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HIV, viral hepatitis and sexually transmissible infections in Australia Annual surveillance report 2025

HIV

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Annual surveillance report 2025

Kirby Institute, UNSW Sydney

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in collaboration with networks in surveillance for HIV, viral hepatitis and sexually transmissible infections

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HIV

We recognise communities and individuals impacted by and at risk of HIV, hepatitis B, hepatitis C, and sexually transmissible infections. These people and communities are crucial stakeholders in the work we do, with invaluable contributions and lived experiences. We acknowledge and affirm their crucial role in the development of this report, and public health surveillance more broadly. This report aims to ensure that ongoing and emerging public health threats and inequities are apparent, and that high quality data are available to inform appropriate public health responses to address these issues. We also acknowledge the ongoing negative impacts stigma and societal discrimination play in perpetuating inequity, and support principles of empowerment, community ownership, and partnership.

The years for comparison in this report are for the 10-year period from 2015 to 2024. Many indicators in the report were affected by the COVID-19-related impacts on travel and access to health care, particularly testing and treatment. These impacts are acknowledged in figures and text throughout the report.

We acknowledge the late Dr Nicholas Medland for his significant contribution to HIV and STI surveillance and research in Australia and throughout the region. He generously provided his time and expertise whenever asked, and his commitment to public health will have a lasting impact. We pay tribute to his memory and legacy. Vale Nick.

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Abbreviations

ABS	Australian Bureau of Statistics
ACCESS	Australian Collaboration for Coordinated Enhanced Sentinel Surveillance
AIDS	acquired immunodeficiency syndrome
ANSPS	Australian Needle Syringe Program Survey
ART	Antiretroviral therapy
CI	confidence interval
DNA	deoxyribonucleic acid
HIV	human immunodeficiency virus
PBS	Pharmaceutical Benefits Scheme
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
RNA	ribonucleic acid
STI	sexually transmissible infection
U=U	undetectable equals untransmittable
UNAIDS	Joint United Nations Programme on HIV/AIDS

1 Summary data

HIV notifications

- There were 757 HIV notifications with a first ever diagnosis in Australia in 2024 a 27% decline in notifications since 2015 (1030 notifications). A decline in notifications between 2019 and 2022 was likely a result of COVID-19-related public health measures that restricted travel and movement, as well as social activity, and healthcare access, including testing.
- Male-to-male sex continues to be the major HIV risk exposure in Australia, accounting for 472 (62%) HIV notifications in 2024 (including those reporting male-to-male sex and injection drug use), with heterosexual sex reported for 203 (27%) notifications, and injection drug use for 19 (3%) notifications.
- Between 2015 and 2024 the HIV notification rate declined among Australian-born people by 53% from 4.4 to 2.1 per 100, 000. In comparison the HIV notification rate increased among people born in Latin America and the Caribbean by 50% from 9.1 to 13.6 per 100 000 and by 77% among people born in the Pacific (excluding Australia) from 3.6 to 6.4 per 100 000.
- In 2024, the HIV notification rate among Australian-born people was 2.1 per 100 000. By comparison the HIV notification rate was 13.6 per 100 000 among people born in Latin America and the Caribbean, 7.7 per 100 000 among people born in Southeast Asia, and 7.4 among people born in Sub-Saharan Africa.
- The number of HIV notifications among Australian-born men attributed to male-to-male sex or male-to-male sex and injection drug use decreased from 444 in 2015 to 205 in 2024, a decline of 54%. In the same period and among men with the same HIV exposure classification, there was a 15% decline in the number of HIV notifications among men born in Asia (from 168 in 2015 to 143 in 2025). By comparison, there was only a 9% decline among men born in other regions (from 137 in 2015 to 124 in 2024).
- Between 2015 and 2024, the HIV notification rate among Aboriginal and Torres Strait Islander peoples declined by 54% from 6.0 to 2.8 per 100 000. For comparison, between 2015 and 2024, the HIV notification rate among non-Indigenous people declined by 35% from 4.3 to 2.8 per 100 000. Trends in HIV notification rates among Aboriginal and Torres Strait Islander peoples are based on small numbers and may reflect localised occurrences rather than national patterns.
- Between 1995 and 2024, 947 cases of potential perinatal HIV exposure among children born in Australia were reported. For the period 2020 – 2024, the HIV vertical transmission rate was 1.5%, compared with 17.5% in the period 1995 – 1998. There were two reported cases of vertical HIV transmission from 2020 to 2024 with two in 2022, with both maternal diagnoses occurring close to delivery.
- Based on the test for immune function (CD4+ T-cell count), 38.4% of HIV notifications in 2024 were classified as late diagnoses (having a CD4+ cell count of less than 350 cells/μL), a drop since 2021, the peak of the COVID-19 pandemic, when 47.5% of HIV notifications were classified as late. These diagnoses are likely to have been in people who acquired HIV at least four years prior to diagnosis. In 2024, the proportions of late HIV diagnoses were higher among people born in Southeast Asia (58%), Oceania (outside Australia) (53%), and Sub-Saharan Africa (47%).

HIV testing

- Among participants in the GBQ+ Community Periodic Surveys, the proportion of non-HIV-positive gay and bisexual men who reported having had a HIV test in the 12 months prior to the survey fluctuated between 58% and 71% and was 67% in 2024. Declines between 2019 and 2021 are likely related to the impacts of the COVID-19 pandemic.
- Among gay and bisexual men attending general practice clinics participating in ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance), the proportion who were tested for HIV at least once in the previous 12 months increased from 59% in 2015 to 70% in 2024. The number of people attending general practice clinics declined following the start of the COVID-19 pandemic and trends in testing should be interpreted with caution.

HIV incidence and prevalence

- HIV incidence (the rate at which HIV negative people are newly diagnosed with HIV) among gay and bisexual men attending sexual health clinics in ACCESS, reduced between 2015 and 2024 (from 0.33 to 0.07 new infections per 100 person-years). Among female sex workers, HIV incidence remained low between 2015 and 2024 and was 0.0 per 100 person-years in 2024.
- In 2024, HIV prevalence (the proportion of all people in Australia who are living with HIV), was estimated to be 0.14%, which is low compared with other high-income and Asia-Pacific countries.
- Between 2015 and 2024, the self-reported HIV prevalence among gay and bisexual men participating in the GBQ+ Community Periodic Surveys fluctuated between 6.8% (in 2024) and 9.2% (in 2021).
- HIV prevalence among people who inject drugs attending needle and syringe programs was estimated to be 2.0% in 2024, and 0.7% if men identifying as gay or bisexual were excluded.

HIV testing and care cascade

- There were an estimated 30 890 people living with HIV in Australia at the end of 2024. Of those, an estimated 94% (28 940) had received an HIV diagnosis. Of those diagnosed, 97% (26 740) were retained in care and 95% (27 480) were receiving antiretroviral therapy (ART). Of those receiving ART, 98% (26 870) had a suppressed viral load (less than 200 HIV-1 RNA copies/mL). Of all people living with HIV in Australia, an estimated 87% had a suppressed viral load.
- There were an estimated 1950 (6%) people living with HIV in Australia in 2024 who were unaware of their HIV status (undiagnosed). The estimated proportion of undiagnosed HIV was highest among people born in Southeast Asia (23%) and those born overseas with a reported exposure of heterosexual sex (45%). The estimated proportion with undiagnosed HIV was also lower among Aboriginal and Torres Strait Islander peoples (2%) and Australian-born men with male-to-male sex as their HIV risk exposure (2%).

Prevention

- In 2024, according to the GBQ+ Community Periodic Surveys, among participants who reported having had casual partners, the majority (79%) were regularly using at least one strategy to prevent HIV transmission (avoiding anal sex, using condoms, or biomedical prevention), up from 68% in 2015. Conversely, this means 21% were not consistently using any of these strategies in 2024.
- On 1 April 2018, pre-exposure prophylaxis (PrEP) became available to eligible individuals through listing on the Pharmaceutical Benefits Scheme (PBS). From this date to the end of December 2024, 85 451 people had ever taken PrEP. At the end of December 2024, 27 865 had taken PrEP in the last three months and 47 938 people had taken PrEP in the last 12 months.
- Among participants in the GBQ+ Community Periodic Surveys, 50% were eligible for PrEP in 2024, slightly up from 36% in 2018. Of those eligible for PrEP in 2024, 96% were aware of PrEP (up slightly from 88% in 2018) and 68% reported using prescribed PrEP in the previous six months (up from 40% in 2018).

2 Interpretation

In 2024, Australia recorded 757 new HIV diagnoses, continuing a downward trend in notifications, with a 27% decline since 2015. This reduction has been most pronounced among Australian-born men reporting male-to-male sex as their HIV exposure risk, reflecting the success of prevention strategies such as pre-exposure prophylaxis (PrEP) and the promotion of U=U (Undetectable = Untransmittable). However, declines have not been observed equally across all populations.

HIV notification rates remain disproportionately high among people born overseas, particularly those from Latin America and the Caribbean, Southeast Asia, and Sub-Saharan Africa. Among overseas-born gay and bisexual men, the decline in HIV diagnoses has been less evident, and late diagnoses remain more frequent than among other populations. In 2024, 38% of all HIV notifications were classified as late diagnoses, with higher proportions among people born in Oceania (excluding Australia), Southeast Asia, and Sub-Saharan Africa.

The number HIV notifications attributed to heterosexual sex has remained approximately constant over the past decade, with an increase in the proportion of total notifications from 20% in 2015 to 27% in 2024. The lack of a decline is accompanied by a high proportion of late diagnoses, indicating delayed testing and diagnosis in this population. Additionally, testing rates among young heterosexual people attending general practice clinics remain low, with only 12% tested in the past year, underscoring the importance of expanding HIV awareness and testing initiatives beyond traditional priority groups.

At the end of 2024, an estimated 30 890 people were living with HIV in Australia. Australia continues to meet the second and third UNAIDS 2025 targets: 95% of diagnosed individuals are on antiretroviral therapy, and 98% of those on treatment have a suppressed viral load. Having an undetectable viral load reduces the risk of onward sexual transmission to zero. However, the first target, 95% of all people living with HIV being diagnosed, has not yet been met, with 6% estimated to be undiagnosed. The estimated proportion undiagnosed is highest among overseas-born heterosexual people and gay and bisexual men.

Vertical transmission remains rare, with only two cases reported between 2020 and 2024. HIV incidence among female sex workers remains among the lowest globally, and prevalence among people who inject drugs remains low due to effective harm reduction strategies.

In 2024, the HIV notification rate among Aboriginal and Torres Strait Islander peoples was the same as the rate among non-Indigenous people (2.8 per 100 000). Trends in HIV notifications among Aboriginal and Torres Strait Islander peoples are based on small numbers, so should be interpreted with caution.

To further reduce HIV transmission and improve outcomes, Australia must continue to expand access to testing, treatment, and prevention—particularly among heterosexual people, overseas-born populations and those diagnosed late. Addressing legal and structural barriers to care, and reducing stigma, remain critical to achieving equitable public health outcomes.

3 HIV notifications

HIV notifications with a previous diagnosis overseas

In 2024, there were 598 HIV cases previously diagnosed overseas with subsequent diagnostic testing conducted in Australia; 31% were in Victoria, 27% were in New South Wales, and 22% were in Queensland (Table 1). Among HIV notifications previously diagnosed overseas, 480 (80%) were male, 460 (77%) were aged 30 years or over, and 295 (49%) were attributed to male-to-male sex or male-to-male sex and injection drug use (Table 1). It should be noted that a higher proportion of notifications among those with a previous diagnosis had exposure not reported compared with notifications with a first every diagnosis in Australia (see Table 3). This reflects less surveillance resources dedicated to those previously diagnosed overseas and therefore less complete surveillance data. Trends in these notifications should be interpreted with caution.These notifications are included in the HIV cascades of treatment and care estimates but excluded from further analyses in this report.

Table 1 Number of HIV notifications in Australia by state/territory and region of diagnosis (Australia or overseas), 2024

	Place of first ever HIV diagnosis		
	Australia	Overseas	Total cases
State/Territory			
Australian Capital Territory	9	3	12
New South Wales	238	161	399
Northern Territory	10	10	20
Queensland	156	132	288
South Australia	31	48	79
Tasmania	3	5	8
Victoria	230	186	416
Western Australia	80	53	133
Australia	**757**	**598**	**1355**

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

Table 2 Characteristics of HIV notifications previously diagnosed overseas, 2015 – 2024

	Year of Australian HIV notification									
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Characteristic										
Total cases[a]	224	260	291	292	345	322	192	344	581	598
Gender[b]										
Male	164	186	229	223	269	240	135	269	466	480
Female	60	73	60	69	76	81	53	72	111	116
Trans and gender diverse	0	0	2	0	0	1	4	3	3	2
Median age (years)										
Male	34	35	34	32	35	36	39	35	33	34
Female	38	34	38	39	36	43	45	38	43	39
Age group (years)[c]										
0-14	0	10	1	0	3	0	1	3	1	3
15-19	2	2	1	7	3	2	1	2	2	1
20-29	59	60	81	78	80	68	19	82	144	134
30-39	87	99	105	110	139	110	73	129	250	264
40-49	51	52	63	59	68	70	49	71	99	102
50+	25	37	40	38	52	72	49	57	85	94
State/Territory										
Australian Capital Territory	6	10	6	2	3	4	8	6	6	3
New South Wales	67	85	105	100	99	92	56	89	116	161
Northern Territory	1	1	2	3	4	3	0	3	8	10
Queensland	50	63	67	64	99	78	37	86	144	132
South Australia	15	11	18	9	20	9	16	23	43	48
Tasmania	0	0	4	7	1	0	2	2	2	5
Victoria	66	74	58	82	88	102	50	112	185	186
Western Australia	19	16	31	25	31	34	23	23	77	53
HIV exposure risk category										
Male-to-male sex[d]	112	116	144	139	166	161	84	180	329	288
Male-to-male sex and injection drug use	6	4	1	5	8	6	1	7	4	7
Heterosexual sex	86	105	94	89	108	80	50	82	120	115
Injection drug use	5	5	0	1	2	4	2	2	4	4
Vertical transmission	2	7	3	2	9	1	3	5	5	7
Receipt of blood/tissue[e]	4	1	1	0	5	2	5	2	2	1
Other/undetermined	9	22	48	56	47	68	47	66	117	176

a) Includes notifications missing gender and age.
b) Not including notifications missing gender.
c) Not including notifications missing age at diagnosis.
d) Includes men who had sex with both men and women.
e) Includes receipt of blood/tissue overseas, so does not indicate transmission through blood products in Australia.

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

HIV notifications with a first ever diagnosis in Australia

The following section focuses on people diagnosed with HIV for the first time in Australia. In 2024, there were 757 HIV notifications in Australia: 650 (86%) among males, 561 (74%) among people aged 30 years and above, and 23 (3%) among Aboriginal and Torres Strait Islander peoples. Around a third of all notifications (218) were classified as newly acquired (evidence of HIV acquisition in the 12 months prior to diagnosis), while 38% (215) of notifications with a recorded CD4+ T-cell count were classified as late diagnoses (Table 3).

A total of 43 141 notifications of HIV with first ever diagnosis in Australia have been reported since 1984, of which 39 119 (91%) were among males, 3616 (8%) among females and 157 (<1%) among trans and gender diverse people. Between 2015 and 2024 the number of notifications decreased by 27% from 1030 to 757. This decline was likely due to targeted prevention measures including the rollout of pre-exposure prophylaxis (PrEP) and the promotion of U=U ('Undetectable equals Untransmittable'; (Table 3). A similar pattern was seen among males, with a 29% decline from 920 notifications in 2015 to 650 notifications in 2024. Notifications among females fluctuated over the same period with COVID-19 pandemic-associated declines between 2020 and 2022 (103 HIV notifications in 2024). Between 2015 and 2024 there were 64 notifications reported among trans and gender diverse people, although it is likely that this figure is an underrepresentation due to potential under reporting of gender diversity in HIV notifications data (Table 3).

By age group, the largest number of notifications in 2024 was among people aged 30 to 39 years (257), followed by people aged 20 to 29 (192), and 40 to 49 years (157). The number of notifications remains low among younger age groups in 2024, with four notifications among those aged under 20 years (Table 3).

Table 3 Characteristics of HIV notifications with a first ever diagnosis in Australia, 2015 – 2024

	Year of first ever HIV diagnosis									
Characteristic	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Total cases[a]	1030	1006	962	840	895	626	542	553	723	757
Gender										
Male	920	913	845	755	791	540	476	460	620	650
Female	108	88	107	81	94	78	61	85	95	103
Trans and gender diverse[b]	2	5	10	4	10	8	5	8	8	4
Aboriginal and Torres Strait Islander Status										
Aboriginal and/or Torres Strait Islander	40	47	31	33	25	16	17	25	24	23
Non-Indigenous	969	955	919	799	857	603	525	521	693	716
Not reported	21	4	12	8	13	7	0	7	6	18
Median age (years)										
Male	35	34	35	35	35	35	37	37	36	36
Female	36	34	34	35	37	36	35	38	36	36
Transgender	35	29	39	30	38	38	34	30	40	35
Age group (years)										
0-14	3	5	2	3	1	1	0	3	0	0
15-19	20	11	12	8	7	10	2	3	3	4
20-29	296	310	253	262	244	162	140	114	174	192
30-39	304	308	313	237	287	198	172	198	254	257
40-49	209	194	170	159	159	127	111	115	135	157
50+	198	178	212	171	197	128	117	120	157	147
Language spoken at home										
English	736	729	539	529	576	490	417	416	503	512
Other language	131	134	135	149	158	101	103	102	167	169
Not reported	163	143	288	162	161	35	22	35	53	76
Newly acquired[c]	418	384	309	278	283	153	113	143	210	218
(% of new diagnoses)	40.6%	38.2%	32.1%	33.1%	31.6%	24.4%	20.8%	25.9%	29.0%	28.8%
Diagnosed late	274	277	263	260	285	269	276	225	225	215
Late HIV diagnosis, %[d]	27.3%	29.3%	32.6%	36.0%	35.8%	41.5%	47.5%	44.1%	36.9%	38.4%
Advanced HIV diagnosis, %	15.1%	17.5%	20.5%	18.9%	22.4%	28.2%	33.3%	29.1%	23.0%	24.4%
Median CD4+ cell count, cells/μL	441.0	420.0	390.0	389.5	378.0	330.0	320.0	317.0	361.0	350.0
State/Territory										
Australian Capital Territory	14	13	13	6	12	8	14	3	5	9
New South Wales	350	318	310	281	282	208	179	169	232	238
Northern Territory	9	23	11	13	7	3	2	3	3	10
Queensland	203	195	186	180	158	107	124	100	157	156
South Australia	43	42	43	31	30	29	21	22	33	31
Tasmania	17	19	12	11	17	6	7	8	6	3
Victoria	285	304	308	260	290	194	140	186	220	230
Western Australia	109	92	79	58	99	71	55	62	67	80
HIV exposure risk category										
Male-to-male sex[e]	700	708	603	518	527	351	323	272	400	410
Male-to-male sex and injection drug use	49	50	49	57	62	61	42	44	57	62
Heterosexual sex	203	204	237	189	209	157	147	166	204	203
Injection drug use	32	14	32	28	23	20	9	18	17	19
Vertical transmission	4	5	3	2	1	1	0	2	0	0
Receipt of blood/tissue[f]	8	1	0	0	3	2	2	2	3	2
Other/undetermined	34	24	38	46	70	34	19	49	42	61

a) Includes gender of 'Other' and 'Not reported'.

b) Does not include transgender people recorded as either male or female.

c) Newly acquired HIV was defined as newly diagnosed infection with a negative or indeterminate HIV antibody test result or a diagnosis of primary HIV within one year before HIV diagnosis. In Victoria from April 2016 there was a change in the laboratory reporting of HIV confirmatory results such that there are expected to be fewer indeterminate results requiring follow-up. This will therefore reduce the number of results which were previously used to provide evidence for newly acquired HIV infections.

d) Late HIV diagnosis was defined as newly diagnosed HIV with a CD4+ cell count of less than 350 cells/μL, and advanced HIV as newly diagnosed infection with a CD4+ cell count of less than 200 cells/μL. Newly acquired HIV were categorised neither late or advanced diagnosis, irrespective of CD4+ cell count. HIV diagnoses classified as advanced include those classified as late.

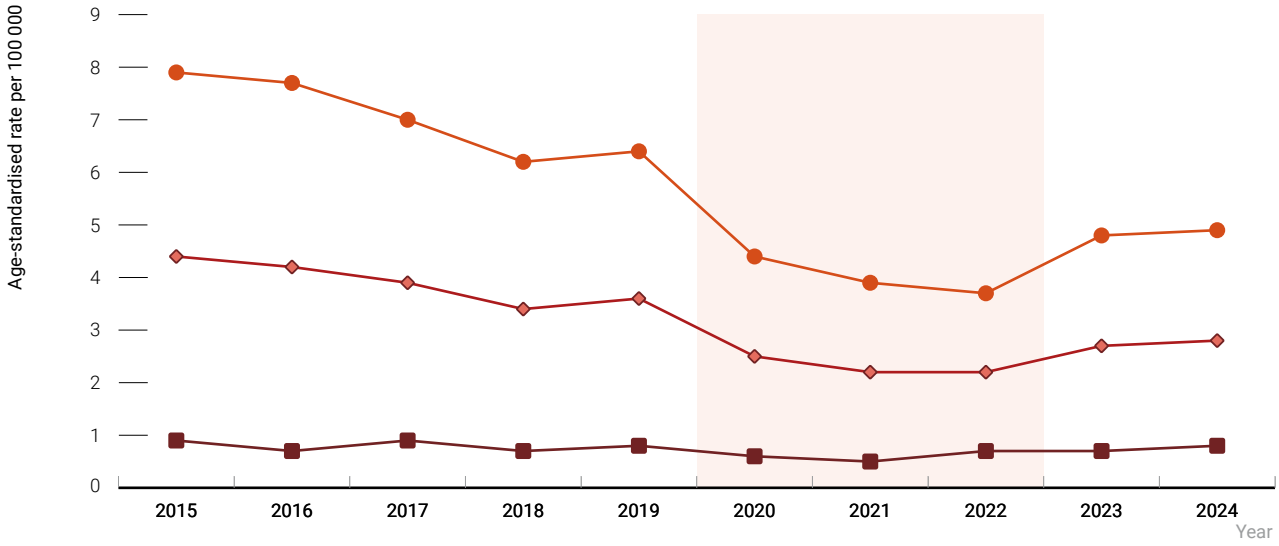
e) Includes men who had sex with both men and women.

f) Includes receipt of blood/tissue overseas, so does not indicate transmission through blood products in Australia.

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

Between 2015 and 2024, the national HIV notification rate declined by 36% from 4.4 to 2.8 per 100 000 population (Figure 1). Reflecting that the HIV epidemic in Australia remains concentrated among gay, bisexual and other men who have sex with men, HIV notification rates among females were lower than males for every year in the reporting period. In 2024, notification rates were 4.9 per 100 000 males and 0.8 per 100 000 females.

Figure 1 HIV notification rate per 100 000 population by gender, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Female	0.9	0.7	0.9	0.7	0.8	0.6	0.5	0.7	0.7	0.8
Male	7.9	7.7	7.0	6.2	6.4	4.4	3.9	3.7	4.8	4.9
Total	4.4	4.2	3.9	3.4	3.6	2.5	2.2	2.2	2.7	2.8

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

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

What does this mean?

HIV diagnosis rates have decline since 2015 with more males diagnosed than females for every year across this period.

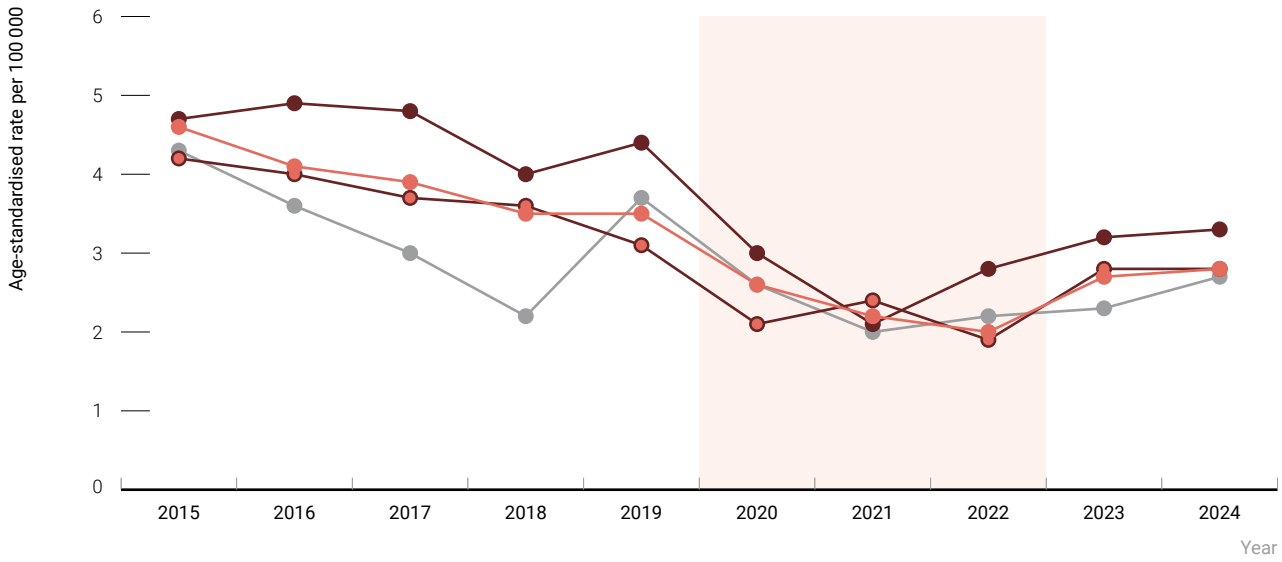
In 2024, HIV notification rates were highest among those aged 30 to 39 years (6.3 per 100 000), 20 to 29 years (5.0 per 100 000) and 40 to 49 years (4.5 per 100 000). Between 2015 and 2024 there was a 41% decline in the notification rate for those aged 20 to 29 years, a 38% decline for those aged 50 years or older, and a 31% decline for those aged 40 to 49 years.

HIV notification rates among males in 2024 were highest for those aged 30 to 39 years (11.1 per 100 000), followed by those aged 20 to 29 years (8.6 per 100 000). In comparison, HIV notification rates among females in 2024 were highest for those aged 30 to 39 years (1.6 per 100 000), followed by those aged 40 to 49 years (1.5 per 100 000). Small numbers of notifications among females when stratified by age group mean that caution should be applied when interpreting these rates. Breakdowns of HIV notification rates by age and gender can be found on the Kirby Institute data site.

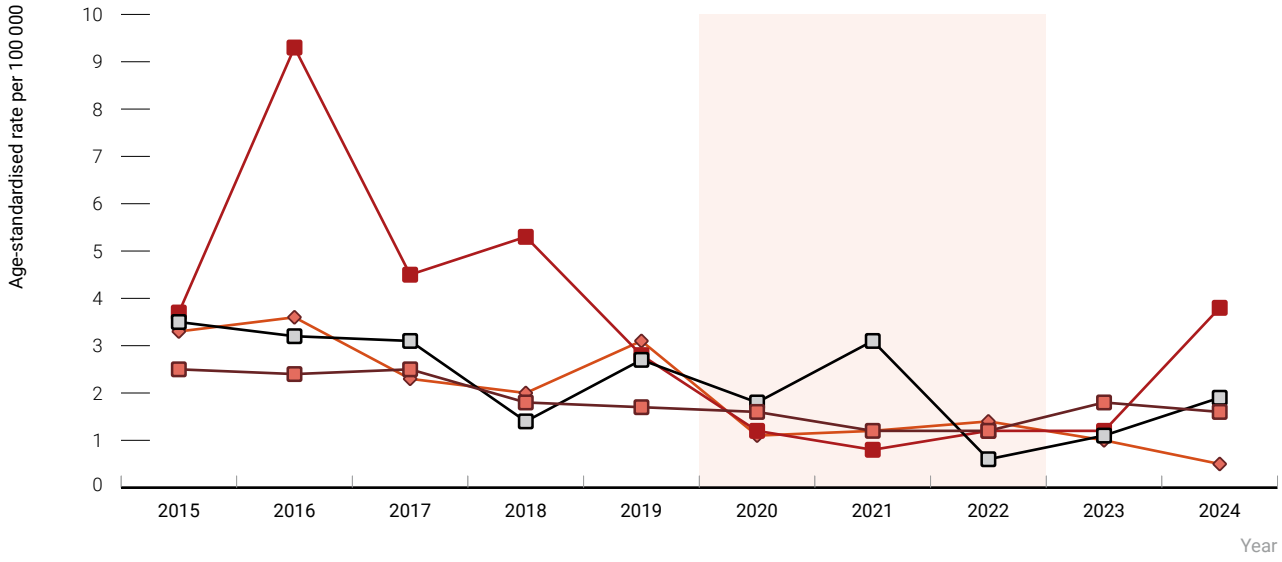
By state and territory, between 2015 and 2024, the HIV notification rate declined by 49% in New South Wales from 4.6 to 2.8 per 100 000, 34% in Queensland from 4.2 to 2.8 per 100 000, 38% in Western Australia from 4.3 to 2.7 per 100 000, and 30% in Victoria (4.7 to 3.3 per 100 000). In 2024, the HIV notification rate was highest in Victoria at 3.3 per 100 000, followed by Queensland and New South Wales at 2.8 per 100 000, and Western Australia at 2.7 per 100 000 (Figure 2).

In the Australian Capital Territory, the Northern Territory, South Australia, and Tasmania, numbers of notifications each year are low, therefore, trends need to be interpreted with caution. Between 2015 and 2024, HIV notification rates declined in all four states and territories. In 2024, the highest HIV notification rate was 3.8 per 100 000 in the Northern Territory, 1.9 per 100 000 in the Australian Capital Territory, 1.6 per 100 000 in South Australia, and 0.5 per 100 000 in Tasmania (Figure 2).

Figure 2 HIV notification rates per 100 000 population by state/territory, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
NSW	4.6	4.1	3.9	3.5	3.5	2.6	2.2	2.0	2.7	2.8
QLD	4.2	4.0	3.7	3.6	3.1	2.1	2.4	1.9	2.8	2.8
VIC	4.7	4.9	4.8	4.0	4.4	3.0	2.1	2.8	3.2	3.3
WA	4.3	3.6	3.0	2.2	3.7	2.6	2.0	2.2	2.3	2.7



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
ACT	3.5	3.2	3.1	1.4	2.7	1.8	3.1	0.6	1.1	1.9
NT	3.7	9.3	4.5	5.3	2.8	1.2	0.8	1.2	1.2	3.8
SA	2.5	2.4	2.5	1.8	1.7	1.6	1.2	1.2	1.8	1.6
TAS	3.3	3.6	2.3	2.0	3.1	1.1	1.2	1.4	1.0	0.5

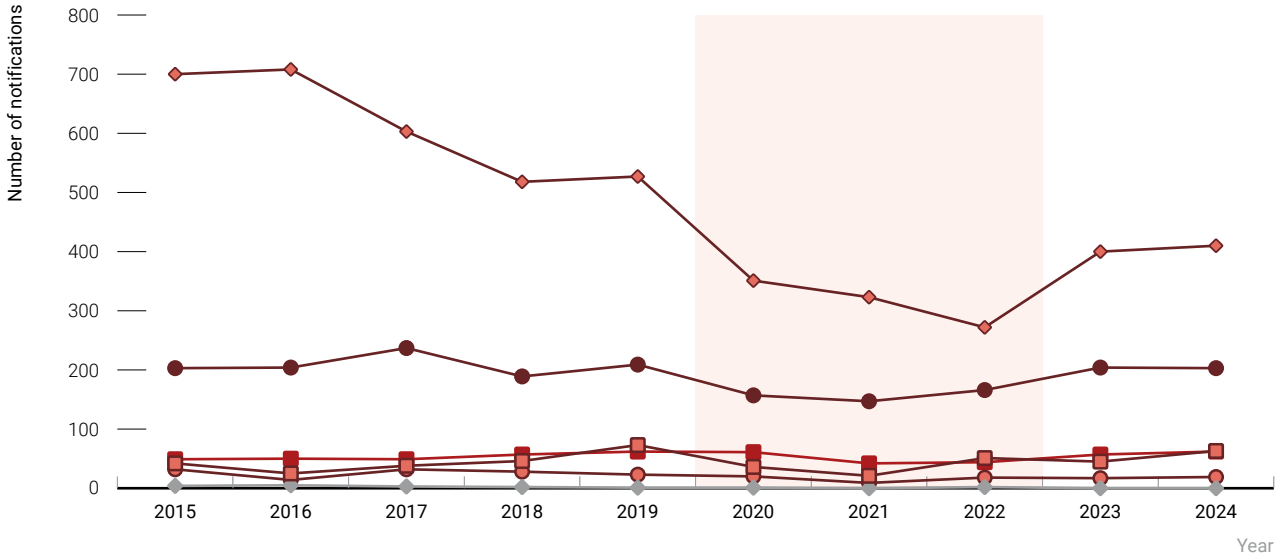
Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

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

HIV risk exposure

Transmission of HIV in Australia continues to occur primarily through male-to-male sexual contact (Figure 3, Table 3). Of the 757 new HIV notifications in 2024, 62% (472) were attributed to male-to-male sex or male-to-male sex and injection drug use, a decline of 37% (749) since 2015. Correspondingly, heterosexual sex accounted for 27% (203) of notifications, an increase from 20% (203) since 2015. In 2024, injection drug use accounted for 3% (19) of notifications (Figure 3, Table 3).

Figure 3 Number of HIV notifications by exposure category, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Male-to-male sex	700	708	603	518	527	351	323	272	400	410
Male-to-male sex and injection drug use	49	50	49	57	62	61	42	44	57	62
Heterosexual contact	203	204	237	189	209	157	147	166	204	203
Injection drug use	32	14	32	28	23	20	9	18	17	19
Vertical transmission	4	5	3	2	1	1	0	2	0	0
Other	42	25	38	46	73	36	21	51	45	63

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
The 'male-to-male sex' category includes men who had sex with both men and women. One diagnosis was attributed to an overseas occupational exposure in healthcare or other settings in the 10 year period 2015 – 2024, and was grouped in the 'Other' category.

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

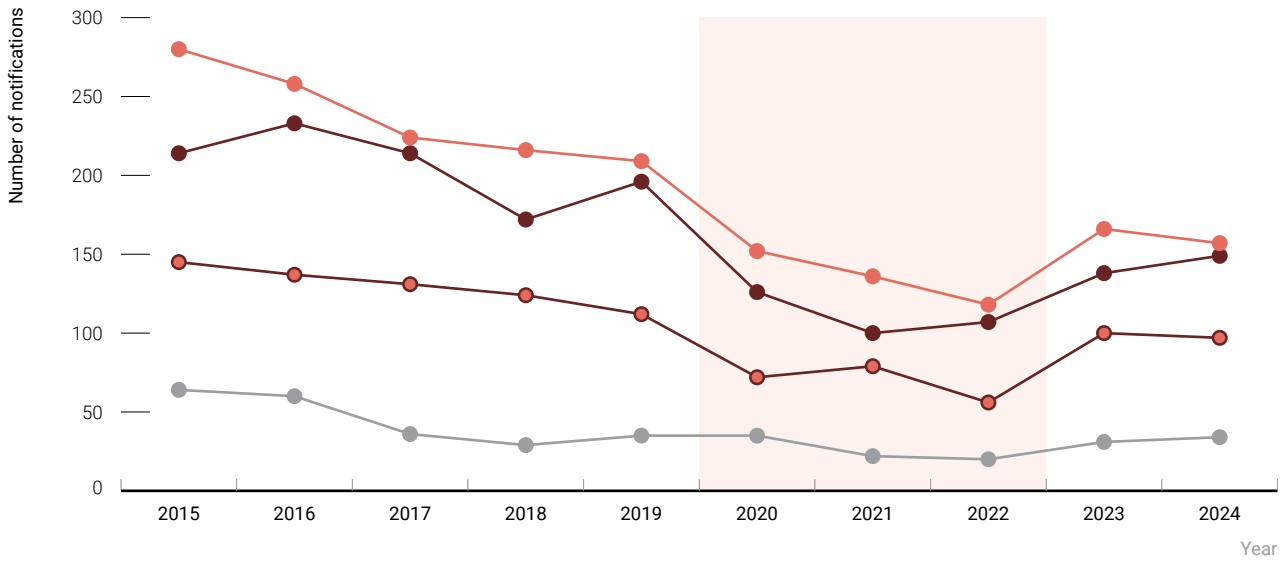
Subpopulations

Gay and bisexual men: Men who have sex with men may identify as gay, bisexual, queer, heterosexual, transgender, or other identities. However, notifications only record data on the most likely HIV risk exposure, which is behavioural, so 'male-to-male sex' is used when describing HIV notifications. This section relates to notifications with a reported exposure of male-to-male sex and male-to-male sex and injection drug use.

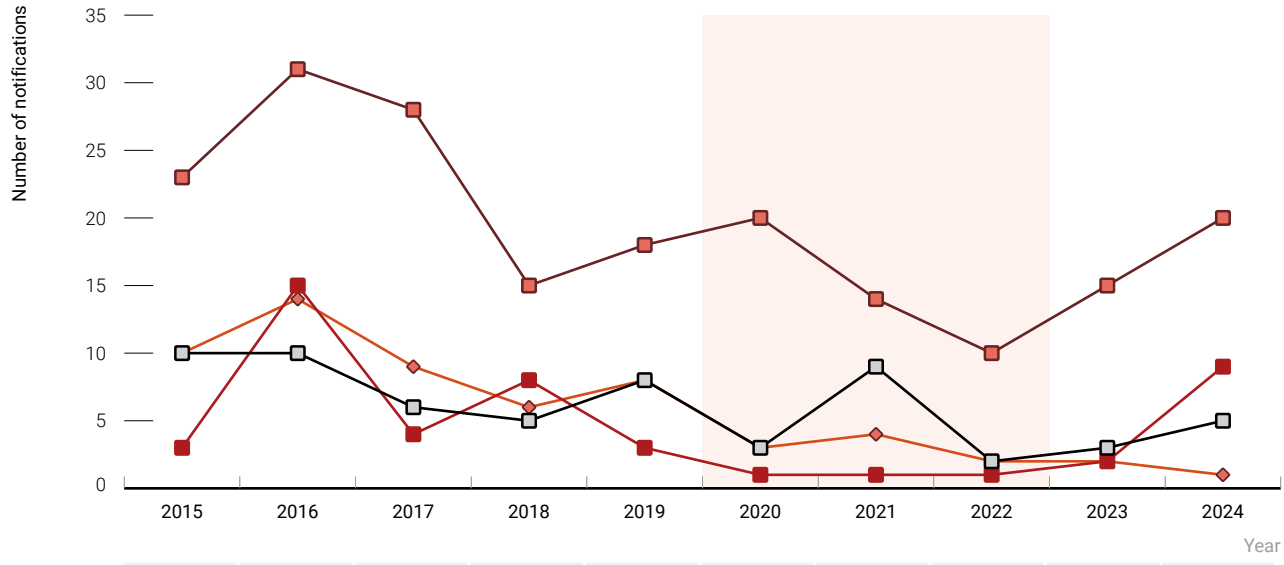
Between 2015 and 2024, there was a 37% decline in HIV notifications attributed to male-to-male sex, despite an increase in notifications between 2020 and 2024. All jurisdictions saw a reduction in the number of notifications attributed to male-to-male sex (Figure 4). In 2024, New South Wales recorded the highest number of notifications with a reported exposure of male-to-male sex (157 notifications), followed by Victoria (149 notifications), Queensland (97 notifications) and Western Australia (34 notifications).

The median age at HIV diagnosis for men reporting male-to-male sex as an HIV risk exposure was 34 years in both 2015 and 2024 (data not shown). Of the 456 cases of HIV newly diagnosed in 2024 for whom exposure to HIV included male-to-male sex, 81 (18%) also reported sex with women, up from 68 (9%) in 2015 (data not shown). There were 62 (8%) men for whom HIV risk exposure also included injection drug use in 2024, up from 49 (5%) in 2015 (Table 3).

Figure 4 HIV notifications among men who reported male-to-male-sex as an exposure risk by state/territory, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
NSW	280	258	224	216	209	152	136	118	166	157
QLD	145	137	131	124	112	72	79	56	100	97
VIC	214	233	214	172	196	126	100	107	138	149
WA	64	60	36	29	35	35	22	20	31	34



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
ACT	10	10	6	5	8	3	9	2	3	5
NT	3	15	4	8	3	1	1	1	2	9
SA	23	31	28	15	18	20	14	10	15	20
TAS	10	14	9	6	8	3	4	2	2	1

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
Includes notifications where the exposure classification was reported as male-to-male sexual contact and injection drug use.

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

Heterosexual people: Notifications only record data on the most likely HIV risk exposure, which is behavioural, so heterosexual is used here to describe people reporting 'heterosexual sex' as their HIV exposure risk. This section relates to notifications with a reported exposure of heterosexual sex.

Over the 10-year period 2015 to 2024, the number of HIV notifications reporting heterosexual sex fluctuated in most Australian states and territories. In 2024, New South Wales recorded the highest number of notifications with a reported exposure of heterosexual sex (61 notifications), followed by Queensland (53 notifications), Victoria (45 notifications) and Western Australia (35 notifications). In the Australian Capital Territory, the Northern Territory, South Australia and Tasmania, the number of HIV notifications in this category remained low. Caution should be applied when interpreting these figures due to small numbers of notifications reported by some jurisdictions. Breakdowns of HIV notifications by exposure and jurisdiction can be found on the Kirby Institute data site.

Trans and gender diverse people: Between 2015 and 2024, there were 67 HIV notifications among people whose gender was reported as trans or gender diverse (Table 3). Of these, 94% identified as non-Indigenous, 33% were Australian-born, and the median age at diagnosis was 36 years. Of those with recorded CD4+ T-cell counts taken within three months of diagnosis, 29% were diagnosed with late-stage HIV (indicated by a CD4+ cell count of less than 350 cells/μL at diagnosis) (data not shown).

It is likely that these 67 notifications are an underrepresentation of the true number of trans and gender diverse people newly diagnosed with HIV, as until 2019, the National HIV Registry only had one variable related to gender which captured if the person identified as male, female, or transgender. This single variable was inadequate as trans and gender diverse people may position `being trans' as a history or experience, rather than an identity, and consider their gender identity as simply female, male, or non-binary. The processes of transition may or may not be part of a trans or gender diverse person's life [(1)]. Some trans people connect strongly with their trans experience, whereas others do not. Thus, many people who identify as a different gender to what sex they were registered as at birth do not identify as transgender [(2)]. This means there is potential for underreporting in the number of transgender people diagnosed with HIV. States and territories now record a two-step gender question including sex at birth and gender at diagnosis which likely collects more complete information for non-cisgender people.

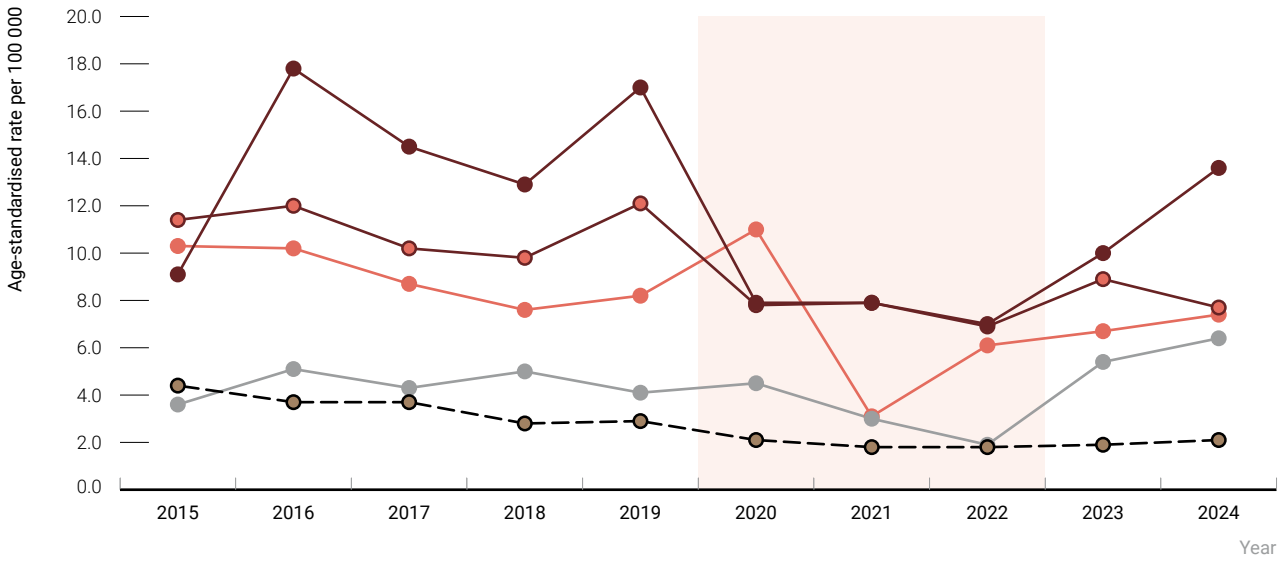
HIV notifications by region of birth: Between 2015 and 2024, among Australian-born people, the HIV notification rate declined by 53% from 4.4 to 2.1 per 100 000. Among people born overseas, HIV notification rates declined or fluctuated for all regions of birth between 2015 and 2024 (Table 4). The highest HIV notification rates in 2024 were among people born in Latin America and the Caribbean (13.6 per 100 000), Southeast Asia (7.7 per 100 000), and Sub-Saharan Africa (7.4 per 100 000) (Table 4). Due to the impact of COVID-19-related travel restrictions, trends in HIV notification rates by region of birth should be interpreted with caution.

Table 4 HIV notification rates per 100 000 population by region of birth, 2015 – 2024

Region of birth	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Australia	4.4	3.7	3.7	2.8	2.9	2.1	1.8	1.8	1.9	2.1
North Africa and the Middle East	5.4	1.9	2.7	2.1	1.2	1.8	2.0	2.5	1.7	2.1
North-East Asia	4.7	3.7	2.2	3.3	2.9	0.9	1.8	1.8	3.0	1.7
North-West Europe and USA & Canada	4.4	3.6	2.1	2.6	3.3	1.2	1.4	1.0	1.8	1.8
Oceania (excluding Australia)	3.6	5.1	4.3	5.0	4.1	4.5	3.0	1.9	5.4	6.4
Latin America and the Caribbean	9.1	17.8	14.5	12.9	17.0	7.9	7.9	7.0	10.0	13.6
Southeast Asia	11.4	12.0	10.2	9.8	12.1	7.8	7.9	6.9	8.9	7.7
Southern and Central Asia	1.8	2.4	1.9	2.2	1.6	1.6	1.1	1.9	2.3	2.1
Southern and Eastern Europe	4.7	2.1	4.5	2.6	2.6	1.1	1.0	2.5	3.0	1.6
Sub-Saharan Africa	10.3	10.2	8.7	7.6	8.2	11.0	3.1	6.1	6.7	7.4

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

Figure 5 HIV notification rates per 100 000 population by selected region of birth, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Australia	4.4	3.7	3.7	2.8	2.9	2.1	1.8	1.8	1.9	2.1
Oceania (excluding Australia)	3.6	5.1	4.3	5.0	4.1	4.5	3.0	1.9	5.4	6.4
Latin America and the Caribbean	9.1	17.8	14.5	12.9	17.0	7.9	7.9	7.0	10.0	13.6
Southeast Asia	11.4	12.0	10.2	9.8	12.1	7.8	7.9	6.9	8.9	7.7
Sub-Saharan Africa	10.3	10.2	8.7	7.6	8.2	11.0	3.1	6.1	6.7	7.4

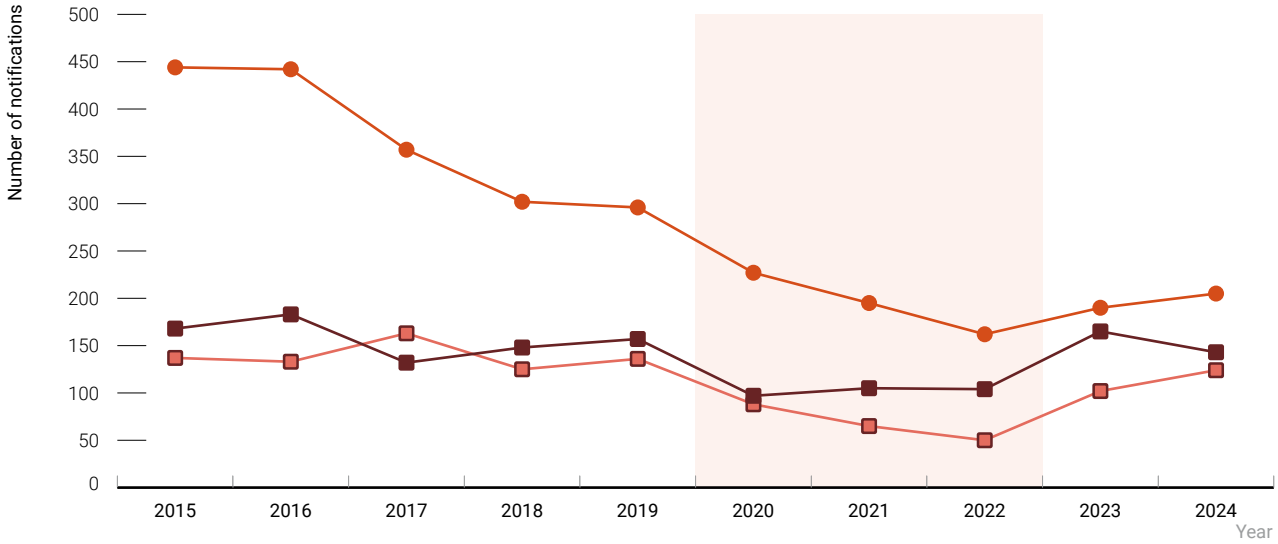
Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

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

Between 2015 and 2025, the number of HIV notifications among Australian-born men attributed to male-to-male sex decreased by 54% from 444 to 205 (43% of all notifications attributed to male-to-male sex in 2024). The declines seen among Australian-born men are likely due to the availability of PrEP (see section on Prevention for further detail) and the promotion of U=U.

Between 2015 and 2024, the number of HIV notifications among men born in Asia (Southeast Asia, Northeast Asia, and Southern and Central Asia) fluctuated between 97 (in 2020) and 183 (in 2016), with 145 notifications in 2024 (30% of all notifications attributed to male-to-male sex). The number of HIV notifications among men born in countries other than Asia declined by 9% from 137 notifications in 2015 to 124 notifications in 2024 (26% of all notifications attributed to male-to-male sex) (Figure 6). International travel was strongly affected by COVID-19 related border closures between 2020 and 2022, which also likely impacted HIV notifications among people born overseas.

Figure 6 HIV notifications among men who reported male-to-male sex as an exposure risk by region of birth, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Born in Australia	444	442	357	302	296	227	195	162	190	205
Born in Asia	168	183	132	148	157	97	105	104	165	143
Born in Other	137	133	163	125	136	88	65	50	102	124

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022. 'Other' includes notifications missing country of birth (less than 3% of notifications in each year apart from 2017 when 7% of notifications among men who reported male-to-male sex as an exposure risk were missing country of birth).

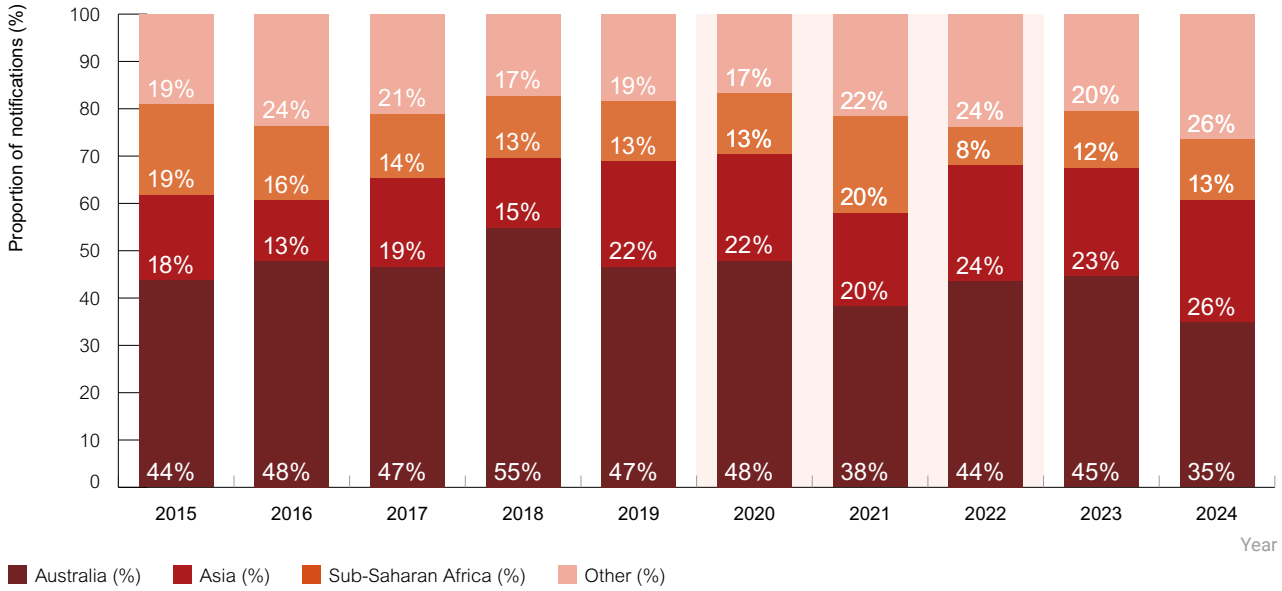
Source: State and territory health authorities; see Methodology for details.

What does this mean?

HIV diagnoses among Australian-born gay and bisexual men have declined since 2015. Among overseas-born gay and bisexual men, this decline has been less evident, especially among men born in Asia.

For HIV notifications attributed to heterosexual sex, the proportion born in Australia declined from 44% in 2015 to 35% in 2024 (60% among men and 40% among women). In the same period, among HIV notifications attributed to heterosexual sex, the proportion of those born in Asia increased from 18% to 26%, while the proportion born in Sub-Saharan Africa and other countries fluctuated (Figure 7).

Figure 7 Proportion of HIV notifications reporting heterosexual sex as exposure risk, by region/country of birth, 2015 – 2024



Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022; 'Other' includes notifications missing country of birth (less than 3% of notifications in each year.

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

Aboriginal and Torres Strait Islander peoples: In 2024 there were 23 HIV notifications among Aboriginal and Torres Strait Islander peoples, representing 3% of the total 757 notifications. The majority (65%) of Aboriginal and/or Torres Strait Islander notifications were male and the median age at diagnosis was 36 years (Table 5).

Table 5 Characteristics of cases of HIV notifications in Aboriginal and Torres Strait Islander peoples, 2015 – 2024

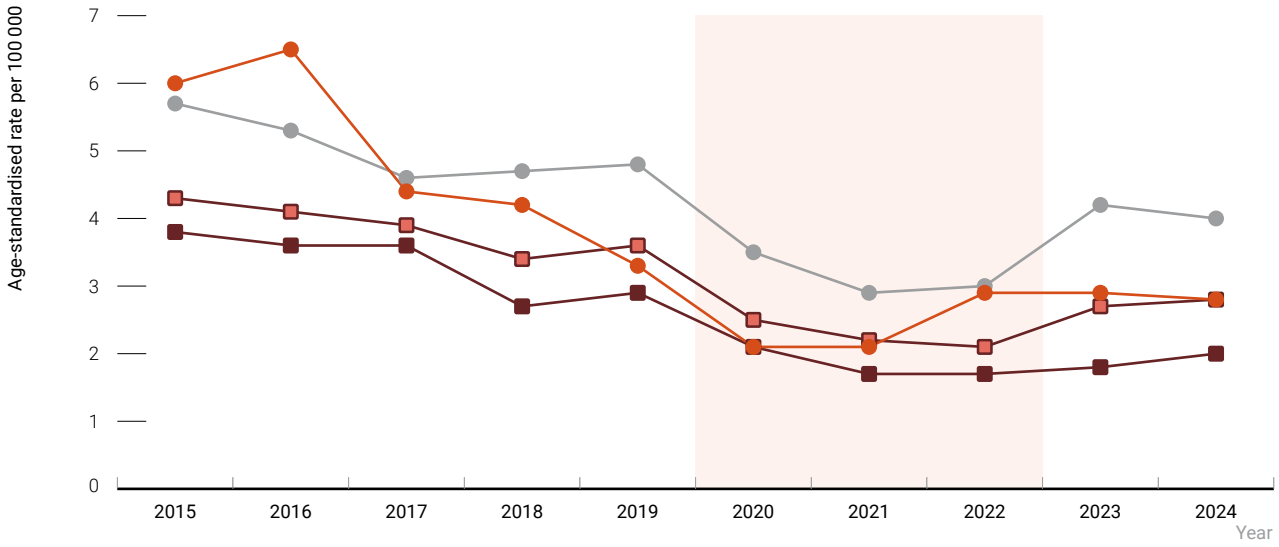
	Year of HIV diagnosis									
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Characteristic										
Total cases[a]	40	47	31	33	25	16	17	25	24	23
Gender										
Male	25	36	41	23	30	20	14	17	22	15
Female	8	4	5	7	3	5	1	0	3	9
Transgender[b]	1	0	1	1	0	0	1	0	0	0
Median age in years	36	31	33	28	31	35	38	34	41	36
Newly acquired HIV[c]										
(% of new diagnoses)	33%	30%	32%	27%	40%	44%	18%	36%	33%	30%
Late and advanced HIV infection status at HIV diagnosis (%)[d]										
Late HIV diagnosis	30%	25%	25%	25%	23%	7%	47%	27%	30%	26%
Advanced HIV diagnosis	16%	14%	7%	21%	9%	0%	20%	14%	17%	11%
State/Territory										
Australian Capital Territory	0	0	0	1	0	0	0	0	0	0
New South Wales	7	10	8	11	7	4	1	6	11	5
Northern Territory	1	5	1	1	0	0	1	0	0	1
Queensland	13	20	11	13	9	7	6	5	8	8
South Australia	2	2	5	1	2	2	0	0	1	0
Tasmania	2	0	1	0	1	0	1	0	0	0
Victoria	8	6	2	4	4	1	3	5	1	6
Western Australia	7	4	3	2	2	2	5	9	3	3
HIV exposure category										
Male-to-male sex[e]	55.0%	57.4%	38.7%	54.5%	48.0%	50.0%	52.9%	40.0%	25.0%	30.4%
Male-to-male sex and injection drug use[f]	10.0%	12.8%	6.5%	12.1%	20.0%	31.3%	11.8%	16.0%	16.7%	26.1%
Heterosexual sex	17.5%	21.3%	25.8%	24.2%	16.0%	12.5%	17.6%	20.0%	50.0%	30.4%
Injection drug use	15.0%	4.3%	22.6%	3.0%	16.0%	0.0%	17.6%	20.0%	8.3%	8.7%
Mother with/at risk of HIV infection	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.0%	0.0%	0.0%
Other/undetermined exposure	2.5%	4.3%	6.5%	6.1%	0.0%	6.3%	0.0%	0.0%	0.0%	4.3%

a) Includes notification missing gender.
b) Does not include transgender people recorded as either male or female.
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
d) within one year before HIV diagnosis.
e) Late HIV diagnosis was defined as newly diagnosed HIV with a CD4+ cell count of less than 350 cells/μL, and advanced HIV as newly diagnosed infection with a CD4+ cell count of less than 200 cells/μL. Newly acquired HIV was categorised as not late or advanced diagnosis irrespective of CD4+ cell count.
f) Includes men who had sex with both men and women.

Source: State and territory health authorities.

Trends in HIV notification rates among Aboriginal and Torres Strait Islander peoples are based on small numbers and may reflect localised occurrences rather than national patterns. The 2021 Census data from the Australian Bureau of Statistics recorded a larger than expected increase in the number of people self-identifying as Aboriginal and/or Torres Strait Islander. This increase was unlikely due to demographic changes (such as from births, death or migration). Because of this change, trend in HIV notification rates between 2019 and 2024 should be interpreted with caution. Further details can be found on the ABS website. Between 2015 and 2024, the HIV notification rate among Aboriginal and Torres Strait Islander peoples declined from 6.0 to 2.8 per 100 000. By comparison, in 2024, the HIV notification rate was 2.0 per 100 000 among Australian-born non-Indigenous people and 2.8 per 100 000 among all non-Indigenous people.

Figure 8 HIV notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2015 – 2024



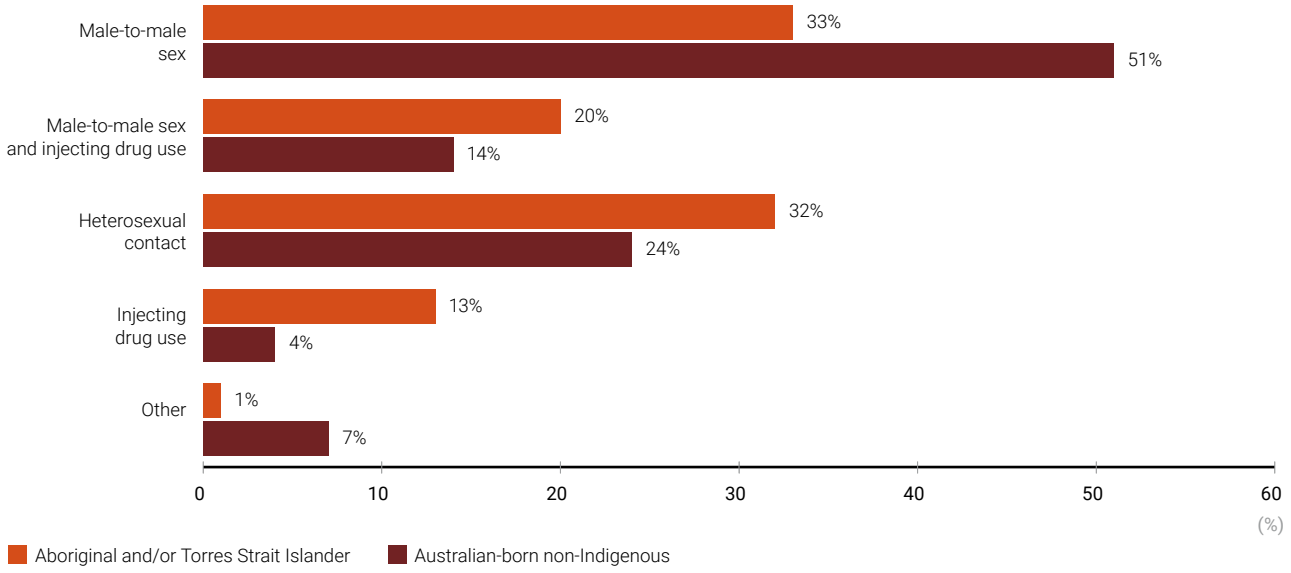
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Aboriginal and Torres Strait Islander people	6.0	6.5	4.4	4.2	3.3	2.1	2.1	2.9	2.9	2.8
Australian-born non-Indigenous people	3.8	3.6	3.6	2.7	2.9	2.1	1.7	1.7	1.8	2.0
All non-Indigenous people	4.3	4.1	3.9	3.4	3.6	2.5	2.2	2.1	2.7	2.8
Overseas-born	5.7	5.3	4.6	4.7	4.8	3.5	2.9	3.0	4.2	4.0

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

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

For the years 2022 – 2024, by exposure classification, a higher proportion of notifications were attributed to injection drug use among Aboriginal and Torres Strait Islander peoples than among non-Indigenous people (13% and 4%, respectively). Conversely, a higher proportion of notifications were attributed to male-to-male sex among Australian-born non-Indigenous people than among Aboriginal and Torres Strait Islander peoples (Figure 9).

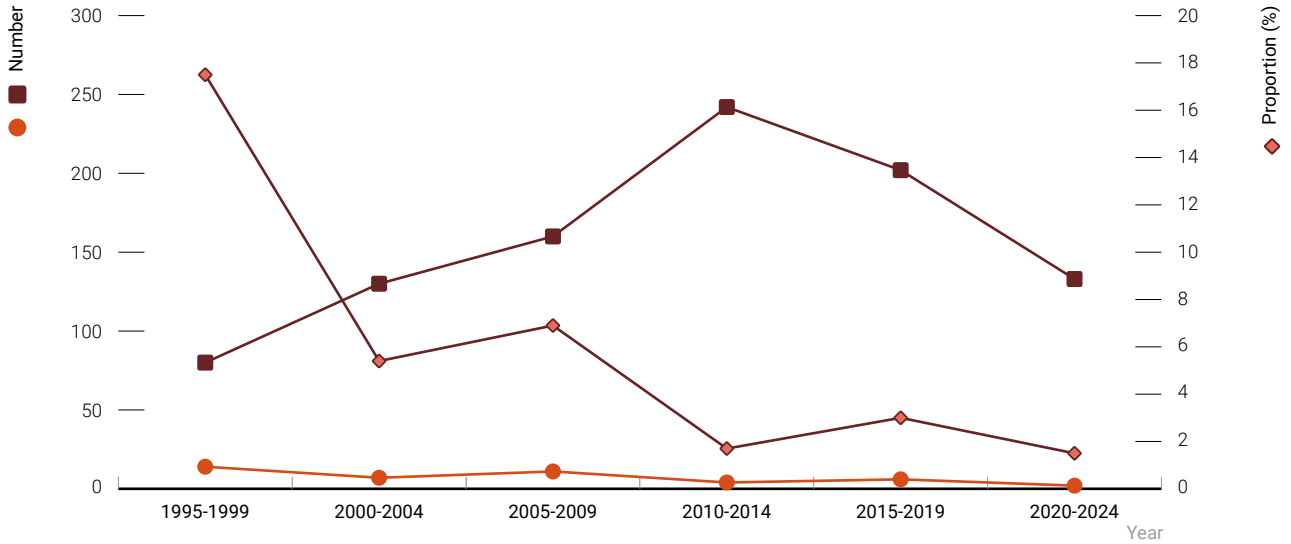
Figure 9 HIV notification exposure category by Aboriginal and Torres Strait Islander status, 2022 – 2024



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

Pregnant people: Between 1995 and 2024, 947 cases of potential perinatal HIV exposure among children born in Australia were reported. For the period 2020 – 2024, the HIV vertical transmission rate was 1.5%, compared with 17.5% in the period 1995 – 1998 (Figure 10). There were two reported cases of vertical HIV transmission from 2020 to 2024 with two in 2022, with both maternal diagnoses occurring close to delivery.

Figure 10 Number of Australian-born children perinatally exposed to HIV and proportion HIV-positive by five-year grouping of birth years, 1995 – 2024



	1995-1999	2000-2004	2005-2009	2010-2014	2015-2019	2020-2024
Perinatally exposed (n)	80	130	160	242	202	133
HIV positive (n)	14	7	11	4	6	2
HIV positive (%)	17.5	5.4	6.9	1.7	3.0	1.5

Source: Australian Paediatric Surveillance Unit; see Methodology for detail.

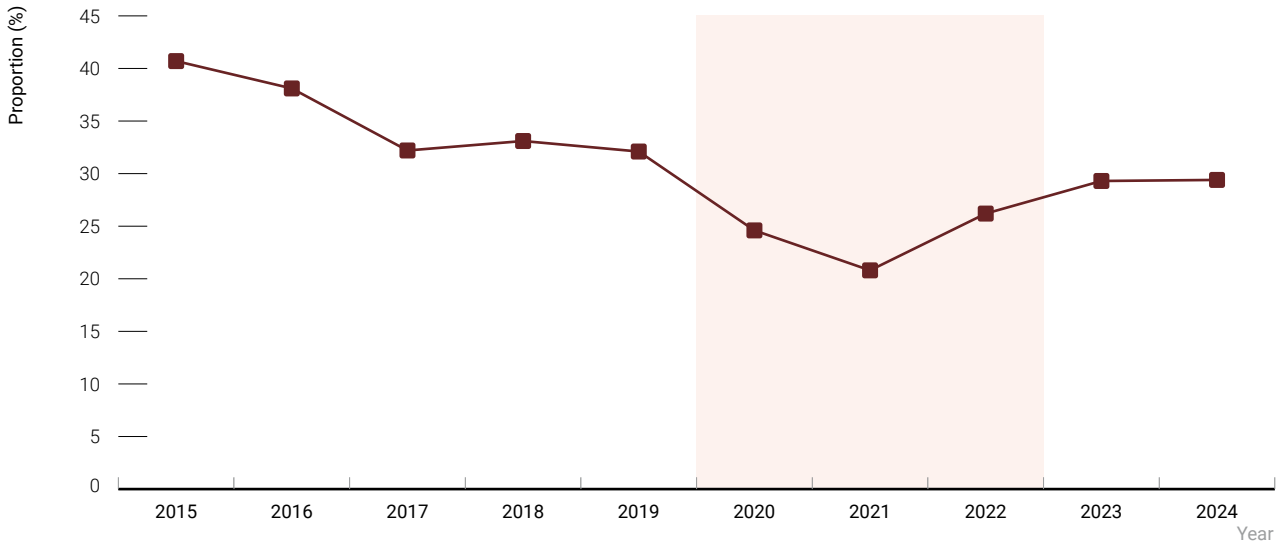
Clinical and immunological markers indicating timing and place of HIV acquisition

HIV notifications classified as newly acquired

Trends in the proportion of HIV notifications classified as newly acquired need to be interpreted with caution as rises could reflect increases in regular testing (allowing determination of recent infection) rather than an actual increase in the number of newly acquired infections. When considering these data, it is important to also note that fewer indeterminate results were recorded after 2016 due to changes in testing practices across several jurisdictions. These changes have reduced the number of results which were previously used to provide evidence for newly acquired HIV infections. In general, HIV testing rates are higher among gay and bisexual men and other men who have sex with men meaning that HIV notifications are more likely to be classified as newly acquired among these populations. Also, access to healthcare and HIV testing was disrupted during the COVID-19 pandemic, which may have led to delayed diagnoses and under-reporting of newly acquired infections during that period.

For some HIV notifications, it is possible to determine whether HIV was acquired in the 12 months prior to diagnosis, on the basis of a recent prior negative or indeterminate HIV test and/or clinical markers (see Methodology for further details). The proportion of all new notifications that were reported to be newly acquired decreased from 40.7% in 2015 to 29.4% in 2024 (Table 3, Figure 11).

Figure 11 The proportion of HIV notifications classified as newly acquired, 2015 – 2024



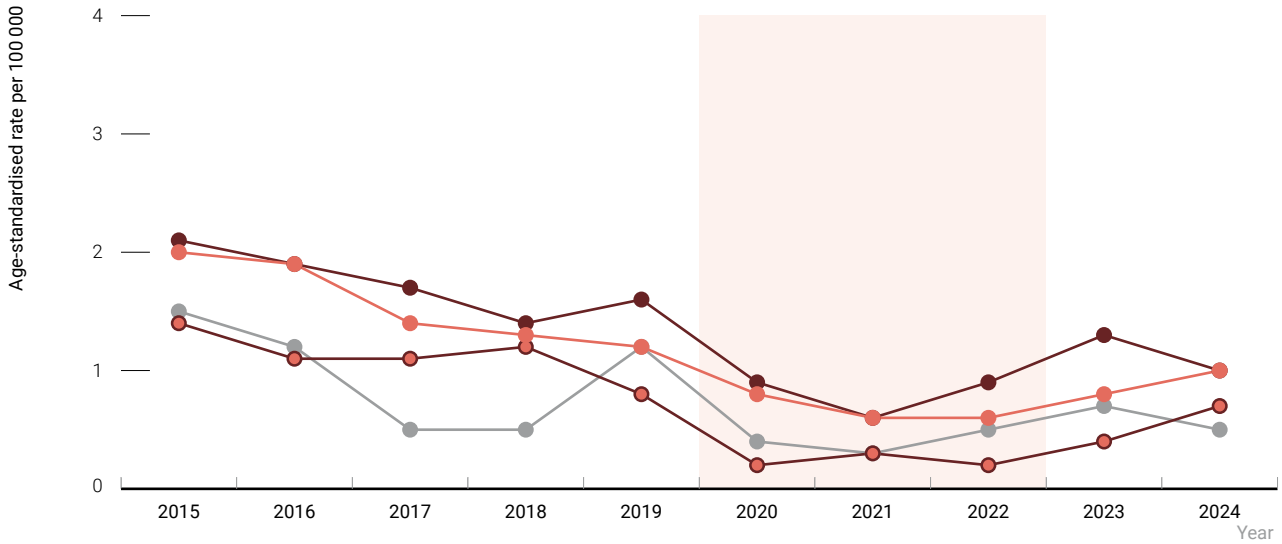
2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
40.7	38.1	32.2	33.1	32.1	24.6	20.8	26.2	29.3	29.4

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
Newly acquired HIV was defined as newly diagnosed infection with a negative or indeterminate HIV antibody test result or a diagnosis of primary HIV within one year before HIV diagnosis.

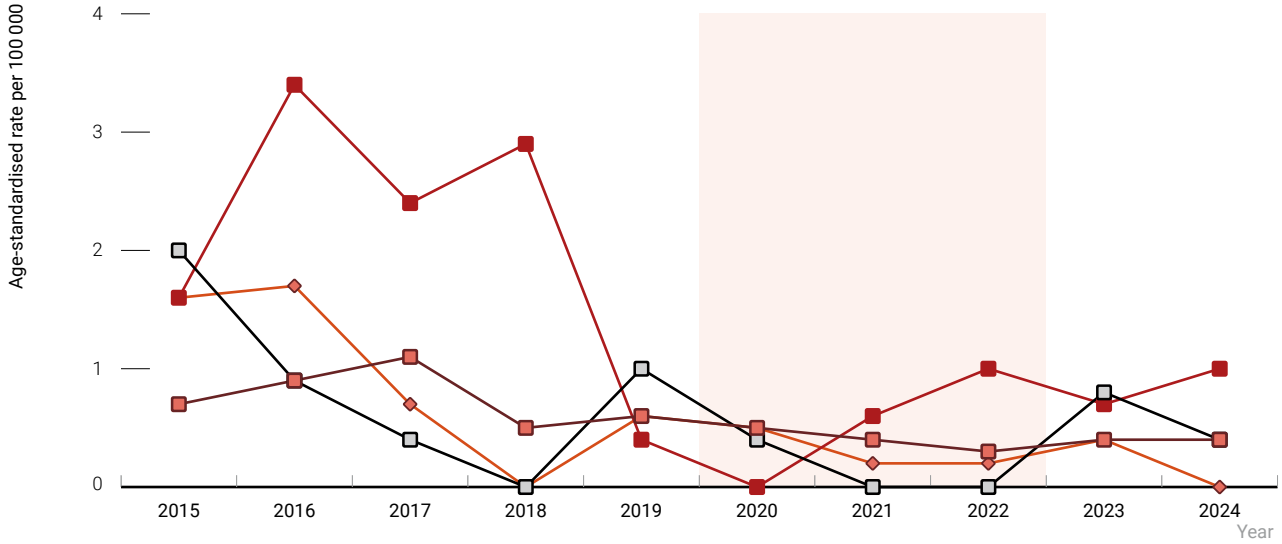
Source: State and territory health authorities; see Methodology for detail.

The rates of newly acquired HIV notifications in 2024 varied by jurisdiction, with the highest rate in New South Wales and Victoria (1.0 per 100 000 in each state) (Figure 12). In the Australian Capital Territory, South Australia, Tasmania, and the Northern Territory the numbers of notifications reported annually are smaller, so trends by jurisdiction need to be interpreted with caution.

Figure 12 HIV notification rates classified as newly acquired per 100 000 population, by state/territory, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
NSW	2.0	1.9	1.4	1.3	1.2	0.8	0.6	0.6	0.8	1.0
QLD	1.4	1.1	1.1	1.2	0.8	0.2	0.3	0.2	0.4	0.7
VIC	2.1	1.9	1.7	1.4	1.6	0.9	0.6	0.9	1.3	1.0
WA	1.5	1.2	0.5	0.5	1.2	0.4	0.3	0.5	0.7	0.5



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
ACT	2.0	0.9	0.4	0.0	1.0	0.4	0.0	0.0	0.8	0.4
NT	1.6	3.4	2.4	2.9	0.4	0.0	0.6	1.0	0.7	1.0
SA	0.7	0.9	1.1	0.5	0.6	0.5	0.4	0.3	0.4	0.4
TAS	1.6	1.7	0.7	0.0	0.6	0.5	0.2	0.2	0.4	0.0

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

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

Likely place of HIV acquisition

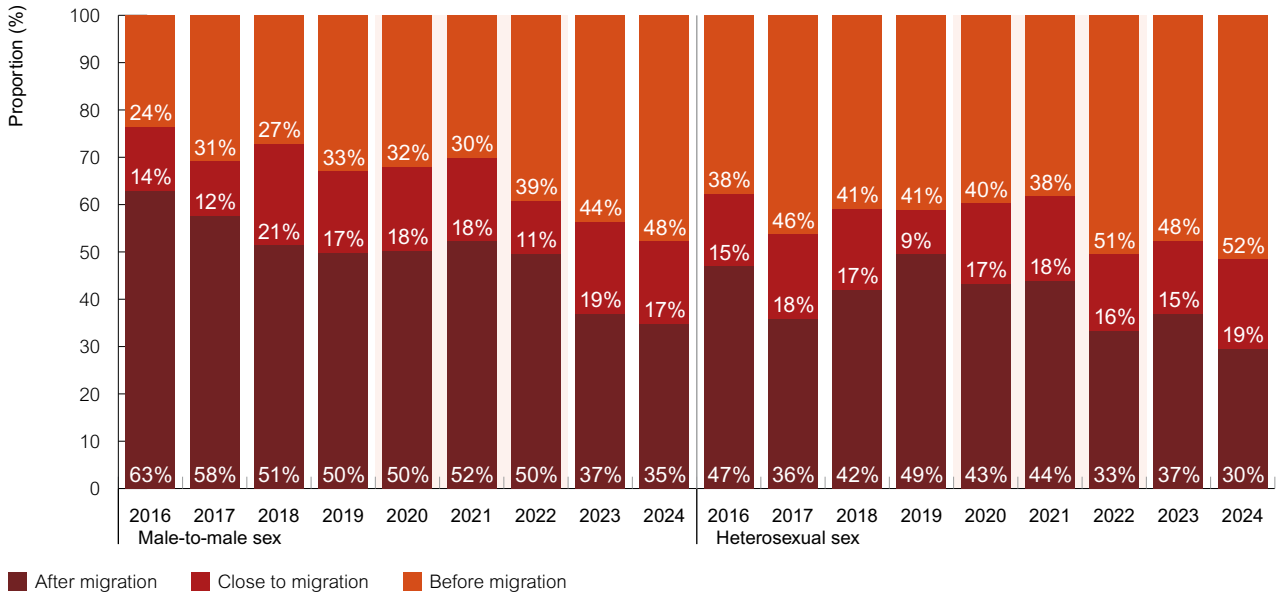
Monitoring the likely place of HIV acquisition and HIV subtype can provide information to enhance understanding of the potential influence of travel and migration on HIV diagnosis trends and to assist with monitoring Australia's pathway to the virtual elimination of local HIV transmission. Using HIV notification data of migrants to Australia, timing of HIV acquisition relative to date of migration to Australia can be estimated. South Australia began reporting year of arrival in 2023 and estimates were only included for South Australia from this year [3].

Of HIV notifications among migrants to Australia attributed to male-to-male sex, the proportion who likely acquired HIV after migration declined from 63% in 2016 to 35% in 2024. Conversely, among this population, the proportion who likely acquired HIV before migration increased from 24% in 2016 to 48% in 2024 (Figure 13). The increase in the proportion of men who likely acquired HIV before migration to Australia should be seen in the context of an overall decline in the number of HIV diagnoses attributed to male-to-male sex (see Table 3).

Of HIV notifications among migrants to Australia attributed to heterosexual sex, the proportion who likely acquired HIV after migration declined from 47% in 2016 to 30% in 2024. Conversely, among this population, the proportion who likely acquired HIV before migration increased from 38% in 2016 to 52% in 2024 (Figure 13).

These trends over time were likely affected by the COVID-19 pandemic. Also, small numbers of notifications among migrants diagnosed with HIV attributed to heterosexual sex mean that trends should be interpreted with caution.

Figure 13 Timing of HIV acquisition among migrants to Australia by exposure, 2016 – 2024



Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
Close to migration = Within six months of migration date.

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

What does this mean?

Among people born overseas and diagnosed with HIV, an increasing proportion likely acquired HIV before migrating to Australia. This trend likely reflects the impact of Australian HIV prevention strategies in reducing local transmissions.

HIV subtype

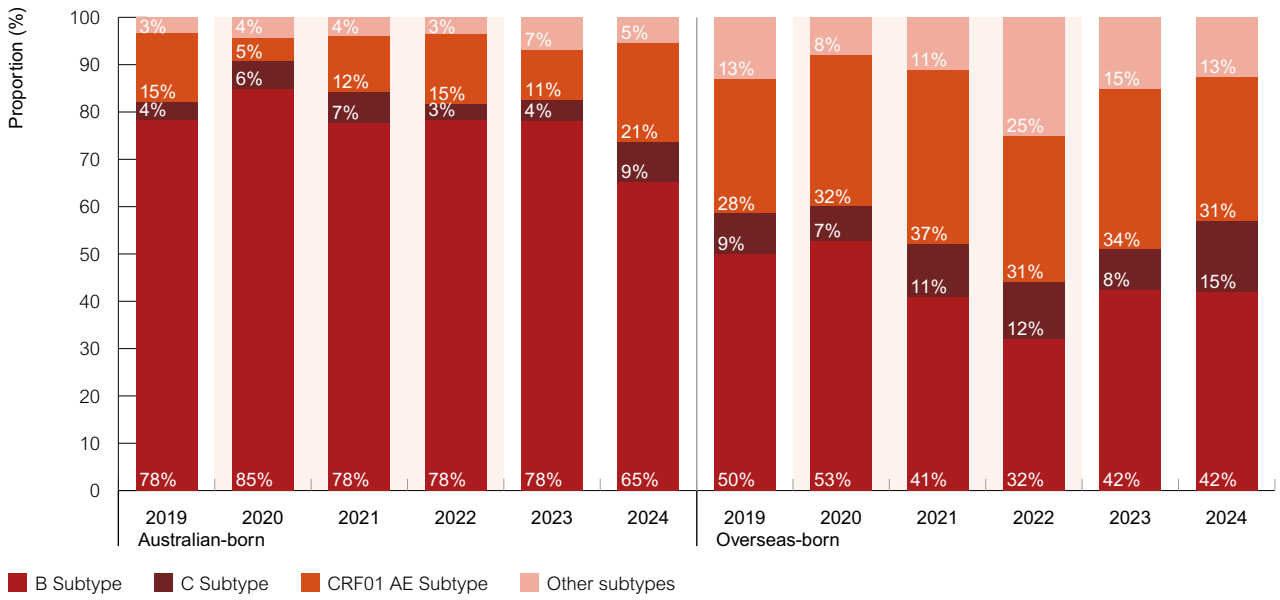
HIV subtype is included in this report as changes in the distribution of subtypes at a population level can inform prevention programs. There are at least nine subtypes of HIV-1 globally, A, B, C, D, F, G, H, J and K. Additionally, different subtypes can combine, creating what is known as a 'circulating recombinant form' [4]. The dominant HIV subtype in the Americas, Western Europe and Australasia is subtype B [5,6]. Subtype C is more common in India and Sub-Saharan Africa [7].

In this report we have included HIV subtype based on HIV notifications with a reported subtype in New South Wales, Queensland, South Australia, and Victoria from 2019 to 2024. In 2024, there were 296 notifications with a reported subtype. These data may not be representative of all notifications Australia-wide, therefore these figures should be interpreted with caution. Future reports will aim to include data from all jurisdictions (see Methodology for further details).

Between 2019 and 2023, among HIV notifications attributed to male-to-male sex and with a reported birthplace of Australia, most were subtype B (between 78% and 85%) compared with non-B subtypes. In 2024 this proportion reduced to 65%. By comparison, among HIV notifications attributed to male-to-male sex and with a reported birthplace of overseas, subtypes were more evenly spread between subtype B (between 32% and 53%) and subtype CRF01 AE (between 28% and 37%) (Figure 14).

Between 2019 and 2024, among HIV notifications attributed to heterosexual sex and with a reported birthplace of Australia, a greater proportion were subtype B (between 38% and 61%) compared with each non-B subtype. By comparison, among HIV notifications attributed to heterosexual sex and with a reported place of birth of overseas, a greater proportion were CRF01 AE (between 31% and 36%) or subtype C (between 23% and 42%) compared with subtype B (between 14% and 20%) (Figure 15).

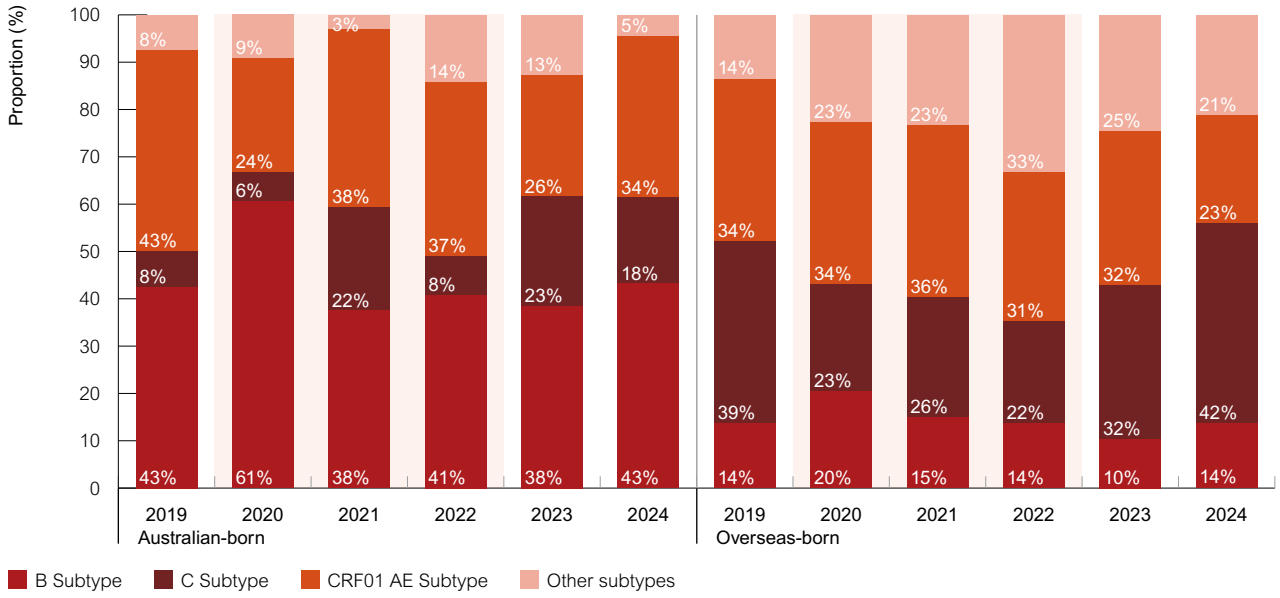
Figure 14 HIV subtype distribution in HIV notifications attributed to male-to-male sex by place of birth, 2019 – 2024



Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
Includes notifications from New South Wales, South Australia, Queensland, and Victoria. Excludes notifications where HIV subtype was not reported.

Source: State/territory health authorities, NSW Linkage Database; see Methodology for detail.

Figure 15 HIV subtype distribution in HIV notifications attributed to heterosexual sex by place of birth, 2019 – 2024



Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
Includes notifications from New South Wales, South Australia, Queensland, and Victoria. Excludes notifications where HIV subtype was not reported.

Source: State/territory health authorities, NSW Linkage Database; see Methodology for detail.

Late and advanced HIV diagnoses

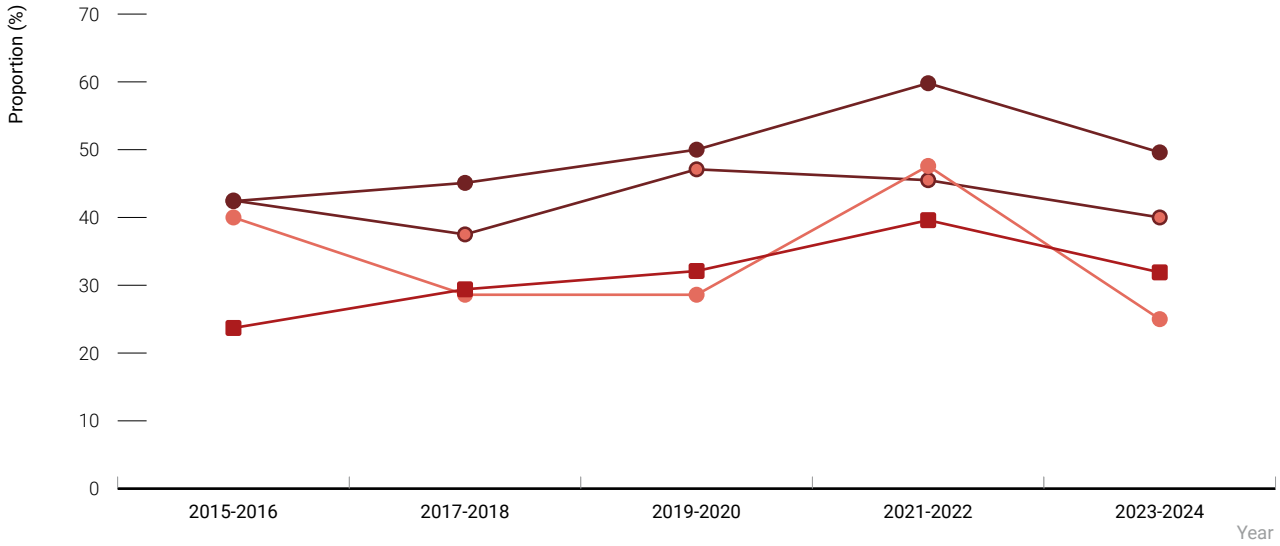
CD4+ cell count at the time of HIV diagnosis can indicate how long a person has had HIV before being diagnosed. The CD4+ cell count is above 500 cells/μL in most people without HIV and declines on average by 50 to 100 cells/μL per year in people with HIV [8]. Late HIV diagnosis is defined as CD4+ cell count less than 350 cells/μL at diagnosis without evidence of a newly acquired HIV infection. Advanced HIV is defined as newly diagnosed infection with a CD4+ cell count of less than 200 cells/μL without evidence of a newly acquired HIV infection (see Methodology for further details).

The proportion HIV cases with a late diagnosis increased from 27.3% in 2015 to 38.4% in 2024 (see Table 3). In 2024, the proportion of HIV notifications with late diagnosis was highest in people born in Southeast Asia (58%), Oceania (excluding Australia) (53%), and Sub-Saharan Africa (47%) (data not shown).

Late HIV diagnoses by key characteristics and exposure category

By exposure category, condensed into two-year groups to account for small numbers of notifications, late diagnoses attributed to heterosexual sex, male-to-male sex and injection drug use have fluctuated. For the years 2023/2024 and for diagnoses attributed to heterosexual sex and injection drug use, the proportions diagnosed late remain high at 49.6% and 40.0%, respectively (Figure 16).

Figure 16 Proportion of late HIV diagnoses by selected exposure category, 2015 – 2024



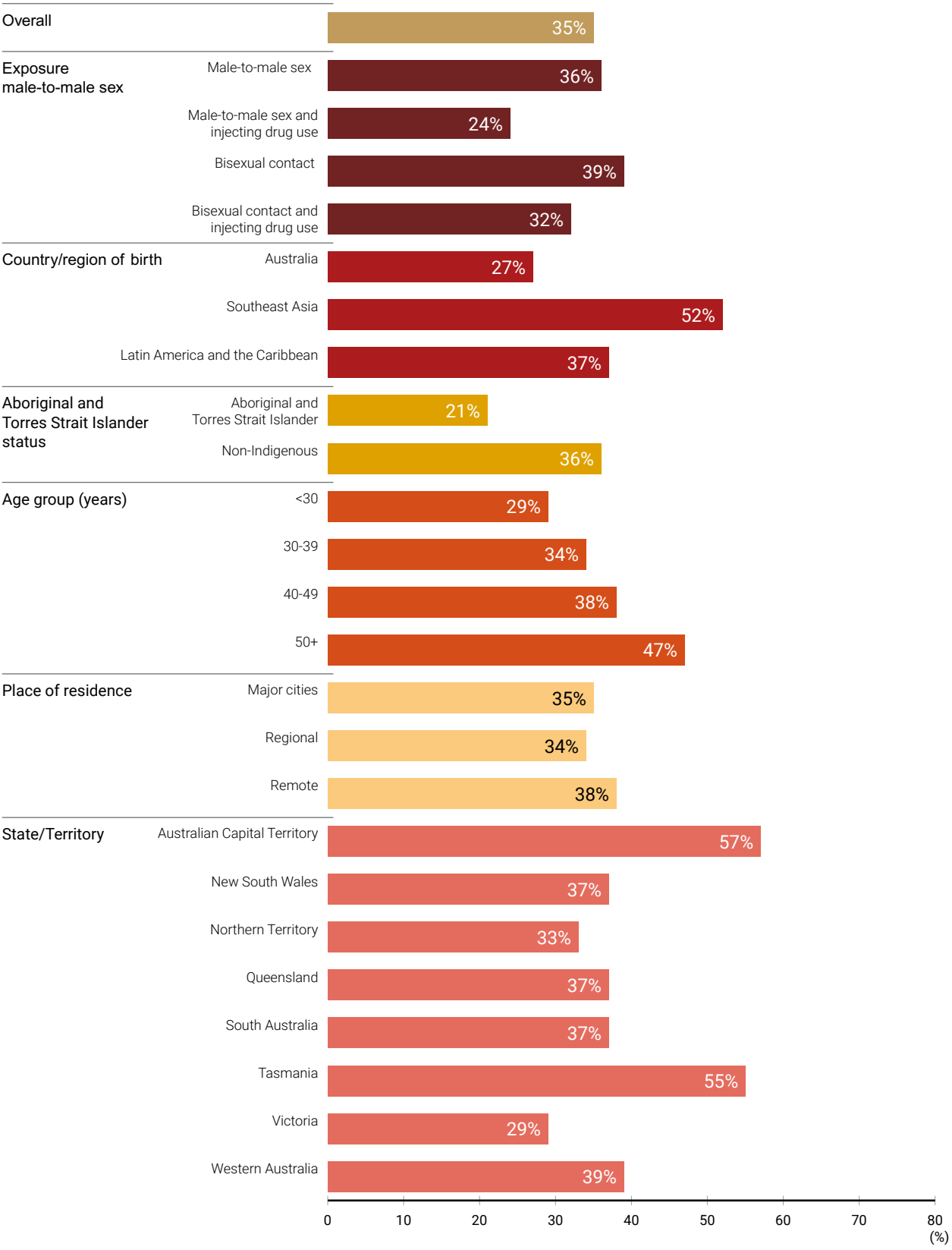
	2015-2016	2017-2018	2019-2020	2021-2022	2023-2024
Male-to-male sex and male-to-male sex and injecting drug use (%)	23.7	29.4	32.1	39.6	31.9
Sex with both men and women (%)	40.0	28.6	28.6	47.6	25.0
Heterosexual sex (%)	42.4	45.1	50.0	59.8	49.6
Injecting drug use (%)	42.5	37.5	47.1	45.5	40.0

Notes: Late HIV diagnosis was defined as new HIV diagnoses with a CD4+ cell count of less than 350 cells/μL. Newly acquired HIV was not categorised as late or advanced diagnoses irrespective of CD4+ cell count. Notifications without a CD4+ cell count available were excluded.

Source: State and territory health authorities.

Among HIV notifications attributed to male-to-male sex for the years 2020 to 2024, late diagnosis was more common among men who reported sex with both men and women (39%), men aged 50 years and older (47%), men born in Southeast Asia (52%), and men living in remote areas (38%) (Figure 17).

Figure 17 Proportion of late HIV diagnoses among men reporting an exposure category that included male-to-male sex by subcategory, 2020 – 2024 (n = 2022)

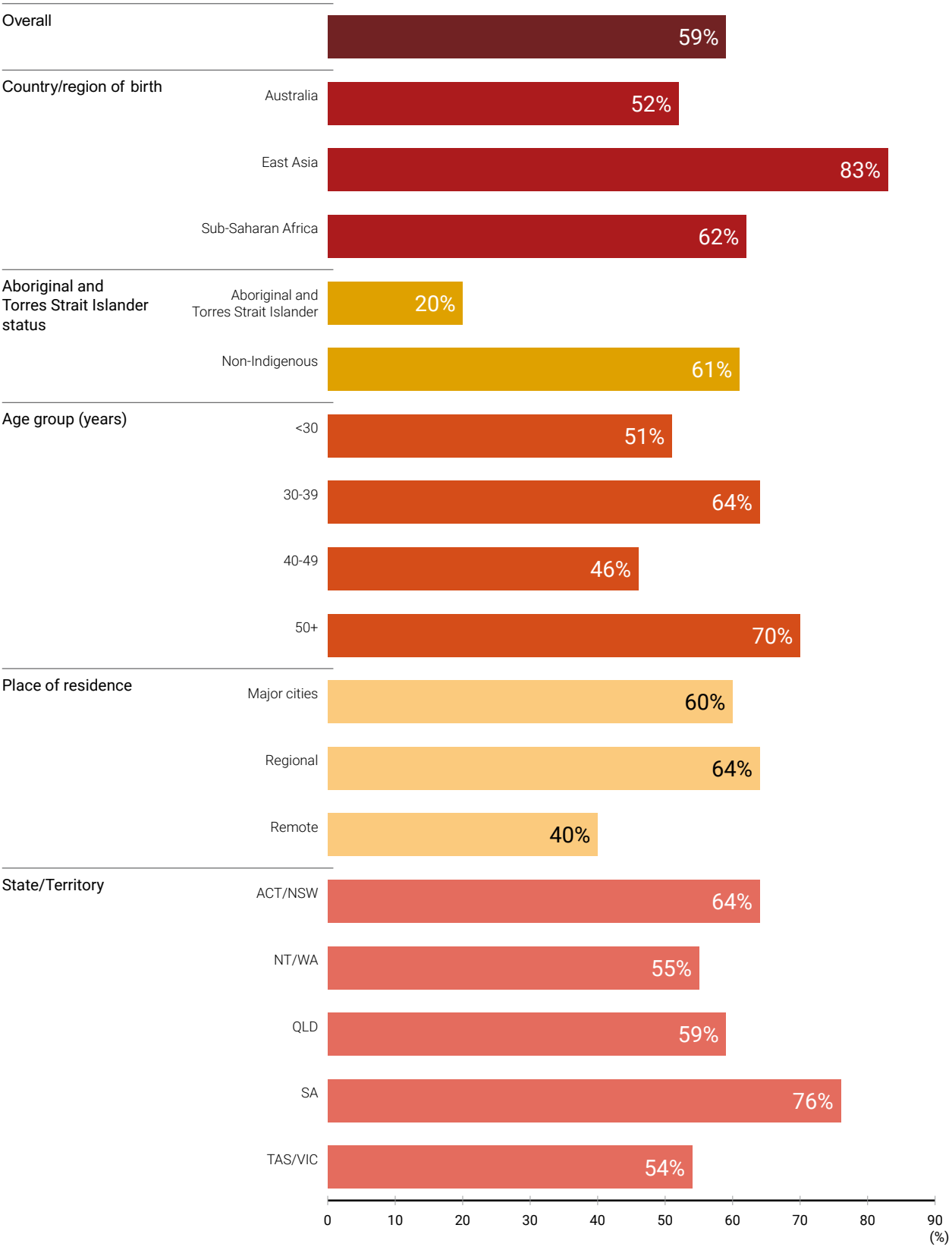


Notes: Late HIV diagnosis was defined as an HIV notification with a CD4+ cell count of less than 350 cells/μL. Newly acquired HIV was categorised as neither late nor advanced diagnoses, irrespective of CD4+ cell count. Notifications without a CD4+ cell count recorded within three months of diagnosis were excluded.

Source: State and territory health authorities.

A high proportion of late diagnoses were reported among people with heterosexual sex as an exposure risk (54% overall, 59% among men and 46% among women), with variation by key demographic characteristics and HIV risk exposure (Figure 18, Figure 19).

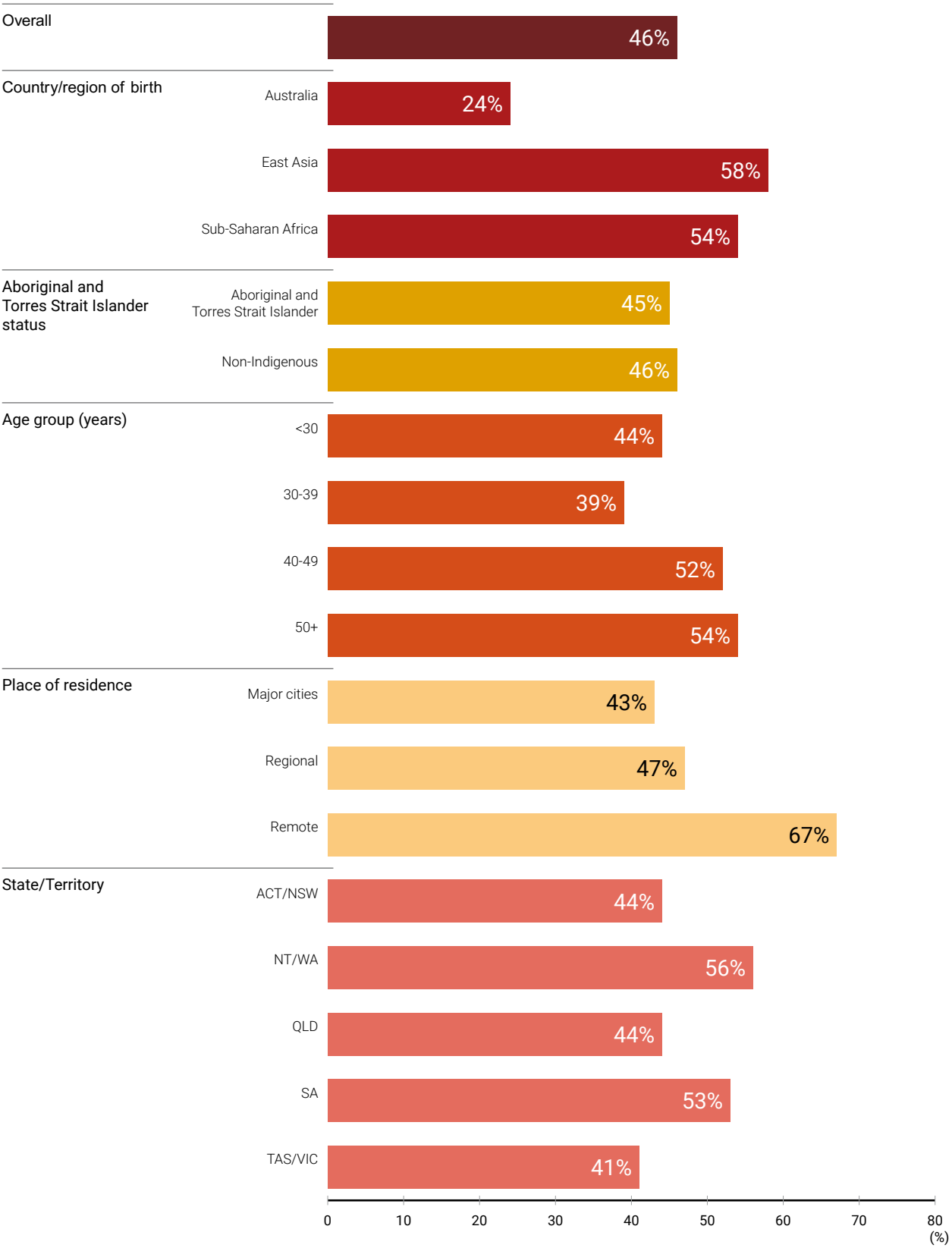
Figure 18 The proportion of late HIV diagnoses among men who reported heterosexual sex as an exposure risk by subcategory, 2020–2024 (n = 453)



Notes: Late HIV diagnosis was defined as an HIV notification with a CD4+ cell count of less than 350 cells/μL. Newly acquired HIV was not categorised as late or advanced diagnoses irrespective of CD4+ cell count. Notifications without a CD4+ cell count recorded within three months of diagnosis were excluded.

Source: State and territory health authorities.

Figure 19 The proportion of late HIV diagnoses among women who reported heterosexual sex as an exposure risk by subcategory, 2020–2024 (n = 318)



Notes: Late HIV diagnosis was defined as an HIV notification with a CD4+ cell count of less than 350 cells/μL. Newly acquired HIV was not categorised as late or advanced diagnoses irrespective of CD4+ cell count. Notifications without a CD4+ cell count recorded within three months of diagnosis were excluded. Caution should be applied when interpreting these data due to low numbers.

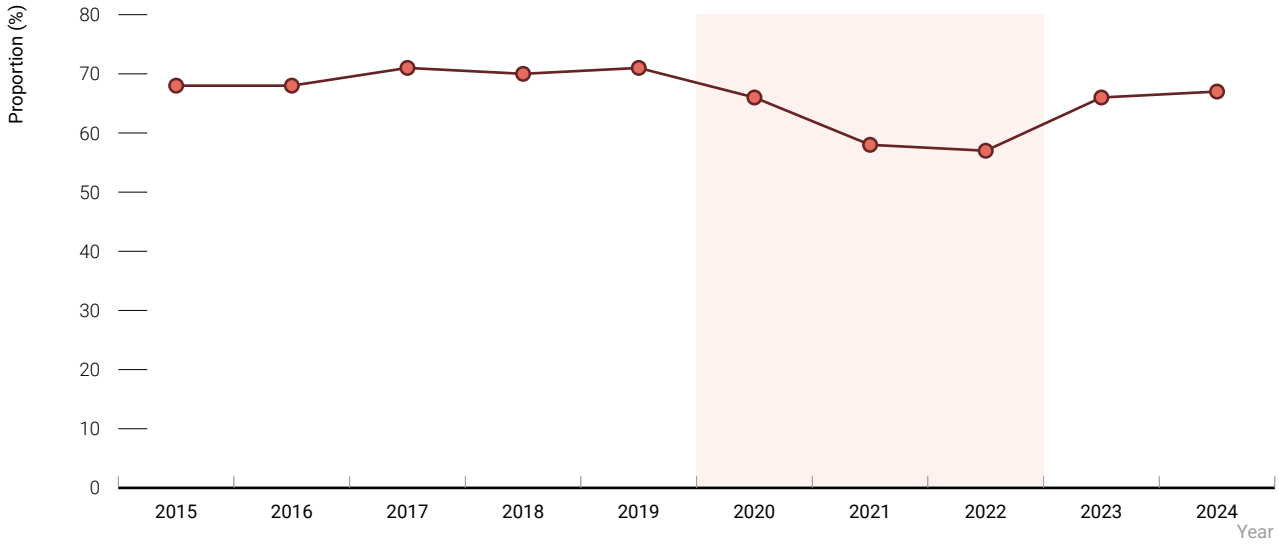
Source: State and territory health authorities.

4 HIV testing

National testing guidelines recommend HIV testing in multiple contexts, such as, according to exposure risk, during antenatal care and for particular priority populations [9]. Guidelines recommend three-monthly testing for all sexually active men who have had sex with another man in the previous three months.

Behavioural surveys measure the proportion of people tested in a year and provide further information about HIV testing patterns in Australia among selected priority populations. In the GBQ+ Community Periodic Surveys [10], the proportion of non-HIV-positive gay and bisexual men who reported having had an HIV test in the 12 months fluctuated between 2015 and 2024 and was 67% in 2024. Between 2019 and 2022 this proportion dropped to 57%, likely due to the impacts of the ongoing COVID-19 pandemic (Figure 20).

Figure 20 Proportion of non-HIV-positive gay and bisexual men tested for HIV in the 12 months prior to completing the surveys, 2015-2024



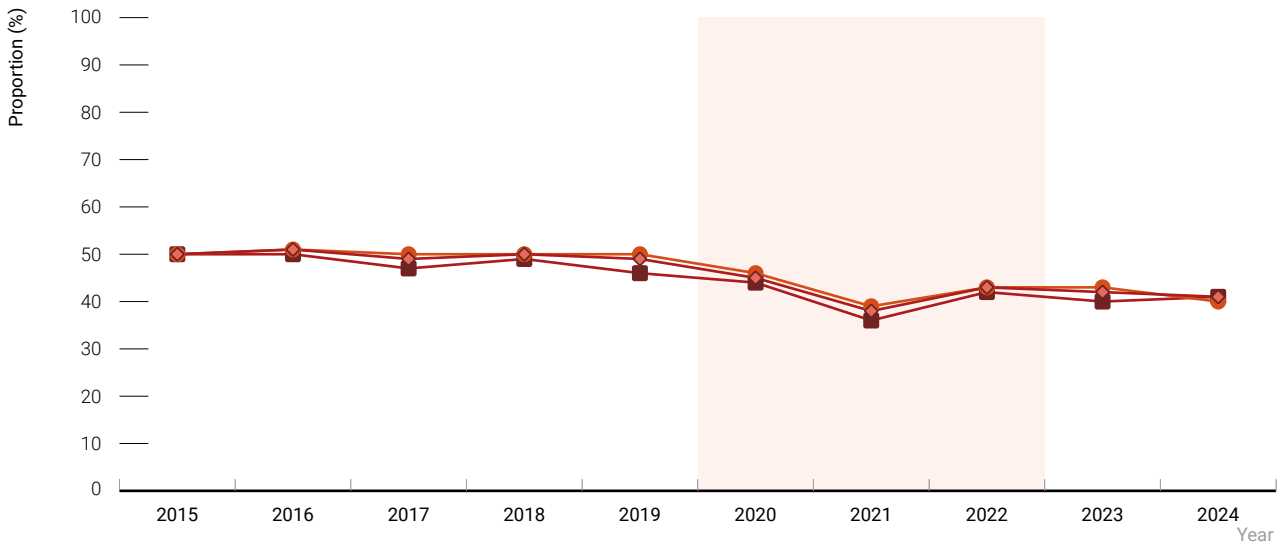
2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
68	68	71	70	71	66	58	57	66	67

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: GBQ+ Community Periodic Surveys.

Based on data from the Australian Needle Syringe Program Survey (ANSPS), in 2024, 41% of people who inject drugs attending needle and syringe programs self-reported having had an HIV test in the 12 months prior to the survey, with similar proportions among men and women (Figure 21). The number of participants of the ANSPS after 2020 were lower than in previous years due to the impacts of the COVID-19 pandemic, and trends over time should be interpreted with caution.

Figure 21 Proportion of people who inject drugs attending needle and syringe programs who reported an HIV test in the past 12 months by gender, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Women (%)	50	50	47	49	46	44	36	42	40	41
Men (%)	50	51	50	50	50	46	39	43	43	40
Total (%)	50	51	49	50	49	45	38	43	42	41

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

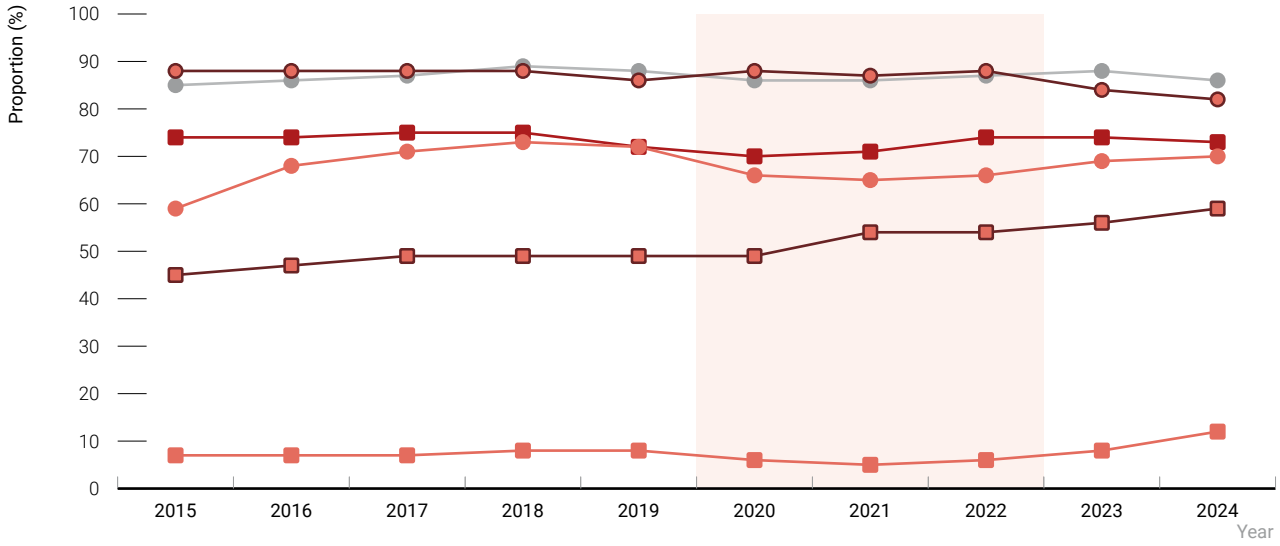
Source: ANSPS; see Methodology for detail.

According to respondents of the GBQ+ Community Periodic Surveys, the most common locations for their latest HIV testing in the previous 12 months among non-HIV-positive gay and bisexual men in 2024 were general practices (46%) and sexual health clinics (39%).

At sentinel sexual health clinics across Australia participating in ACCESS (see Methodology for further detail), the proportion of gay and bisexual men who were tested for HIV at least once in the previous 12 months fluctuated between 86% and 88% between 2015 and 2022 then declined to 82% in 2024 (Figure 22). Among gay and bisexual men attending high-caseload general practice clinics, the proportion who were tested for HIV at least once in a year fluctuated between 59% and 72% with declines over the peak of the pandemic (70% in 2024). Declines in the numbers of gay and bisexual men attending sexual health clinics and general practice clinics between 2020 and 2022 mean that trends in testing should be interpreted with caution.

Among other priority populations attending sexual health clinics participating in ACCESS, the proportion of female sex workers who were tested for HIV at least once in a year remained greater than 85% for each year from 2015 to 2024 and was 86% in 2024. In 2024, among people attending sexual health clinics who were recorded as having recently injected drugs, 73% received an HIV test in the previous 12 months, similar to the preceding nine years. Among young heterosexual people (aged 16-29 years) attending sexual health clinics, 59% received an HIV test in the previous 12 months in 2024. By contrast, among young heterosexual people attending general practice clinics in 2024, only 12% received an HIV test in the previous 12 months (Figure 22).

Figure 22 Proportion of sexual health and high-caseload general practice clinic attendees tested for HIV in a year by priority population, 2015 – 2024



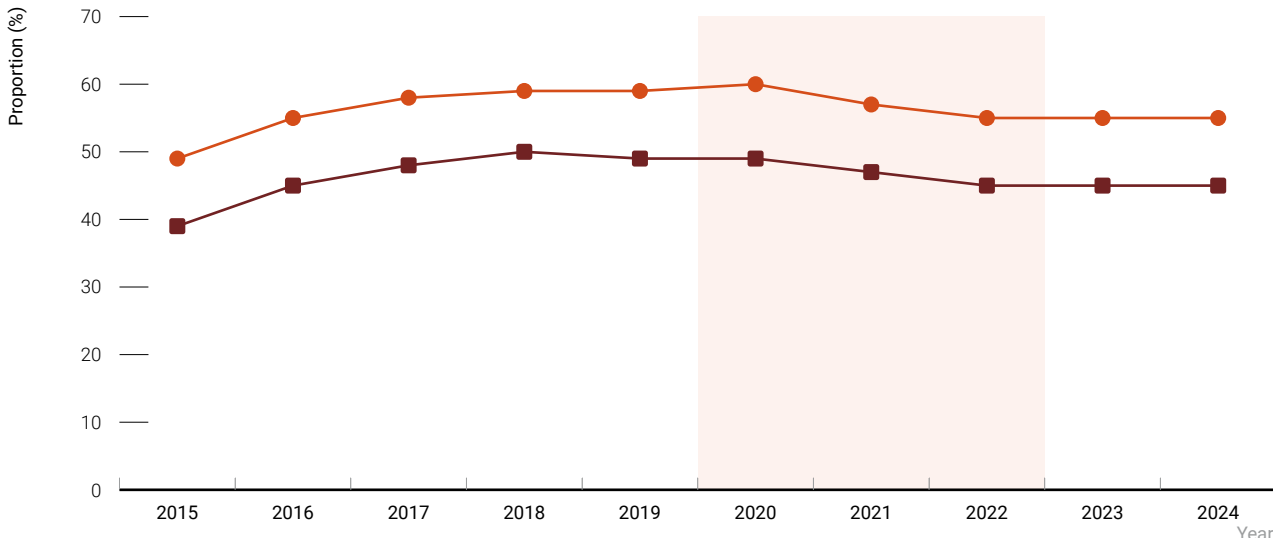
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Gay and bisexual men, sexual health clinic (%)	88	88	88	88	86	88	87	88	84	82
Gay and bisexual men, general practice (%)	59	68	71	73	72	66	65	66	69	70
Heterosexuals aged 16-29y, sexual health clinic (%)	45	47	49	49	49	49	54	54	56	59
Heterosexuals aged 16-29y, general practice (%)	7	7	7	8	8	6	5	6	8	12
People who inject drugs, sexual health clinic (%)	74	74	75	75	72	70	71	74	74	73
Female sex workers, sexual health clinic (%)	85	86	87	89	88	86	86	87	88	86

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
High-caseload general practice clinics include primary healthcare general practice clinics with a high caseload of gay and bisexual men.

Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); see Methodology for detail.

Among gay and bisexual men attending sexual health clinics, the proportion who had a repeat HIV test within 13 months of a previous HIV test increased from 49% in 2015 to 55% in 2024. In this period, the proportion retested within seven months of a previous HIV test increased from 39% in 2015 to 45% in 2024 (Figure 23).

Figure 23 HIV retesting among gay and bisexual men attending sexual health clinics, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Re-tested at 1-7 months (%)	39	45	48	50	49	49	47	45	45	45
Re-tested at 1-13 months (%)	49	55	58	59	59	60	57	55	55	55

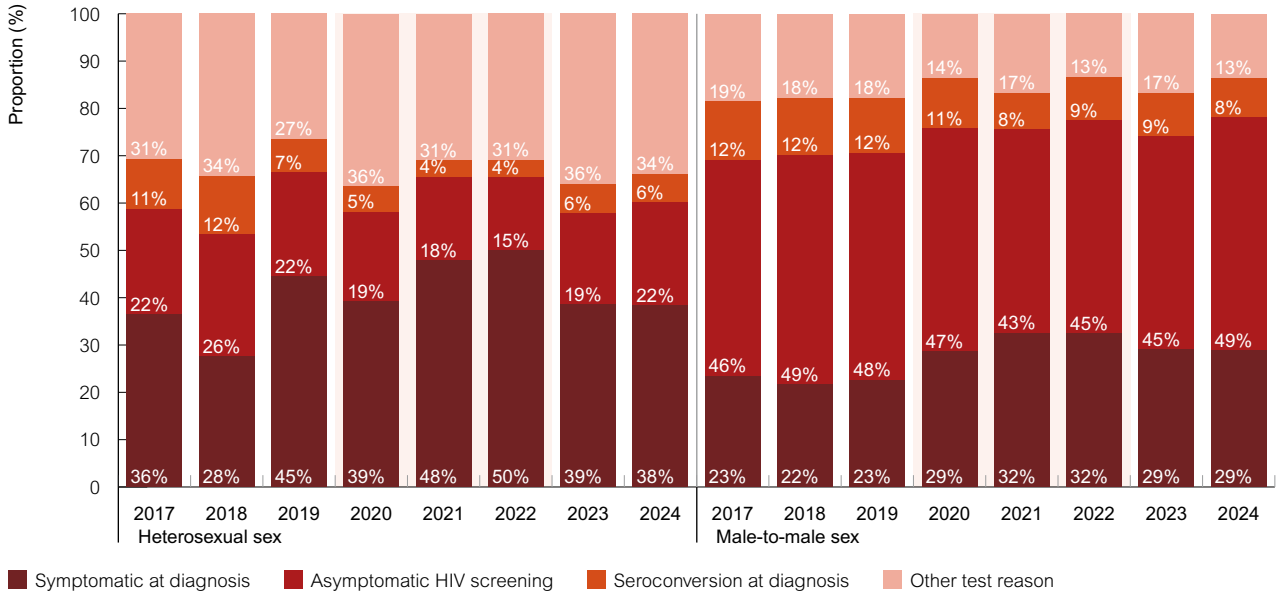
Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); see Methodology for detail.

Reason for HIV test is routinely reported by the diagnosing clinician as part of an HIV notification and is subsequently recorded in the National HIV Registry. Reasons for testing recorded in the National HIV Registry include contact tracing, reported risk behaviour, bloodborne virus screening, STI screening, testing due to clinical symptoms indicative of HIV, pregnancy/fertility screening, immigration screening, reactive self-test, reactive point-of-care test, and HIV preexposure prophylaxis (PrEP) screening. Multiple reasons for testing may be recorded in a single HIV notification. Using these test reasons as well as clinical status at diagnosis, the four HIV test reason categories were derived: asymptomatic HIV screening, symptomatic at diagnosis, seroconverting at diagnosis, and other test reason [11].

Between 2017 and 2024, among HIV notifications attributed to male-to-male sex, the proportion of HIV diagnoses resulting from asymptomatic screening was close to or more than double that of HIV notifications attributed to heterosexual sex (Figure 24). Conversely, for each year in the reporting period, among HIV notifications attributed to heterosexual sex, the proportion of HIV diagnoses resulting from testing while symptomatic was higher than HIV notifications attributed to male-to-male sex.

Figure 24 Reason for HIV test by exposure group, 2015 – 2024



Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: State/territory health authorities.

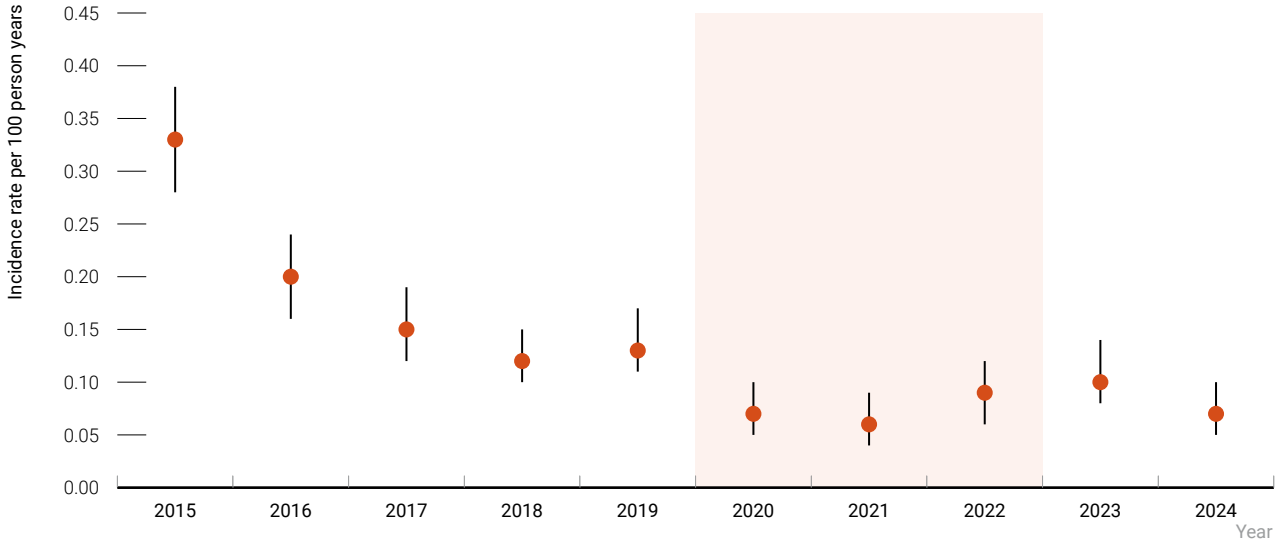
5 HIV incidence

HIV incidence is the best indicator of changes in transmission in a population. HIV incidence is calculated by dividing the number of seroconversions among people undergoing repeat HIV testing at sexual health services by total time at risk for those undergoing testing (determined by the time between repeat HIV tests). Further details about the methods used can be found in the Methodology.

For the years 2015 – 2024, among gay and bisexual men attending sexual health services and general practice clinics participating in ACCESS who had at least one repeat HIV test (n = 162 718), there were 839 seroconversions during 556 337 person-years at risk. The HIV incidence rate in 2024 was 0.07 new infections per 100 person-years down from 0.33 per 100 person-years in 2015 (Figure 25).

In the same period, among female sex workers attending sexual health services and general practice clinics who had at least one repeat HIV test (n=27 744), there were six seroconversions during 62 832 person-years at risk (Figure 26). Between 2015 and 2024, the HIV incidence rate among female sex workers remained low, between 0.00 and 0.03 per 100 person-years and was 0.00 per 100 person-years in 2024.

Figure 25 HIV incidence rate per 100 person-years among gay and bisexual men attending sexual health clinics, 2015 – 2024

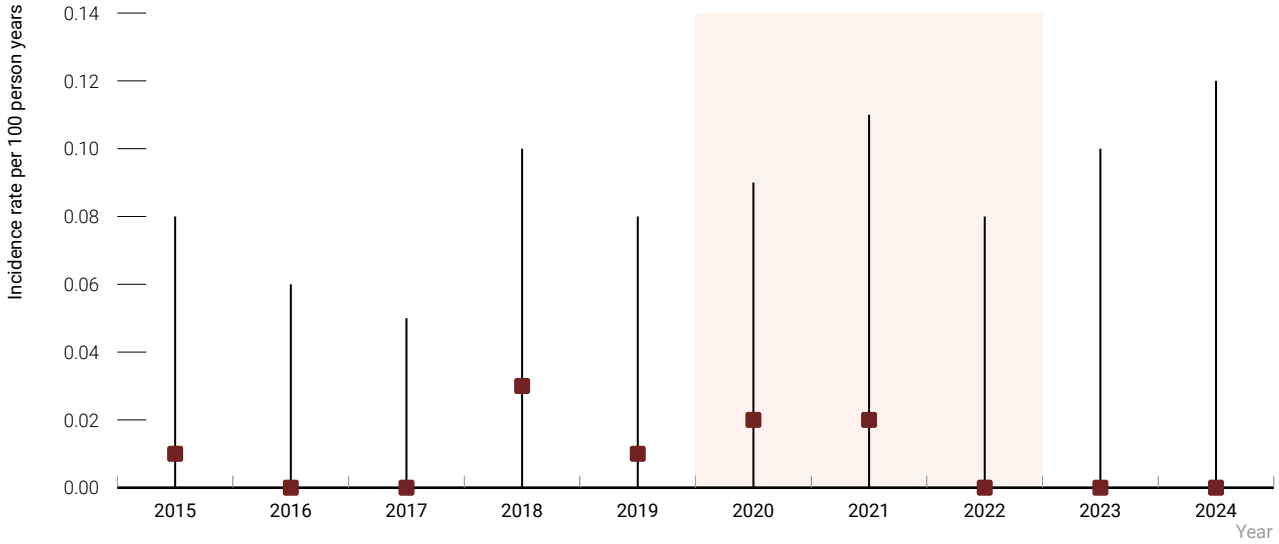


	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Incidence rate	0.33	0.20	0.15	0.12	0.13	0.07	0.06	0.09	0.10	0.07

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
These incidence estimates represent populations attending sexual health clinics and may not be generalised to broader priority populations.

Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); see Methodology for detail.

Figure 26 HIV incidence rate per 100 person-years among female sex workers attending sexual health clinics, 2015 – 2024



Incidence rate

0.01	0.00	0.00	0.03	0.01	0.02	0.02	0.00	0.00	0.00

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
These incidence estimates represent populations attending sexual health clinics and may not be generalised to broader priority populations.

Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); see Methodology for detail.

6 Number of people living with HIV and prevalence

Number of people living with HIV

At the end of 2024, among the 30 890 people estimated to be living with HIV in Australia, 22 010 people were estimated to have acquired HIV through male-to-male sex, 7690 through heterosexual sex, and 620 through injection drug use (Table 6).

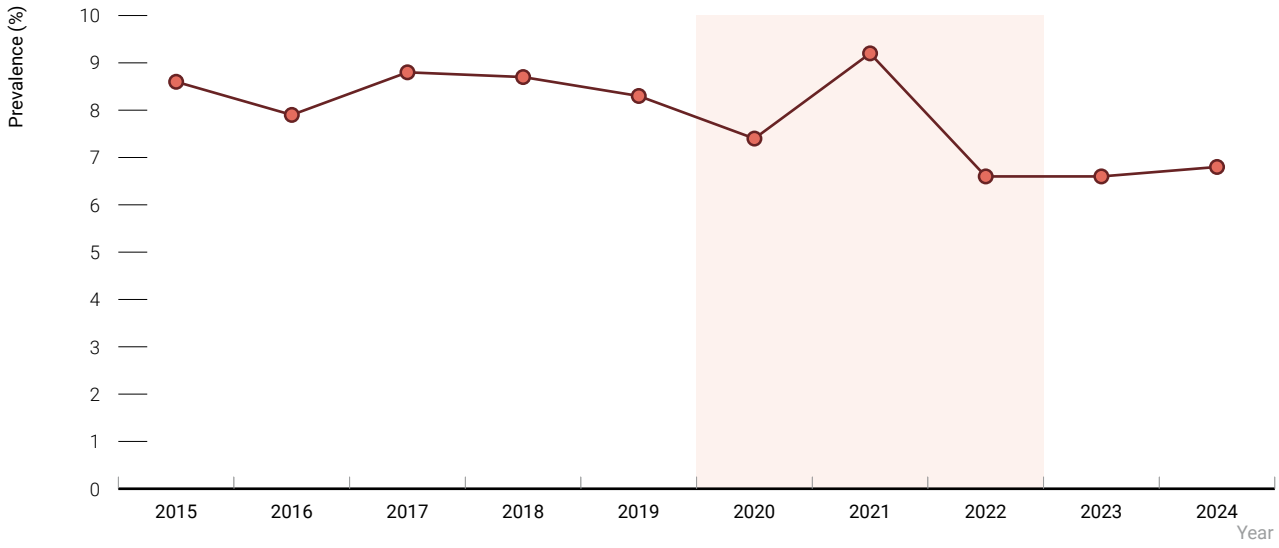
There were an estimated 610 Aboriginal and/or Torres Strait people living with HIV in Australia at the end of 2024. After adjusting for missing country of birth data, there were an estimated 3730 people living with HIV born in Southeast Asia, 1880 born in Sub-Saharan Africa, and 1220 people born in Latin America or the Caribbean (Table 6).

HIV prevalence

The estimated HIV prevalence in Australia (the proportion of people who are living with HIV) in 2024 was 0.14% among adults aged older than 15 years (Table 6). The prevalence in Australia is low compared with that reported to UNAIDS by other high-income countries including the United States (0.4% in 2022) and the United Kingdom (0.3% in 2023). In the wider Asia-Pacific region including Australia, HIV prevalence was an estimated 0.2% in 2024 [12]. HIV prevalence among Aboriginal and Torres Strait Islander peoples was estimated to be 0.09% in 2024.

According to the GBQ+ Community Periodic Surveys, between 2015 and 2024, self-reported HIV prevalence among men in the surveys fluctuated between 6.8% (in 2024) and 9.2% (in 2021) (Figure 27). These data reflect community-attached gay and bisexual men and are based on self-reported HIV status and therefore need to be interpreted with caution.

Figure 27 Self-reported HIV prevalence among men participating in the GBQ+ Community Periodic Surveys, 2015 – 2024



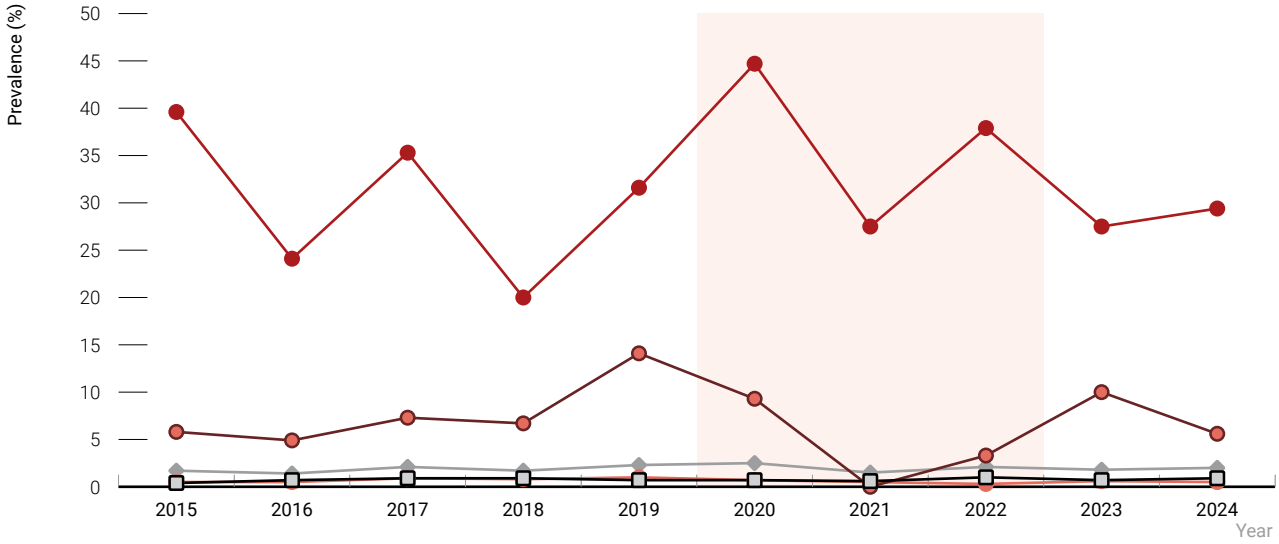
Prevalence (%)	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
	8.6	7.9	8.8	8.7	8.3	7.4	9.2	6.6	6.6	6.8

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: GBQ+ Community Periodic Surveys.

IV prevalence remains low among people who inject drugs, ranging between 1.4% and 2.5% among people attending needle and syringe programs recruited for the ANSPS in the past 10 years and was 2.0% in 2024 (0.7% if men identifying as gay or bisexual are excluded from the sample) (Figure 28). The number of participating needle and syringe programs and the number of ANSPS respondents from 2020 were lower than in previous years due to the impact of the COVID-19 pandemic and public health measures designed to reduce community transmission during the ANSPS data collection period.

Figure 28 HIV prevalence among people who attend needle and syringe programs by gender and sexual identity, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Women (%)	0.4	0.7	0.9	0.9	0.7	0.7	0.6	1.0	0.7	0.9
Gay men (%)	39.6	24.1	35.3	20.0	31.6	44.7	27.5	37.9	27.5	29.4
Bisexual men (%)	5.8	4.9	7.3	6.7	14.1	9.3	0.0	3.3	10.0	5.6
Heterosexual men (%)	0.5	0.5	0.9	0.8	1.0	0.7	0.5	0.3	0.6	0.5
Total (%)	1.7	1.4	2.1	1.7	2.3	2.5	1.5	2.1	1.8	2.0

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

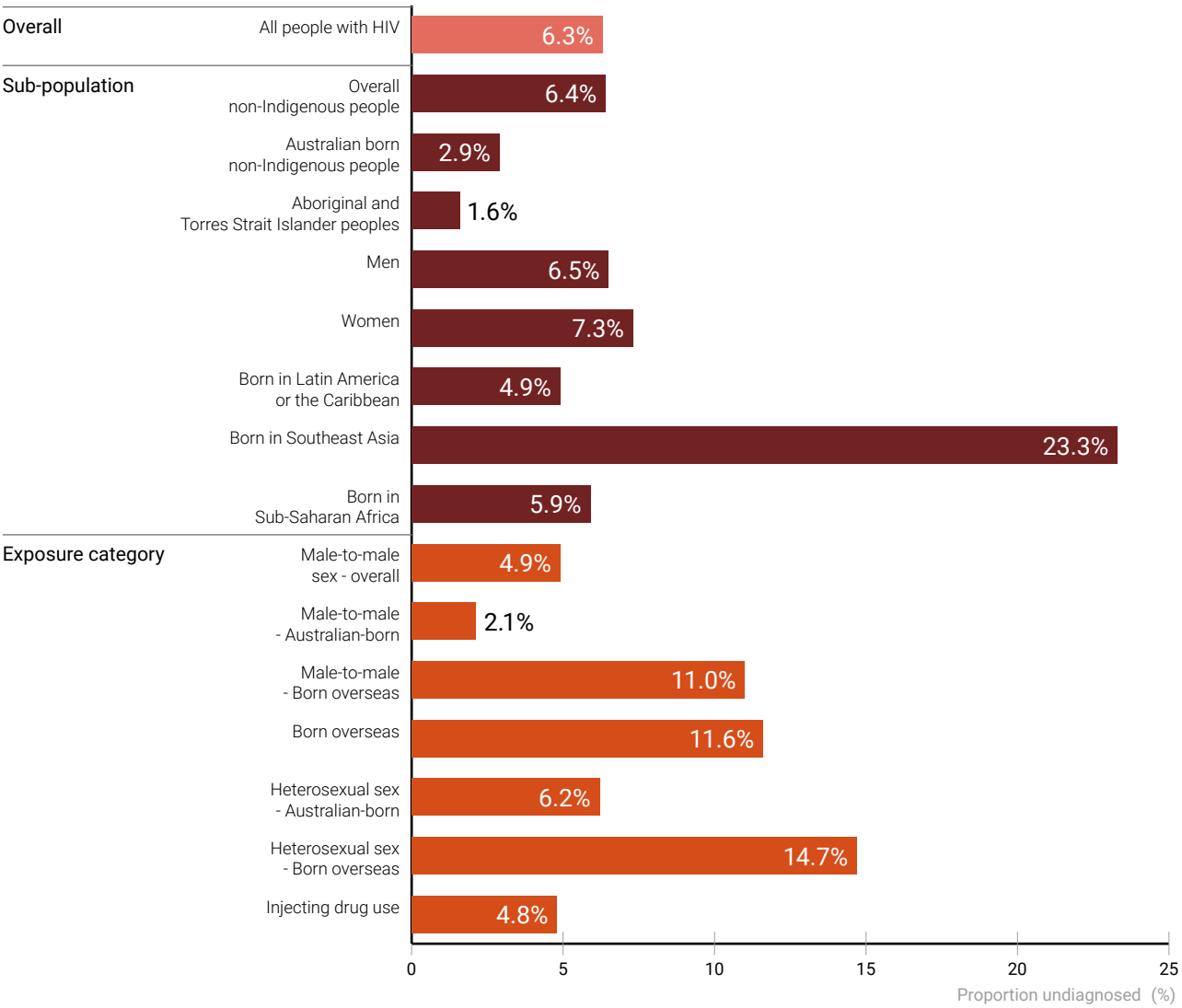
Source: ANSPS, see Methodology for detail.

Undiagnosed HIV

At the end of 2024, an estimated 1950 people (6.3% of all people living with HIV) were living with HIV who were unaware of their HIV status (undiagnosed). The proportion undiagnosed was 6.4% among men, 7.3% among women, 2.9% among Australian-born non-Indigenous people, and 1.6% among Aboriginal and Torres Strait Islander peoples. People living with HIV born in Southeast Asia had the highest proportion of people who were undiagnosed (23.3%), followed by people living with HIV born in Sub-Saharan Africa (5.9%) and Latin America or the Caribbean (4.9%) (Table 6, Figure 29). For further information on how estimates for the number of people living with undiagnosed HIV, see the Methodology.

The proportion with undiagnosed HIV was lower among Australian-born men with male-to-male sex as an exposure risk (2.1%) than in overseas-born men with male-to-male sex as an exposure risk (11.0%). Similarly, the proportion with undiagnosed HIV was lower among Australian-born people with heterosexual sex as an exposure risk (6.2%) than in overseas-born people with heterosexual sex as an exposure risk (14.7%). Detailed estimates for the proportion of undiagnosed HIV by subpopulation are available on the Kirby Institute data site.

Figure 29 Estimated proportion of people living with HIV who are undiagnosed by demographic group and exposure, 2024



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

Table 6 Estimated number of people living with HIV and HIV prevalence by selected exposure classification and subpopulation, 2024

	People living with HIV (range)	Number diagnosed (range)	Number undiagnosed (range)	Proportion undiagnosed	HIV prevalence (range)	Population size[2] (>15 years of age)
Demographics						
Total[1]	30 890 (27 480 to 35 990)	28 940 (27 480 to 33 620)	1 950 (0 to 2 370)	6.3%	0.14% (0.12% to 0.16%)	22 602 181
Sub-population						
Men	26 340 (23 650 to 31 350)	24 630 (23 650 to 29 270)	1 710 (0 to 2 080)	6.5%	0.24% (0.21% to 0.28%)	11 138 226
Women	4 410 (4 070 to 4 720)	4 090 (3 900 to 4 230)	320 (170 to 490)	7.3%	0.04% (0.04% to 0.04%)	11 463 955
Aboriginal and/or Torres Strait Islander people	610 (520 to 670)	600 (510 to 660)	10 (10 to 10)	1.6%	0.09% (0.07% to 0.07%)	709 482
Australian born non-Indigenous	16 680 (13 980 to 19 450)	16 190 (13 670 to 18 630)	490 (310 to 820)	2.9%	0.12% (0.10% to 0.12%)	13 531 838
Overall non-Indigenous	30 270 (25 440 to 35 270)	28 340 (23 910 to 32 940)	1 930 (1 530 to 2 330)	6.4%	0.14% (0.12% to 0.16%)	21 892 699
Born in Latin America or the Caribbean	1 220 (1 070 to 1 390)	1 160 (1 020 to 1 310)	60 (50 to 80)	4.9%	0.44% (0.38% to 0.50%)	279 660
Born in Southeast Asia	3 730 (3 150 to 4 420)	2 860 (2 400 to 3 380)	870 (750 to 1 040)	23.3%	0.3% (0.25% to 0.35%)	1 263 240
Born in Sub-Saharan Africa	1 880 (1 530 to 2 330)	1 770 (1 460 to 2 130)	110 (70 to 200)	5.9%	0.43% (0.35% to 0.54%)	434 220
Exposure group[3]						
Male-to-male sex	22 010 (17 840 to 26 570)	20 930 (16 980 to 25 180)	1 080 (860 to 1 390)	4.9%		
Male-to-male sex Australian-born	14 110 (11 690 to 16 640)	13 810 (11 510 to 16 050)	300 (180 to 590)	2.1%		
Male-to-male sex - Overseas-born	8 180 (6 010 to 11 200)	7 280 (5 330 to 10 110)	900 (680 to 1 090)	11.0%		
Heterosexual sex	7 690 (6 330 to 9 190)	6 800 (5 740 to 7 990)	890 (590 to 1 200)	11.6%		
Heterosexual sex - Australian-born	2 580 (2 150 to 3 230)	2 420 (2 030 to 2 830)	160 (120 to 400)	6.2%		
Heterosexual sex - Overseas-born people	4 830 (3 720 to 6 270)	4 120 (3 230 to 5 300)	710 (490 to 970)	14.7%		
People who use inject drugs	620 (460 to 930)	590 (440 to 860)	30 (20 to 70)	4.8%		

1 Sum of subpopulations will not add to the total estimated people living with HIV due to people potentially associated with multiple categories.
2 Population estimates not available for men who have sex with men, heterosexual people or people who inject drugs.
3 Exposure group includes people reporting each relevant risk exposure at time of diagnosis.

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

7 The HIV diagnosis and care cascade

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 (Table 7, Figure 30). Methods and the associated uncertainties are described in detail in the Methodology. The approach and presentation have been refined from previous years based on recommendations from a national stakeholder reference group (see Acknowledgements), and therefore estimates reported this year cannot be directly compared with estimates reported in previous years.

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 2024, there were an estimated 30 890 people living with HIV in Australia. Of these an estimated 94% (28 940) had been diagnosed, increasing from 91% in 2020 (26 250), meaning that Australia has yet to meet the UNAIDS 2025 target. Of those diagnosed at the end of 2024, an estimated 97% (27 980) were retained in care, similar to 96% (25 380) in 2020. Also, of those diagnosed 95% (27 480) were receiving antiretroviral therapy, an increase from 92% (23 450) in 2019 and 98% (26 870) of those on antiretroviral therapy had a suppressed viral load, a slight increase from 97% (24 300) since 2020 (Table 7, Figure 30). This corresponds to 88% of all people living with HIV (diagnosed and undiagnosed) having a suppressed viral load in 2024, meeting the 2025 UNAIDS target of 87%.

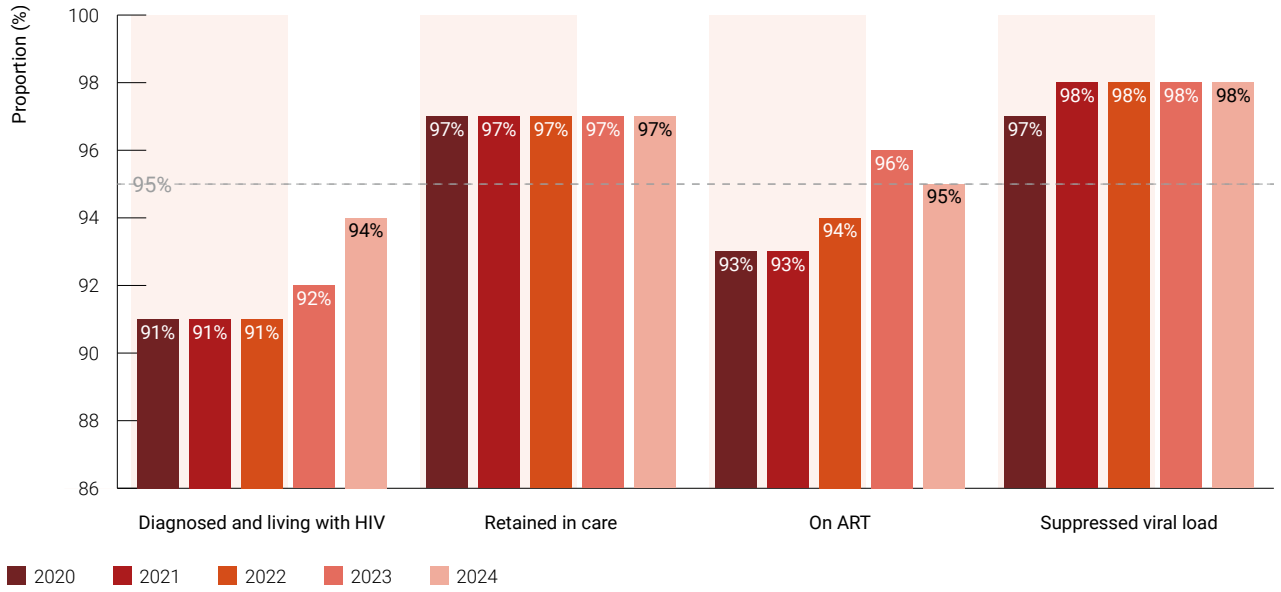
The cascade also shows the gaps at the end of 2024, with an estimated 4020 (13%) of all people living with HIV not having a suppressed viral load. Of these, an estimated 49% were undiagnosed, 24% were diagnosed but not in care, 13% were in care but not on antiretroviral therapy, and 15% were on antiretroviral therapy but had not achieved viral suppression (Figure 30). More detailed cascade estimates, including by gender, can be found on the Kirby Institute data site.

Table 7 The HIV diagnosis and care cascade estimates, 2020 – 2024

Year	Living with HIV (range)	Living with HIV and diagnosed (range)	Retained in care (range)	Receiving antiretroviral therapy (range)	Suppressed viral load (range)
2020	28 920 (32 860 to 25 130)	26 250 (30 040 to 24 240)	25 380 (29 050 to 24 240)	24 300 (24 360 to 24 240)	23 460 (23 750 to 23 170)
2021	29 340 (33 470 to 25 360)	26 600 (30 570 to 24 520)	25 730 (29 560 to 24 520)	24 750 (24 640 to 24 520)	24 180 (24 290 to 23 740)
2022	29 780 (34 200 to 25 510)	27 100 (31 290 to 25 420)	26 210 (30 260 to 25 420)	25 470 (25 520 to 25 420)	25 070 (25 300 to 24 840)
2023	30 340 (35 120 to 26 820)	27 950 (32 390 to 26 820)	27 030 (31 320 to 26 820)	26 820 (26 820 to 26 820)	26 150 (26 410 to 25 900)
2024	30 890 (35 990 to 27 480)	28 940 (33 620 to 27 480)	27 980 (32 510 to 27 480)	27 480 (27 480 to 27 480)	26 870 (27 130 to 26 610)

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

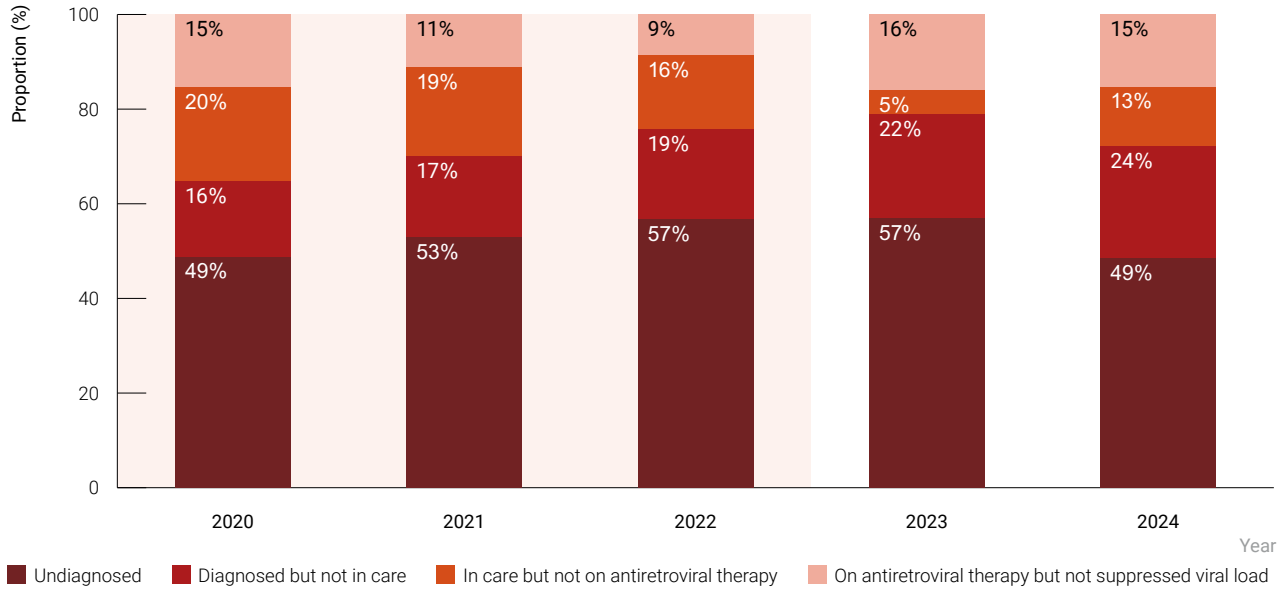
Figure 30 HIV diagnosis and care cascade, 2020 – 2024



Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

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

Figure 31 People living with HIV who have not achieved suppressed viral load by cascade stage, 2020 – 2024



Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

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

8 HIV treatment

Over the past 10 years, there has been a successful increase in the number of people living with HIV, the proportion receiving effective treatment, and the proportion achieving suppressed viral load. While HIV treatments do not cure the infection, it prevents HIV-related illness and maintains health. HIV treatment that maintains an undetectable viral load also reduces the risk of onward transmission through sexual contact to zero and is referred to as U=U [13].

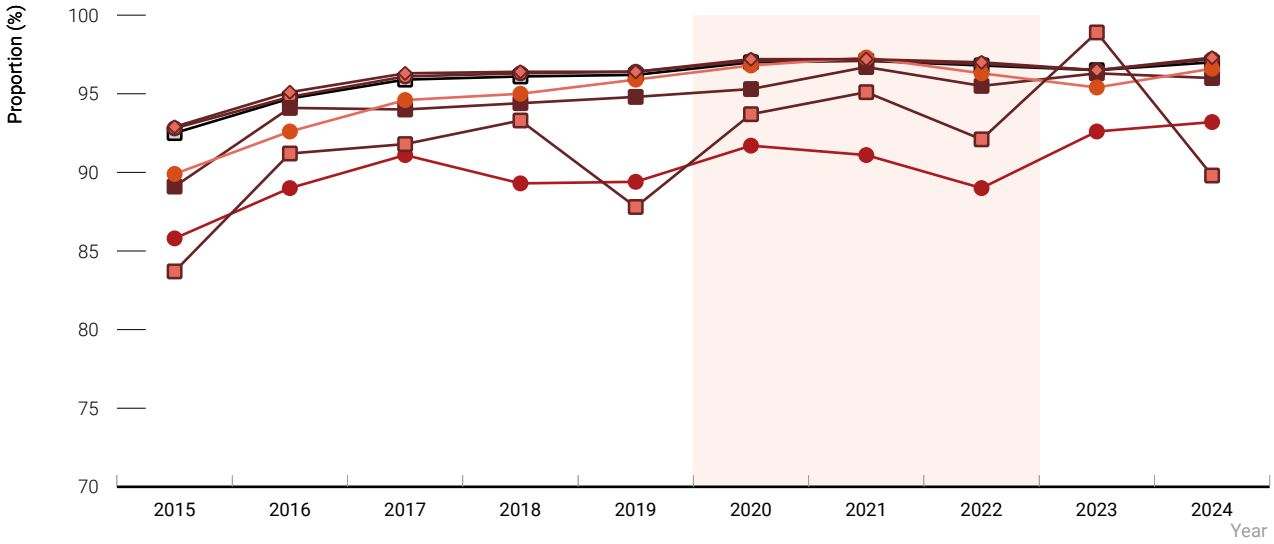
The estimated treatment coverage among people diagnosed with HIV in Australia is presented in the diagnosis and care cascades: 95% of people with diagnosed HIV were receiving antiretroviral therapy in 2024, (96% of males and 94% of females; refer to Kirby Institute data site).

Suppressed viral load

HIV viral load represents the amount of HIV in a person's blood, with higher levels increasing the chances of HIV sexual transmission during risk exposures. Studies have shown that regularly taking combination antiretroviral treatment sustains a suppressed viral load and reduces the likelihood of HIV transmission to zero [14]. As treatment coverage has increased in Australia, there has been a corresponding increase in the proportion of people with suppressed viral load (<200 copies/mL).

This increased from 92.5% in 2015 to 97.0% in 2024 at sexual health clinics participating in ACCESS (Figure 32). The number accessing care through ACCESS clinics declined from 2020, likely related to the impacts of the COVID-19 pandemic (data not shown). See Methodology for further detail.

Figure 32 Proportion of patients with suppressed viral load among people attending sexual health clinics and high case load GP clinics in ACCESS by priority population, 2015 – 2024



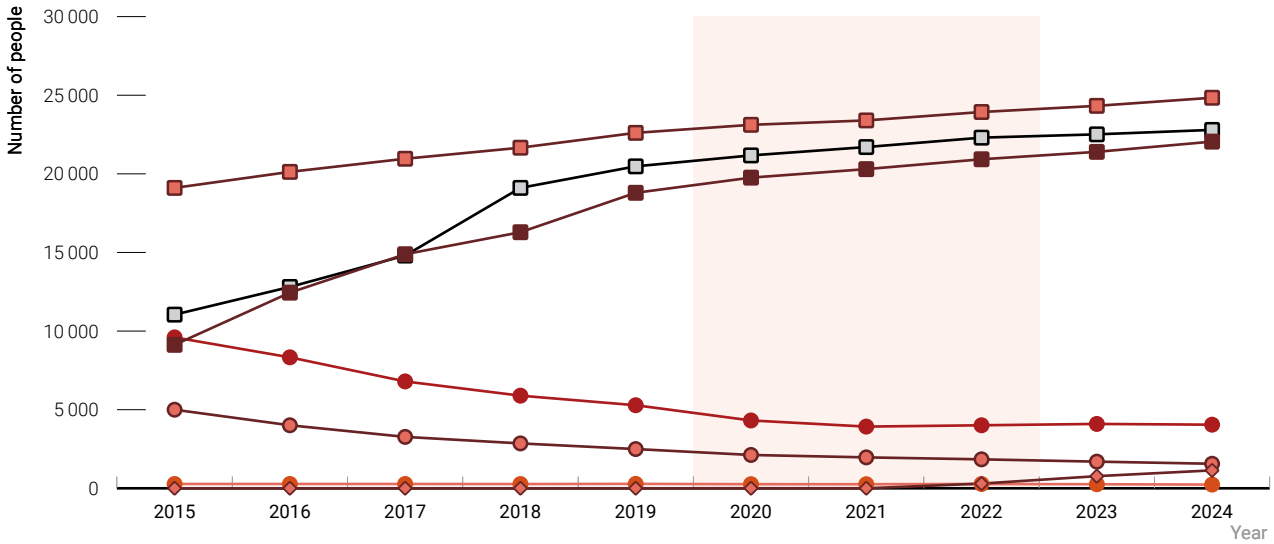
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Overall (%)	92.5	94.7	95.9	96.1	96.2	97.0	97.1	96.8	96.5	97.0
Aboriginal and/or Torres Strait Islander people (%)	85.8	89.0	91.1	89.3	89.4	91.7	91.1	89.0	92.6	93.2
Men (%)	92.8	94.8	96.1	96.3	96.4	97.1	97.1	96.9	96.5	97.2
Women (%)	89.1	94.1	94.0	94.4	94.8	95.3	96.7	95.5	96.3	96.0
CALD (%)	89.9	92.6	94.6	95.0	95.9	96.8	97.3	96.3	95.4	96.6
MSM (%)	92.9	95.1	96.3	96.4	96.4	97.2	97.2	97.0	96.5	97.3
PWID (%)	83.7	91.2	91.8	93.3	87.8	93.7	95.1	92.1	98.9	89.8

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
Suppressed viral load equals 200 copies/mL or less. CALD = Culturally and linguistically diverse people; MSM = Men who have Sex with Men; PWID = People who use injection drugs.

Source: ACCESS (Australian Collaboration for Coordinated Enhanced Sentinel Surveillance); see Methodology for detail.

Antiretroviral treatment guidelines are updated annually in Australia as over time, new drugs and formulations become available. This results in changes to recommended drug combinations. Antiretroviral drugs have differing potency and side-effect profiles, and it is important to monitor their use. Between 2015 and 2024, the number of people receiving integrase inhibitors increased from 9125 to 22 049. Conversely the number of people receiving non-nucleoside reverse transcriptase inhibitors more than halved from 9598 in 2015 to 4046 in 2024. In the same period, the number of people receiving any PBS-subsidised antiretroviral therapy increased from 19 106 to 24 840 (Figure 33).

Figure 33 Number of people dispensed ART by drug class, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Any NRTI	11 046	12 805	14 802	19 107	20 476	21 172	21 703	22 302	22 512	22 795
Any NNRTI	9 598	8 330	6 797	5 892	5 283	4 315	3 925	4 008	4 094	4 046
Any Protease Inhibitor	4 999	4 008	3 270	2 855	2 496	2 120	1 967	1 842	1 696	1 561
Any Integrase Inhibitor	9 125	12 444	14 887	16 287	18 794	19 759	20 300	20 927	21 398	22 049
Any other ART (enfuvirtide or maraviroc)	275	275	275	270	281	262	260	274	258	236
Any long acting injectable ART	0	0	0	0	0	0	0	300	772	1 140
Any ART	19 106	20 125	20 960	21 663	22 607	23 117	23 397	23 933	24 324	24 840

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022; excludes temporary residents who are ineligible for Medicare; due to PrEP dispensed as part of PrEP implementation programs, the NRTI dispensing numbers for the years 2015 to 2016 may be slightly over or underestimated; NRTI: nucleoside reverse transcriptase inhibitor; NNRTI: non-nucleoside reverse transcriptase inhibitor; ART: antiretroviral therapy.

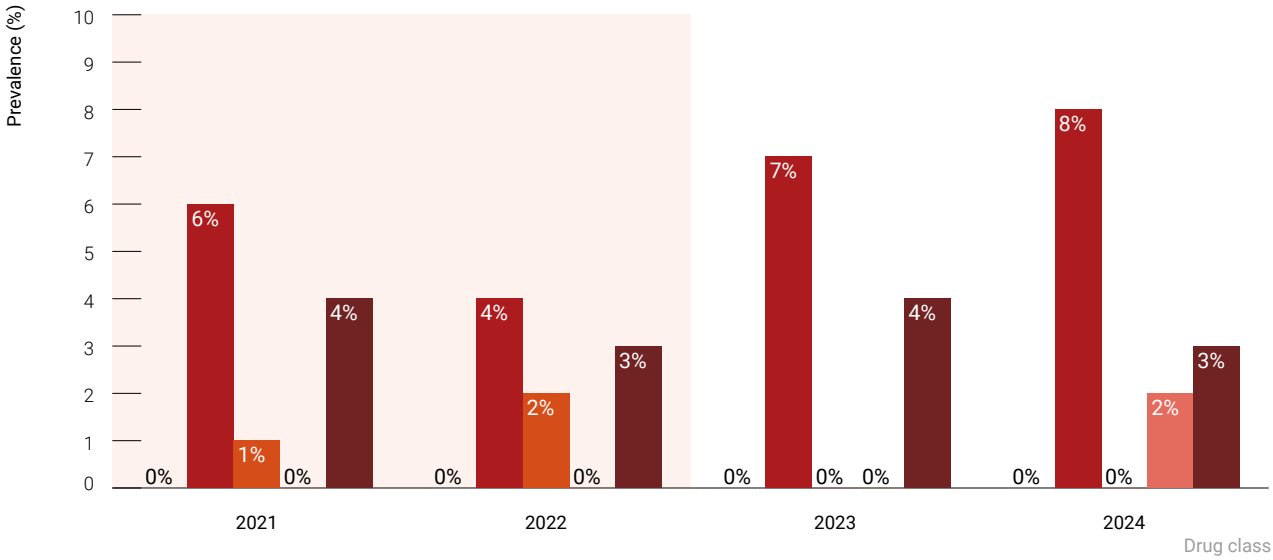
Source: Pharmaceutical Benefits Scheme.

HIV transmitted drug resistance

Due to the scale-up of HIV treatments and pre-exposure prophylaxis (PrEP) in Australia it is important to monitor the prevalence of transmitted HIV drug resistance. HIV resistance testing is recommended for all new HIV diagnoses in Australia. In this report we focus on drug resistance mutations (DRMs) in HIV notifications, identified using the Stanford HIV Drug Resistance genotypic resistance interpretation system, using data from Queensland and South Australia from 2021 to 2024 (see Methodology for further details). Only drug resistance tests taken within three months of HIV diagnosis were included to better capture transmitted drug resistance. These data account for a quarter of national notifications for the years reported and may not be nationally representative but provide information about resistance patterns in these states.

Between 2021 and 2024, DRM prevalence among people notified with HIV fluctuated between 3% and 4% and was 3% in 2024 (Figure 34). By drug class, higher prevalence was observed for non-nucleoside reverse transcriptase inhibitor (NNRTI) DRMs. No DRMs conferring resistance to integrase inhibitors (INIs) were observed over the reporting period.

Figure 34 HIV drug resistance prevalence among people notified with HIV attributed to male-to-male sex by drug class, 2019 – 2024



Drug class	2021	2022	2023	2024
INI resistance (%)	0	0	0	0
NNRTI resistance (%)	6	4	7	8
NRTI resistance (%)	1	2	0	0
PI Resistance (%)	0	0	0	2
Any drug resistance (%)	4	3	4	3

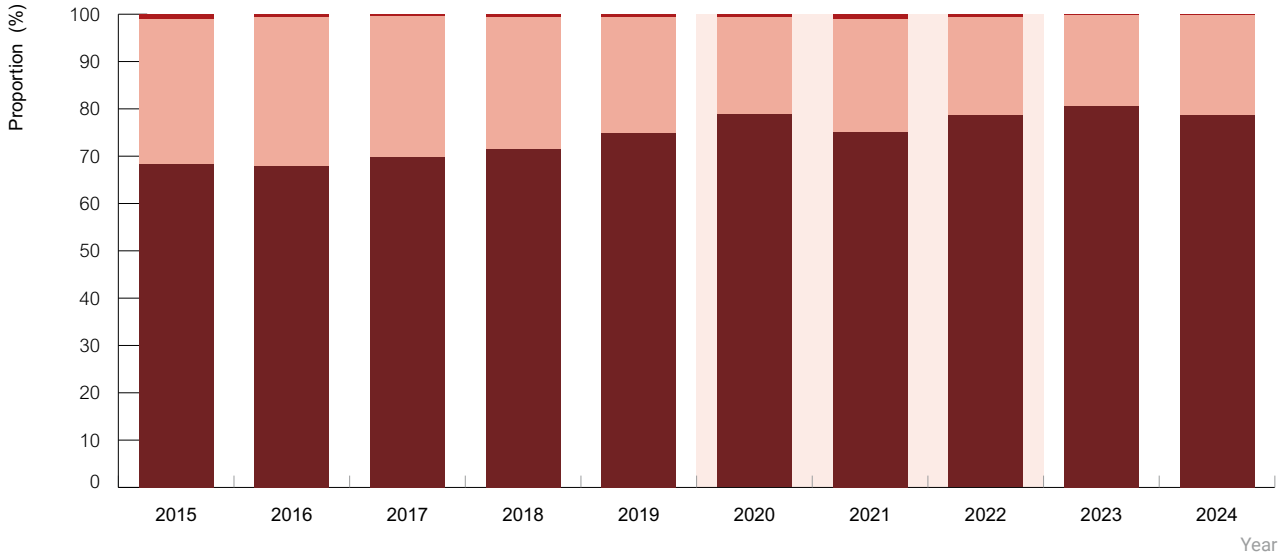
Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
Abbreviations: NRTI = nucleoside reverse transcriptase inhibitor; NNRTI = non-nucleoside reverse transcriptase inhibitor; ART = antiretroviral therapy.
Source: Queensland Health and South Australia Health; see Methodology for detail.

9 HIV prevention

Primary prevention strategies aim to protect people from acquiring HIV. They include: condom use; harm reduction strategies such as needle and syringe programs, opioid substitution therapy and peer-based interventions to reduce injecting risk behaviour [15–17]; and biomedical prevention strategies such as post-exposure prophylaxis (PEP) and PrEP. Testing and treatment are secondary prevention strategies, as they prevent transmission to others due to behavioural changes after diagnosis or starting treatment and achieving undetectable (suppressed) viral load, which reduces the risk of onward transmission to zero.

According to the GBQ+ Community Periodic Surveys, the majority (79%) of HIV-negative/unknown-HIV-status gay and bisexual men who had casual partners were regularly using strategies in 2024 to protect themselves against acquiring HIV, including avoiding anal sex, using condoms, or biomedical prevention. Inversely, 21% of HIV-negative gay and bisexual men engaging in anal intercourse with casual partners in the past six months reported not consistently using these prevention strategies with casual partners of unknown HIV or PrEP status, down from 32% in 2015 (Figure 35).

Figure 35 HIV risk behaviour in men with casual partners, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Any condomless sex by participants living with HIV not on ART or with a detectable viral load (%)	1	1	1	1	1	1	1	1	0	0
Condomless sex by HIV-negative participants not on prescribed PrEP or HIV status unknown participants (%)	31	31	30	28	25	21	24	21	19	21
Participants using at least one strategy to prevent HIV transmission (%)	68	68	70	72	75	79	75	79	81	79

Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
CLAIC = condomless anal intercourse.

Source: GBQ+ Community Periodic Surveys.

Use of sterile needles and syringes

The reuse of needles and syringes that have been used by others (receptive syringe sharing) is the major risk factor for the transmission of HIV, hepatitis B, and hepatitis C among people who inject drugs. Harm reduction strategies such as needle and syringe programs, opioid substitution therapy and peer interventions can reduce injecting risk behaviour [15–17]. Opioid substitution therapy has been shown to reduce the incidence of HIV and hepatitis C among people who inject drugs [17–19]. Health promotion is important to enhance the effectiveness of these harm reduction strategies and to support people to inject more safely. Each year over the 10-year period 2015 to 2024, between 16% and 19% of people who inject drugs attending needle and syringe programs and recruited to the ANSPS reported receptive syringe sharing in the last month and was 19% in 2024 (see Hepatitis C chapter).

Blood screening

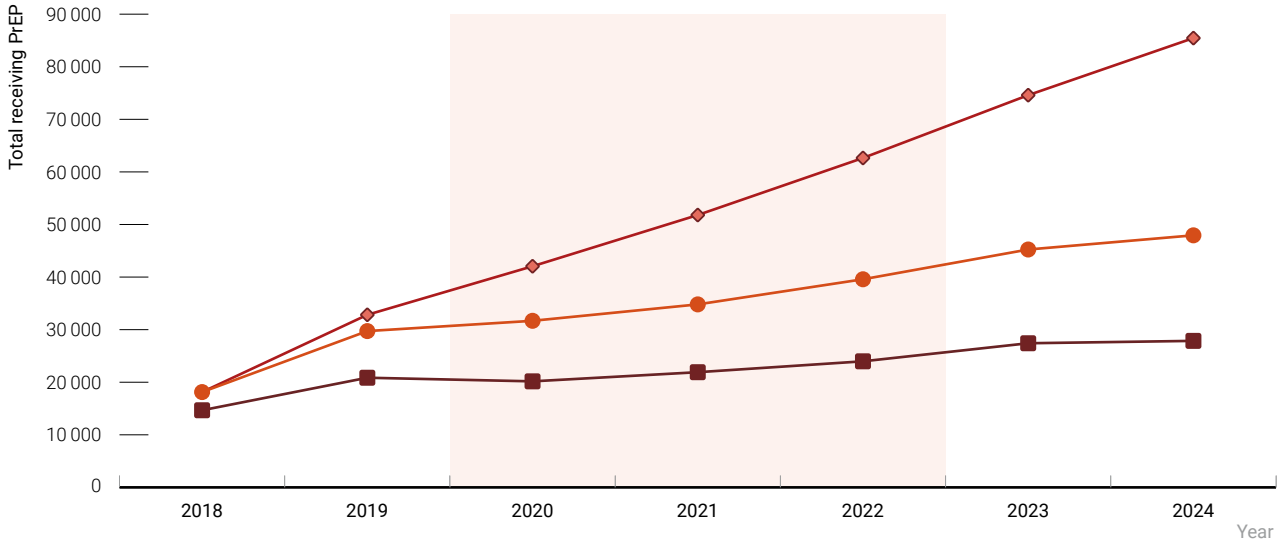
Since 1985, all blood donors have been screened for HIV to prevent onward transmission to recipients of blood products. There has been no known case of HIV acquisition through blood transfusion in Australia since the late 1990s. For further information, see Transfusion-transmissible infections in Australia: 2025 Surveillance Report, prepared by the Kirby Institute, UNSW Sydney and Australian Red Cross Lifeblood [20].

Pre-exposure prophylaxis (PrEP)

PrEP is the use of antiretroviral treatment by HIV-negative people to reduce their risk of acquiring HIV. PrEP is highly effective in people who use it according to guidelines. PrEP became available to eligible individuals on 1 April 2018 through listing on the PBS. The most recent clinical guidelines describing who may be suitable for PrEP use can be found on the ASHM website.

Between the start of 2018 to the end of December 2024, 85 451 people have taken PrEP. In the same period, the number of people who have taken PrEP in the previous 12 months increased from 18 128 to 47 938 (Figure 36). The number of people who had taken PrEP in the previous three months increased from 14 668 in December 2018 to 27 865 in December 2024.

Figure 36 Number of people taking PrEP by recency, 2018 – 2024



	2018	2019	2020	2021	2022	2023	2024
Ever	18 128	32 823	42 055	51 799	62 648	74 595	85 451
Past 12 months	18 128	29 727	31 682	34 803	39 581	45 242	47 938
Past three months	14 668	20 855	20 168	21 907	23 978	27 413	27 865

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

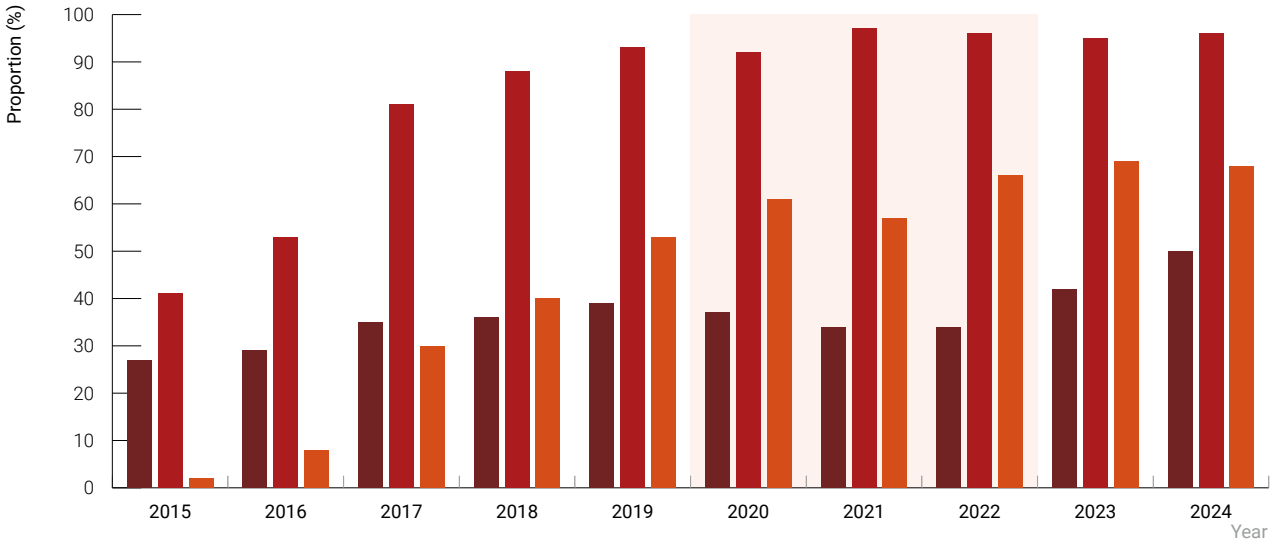
Source: Monitoring HIV pre-exposure prophylaxis (PrEP) uptake in Australia, Kirby Institute, UNSW Sydney.

What does this mean?

Despite plateauing over the peak of the COVID-19 pandemic, increasing numbers of people are recorded as taking PrEP recently (within the last three months).

Among participants of the GBQ+ Community Periodic Surveys, 50% were eligible for PrEP in 2024, up from 36% in 2018 when subsidised PrEP became available through the PBS. Of those eligible for PrEP, 96% were aware of PrEP, up from 8% in 2018, and 68% reported using prescribed PrEP in the previous six months, up from 40% in 2018 (Figure 33).

Figure 37 PrEP cascade for non-HIV-positive men, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Eligible for PrEP* (%)	27	29	35	36	39	37	34	34	42	50
Proportion eligible who were aware of PrEP** (%)	41	53	81	88	93	92	97	96	95	96
Proportion eligible who used prescribed PrEP in the previous 6 months*** (%)	2	8	30	40	53	61	57	66	69	68

Notes:
The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.
The eligibility criteria were operationalised as follows:

- Any receptive condomless anal intercourse (CLAI) with casual male partners in the previous six months
- Any CLAI with a HIV-positive regular male partner who did not have an undetectable viral load in the previous six months
- Tested and diagnosed with any sexually transmissible infection (STI) other than HIV in the previous 12 months
- Any use of crystal methamphetamine in the previous six months

* Later guidelines have expanded the eligibility criteria for PrEP.

** Awareness of PrEP was assessed with the question, "What do you know about pre-exposure prophylaxis (PrEP)?". Participants who answered "It's available now" were classified as aware of PrEP.

*** PrEP use was assessed with the question, "In the last 6 months, did you take anti-HIV medication regularly to protect yourself from HIV (PrEP)?". Participants who answered "Yes, I was prescribed anti-HIV medication to take every day" were classified as using PrEP. In 2019, updated answers included "Yes, I took it daily / most days" (i.e., regular users) and "Yes, I took it around the time of sex (but not daily)" (i.e., on-demand users).

Source: Annual Report on Trends in Behaviour, Centre for Social Research in Health, UNSW Sydney.

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