.3	0.4	0.5	0.0	0.0
21-29 years (%)	8.9	13.5	3.7	5.7	6.3	5.4	4.7	5.0	4.6	4.3	4.7	0.9	1.6	1.6	0.7	2.9	1.1	0.5
≥30 years (%)	7.0	7.0	3.4	5.4	6.5	2.5	5.0	2.9	1.8	1.3	3.1	2.2	2.0	1.1	0.6	1.4	1.5	1.3

Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); Genital Wart Surveillance Network.

4 HIV

Please see p. 8 for summary.

HIV notifications

All jurisdictions have high completeness rates (>95%) for the reporting of Aboriginal and Torres Strait Islander status in HIV notifications over the ten years of reporting (2014–2023) and thus data from all jurisdictions are included. There were 722 new HIV notifications in Australia in 2023, of which 24 (3%) were among Aboriginal and Torres Strait Islander peoples [1]. Of these 24 notifications, 15 were reported as male and nine female, the median age at diagnosis was 40.5 years (Table 6).

Between 2014 and 2016, the number of HIV notifications in Aboriginal and Torres Strait Islander peoples increased steadily, from 34 notifications in 2014 to 47 notifications in 2016 followed by a reduction between 2016 and 2019. Between 2019 and 2023 the number of notifications has fluctuated, with 25 and 24 notifications in 2022 and 2023, respectively. A similar trend was seen among males and females with more notifications among males than females for every year from 2014 to 2023. Overall trends in HIV notifications from 2020 to 2022 were likely influenced by COVID-19, including changes to sexual behaviour, healthcare access and testing practices, and travel.

Table 6 Characteristics of HIV notifications in Aboriginal and Torres Strait peoples, by characteristic, 2014–2023

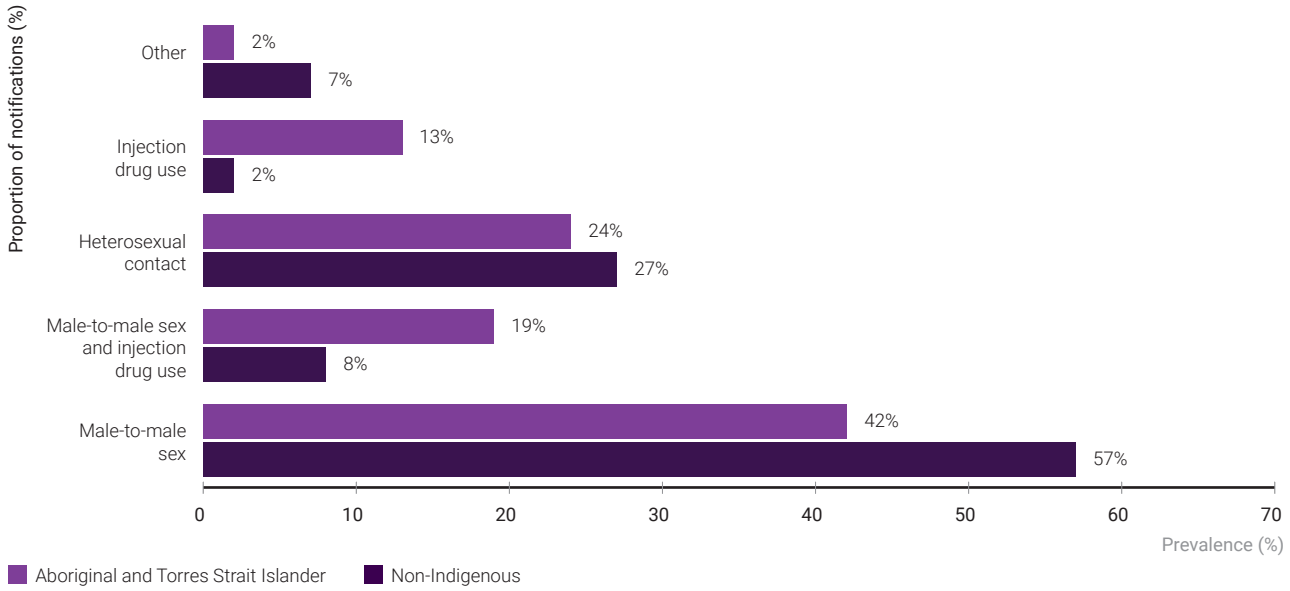
Characteristic	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total cases[a]	34	40	47	31	33	25	16	17	25	24
Gender[b]										
Male	25	36	41	23	30	20	14	17	22	15
Female	8	4	5	7	3	5	1	0	3	9
Newly acquired HIV infections[c]	24%	33%	30%	32%	27%	40%	44%	18%	36%	33%
Median age	33.5	35.5	31.0	33.0	28.0	31.0	34.5	38.0	34.0	40.5
Late and advanced HIV infection status at HIV diagnosis (%)[d]										
Late diagnosis	32%	30%	25%	25%	25%	23%	6%	41%	21%	30%
Advanced diagnosis	19%	16%	14%	7%	21%	9%	0%	20%	14%	17%
State/Territory										
Australian Capital Territory	1	0	0	0	1	0	0	0	0	0
New South Wales	7	7	10	8	11	7	4	1	6	11
Northern Territory	1	1	5	1	1	0	0	1	0	0
Queensland	14	13	20	11	13	9	7	6	5	8
South Australia	0	2	2	5	1	2	2	0	0	1
Tasmania	2	2	0	1	0	1	0	1	0	0
Victoria	6	8	8	2	4	4	1	3	5	1
Western Australia	3	7	7	3	2	2	2	5	9	3
Exposure category										
Male-to-male sex[e]	35%	55%	57%	39%	55%	48%	50%	53%	40%	25%
Male-to-male sex and injecting drug use	9%	10%	13%	6%	12%	20%	31%	12%	16%	17%
Heterosexual contact	18%	18%	21%	26%	24%	16%	13%	18%	20%	50%
Injecting drug use	26%	15%	4%	23%	3%	16%	0%	18%	20%	8%
MTCT	0%	0%	0%	0%	0%	0%	0%	0%	4%	0%
Other	12%	3%	4%	6%	6%	0%	6%	0%	0%	0%

a Total includes Transgender. Not adjusted for multiple reporting.
b Doesn't include 'Other/not reported'.
c Newly acquired HIV was defined as a new HIV diagnosis with a negative or indeterminate HIV antibody test result or a diagnosis of primary HIV within one year before HIV diagnosis.
d Late HIV diagnosis was defined as newly notified HIV with a CD4+ cell count of less than 350 cells/μL, and advanced HIV as newly notified infection with a CD4+ cell count of less than 200 cells/μL. Newly acquired HIV was not categorised as a late or advanced diagnosis irrespective of CD4+ cell count.
e Includes males who had sex with both males and females.

Source: State and Territory health authorities; includes all jurisdiction.

Between 2019 and 2023, by exposure classification, the proportion of notifications attributed to heterosexual sex was 24% in Aboriginal and Torres Strait Islander peoples, compared with 27% among non-Indigenous. The proportion of notifications attributed to injection drug use was 13% among Aboriginal and Torres Strait Islander peoples compared with 2% among non-Indigenous people. The proportion of HIV notifications attributed to male-to-male sex was 42% among Aboriginal and Torres Strait Islander peoples, compared with 57% among non-Indigenous people. The proportion of HIV notifications attributed to male-to-male sex and injecting drug use was 19% among Aboriginal and Torres Strait Islander peoples and 8% among non-Indigenous peoples (Figure 35).

Figure 35 HIV notification exposure category by Aboriginal and Torres Strait Islander status, 2019–2023

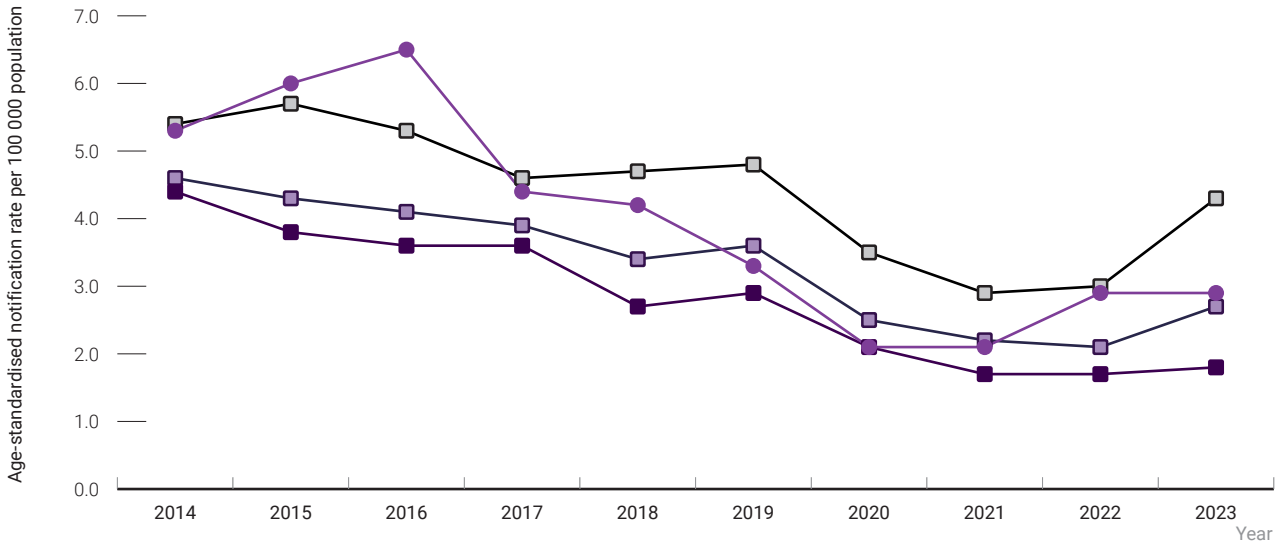


Source: State and territory health authorities; see Methodology for detail.

Notification rates

Between 2014 and 2016, the age standardised HIV notification rate among Aboriginal and Torres Strait Islander peoples increased from 5.3 to 6.5 per 100 000 population and then declined to 3.3 per 100 000 population in 2019. Rates declined further during 2020 and 2021 (2.1 per 100 000 both years). In 2022, the HIV notification rate increased to 2.9 per 100 000 among Aboriginal and Torres Strait Islander peoples and remained the same in 2023. Among all non-Indigenous people, the HIV notification rate in 2023 was 2.7 per 100 000. HIV notification rates for Aboriginal and Torres Strait Islander peoples and non-Indigenous people were similar between 2017 and 2023. Trends in HIV notification rates in the Aboriginal and Torres Strait Islander population are based on small numbers and may reflect localised occurrences rather than national patterns (Figure 36).

Figure 36 HIV notification rate by Aboriginal and Torres Strait Islander status per 100 000 population, 2014-2023



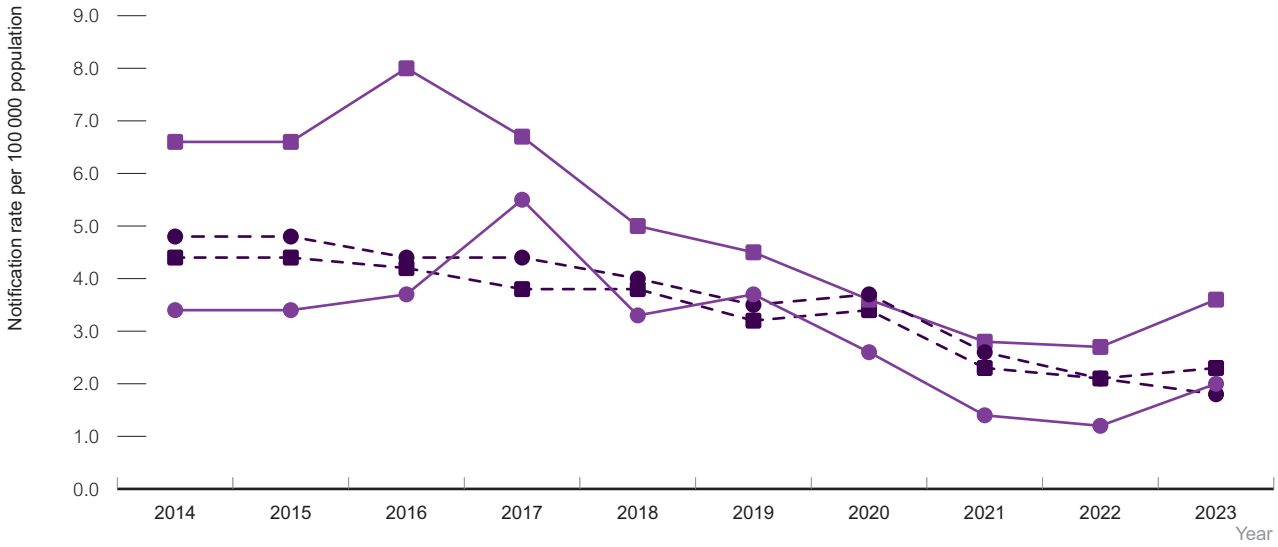
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples	5.3	6.0	6.5	4.4	4.2	3.3	2.1	2.1	2.9	2.9
Australian-born non-Indigenous people	4.4	3.8	3.6	3.6	2.7	2.9	2.1	1.7	1.7	1.8
All non-Indigenous people	4.6	4.3	4.1	3.9	3.4	3.6	2.5	2.2	2.1	2.7
Overseas-born	5.4	5.7	5.3	4.6	4.7	4.8	3.5	2.9	3.0	4.3

Source: State and territory health authorities; see Methodology for detail.

By age group, HIV notification rates decreased between 2014 and 2023 among Aboriginal and Torres Strait Islander peoples aged 34 years and younger and were 3.4 per 100 000 and 2.0 per 100 000 respectively. Among Aboriginal and Torres Strait Islander peoples aged 35 years or older, HIV notification rates declined from 6.6 per 100 000 in 2014 to 2.7 per 100 000 in 2022. Rates increased in both age groups between 2022 and 2023 to 2.0 per 100 000 and 3.6 per 100 000 respectively (Figure 37).

Amongst non-Indigenous people aged both 34 years and younger and 35 years or older, rates declined between 2014 and 2023. In 2023, HIV notification rates were 1.8 per 100 000 among those aged 34 years or younger, and 2.3 per 100 000 among those aged 35 years or older. Due to small numbers of notifications by age group among Aboriginal and Torres Strait Islander peoples, trends over time should be interpreted with caution.

Figure 37 HIV notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, and age group, 2014–2023



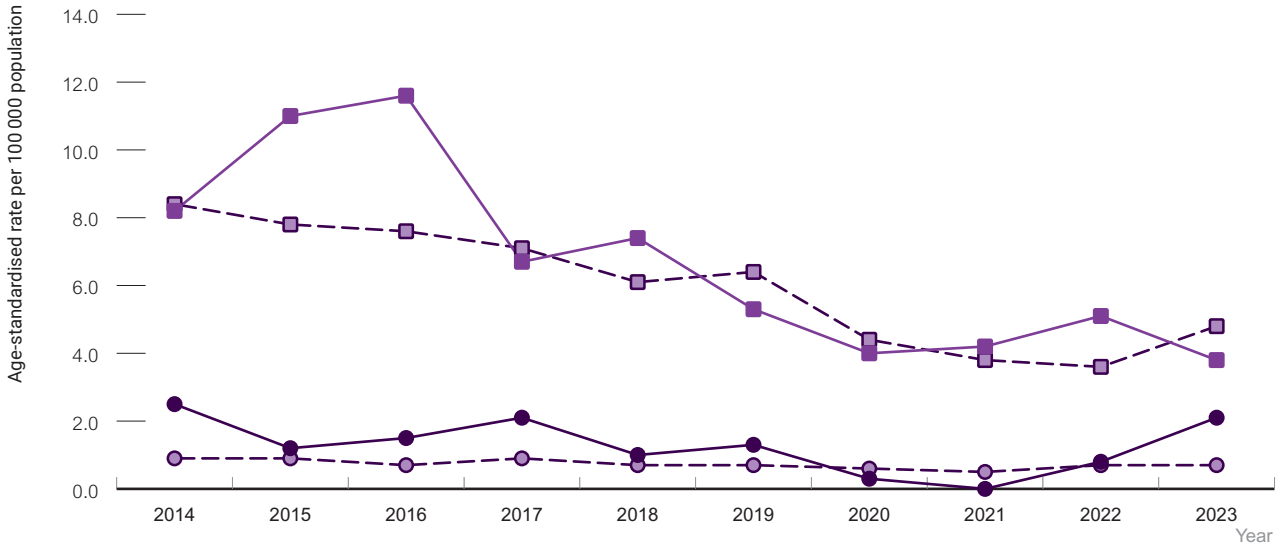
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander <35 years	3.4	3.4	3.7	5.5	3.3	3.7	2.6	1.4	1.2	2.0
Non-Indigenous <35 years	4.8	4.8	4.4	4.4	4.0	3.5	3.7	2.6	2.1	1.8
Aboriginal and Torres Strait Islander ≥35 years	6.6	6.6	8.0	6.7	5.0	4.5	3.6	2.8	2.7	3.6
Non-Indigenous ≥35 years	4.4	4.4	4.2	3.8	3.8	3.2	3.4	2.3	2.1	2.3

Source: State and territory health authorities; see Methodology for detail.

Age standardised HIV notification rates among Aboriginal and Torres Strait Islander males steadily increased from 8.2 per 100 000 in 2014 to 11.6 per 100 000 in 2016 and then declined by 67% to 3.8 per 100 000 in 2023. Over this period HIV notification rates among non-Indigenous males decreased from 8.4 per 100 000 to 4.8 per 100 000 (Figure 38).

Age standardised notification rates among Aboriginal and Torres Strait Islander females and non-Indigenous females remained below the rates of males in both populations for every year between 2014 and 2023. The HIV notification rate among Aboriginal and Torres Strait Islander females remained low during this period and was 2.1 per 100 000 in 2023 (Figure 38).

Figure 38 HIV notification rate per population by Aboriginal and Torres Strait Islander status and gender, 2014–2023

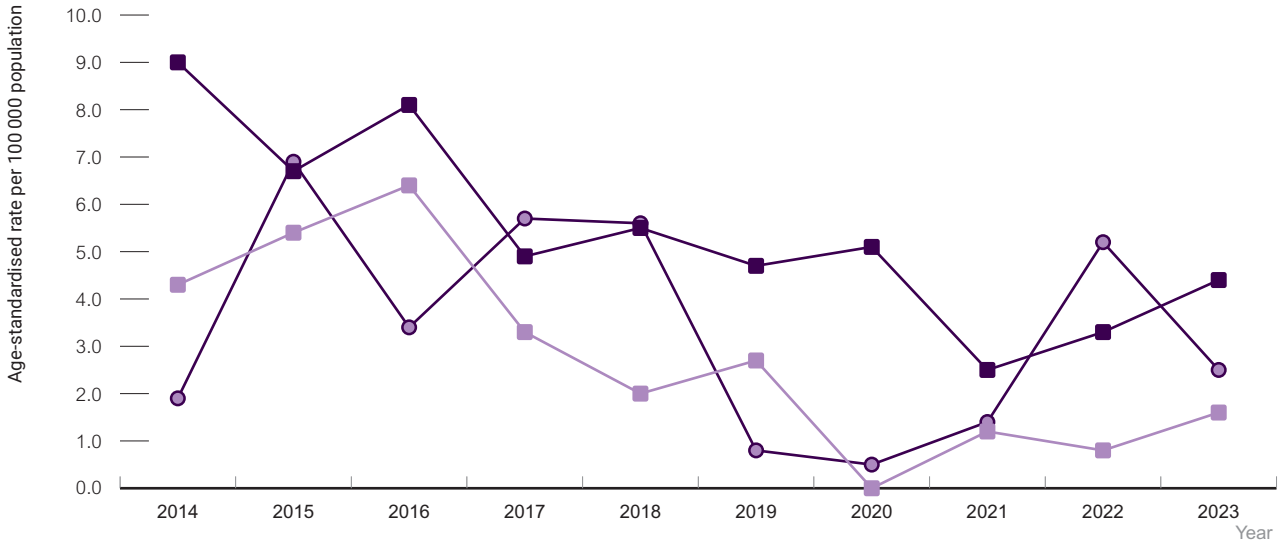


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander males	8.2	11.0	11.6	6.7	7.4	5.3	4.0	4.2	5.1	3.8
Non-Indigenous males	8.4	7.8	7.6	7.1	6.1	6.4	4.4	3.8	3.6	4.8
Aboriginal and Torres Strait Islander females	2.5	1.2	1.5	2.1	1.0	1.3	0.3	0.0	0.8	2.1
Non-Indigenous females	0.9	0.9	0.7	0.9	0.7	0.7	0.6	0.5	0.7	0.7

Source: State and territory health authorities; see Methodology for detail.

HIV notification rates among Aboriginal and Torres Strait Islander peoples residing in regional areas increased by 1.4 times between 2014 and 2016 from 4.3 to 6.4 per 100 000, and then declined by 75% between 2016 and 2023 to 1.6 per 100 000. In major cities the HIV notification rate declined from 9.0 per 100 000 in 2014 to 1.6 per 100 000 in 2023 with fluctuations in the interim. Due to the small number of HIV notifications, the HIV notification rate in remote areas fluctuated between 2014 and 2023 and was 2.5 per 100 000 in 2023 (Figure 39). Caution should be taken in interpretation of these trends, due to small numbers of notifications.

Figure 39 HIV notification rate in Aboriginal and Torres Strait Islander peoples per 100 000 population by area of residence, 2014–2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Major cities	9.0	6.7	8.1	4.9	5.5	4.7	5.1	2.5	3.3	4.4
Regional	4.3	5.4	6.4	3.3	2.0	2.7	0.0	1.2	0.8	1.6
Remote	1.9	6.9	3.4	5.7	5.6	0.8	0.5	1.4	5.2	2.5

Source: State and territory health authorities; see Methodology for detail.

HIV Cascade of care

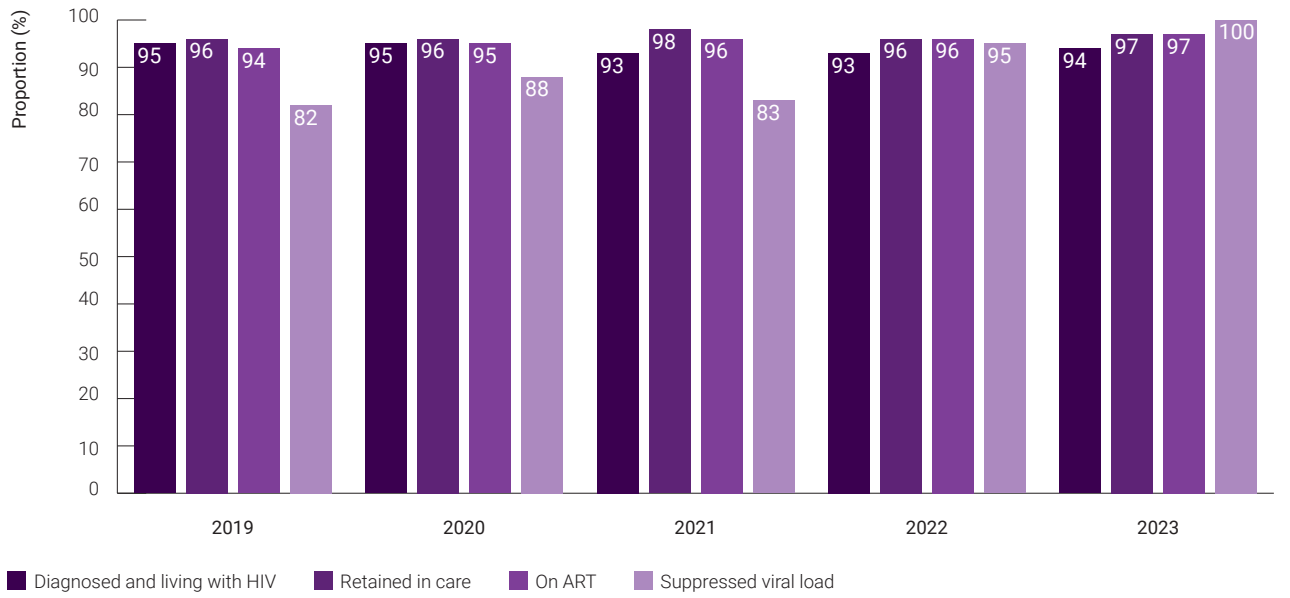
This report includes the 'HIV diagnosis and care cascade', which estimates the number of people living with HIV in Australia, the number and proportion who are diagnosed, receiving antiretroviral treatment, retained in care (having had a viral load or CD4+ cell count in the past year) and who have a suppressed viral load (<200 HIV-1 RNA copies/mL) These estimates are used to support the improvement of the delivery of services to people with HIV across the entire continuum of care. Using available data and accounting for uncertainties, the number of people in each stage of the cascade in Australia was estimated.

UNAIDS has set targets for HIV diagnosis and treatment by the year 2025: 95% of all people living with HIV to be diagnosed, 95% of all people with diagnosed HIV to be on antiretroviral therapy, and 95% of all people receiving antiretroviral therapy to have a suppressed viral load. This corresponds to 86% of all people living with HIV having a suppressed viral load.

At the end of 2023, there were an estimated 620 (540-680), Aboriginal and Torres Strait Islander peoples living with HIV in Australia. Of these an estimated 94% (580) had been diagnosed, decreasing from 95% in 2019 (540), meaning that Australia has yet to meet the UNAIDS 2025 target. Of those diagnosed at the end of 2023, an estimated 97% (560) were retained in care, similar to 96% (520) in 2019. Of those diagnosed, 97% (548) were receiving antiretroviral therapy, an increase from 94% (510) in 2019 and 100% (548) of those on antiretroviral therapy had a suppressed viral load, a significant increase from 82% (420) since 2019 (Figure 40).

At the end of 2023, an estimated 40 Aboriginal and Torres Strait Islander people (6% of all people living with HIV) (Table 7) were living with HIV who were unaware of their HIV status (undiagnosed).

Figure 40 HIV cascade of care, 2019–2023



Source: See Methodology for details of mathematical modelling used to generate estimates

Table 7 Undiagnosed proportion among Aboriginal and Torres Strait Islander people, 2023

	People living with HIV (range)	Number diagnosed (range)	Number undiagnosed (range)	Proportion undiagnosed	HIV prevalence (range)	Population size (>15 years of age)
Demographics						
Total	30 010 (26 700 to 35 220)	27 650 (26 700 to 32 390)	2 360 (0 to 2830)	8%	0.14% (0.12 to 0.16%)	22 172 598
Aboriginal and Torres Strait Islander peoples	620 (540 to 680)	580 (500 to 640)	40 (40 to 40)	6%	0.09% (0.08 to 0.10%)	692 274
Australian born non-Indigenous	16 580 (14 000 to 19 230)	15 960 (13 570 to 18 300)	620 (430 to 930)	4%	0.12% (0.10 to 0.14%)	13 700 784
Overall non-Indigenous	29 470 (24 540 to 34 690)	27 070 (22 710 to 31 730)	2400 (1 830 to 2 9 60)	8%	0.14% (0.11% to 0.16%)	21 480 324

Prevalence

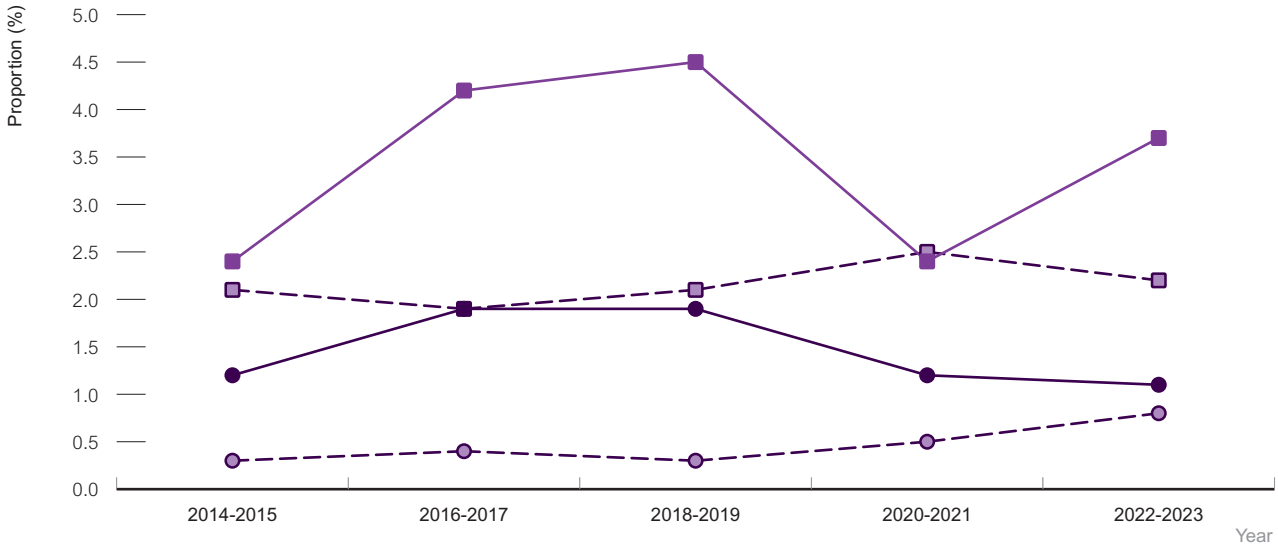
HIV prevalence is the proportion of people who are living with HIV in a given year. At the end of 2023, an estimated 620 Aboriginal and/or Torres Strait Islander people were living with HIV in Australia. The estimated HIV prevalence among Aboriginal and Torres Strait Islander peoples 0.09% (0.08 %-0.10%) in 2023 (Table 7).

Periodic surveys have also measured HIV prevalence among subpopulations of Aboriginal and Torres Strait Islander peoples, specifically those who engage with needle and syringe programs. These data may not be representative of all Aboriginal and Torres Strait Islander peoples who inject drugs.

Data collected annually from the ANSPS [4] provide insight into the demographics, risk behaviours, and blood borne virus prevalence among people who inject drugs who attend needle and syringe programs. In the periods from 2014–2015 to 2022–2023, the proportion of participants in the ANSPS identifying as Aboriginal and Torres Strait Islander increased from 19% in 2019 to 25% in 2023.

The overall HIV prevalence among Aboriginal and Torres Strait Islander respondents in the ANSPS was 2.3% (data not shown). As reported in the survey, between 2014–2015 and 2022–2023, HIV prevalence fluctuated and was 2.4% and 4.5% respectively among Aboriginal and Torres Strait Islander men, and from 1.1% to 1.9% among Aboriginal and Torres Strait Islander women. For the years 2022–2023, the HIV prevalence among non-Indigenous men and women fluctuated and was 2.2% and 0.8% respectively (Figure 41).

Figure 41 HIV prevalence in needle and syringe program participants by Aboriginal and Torres Strait Islander status and gender, 2014–2023



	2014-2015	2016-2017	2018-2019	2020-2021	2022-2023
Aboriginal and Torres Strait Islander men (%)	2.4	4.2	4.5	2.4	3.7
Non-Indigenous men (%)	2.1	1.9	2.1	2.5	2.2
Aboriginal and Torres Strait Islander women (%)	1.2	1.9	1.9	1.2	1.1
Non-Indigenous women (%)	0.3	0.4	0.3	0.5	0.8

Note: Data is grouped due to low numbers.

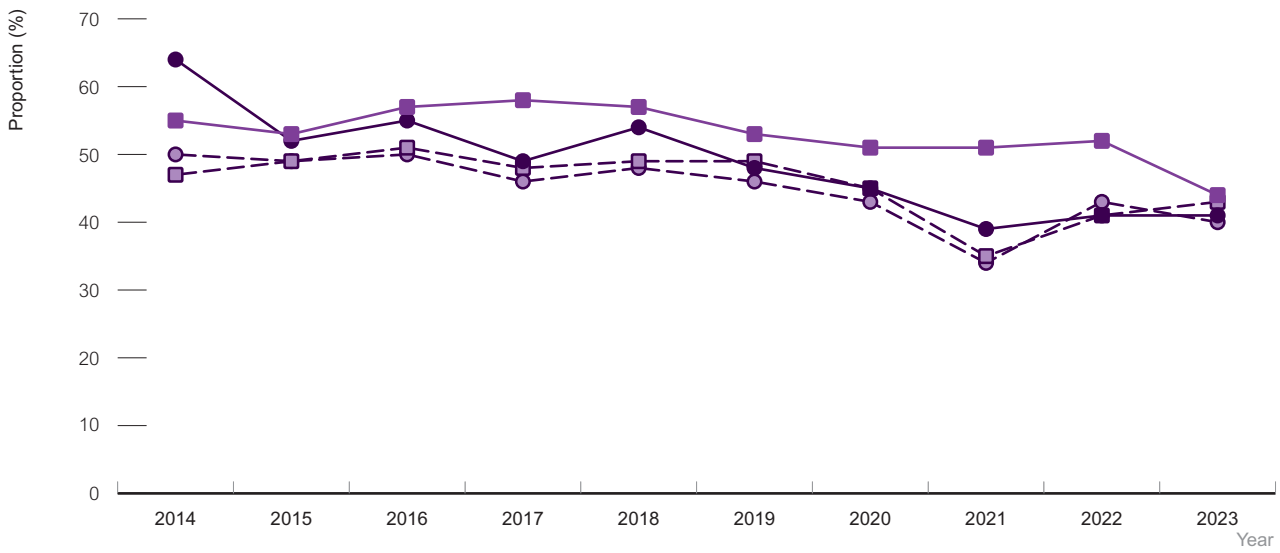
Source: Australian Needle Syringe Program Survey.

Testing

National testing guidelines recommend HIV testing in multiple contexts, including after potential HIV risk exposure, during antenatal care, and for particular priority populations. The Fifth National Aboriginal and Torres Strait Islander blood borne viruses and sexually transmissible infections strategy 2018–2022 prioritises annual testing for STIs, including HIV.

Among ANSPS participants, a higher proportion of Aboriginal and Torres Strait Islander women than non-Indigenous women reported having had an HIV test in the past 12 months for each year between 2014 and 2023, except for 2022 (41% vs 40% in 2023). Similarly, a higher proportion of Aboriginal and Torres Strait Islander men than non-Indigenous men reported a HIV test in the past 12 months each year between 2014 and 2023 (44% vs 43% in 2023) (Figure 42). These data may not be representative of all Aboriginal and Torres Strait Islander peoples who inject drugs.

Figure 42 Proportion of people who inject drugs seen at needle and syringe programs who reported an HIV antibody test in the past 12 months by Aboriginal and Torres Strait Islander status and gender, 2014–2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander women (%)	64	52	55	49	54	48	45	39	41	41
Non-Indigenous women (%)	50	49	50	46	48	46	43	34	43	40
Aboriginal and Torres Strait Islander men (%)	55	53	57	58	57	53	51	51	52	44
Non-Indigenous men (%)	47	49	51	48	49	49	45	35	41	43

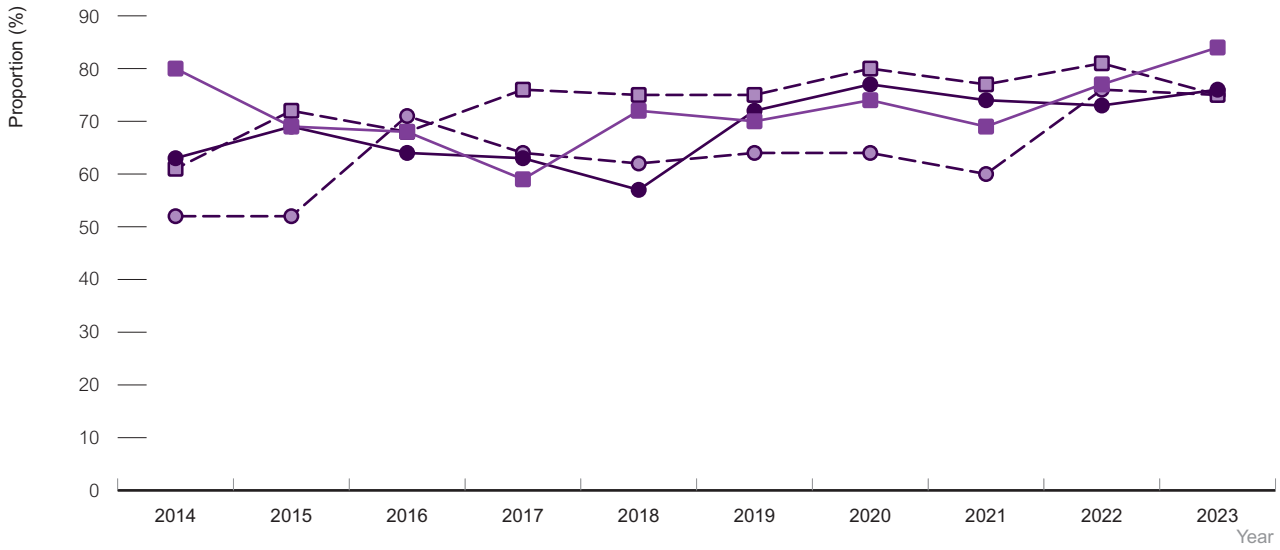
Source: Australian Needle Syringe Program Survey; see Methodology for detail.

Condom use

According to the ANSPS, more than half of Aboriginal and Torres Strait Islander respondents (who used injection drugs) reported inconsistent condom use with casual partners in all years 2014–2023. This proportion fluctuated among men (range 59-84%) but increased among women from 63% in 2014 to 76% in 2023. Among non-Indigenous people, inconsistent condom use increased among women (52% in 2014 to 75% in 2023) and men (61% in 2013 to 75% in 2022). In 2023, inconsistent condom use with casual partners was slightly higher among Aboriginal and Torres Strait Islander women than among non-Indigenous women (76% and 75%, respectively), and higher among Aboriginal and Torres Strait Islander men than among non-Indigenous men (84% and 75%, respectively). (Figure 42).

As above, these data may not be representative of all Aboriginal and Torres Strait Islander peoples who inject drugs.

Figure 43 Prevalence of inconsistent condom use with casual partners in the last month among people who inject drugs attending needle and syringe programs by Aboriginal and Torres Strait Islander status and gender, 2014–2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander women (%)	63	69	64	63	57	72	77	74	73	76
Non-Indigenous women (%)	52	52	71	64	62	64	64	60	76	75
Aboriginal and Torres Strait Islander men (%)	80	69	68	59	72	70	74	69	77	84
Non-Indigenous men (%)	61	72	68	76	75	75	80	77	81	75

Denominator is those who had sex with one or more casual partners in the last month.

Source: Australian Needle Syringe Program Survey; see Methodology for detail.

5 Hepatitis C

Please see p. 9 for summary. Due to data quality, data describing newly acquired hepatitis C notifications are not presented in this report. Future reporting may include data describing newly acquired hepatitis C.

Hepatitis C notifications

This section focuses on notified cases of hepatitis C infection, which means that a person previously not known to have the infection has since been tested and now found to have hepatitis C, or in a person who has been cured, and subsequent testing has identified reinfection.

A total of 7602 hepatitis C notifications were reported in 2023 in Australia; 1499 (20%) occurred among Aboriginal and Torres Strait Islander peoples, 3793 (50%) were among non-Indigenous people, and there were a further 2310 (30%) notifications among people for whom Aboriginal and Torres Strait Islander status was not reported [1]. Details of Aboriginal and Torres Strait Islander notifications for the 2019-2023 reporting period are provided in Table 8.

Table 8 Hepatitis C notifications in Aboriginal and Torres Strait Islander peoples, by characteristic, 2019–2023

Characteristic	2019	2020	2021	2022	2023
Total cases	1536	1308	1399	1178	1499
Sex[a]					
Male	439	417	407	334	343
Female	1097	891	991	844	1152
Age group					
0-14	9	17	10	6	5
15-24	416	335	289	271	364
25-39	754	599	697	531	747
≥40	357	357	403	370	383
State/Territory[b]					
Australian Capital Territory	23	21	14	8	12
New South Wales	435	379	301	324	480
Northern Territory	32	25	28	22	37
Queensland	620	547	639	448	521
South Australia	55	42	41	33	36
Tasmania	15	6	9	6	4
Victoria	63	18	49	58	88
Western Australia	293	270	318	279	321

Excludes 'Not reported';

a The National Notifiable Diseases Surveillance System includes the variable 'Sex' to indicate Sex/Gender. For reporting purposes, 'Sex' is used as 'Gender' was not reported historically.

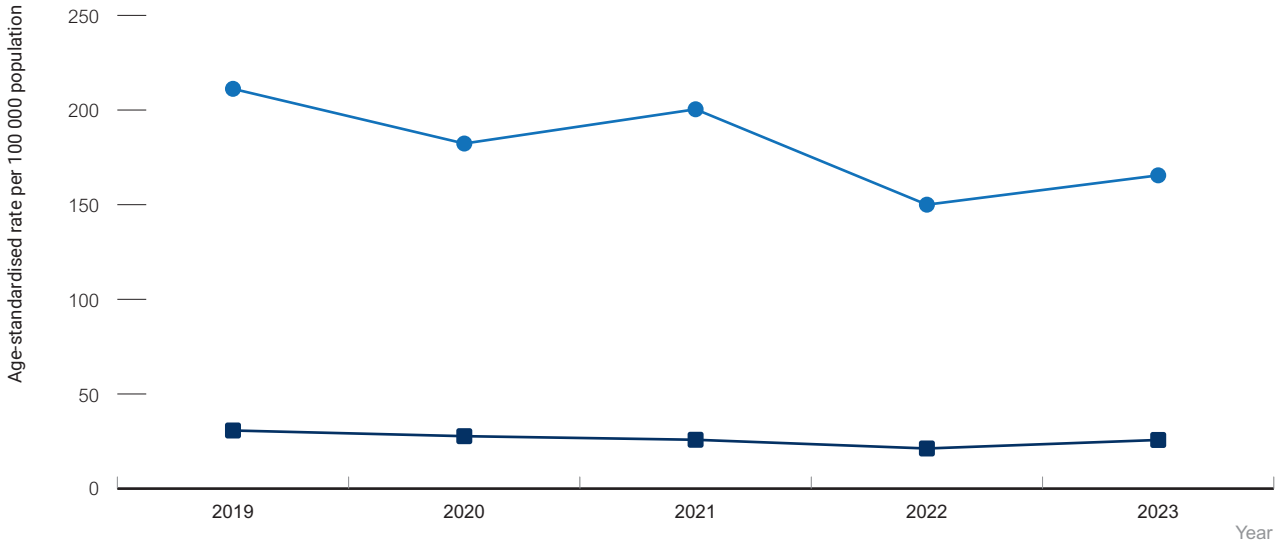
b Numbers of notifications in some jurisdictions may be strongly influenced by completeness of Aboriginal and Torres Strait Islander status.

Source: National Notifiable Diseases Surveillance System.

Aboriginal and Torres Strait Islander hepatitis C notification rates are based on data from five jurisdictions (the Northern Territory, Queensland, South Australia, Tasmania and Western Australia) where Aboriginal and Torres Strait Islander status was ≥50% complete for all hepatitis C notifications for each of the five years 2019–2023. Incomplete reporting of Aboriginal and Torres Strait Islander status can result in a misrepresentation of the true extent of the notifications in Aboriginal and Torres Strait Islander peoples and may not reflect national trends.

The age-standardised notification rate of hepatitis C in Aboriginal and Torres Strait Islander peoples decreased by 21% from 211.2 per 100 000 in 2019 to 165.5 per 100 000 in 2023, with fluctuations during this period. By comparison, among non-Indigenous people, the hepatitis C notification rate steadily decreased by 32% from 30.7 per 100 000 in 2019 to 25.7 per 100 000 in 2023 (Figure 44). In 2023, the age-standardised hepatitis C notification rate for Aboriginal and Torres Strait Islander peoples was more than six times as high as compared to non-Indigenous people (165.5 per 100 000 vs 25.7 per 100 000).

Figure 44 Age standardised hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2019–2023

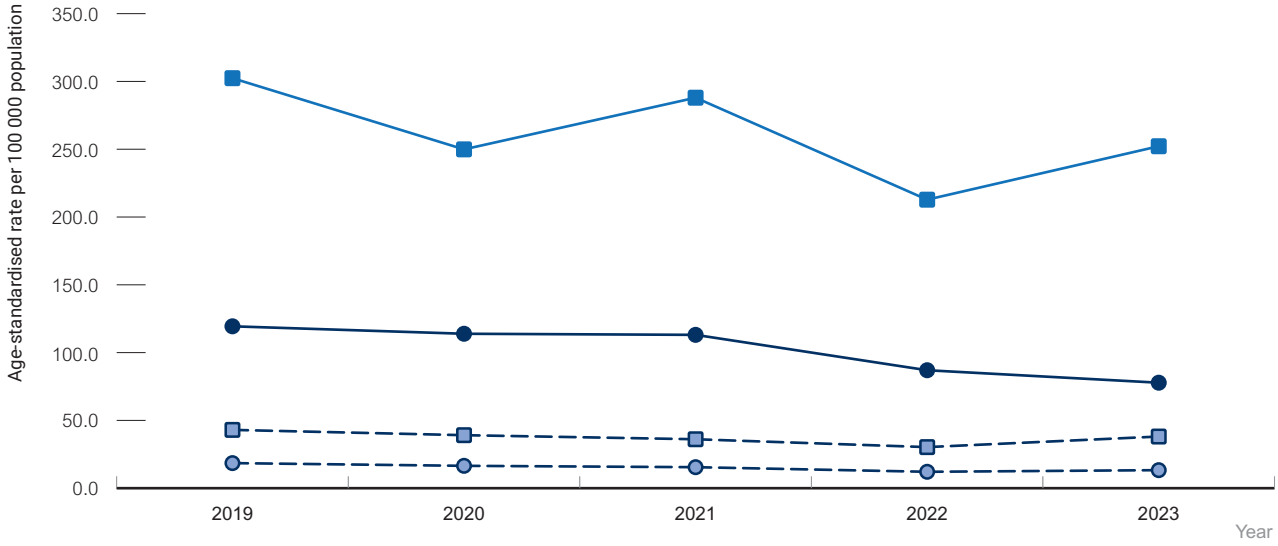


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples	211.2	182.3	200.4	150.0	165.5
Non-Indigenous people	30.7	27.7	25.8	21.2	25.7

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In all years from 2019 to 2023, among Aboriginal and Torres Strait Islander peoples, the age standardised hepatitis C notification rate was higher in males and females than in gender equivalent non-Indigenous people (Figure 44). Rates among Aboriginal and Torres Strait Islander males were 3.2 times higher than their females' counterparts. Among Aboriginal and Torres Strait Islander males, the hepatitis C notification rate decreased by 16% from 302.4 per 100 000 in 2019 to 252.2 per 100 000 in 2023, with fluctuations during this period. Similarly, among Aboriginal and Torres Strait Islander females, the hepatitis C notification rate decreased by 34% from 119.4 per 100 000 in 2019 to 77.8 per 100 000 in 2023, with fluctuations during this period (Figure 45).

Figure 45 Hepatitis C notification rates per 100 000 population by Aboriginal and Torres Strait Islander status and gender, 2019–2023

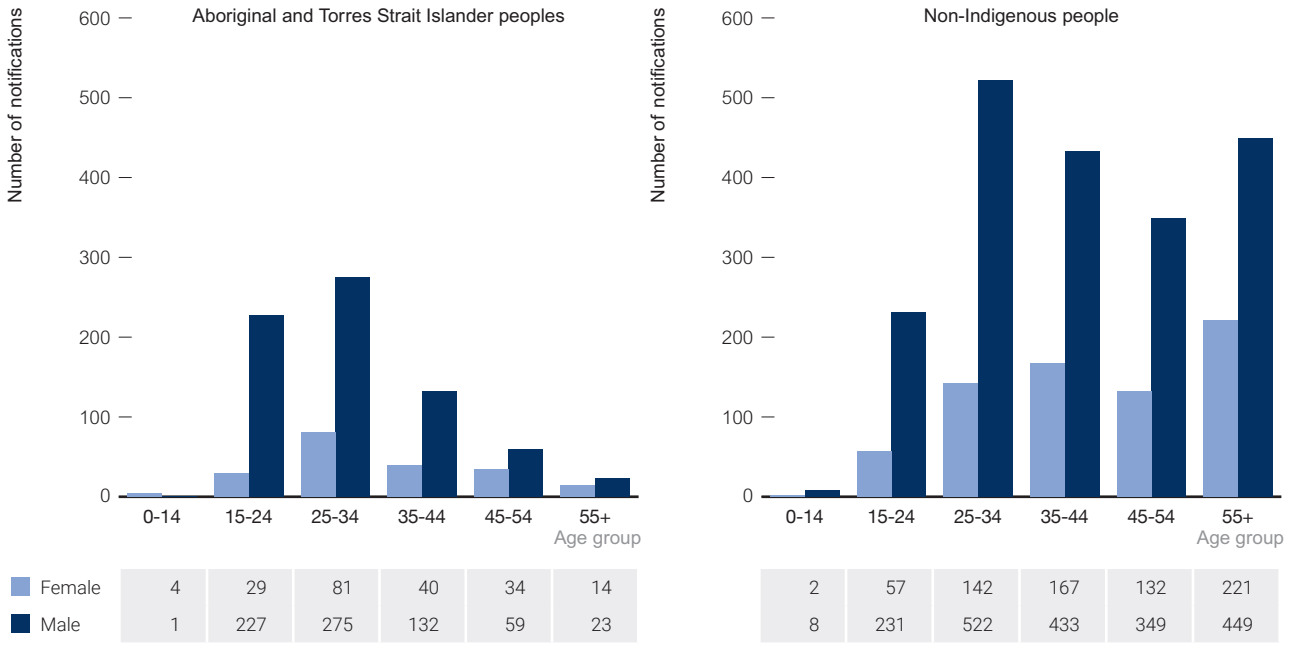


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander female	119.4	113.9	113.1	87.0	77.8
Aboriginal and Torres Strait Islander male	302.4	249.9	288.0	212.8	252.2
Non-Indigenous female	18.5	16.5	15.5	12.1	13.3
Non-Indigenous male	43.0	39.1	36.1	30.3	38.1

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2023, 24% of hepatitis C notifications in Aboriginal and Torres Strait Islander peoples occurred in people aged between 25 to 34 years. By comparison, among non-Indigenous people, 30% of hepatitis C notifications occurred in people aged 45 years and older. Similar trends in proportions were seen among males and females (Figure 46).

Figure 46 Number of hepatitis C notifications by Aboriginal and Torres Strait Islander status, age, and gender, 2023

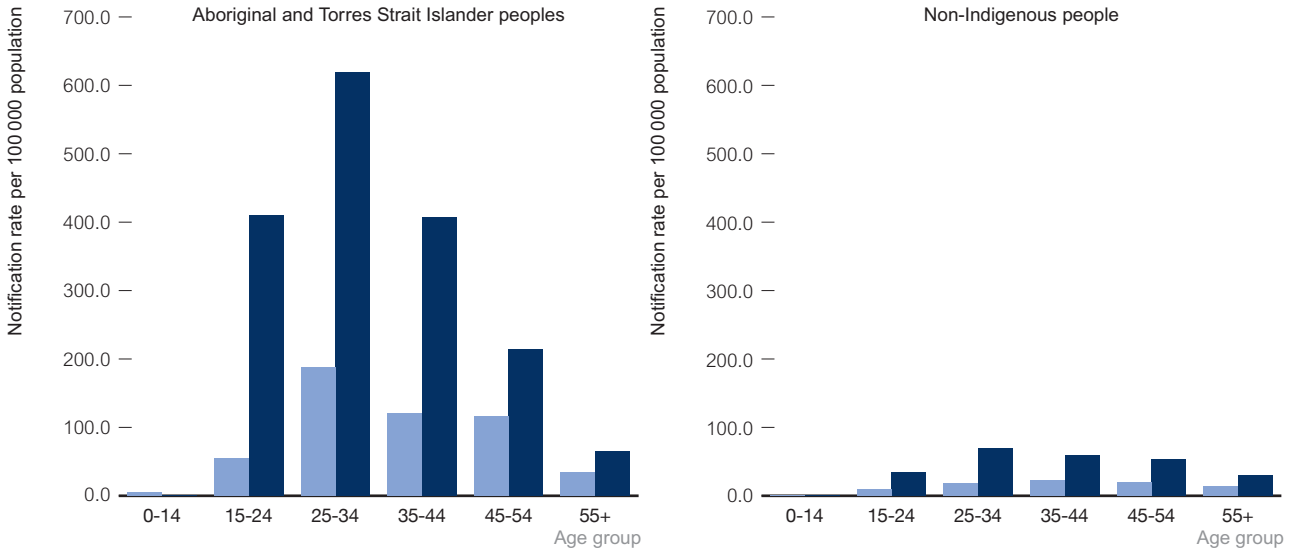


	Aboriginal and Torres Strait Islander peoples						Non-Indigenous people					
	0-14	15-24	25-34	35-44	45-54	55+	0-14	15-24	25-34	35-44	45-54	55+
Female	4	29	81	40	34	14	2	57	142	167	132	221
Male	1	227	275	132	59	23	8	231	522	433	349	449

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2023, the highest notification rates among both Aboriginal and Torres Strait Islander females were among those aged 25 to 34 years (187.4 per 100 000). In contrast among non-Indigenous females the highest rate was among those aged 35 to 44 years (59.4 per 100 000). For both Aboriginal and Torres Strait Islander males and non-Indigenous males highest rates were among those aged 25 to 34 years (619.4 per 100 000 and 69.2 per 100 000). By gender, hepatitis C notification rates for Aboriginal and Torres Strait Islander males and females were higher than notification rates for non-Indigenous males and females for every age group in 2023 (Figure 47).

Figure 47 Hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, gender and age group, 2023

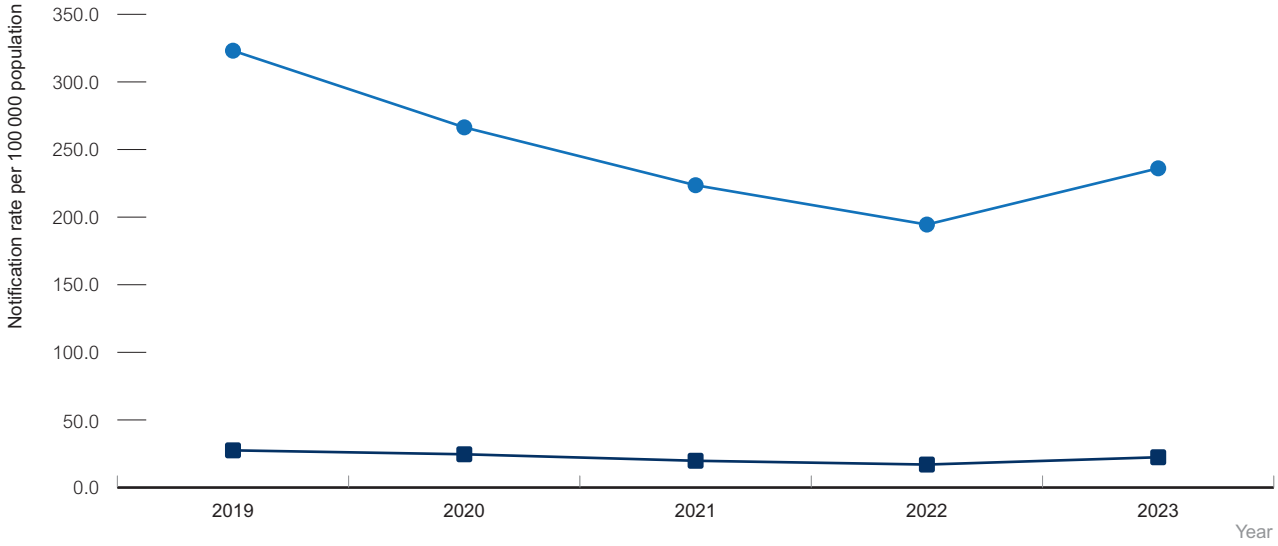


	Aboriginal and Torres Strait Islander peoples						Non-Indigenous people					
	0-14	15-24	25-34	35-44	45-54	55+	0-14	15-24	25-34	35-44	45-54	55+
Female	4.5	54.7	187.4	120.4	116.6	34.9	0.2	9.2	18.9	22.5	19.6	13.4
Male	1.1	409.4	619.4	406.6	214.1	65.7	0.9	34.8	69.2	59.4	53.0	29.6

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

Compared with older age-groups, most primary hepatitis C infections among those aged 15 to 24 years are recently acquired [4]. Therefore, trends in the rate of notifications among those aged 15 to 24 years are used here as a proxy for the incidence of hepatitis C infection. The hepatitis C notification rate in Aboriginal and Torres Strait Islander peoples aged 15 to 24 years declined by 27% from 323.1 per 100 000 in 2019 to 236.1 per 100 000 in 2023. Similarly, the hepatitis C notification rate among non-Indigenous people aged 15 to 24 years declined by 19% from 27.5 per 100 000 in 2019 to 22.4 per 100 000 in 2023 (Figure 48). A breakdown of hepatitis C notification rates by age-group and Aboriginal and Torres Strait Islander status can be found on the Kirby Institute data site.

Figure 48 Hepatitis C notification rate per 100 000 in people aged 15-24 years and younger by Aboriginal and Torres Strait Islander status, 2019–2023

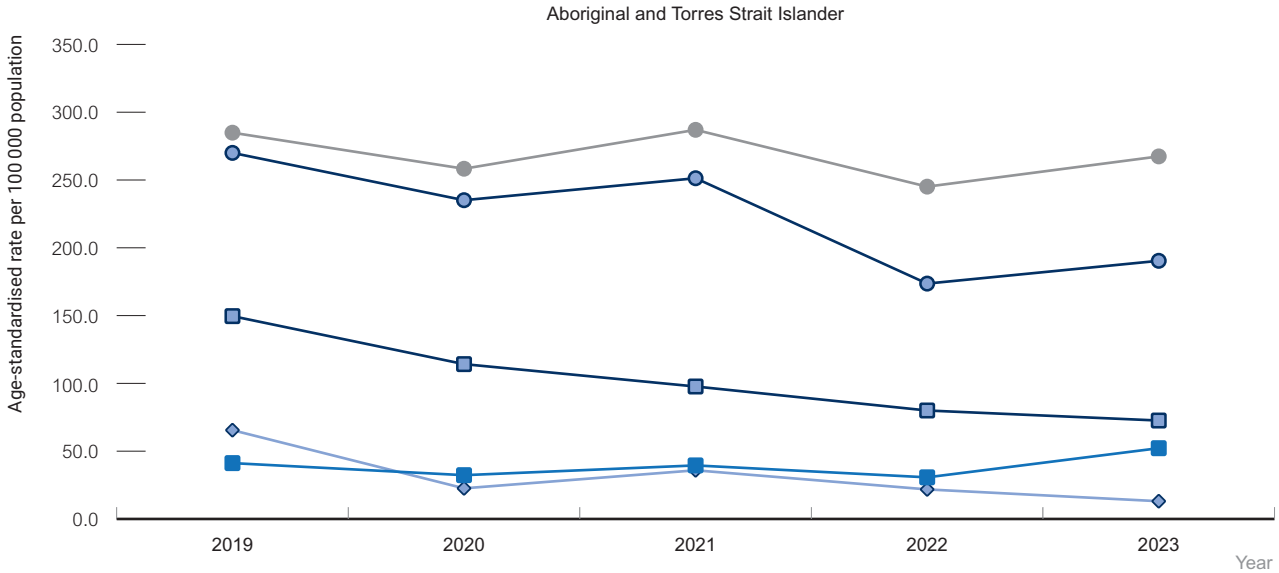


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples	323.1	266.4	223.6	194.5	236.1
Non-Indigenous people	27.5	24.6	19.8	17.0	22.4

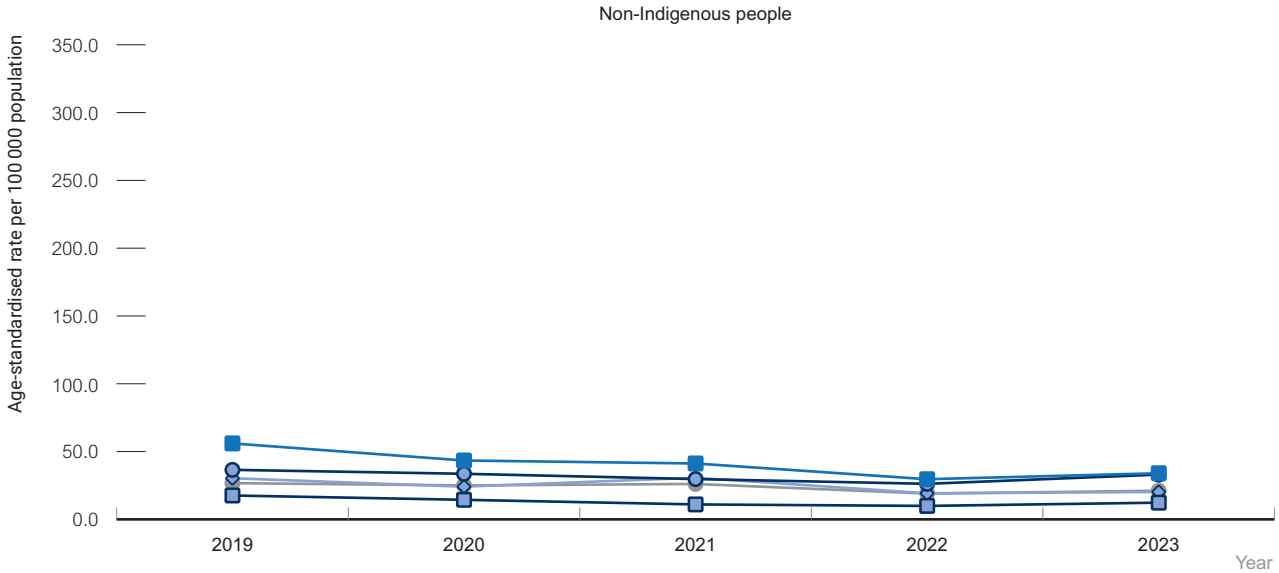
Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2023, hepatitis C notification rates among Aboriginal and Torres Strait Islander peoples were highest in Western Australia (267.4 per 100 000), followed by Queensland (190.4 per 100 000), and South Australia (72.6 per 100 000). In the Northern Territory and Western Australia hepatitis C notification rates fluctuated between 2019 and 2023. In all other states and territories rates declined (Figure 49).

Figure 49 Hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and state/territory, 2019–2023



	2019	2020	2021	2022	2023
NT	41.2	32.3	39.5	30.7	52.2
QLD	270.0	235.1	251.3	173.6	190.4
SA	149.6	114.2	97.7	80.0	72.6
TAS	65.5	22.6	35.9	21.8	13.1
WA	284.9	258.3	287.0	245.1	267.4

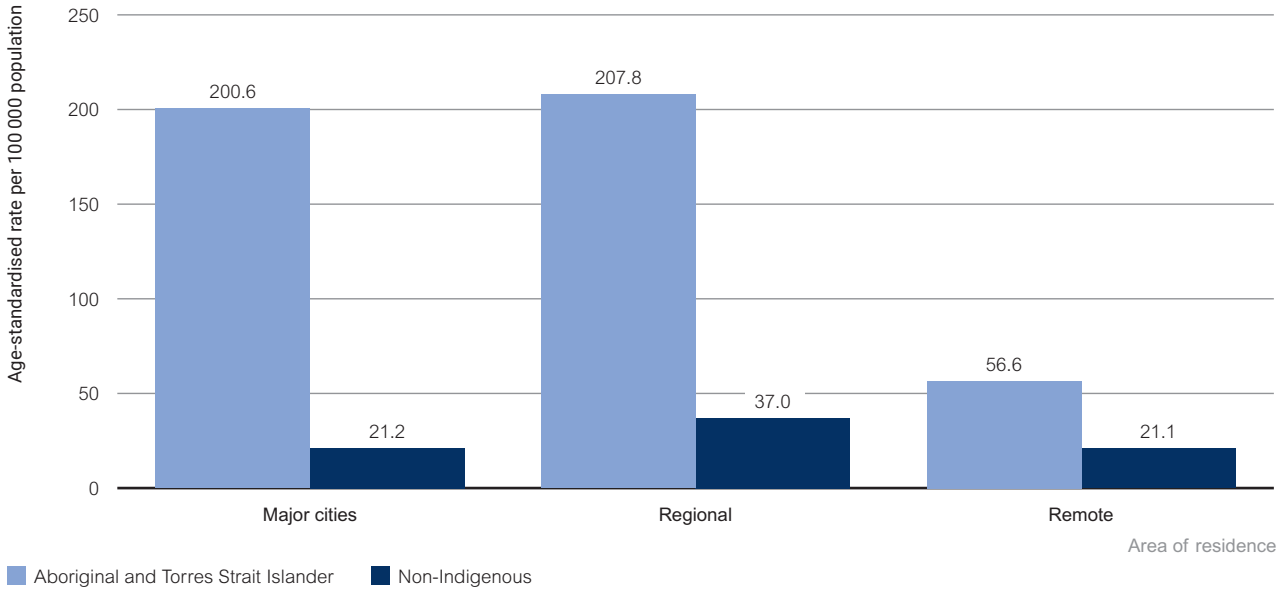


	2019	2020	2021	2022	2023
NT	56.0	43.4	41.2	29.6	34.0
QLD	36.5	33.6	29.7	26.2	33.0
SA	17.6	14.4	11.0	9.9	12.3
TAS	30.3	24.1	30.7	19.2	20.2
WA	26.7	25.0	26.1	19.0	21.1

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2023, the hepatitis C notification rate in major cities was 9 times as high in Aboriginal and Torres Strait Islander peoples compared to non-Indigenous people (200.6 and 21.2 per 100 000, respectively). In regional areas, the rate among Aboriginal and Torres Strait Islander peoples was almost six times as high as among non-Indigenous people (207.8 and 37 per 100 000, respectively). In remote areas, hepatitis C notification rates among the Aboriginal and Torres Strait Islander population were almost three times as high as among non-Indigenous people (56.6 and 21.1 per 100 000, respectively) (Figure 50).

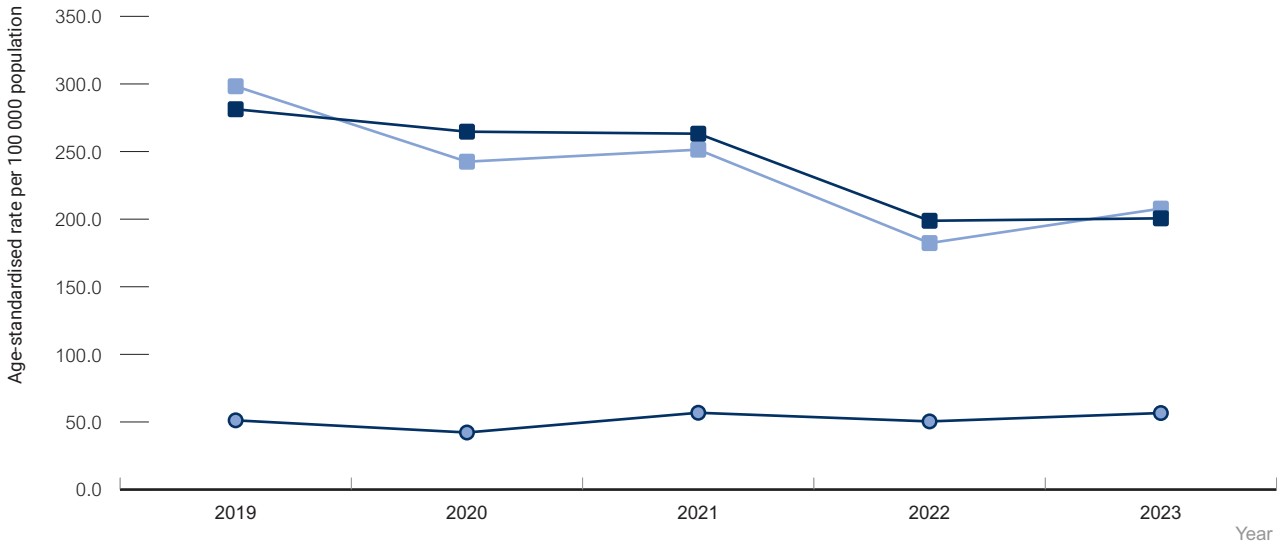
Figure 50 Hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and area of residence, 2023



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

Hepatitis C notification rates declined by 29% among Aboriginal and Torres Strait Islander peoples living in major cities from 2019 to 2023 (281.3 per 100 000 and 200.6 per 100 000 respectively) and by 30% among Aboriginal and Torres Strait Islander people living in regional areas (298.3 per 100 000 to 207.8 per 100 000). In remote areas rates fluctuated and were 56.6 per 100 000 in 2023 (Figure 51).

Figure 51 Hepatitis C notification rate per 100 000 population among Aboriginal and Torres Strait Islander peoples by area of residence, 2019–2023



	2019	2020	2021	2022	2023
Major cities	281.3	264.7	263.2	198.8	200.6
Regional	298.3	242.5	251.4	182.3	207.8
Remote	51.2	42.2	56.8	50.4	56.6

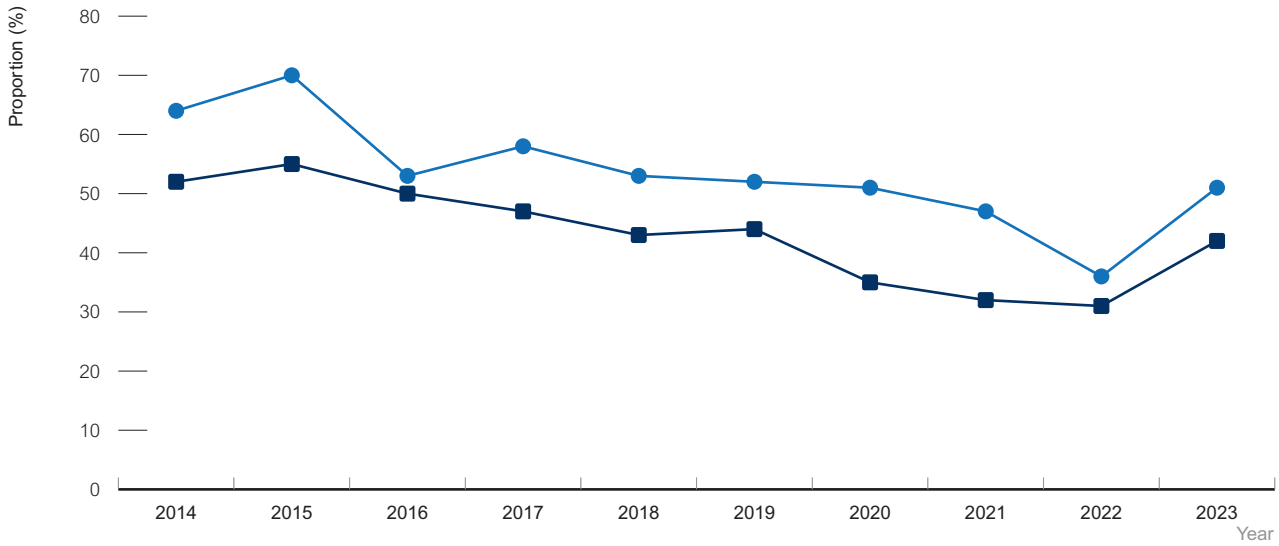
Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

Hepatitis C prevalence

Australia's hepatitis C epidemic affects many people across differing age groups, ethnicities, and sociodemographic backgrounds including Aboriginal and Torres Strait Islander peoples. Key populations include people with a history of injecting drug use and people with a history of incarceration.

Between 2014 and 2015, the hepatitis C antibody prevalence among Aboriginal and Torres Strait Islander participants of the ANSPS increased from 64% to 70%, and then declined to 36% in 2022. Between 2022 and 2023 the prevalence increased to 51%. For each year between 2014 and 2023 hepatitis C antibody prevalence was higher among Aboriginal and Torres Strait Islander ANSPS respondents than among non-Indigenous respondents (Figure 52).

Figure 52 Hepatitis C antibody prevalence in needle and syringe program participants by Aboriginal and Torres Strait Islander status, 2014–2023



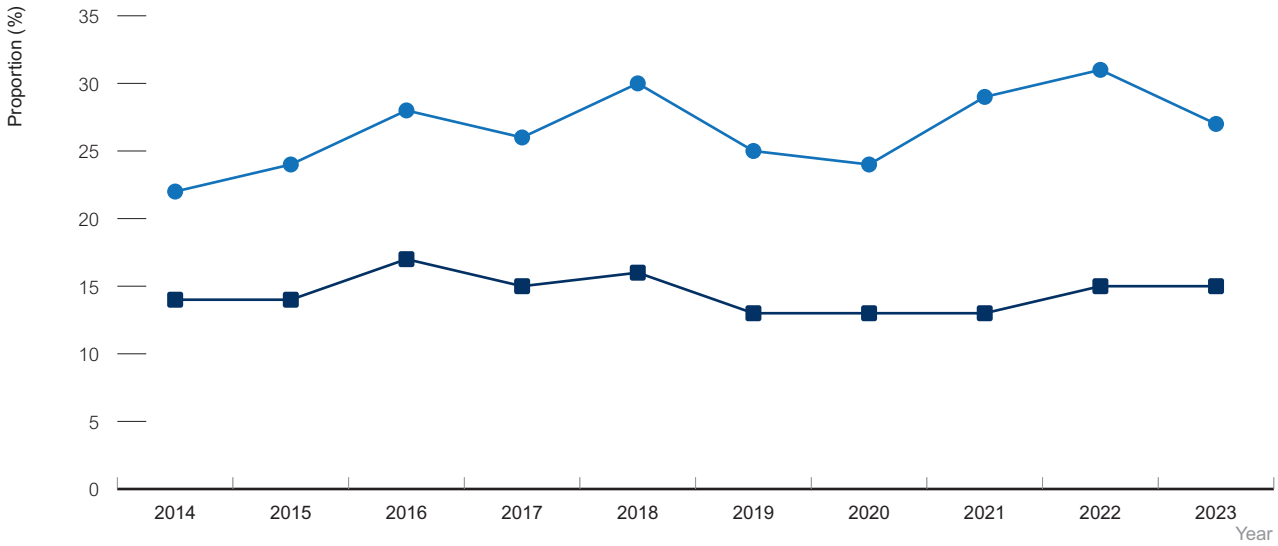
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples (%)	64	70	53	58	53	52	51	47	36	51
Non-Indigenous people (%)	52	55	50	47	43	44	35	32	31	42

Source: Australian Needle Syringe Program Survey; see Methodology for detail.

Injection drug use

Receptive syringe sharing was determined in the ANSPS by the question: 'How many times in the last month did you reuse a needle and syringe after someone else had used it, including your sex partner (even if it was cleaned)?'. The proportion of Aboriginal and Torres Strait Islander people participating in the survey who reported receptive syringe sharing increased from 22% in 2014 to 27% in 2023. This proportion was higher among Aboriginal and Torres Strait Islander participants than among non-Indigenous participants in each of the years 2014–2023 (Figure 53).

Figure 53 Prevalence of receptive syringe sharing by needle and syringe program participants by Aboriginal and Torres Strait Islander status, 2014–2023



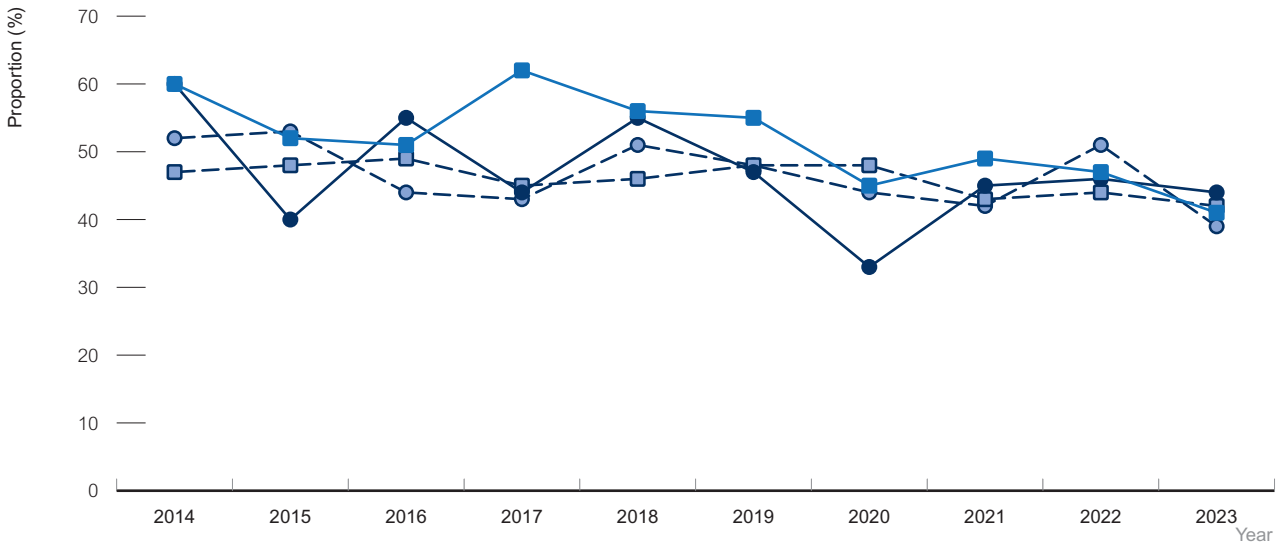
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples (%)	22	24	28	26	30	25	24	29	31	27
Non-Indigenous people (%)	14	14	17	15	16	13	13	13	15	15

Source: Australian Needle Syringe Program Survey; see Methodology for detail.

Testing

Of Aboriginal and Torres Strait Islander women who were hepatitis C antibody negative and who participated in the ANSPS, the proportion who reported a hepatitis C antibody test in the past 12 months declined over the period 2014 to 2023 from 60% to 44%, however the proportion fluctuated over last 10 years between 33% and 60%. (Figure 54). The proportion of participating Aboriginal and Torres Strait Islander men who were hepatitis C antibody negative and who reported a hepatitis C antibody test in the past 12 months also declined between 2014 and 2023 from 60% to 41%. Among non-Indigenous women who were hepatitis C antibody negative, the proportion tested fluctuated between 2014 and 2023 and was 39% in 2023. A similar trend was seen among the hepatitis C antibody negative non-Indigenous men, with the proportion of ANSPS participants who reported a hepatitis C antibody test in the past 12 months 42% in 2023 (Figure 54).

Figure 54 Proportion of ANSPS participants who were hepatitis C antibody negative and reported a hepatitis C antibody test in the past 12 months, by Aboriginal and Torres Strait Islander status, 2014–2023



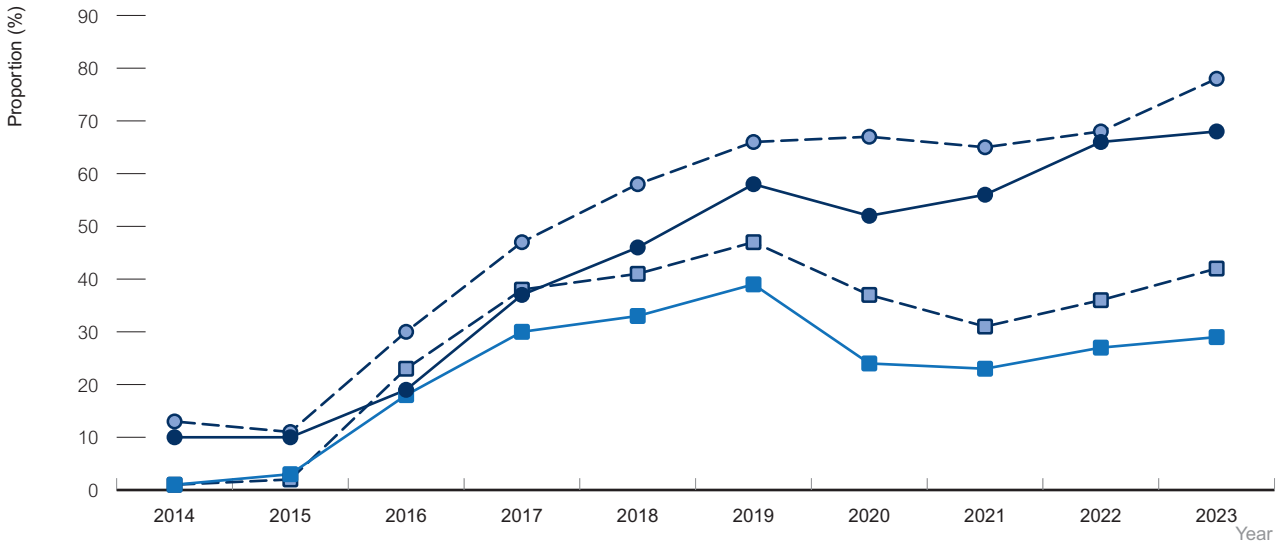
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander women (%)	60	40	55	44	55	47	33	45	46	44
Non-Indigenous women (%)	52	53	44	43	51	48	44	42	51	39
Aboriginal and Torres Strait Islander men (%)	60	52	51	62	56	55	45	49	47	41
Non-Indigenous men (%)	47	48	49	45	46	48	48	43	44	42

Source: Australian Needle Syringe Program Survey; see Methodology for detail

Treatment

In 2023, among Aboriginal and Torres Strait Islander participants in the ANSPS, 68% reported a lifetime history of hepatitis C treatment, an increase from 10% in 2014 (Figure 55). In 2023, Aboriginal and Torres Strait Islander participants had lower lifetime uptake of treatment than non-Indigenous participants (68% vs 78%). In 2023, Aboriginal and Torres Strait Islander participants had lower uptake of treatment in the last 12 months than non-Indigenous participants (29% vs 42%). Increases in treatment uptake after 2015 reflect PBS-subsidised interferon-free direct-acting antiviral regimens becoming available in Australia in March 2016.

Figure 55 Hepatitis C antiviral therapy ever for hepatitis C antibody-positive needle syringe program participants, by Aboriginal and Torres Strait Islander status, 2014–2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Lifetime history of treatment - Aboriginal and Torres Strait Islander (%)	10	10	19	37	46	58	52	56	66	68
Treatment in the last 12 months - Aboriginal and Torres Strait Islander (%)	1	3	18	30	33	39	24	23	27	29
Lifetime history of treatment - non-Indigenous (%)	13	11	30	47	58	66	67	65	68	78
Treatment in the last 12 months - non-Indigenous (%)	1	2	23	38	41	47	37	31	36	42

Source: Australian Needle Syringe Program Survey; see Methodology for detail.

6 Hepatitis B

Please see p. 9 for summary.

Hepatitis B notifications

This section focuses on notified cases of hepatitis B infection, which means that a person previously not known to have the infection has since been tested and now found to have hepatitis B.

There was a total of 5390 hepatitis B notifications in Australia in 2023. Of these 135 (2.5%) were among Aboriginal and Torres Strait Islander peoples (Table 8), 3213 (60%) were among non-Indigenous people, and 2042 (38%) were among people for whom Aboriginal and Torres Strait Islander status was not reported [1]. Details of Aboriginal and Torres Strait Islander notifications for the 2019-2023 reporting period are provided in Table 9.

Table 9 Hepatitis B notifications in Aboriginal and Torres Strait peoples, by characteristic, 2019–2023

Characteristic	2019	2020	2021	2022	2023
Total cases	154	173	162	108	135
Sex[a]					
Male	60	69	61	40	40
Female	94	104	101	68	95
Age group					
<20	14	12	10	7	6
20-29	20	24	13	14	20
30-39	47	44	28	22	32
40-49	35	42	50	18	31
50-59	21	33	34	27	20
60-69	12	13	19	14	21
70+	5	5	8	6	5
State/Territory[b]					
Australian Capital Territory	2	0	0	2	1
New South Wales	48	42	39	31	33
Northern Territory	17	21	6	11	29
Queensland	59	59	57	29	32
South Australia	6	10	1	2	1
Tasmania	1	0	0	0	0
Victoria	3	2	4	2	5
Western Australia	18	39	55	31	34

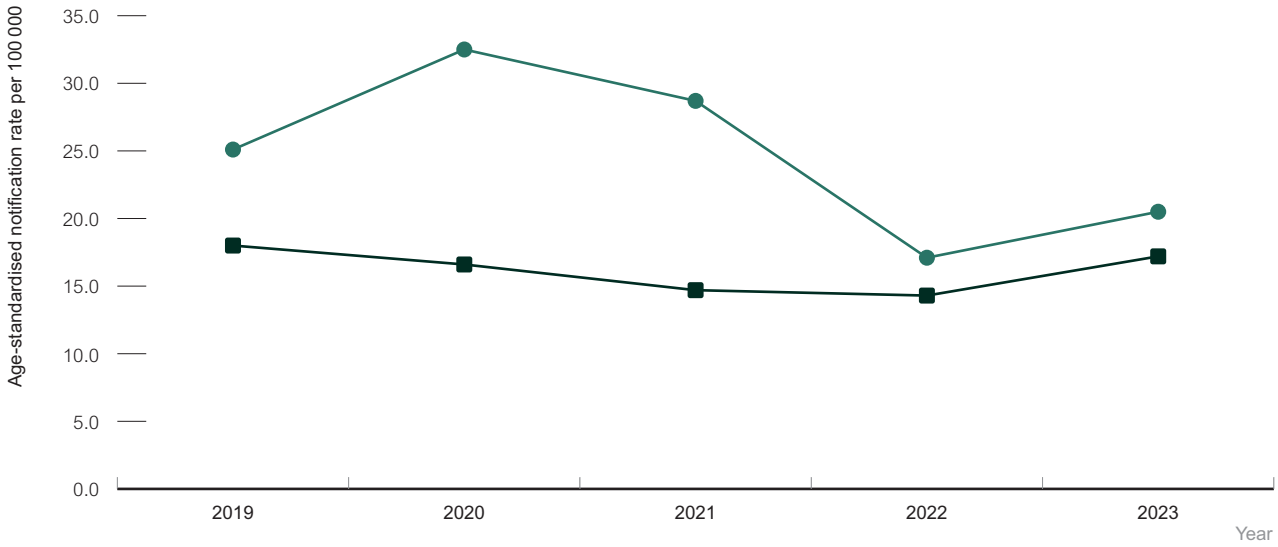
a Excludes 'Not reported'; The National Notifiable Diseases Surveillance System includes the variable 'Sex' to indicate Sex/Gender.
b Numbers of notifications in some jurisdictions may be strongly influenced by completeness of Aboriginal and Torres Strait Islander status.

Source: National Notifiable Diseases Surveillance System.

In the five-year period 2019–2023, Aboriginal and Torres Strait Islander status was recorded for at least 50% of notifications per year in the Australian Capital Territory, the Northern Territory, Queensland, South Australia, Tasmania and Western Australia. These six jurisdictions are therefore included in reporting below.

Incomplete reporting of Aboriginal and Torres Strait Islander status can result in a misrepresentation of the true extent of the notifications in Aboriginal and Torres Strait Islander peoples and may not reflect national trends. The hepatitis B age standardised notification rate among Aboriginal and Torres Strait Islander peoples decreased by 18.3% between 2019 and 2023 from 25.1 per 100 000 to 20.5 per 100 000. The hepatitis B notification rate among non-Indigenous people declined by 20.6% between 2019 and 2022 from 18.0 to 14.3 per 100 000. Between 2022 and 2023 the hepatitis rate increased to 17.2 per 100 000 (Figure 56).

Figure 56 Hepatitis B notification rate per 100 000 population by, Aboriginal and Torres Strait Islander status, 2019–2023



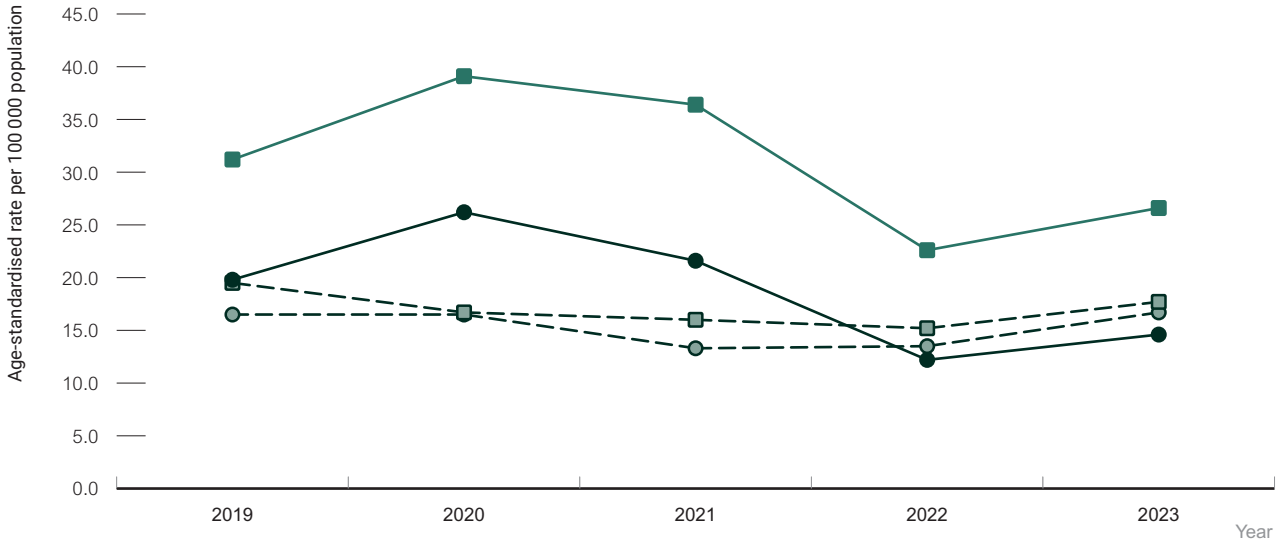
	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples	25.1	32.5	28.7	17.1	20.5
Non-Indigenous people	18.0	16.6	14.7	14.3	17.2

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

For the years 2019 to 2023, age standardised hepatitis B notification rates have been consistently higher in Aboriginal and Torres Strait Islander males than in Aboriginal and Torres Strait Islander females. Hepatitis B rates declined among Aboriginal and Torres Strait Islander females by 26.3% between 2019 and 2023 (19.8 per 100 000 to 14.6 per 100 000). Similarly, amongst Aboriginal and Torres Strait Islander males, rates decreased by 14.7% (31.2 to 26.6 per 100 000).

In the same period, hepatitis B notification rates remained stable among non-Indigenous females at 16.5 and 16.7 per 100 000 and declined among non-Indigenous males from 19.5 to 17.7 per 100 000 (Figure 57).

Figure 57 Hepatitis B notification rates per 100 000, by Aboriginal and Torres Strait Islander status and gender, 2019–2023

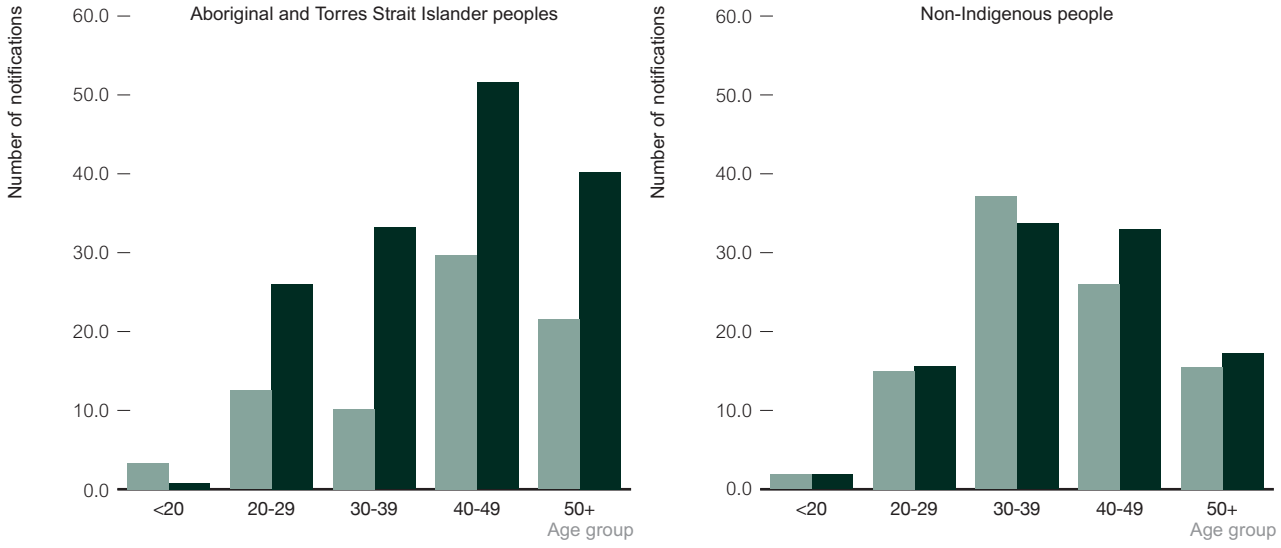


	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander females	19.8	26.2	21.6	12.2	14.6
Aboriginal and Torres Strait Islander males	31.2	39.1	36.4	22.6	26.6
Non-Indigenous females	16.5	16.5	13.3	13.5	16.7
Non-Indigenous males	19.5	16.7	16.0	15.2	17.7

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Indigenous status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2023, hepatitis B notification rates among Aboriginal and Torres Strait Islander peoples were highest among men and women aged 40 to 49 (Figure 58). Among non-Indigenous men and women hepatitis B notification rates were highest among men and women aged 30 to 39. Small numbers of notifications among Aboriginal and Torres Strait Islander peoples mean that comparisons by age-group should be conducted with caution.

Figure 58 Hepatitis B notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, age group, and gender, 2023

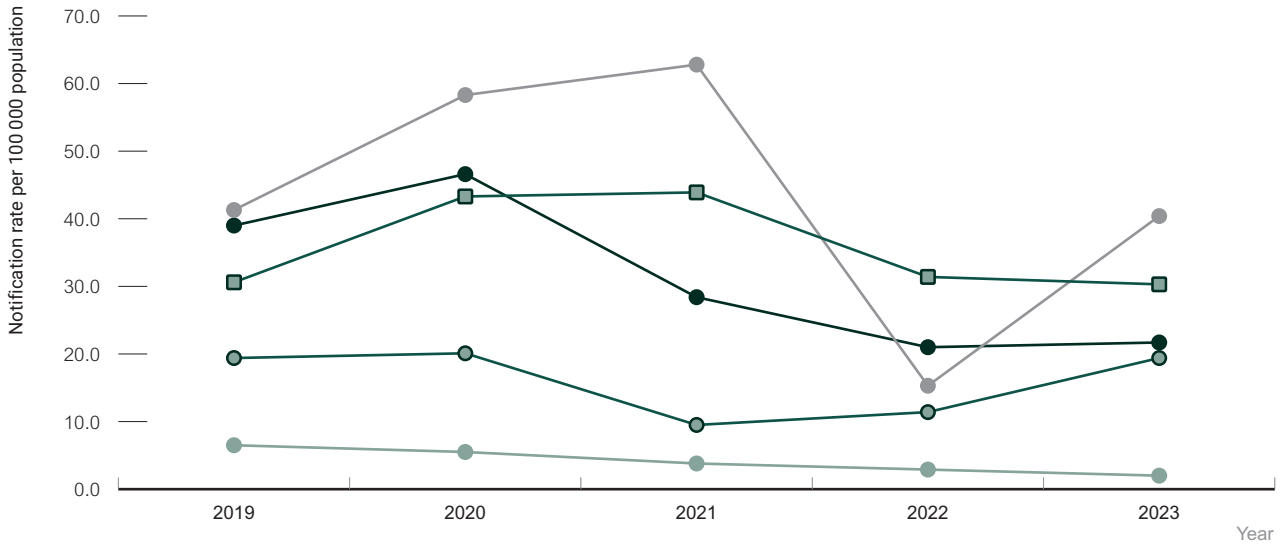


	Aboriginal and Torres Strait Islander peoples					Non-Indigenous people				
	<20	20-29	30-39	40-49	50+	<20	20-29	30-39	40-49	50+
Females	3.3	12.5	10.2	29.7	21.5	1.9	15.0	37.1	26.0	15.5
Males	0.8	26.0	33.2	51.6	40.2	1.9	15.6	33.7	33.0	17.3

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

By age-group, the highest hepatitis B rates in 2023 were among those aged 40 to 49 years (40.4 notifications per 100 000) followed by those aged over 50 years (30.3 per 100 000), likely reflecting the impact of childhood and adolescent vaccination programs in the younger age groups (Figure 59).

Figure 59 Hepatitis B notification rate per 100 000 population among Aboriginal and Torres Strait Islander peoples by age group, 2019–2023

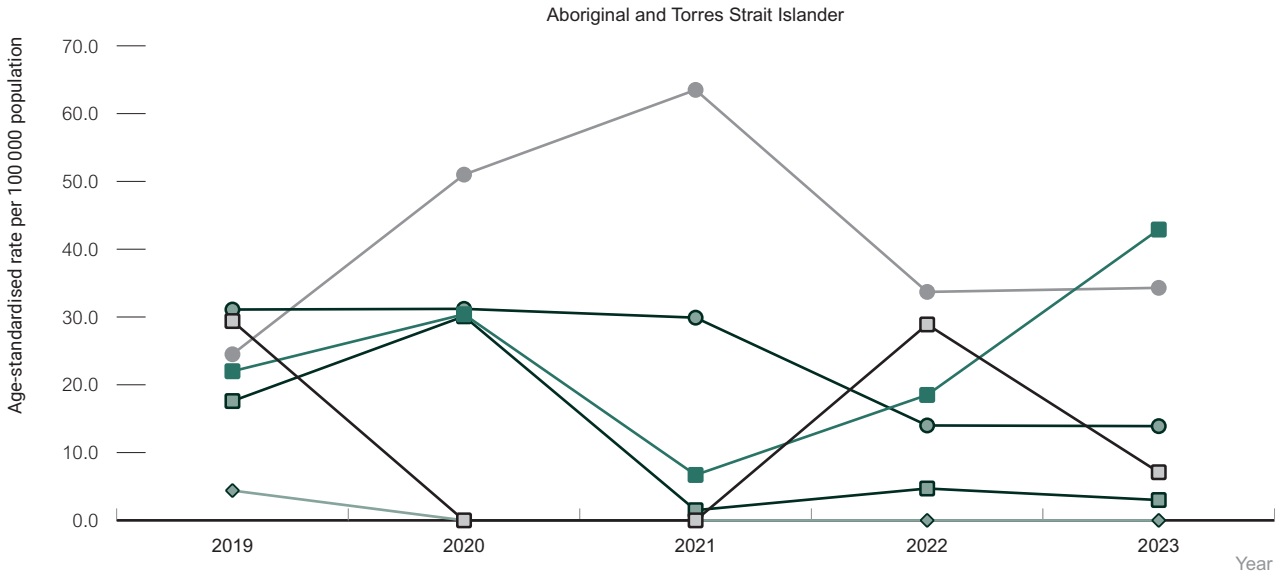


	2019	2020	2021	2022	2023
<20	6.5	5.5	3.8	2.9	2.0
20-29	19.4	20.1	9.5	11.4	19.4
30-39	39.0	46.6	28.4	21.0	21.7
40-49	41.3	58.3	62.8	15.3	40.4
50+	30.6	43.3	43.9	31.4	30.3

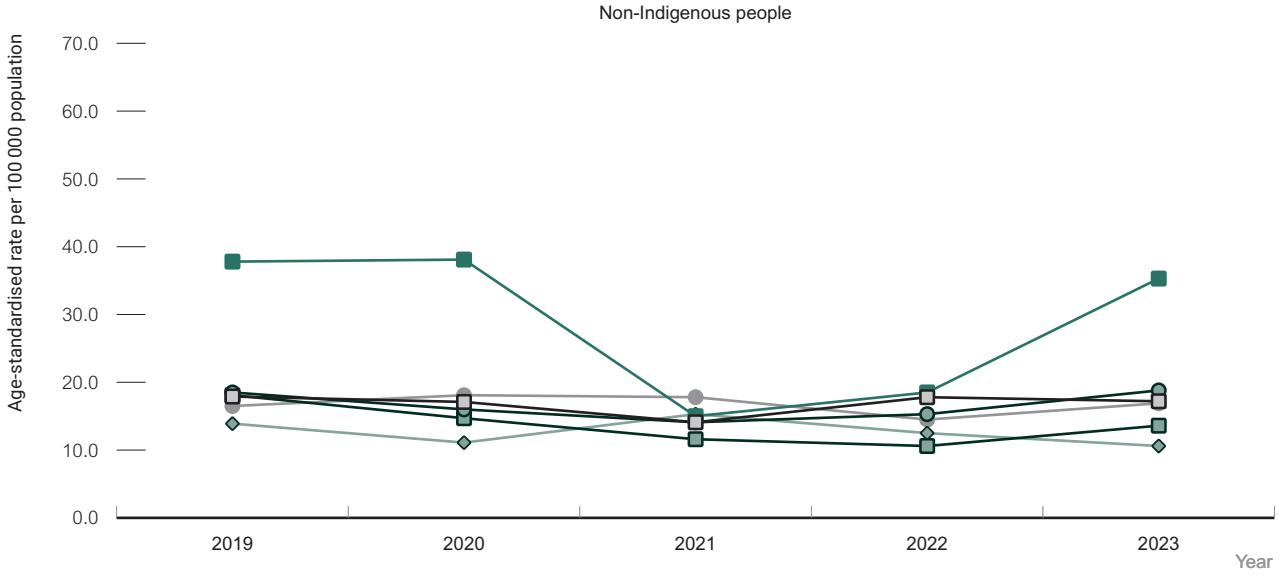
Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2023, hepatitis B notification rates among Aboriginal and Torres Strait Islander peoples were highest in the Northern Territory (42.9 per 100 000), followed by Western Australia (34.3 per 100 000). Interpretation of trends over time by state and territory are difficult due to the overall small number of notifications (Figure 60).

Figure 60 Hepatitis B notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and state/territory, 2019–2023



	2019	2020	2021	2022	2023
ACT	29.4	0.0	0.0	28.9	7.1
NT	22.0	30.4	6.7	18.5	42.9
QLD	31.1	31.2	29.9	14.0	13.9
SA	17.6	30.1	1.5	4.7	3.0
TAS	4.4	0.0	0.0	0.0	0.0
WA	24.5	51.0	63.5	33.7	34.3

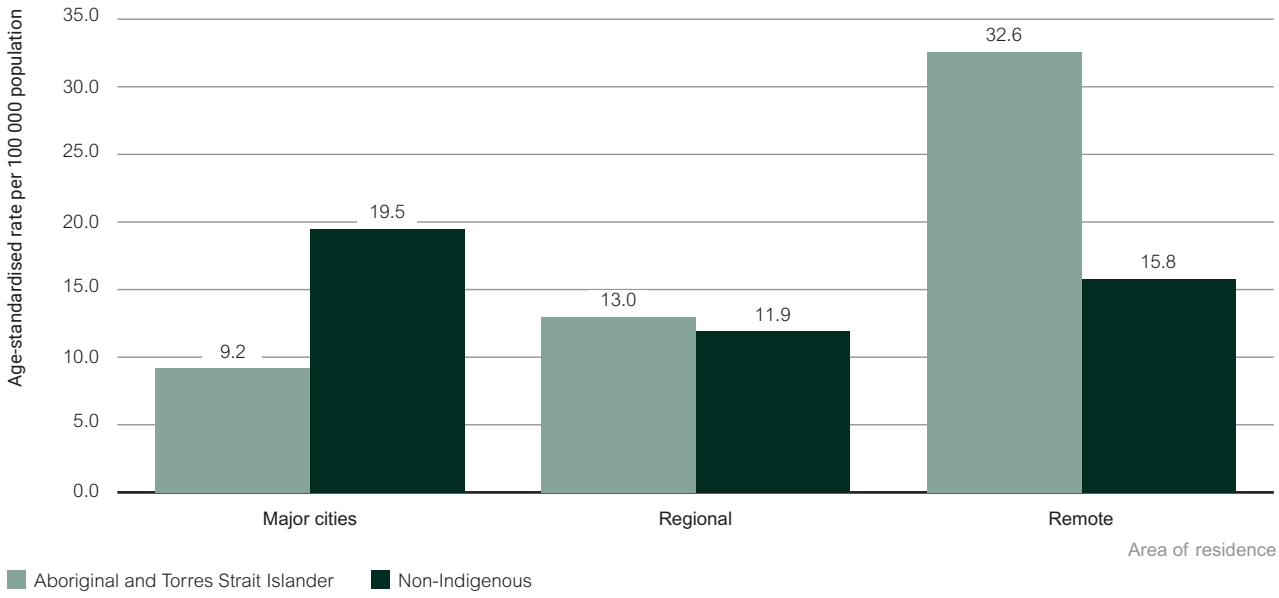


	2019	2020	2021	2022	2023
ACT	17.9	17.1	14.1	17.8	17.2
NT	37.8	38.1	15.0	18.5	35.3
QLD	18.5	16.0	14.1	15.3	18.8
SA	18.1	14.7	11.6	10.6	13.6
TAS	13.9	11.1	15.3	12.5	10.6
WA	16.5	18.1	17.8	14.5	16.9

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

In 2023, the hepatitis B notification rate among Aboriginal and Torres Strait Islander peoples was highest among people living in remote areas (32.6 per 100 000), followed by regional areas (13 per 100 000), then major cities (9.2 per 100 000). The hepatitis B notification rate in Aboriginal and Torres Strait Islander peoples was higher than among non-Indigenous people in all regional and remote areas. (Figure 61).

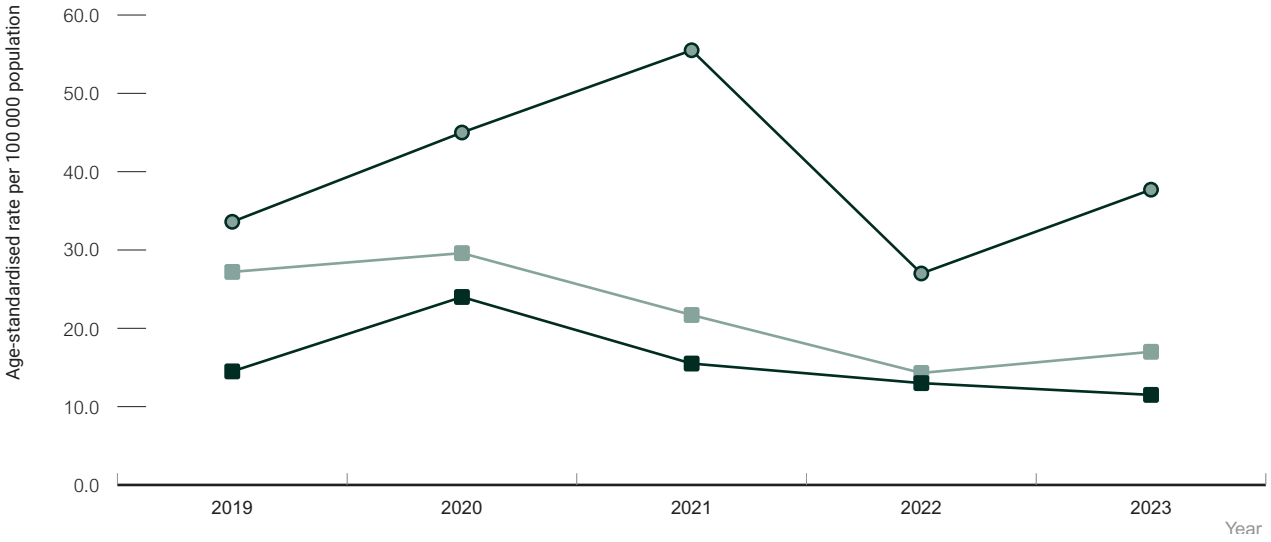
Figure 61 Hepatitis B notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and area of residence, 2023



Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Non-Indigenous people was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

Over the five-year reporting period, hepatitis B notification rates among Aboriginal and Torres Strait Islander peoples decreased across all areas of residence except the remote areas. Rates increased by 12% in remote areas (33.6 per 100 000 in 2019 and 37.7 in 2023), decreased by 37.5% in regional areas (27.2 per 100 000 in 2019 and 17 in 2023) and 21% in major cities (14.5 per 100 000 in 2019 and 11.5 in 2023) (Figure 62).

Figure 62 Hepatitis B notification rate per 100 000 population among Aboriginal and Torres Strait Islander peoples, by area of residence, 2019–2023



	2019	2020	2021	2022	2023
Major cities	14.5	24.0	15.5	13.0	11.5
Regional	27.2	29.6	21.7	14.3	17.0
Remote	33.6	45.0	55.5	27.0	37.7

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Indigenous status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania and Western Australia).

Newly acquired hepatitis B infection

Newly acquired hepatitis B infection is defined as hepatitis B infection in a person previously known not to have the infection within the last two years. Determination of a case as 'newly acquired' is heavily reliant on public health follow-up, with the method and intensity of follow-up varying by jurisdiction and over time. Because of risk of misinterpretation of low numbers, data on newly acquired hepatitis B infection is not included in this report.

Hepatitis B prevalence

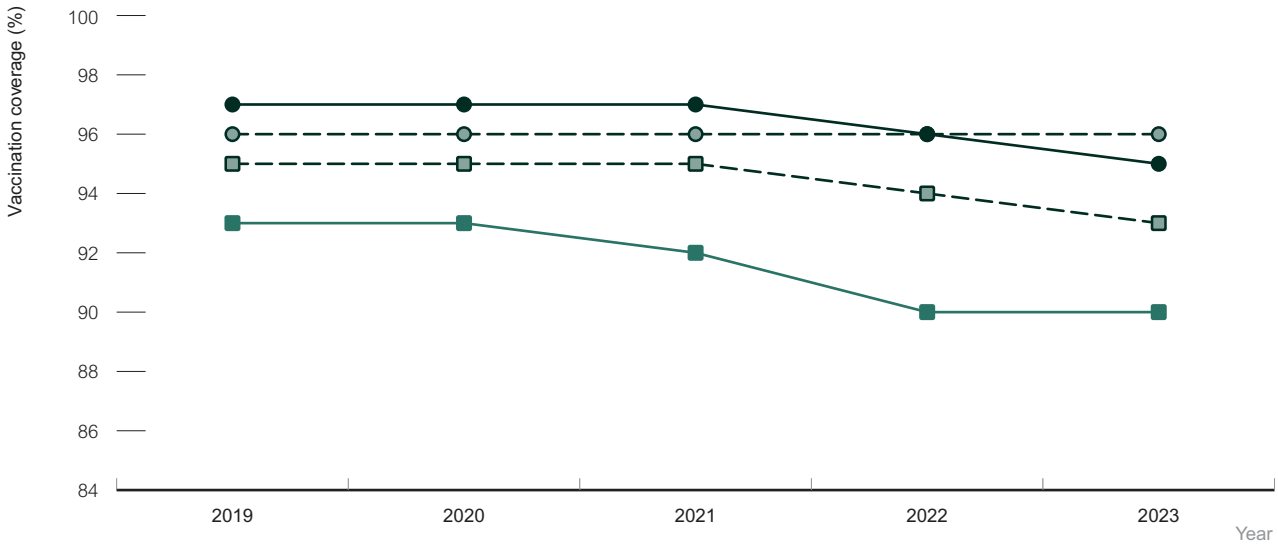
Data relating to hepatitis B was not available at the time of reporting. The 2022 estimates are published in the Viral Hepatitis Mapping Project: Hepatitis C. Future reporting will include modelled 2023 hepatitis B prevalence estimates.

Vaccination

In the Northern Territory in 1985, hepatitis B screening was introduced for all pregnant women as well as vaccination for infants born to people living with chronic hepatitis B infection. In 1990, universal infant vaccination was implemented in the Northern Territory and, in 1998, a catch-up program targeting children aged 6–16 years was introduced. A universal school-based hepatitis B vaccination catch-up program for adolescents aged 12–15 years commenced in 1998 and in other jurisdictions of Australia, hepatitis B vaccination of all infants commenced in 2000 [5].

Over the period 2019–2023, hepatitis B vaccination coverage proportions for children were high although the vaccination coverage has been declining since 2021 for Aboriginal and Torres Strait Islander children. For Aboriginal and Torres Strait Islander children, coverage was marginally lower than for non-Indigenous children at 12 months of age (at 90% to 93%). At 24 months of age, vaccination coverage was similar between Aboriginal and Torres Strait Islander children was 95% and for non-Indigenous children, was 96% (Figure 63).

Figure 63 Hepatitis B vaccination coverage estimates at 12 and 24 months by Aboriginal and Torres Strait Islander status, 2019–2023



	2019	2020	2021	2022	2023
Aboriginal and Torres Strait Islander peoples 12 months (%)	93	93	92	90	90
Aboriginal and Torres Strait Islander peoples 24 months (%)	97	97	97	96	95
Non-Indigenous 12 months (%)	95	95	95	94	93
Non-Indigenous 24 months (%)	96	96	96	96	96

Source: National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases.

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- SA - Clinic 275 Sexual Health, Adelaide
- TAS - Hobart Sexual Health Service, Hobart; Launceston Sexual Health Service, Launceston; Devonport Sexual Health Service, Devonport
- VIC - Melbourne Sexual Health Centre, Melbourne; Barwon Reproductive and Sexual Health Clinic, Geelong
- WA - Fremantle Hospital Sexual Health Clinic, Fremantle

Collaboration of Australian Needle Syringe Programs

- ACT - Directions ACT, Canberra
- NSW - ACON Hunter; First Step Program Port Kembla; Hunter Harm Reduction Services, Newcastle; Kirketon Road Centre and Clinic 180, Kings Cross; Mid North Coast Harm Reduction, Coffs Harbour; NSW Users and AIDS Association, Surry Hills; Northern NSW Harm Reduction, Ballina, Byron Bay, Lismore, Nimbin, and Tweed Heads; Sydney Harm Minimisation, Redfern, Canterbury and RPA Hospital; South Court Primary Care NSP, Nepean; Western Sydney HIV/ Hepatitis C Prevention Service, Blacktown, Mount Druitt and Parramatta, St Vincent's Centre for Applied Medical Research, NSW State Reference Laboratory for HIV at St Vincent's Hospital
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- SA - Drug and Alcohol Services South Australia, Adelaide; Anglicare Salisbury, Salisbury; Drug Arm, Warradale; Hindmarsh Centre, Hindmarsh; Noarlunga Community Health Service, Noarlunga; Nunkuwarrin Yunti Community Health Centre, Adelaide; Port Adelaide Community Health Centre, Port Adelaide; Street Link Youth Health Service, Adelaide
- TAS - Anglicare NSP Service, Hobart and Glenorchy; Clarence Community Health Centre, Clarence; Burnie NSP Service, Burnie
- VIC - Barwon Health Drug and Alcohol Services, Geelong; Health Information Exchange, St Kilda; Health Works, Footscray; Inner Space, Collingwood; North Richmond NSP, North Richmond; Southern Hepatitis/HIV/AIDS Resource and Prevention Service, Melbourne
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- Australasian Society for Infectious Diseases, Melbourne, VIC
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- Australian Injecting and Illicit Drug Users League, Canberra, ACT
- Australian Institute of Health and Welfare, Canberra, ACT
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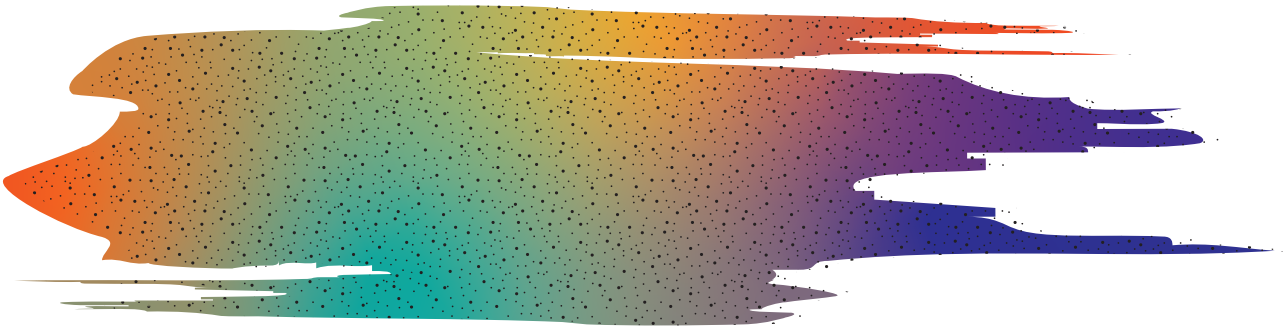
Cover Artwork Narrative & Description

The circles represent the different communities and organisations we are part of. These circles are all made up of many other circles with different styles and patterns, this is symbolic of the different kinds of people that make up a community or an organisation. Each person has their own story, knowledge and experience.

The background is made up of the changing landscapes as we move across this land from country to country. There is blue for the coast, with yellow sands. We move further inland and get rainforest green and bushland before coming into the oranges and burnt umbers that make up the deserts and grasslands.



The lines that connect everything together have two meanings. They represent the way we engage with each other, with services, the way we move about across country. They also represent the way we can easily spread viruses and diseases if we are not careful about the way we engage with others. Everybody communicates differently and we engage services at different times and for different reasons. We are all on a journey and that will look different for each person.

KOORI DESIGNS