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Human Immunodeficiency Virus (HIV)

Position Statement

September 2026

About the Royal Australasian College of Physicians (RACP)

The Royal Australasian College of Physicians (RACP) trains, educates and advocates on behalf of over 24,500 physicians and 9,700 trainee physicians in a broad range of specialties across Australia and Aotearoa New Zealand. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and the community.

About the Australasian Chapter of Sexual Health Medicine (AChSHM)

The Australasian Chapter of Sexual Health Medicine (AChSHM) is the specialised area of practice concerned with healthy sexual relations. Sexual health physicians provide a clinical and public health perspective to issues related to sexual health. These specialists complete advanced training in sexual health medicine following on from either a fellowship in a related discipline or basic specialist physician training. Most sexual health physicians in Australia and Aotearoa New Zealand work in public sexual health clinics, often in multi-disciplinary teams.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work.



The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

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Introduction

This document outlines the Australasian Chapter of Sexual Health Medicine's (AChSHM) position on Human Immunodeficiency Virus (HIV) and the effort to end its transmission in Australia and Aotearoa New Zealand.

The information in this document is informed by scientific evidence as well as the expertise and practical experience of sexual health medicine physicians. Sexual health medicine physicians play a crucial role in ending HIV transmission.

This document provides recommendations to governments and other relevant agencies aimed at ending the transmission of HIV, as well as improving health care and health outcomes for people living with HIV in Australia and Aotearoa New Zealand.

****A note on language, terminology and data****

All efforts have been made to ensure appropriate language and terminology is used throughout this document.

AChSHM acknowledges that some of the language used may become outdated in the future as agreed language and preferred terminology changes.

This document refers to the virtual elimination of HIV transmission. Virtual elimination will be achieved when there has been a 90% reduction in new diagnoses since 2010, which will mean HIV is no longer a challenge to public health.¹

When referring to official datasets, this document uses the terminology of that specific publication.

Data since 2020 is likely to have been affected by the COVID-19 pandemic, particularly public health measures placed on travel and movement, social activity, and healthcare access, including testing.²

The role of sexual health medicine physicians in the management of HIV

The management of HIV, and in particular the effort to end its transmission, involves a wide range of medical specialties, healthcare professionals, government departments, agencies and community groups.

Most importantly, the management of HIV must be underpinned by the principle of ‘greater and meaningful involvement of people living with HIV’.³ This principle aims to prioritise the rights of people living with HIV, particularly their right to lead and guide decision-making processes that affect them directly. It is acknowledged that centring people living with HIV in research, policy making and healthcare not only embodies their right to self-determination but also enhances the effectiveness of these measures and actions.

A range of medical specialties may be involved in the health care of a person living with HIV, including infectious diseases, immunology and public health medicine, as well as general practitioners, nursing, allied health and other healthcare professionals such as pharmacists. As a document from the AChSHM, the information that follows focuses on the important role that sexual health medicine physicians play in this collaborative effort.

Sexual health medicine physicians oversee and provide a range of sensitive, appropriate measures aimed at reducing the incidence of HIV infection in the community, as well as improving testing and management practices. These measures span evidence-informed advice, education, research, evaluation, testing, management, surveillance, health care and support.

Routine clinical practices for sexual health medicine physicians include HIV related tests, treatment such as with antiretroviral therapy (ART), counselling and referrals to other appropriate health and welfare services. Suboptimal HIV management leads to adverse health outcomes for people living with HIV, higher rates of onward transmission and potential antiretroviral resistance in the community, as well as consequent complications or conditions that often require more complex and expensive treatments.⁴

Sexual health medicine physicians inform priority populations and healthcare professionals regarding HIV prevention, testing and treatment. They oversee multidisciplinary teams and integrated/collaborative models of care. Sexual health medicine physicians also provide healthcare professionals with education regarding new HIV related technologies and research, such as rapid testing in non-laboratory settings, particularly in non-specialist HIV services and community-based organisations.⁴

Sexual health medicine physicians also play an important role in the implementation of the [Ninth National HIV Strategy 2024-2030](#) and the [National HIV Action Plan for Aotearoa New Zealand 2023-2030](#).

Recommendations

To end HIV transmission and improve health care for people living with, or at increased risk of, HIV in Australia and Aotearoa New Zealand, we call on governments and relevant agencies to take the following actions:



1. Fully fund free universal access to HIV healthcare services in Australia and Aotearoa New Zealand

This should include:

- HIV testing, including initial testing and any additional testing required to confirm a positive HIV result
- HIV Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) assessment, prescribing and supply (including full sexually transmitted infection (STI) screening and renal monitoring as directed by existing guidelines)
- Antiretroviral therapy (ART) prescribing, supply and ongoing monitoring.
- Tests related to ongoing monitoring for people living with HIV or for PrEP

(Some of these measures are already funded in one or other of Australia and Aotearoa New Zealand).



2. Increase funding for the sexual health care sector in Australia and Aotearoa New Zealand

Expand existing services and establish new services to ensure access to HIV testing and ongoing treatment and care that are person-centred, accessible, equitable, multidisciplinary and culturally safe.



3. Fund and support implementation of innovative, evidence-informed and equitable multidisciplinary models of care for HIV prevention and management in Australia and Aotearoa New Zealand

These models of care should:

- Meet the needs of people living with HIV, including those who are ageing
- Ensure quality of care across services
- Include models for regional, rural and remote areas and areas of healthcare workforce shortages
- Be accessible and safe for priority populations and those at risk of greater stigma or barriers
- Support shared and other collaborative care models between relevant healthcare professionals for people living longer with HIV.



4. Increase access to prescribers and/or supply of PrEP

This can be supported by expanding PrEP prescribing rights to pharmacists and/or nurse practitioners, with appropriate frameworks for training and testing, in line with current standards, to ensure delivery of a safe and appropriate model of care.



5. Increase awareness of the variety of HIV testing options available beyond laboratory-based testing

Campaigns targeted to healthcare professionals and the community give people agency to choose a testing option appropriate to their preferences and circumstances.



6. Expand education campaigns and policy and legislative protections to address HIV stigma and discrimination

This needs to include targeted, evidence-informed initiatives that promote accurate understanding of transmission risk, protect the rights of people living with HIV, and support stigma-free access to testing, treatment, and care across all healthcare and community settings.



7. Fund a gap analysis and identify ways to improve HIV treatment and care for Aboriginal, Torres Strait Islander, Māori and Pacific communities in Australia and Aotearoa New Zealand

Services must be culturally safe and co-designed to meet the needs of communities, with an aim to move to Indigenous-led services as soon as possible.



8. Increase funding for Aboriginal Community Controlled Health Organisations (ACCHO) in Australia and kaupapa Māori and Pacific-led models of care in Aotearoa New Zealand

Services need to continue to build their culturally safe, effective and comprehensive approach to HIV prevention, testing and care.



9. Broaden undergraduate and postgraduate education and training of healthcare professionals in HIV prevention, testing and management

This education should include:

- Mandatory inclusion of HIV education in all undergraduate and postgraduate curricula for all healthcare professionals
- Investment in education and training opportunities to support primary healthcare services, particularly in regional, rural and remote locations
- Integrate HIV clinical indicator conditions in clinical training, guidelines and resources across all healthcare professions to increase strategic HIV testing in these clinical indicator settings, normalise HIV testing and reduce associated stigma in a cost-effective manner.⁵



10. Investigate options for opt-out HIV testing in primary healthcare settings and hospitals

This offers a method of increasing opportunistic testing and reducing rates of undiagnosed HIV, working with relevant stakeholders to ensure new testing policies are implemented effectively and appropriately.

This can include through sustained partnerships, capacity building, and investment in locally led prevention, testing, and treatment programs that strengthen healthcare systems and ensure equitable access to appropriate care.

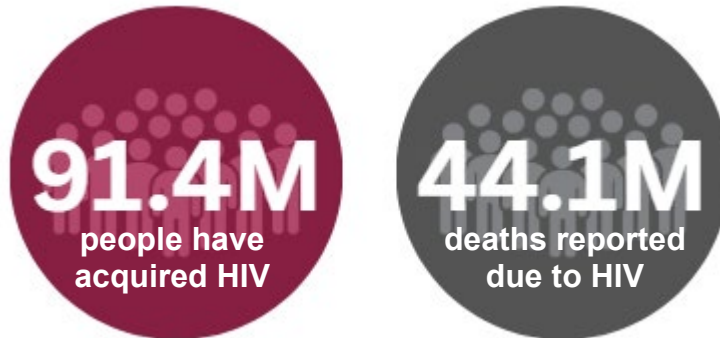


11. Support initiatives in the Pacific and other areas to contribute to the efforts to virtually eliminate HIV transmission globally

This can include through sustained partnerships, capacity building, and investment in locally led prevention, testing, and treatment programs that strengthen healthcare systems and ensure equitable access to appropriate care.

HIV

Since its discovery in the early 1980s, 91.4 million people worldwide have acquired HIV, with approximately 44.1 million deaths reported due to HIV.⁶



HIV is a virus that impairs the body's immune system by reducing CD4⁺ cells. Without treatment, HIV damages the immune system, which can lead to serious infections and cancers over time.⁷ If untreated, HIV can progress to acquired immunodeficiency syndrome (AIDS), the most advanced stage of the infection.⁸

HIV is treatable and transmission of HIV is fully preventable.⁹

HIV is transmitted following contact with infected bodily fluids, typically via unprotected sex, blood-to-blood contact (e.g. sharing injecting equipment) and vertical transmission (from parent to child during pregnancy, childbirth or through breast/chest feeding).¹⁰

HIV-related stigma and discrimination can profoundly affect a person's wellbeing, often resulting in social isolation, poorer mental health, and overall worse health outcomes.¹¹

Key achievements

The number of people diagnosed with HIV in Australia and Aotearoa New Zealand has seen a downward trend in the last decade:^{2 12}



The decline has primarily been driven by a reduction in the number of gay and bisexual men who have sex with men (GBMSM) diagnosed with HIV, particular among Australian born GBMSM in Australia and GBMSM who acquired HIV locally in Aotearoa New Zealand.



Both countries continue to sustain low prevalence among sex workers and amongst people who inject drugs, through high levels of engagement in prevention strategies and treatments amongst these groups.



Both countries have very low rates of vertical transmission, with the rate of Australian-born children perinatally exposed to HIV receiving a HIV diagnosis between 2020 and 2024 at 1.5% (compared to 17.5% between 1995-1998). In Aotearoa New Zealand, there were zero cases of vertical transmission between 2007 and 2023.

Australia's key achievements include:



Continued reduction in HIV notifications, with a decrease of 27% between 2015 and 2024.²



HIV transmission rates in Inner Sydney, New South Wales - the former epicentre of the HIV epidemic in Australia - **so low as to be virtually eliminated**.¹³



Continued decline in Australian-born GBMSM diagnosed with HIV, with a 53% decrease in annual HIV diagnoses from 2015 to 2024.²



Access to free or affordable HIV testing and treatment, regardless of residency or Medicare status (noting that some jurisdictions may charge a co-payment).¹⁴



The rapid uptake of oral PrEP since it was included on the Pharmaceutical Benefits Scheme (PBS) in 2018, reaching a peak of 47,938 individuals who were dispensed PrEP within the past 12 months in 2024.¹⁵



Strong performance against the Joint United Nations Programme on HIV/AIDS (UNAIDS) care cascade target of 95-95-95 for 2025. These targets require 95% of all people living with HIV to know their HIV status, 95% of all people with diagnosed HIV infection to receive sustained antiretroviral therapy, and 95% of all people receiving antiretroviral therapy to have viral suppression by 2025.¹⁶



In 2024, it was estimated that **94% of people living with HIV in Australia had received a HIV diagnosis**, which is almost at the UNAIDS target of 95%. Further, by 2024, **Australia met or exceeded the other two targets for 2025**, with 97% of people with a diagnosis engaging in care, and 95% receiving ART. Finally, in 2024, **98% of people receiving ART had a suppressed viral load**.²



Sustained low rates of HIV infection among sex workers, which are some of the lowest in the world.²

Key achievements in Aotearoa New Zealand include:



A continuing decline in HIV transmission, with the number of diagnoses (n=80) in 2025 remaining below the peak in 2016. This decline is driven by an ongoing reduction in the number of people first diagnosed with HIV in Aotearoa New Zealand – particularly among GBMSM who are reported to have acquired HIV locally.²



Fully funded HIV treatment and care for anyone living with HIV in Aotearoa New Zealand, regardless of residency status.¹⁷



Aotearoa New Zealand was **one of the first countries to fully fund access to PrEP**.¹⁸



In 2021, Aotearoa New Zealand **removed all restrictions relating to HIV for entry, travelling and residency**.¹⁹



Almost no transmission of HIV through injecting drug use, due to effective needle exchange programs.¹²



A very low prevalence of HIV in sex workers, largely due to decriminalisation of sex work.²⁰

Priority populations

While all people can potentially be at risk of acquiring HIV, **actions must be prioritised for populations who may be disproportionately impacted by HIV.**^{1 20} Some of the populations are common across Australia and Aotearoa New Zealand while others are country specific.

Any response to the transmission and management of HIV must prioritise populations that are at high risk, noting that people may identify as members of multiple priority populations, leading to a diverse range of unique intersecting experiences, challenges and risk factors.

AUSTRALIA

All people living with HIV
Gay, bisexual and other men who have sex with men (GBMSM)
People from culturally and linguistically diverse populations, and people born overseas
Aboriginal and Torres Strait Islander peoples
Sex workers
People who inject drugs
Trans and gender diverse people
People in custodial settings and detention centres

AOTEAROA NEW ZEALAND

People living with HIV
Gay and bisexual men who have sex with men (GBMSM)
People who have migrated from high HIV prevalence countries
Māori at risk of and living with HIV
Sex workers
People who inject drugs
Transgender and non-binary people

Source: [Ninth National HIV Strategy 2024-2030](#) (Australia) and [National HIV Action Plan for Aotearoa New Zealand 2023-2030](#)

In addition, people experiencing homelessness and/or mental health have also been identified to have greater risk of HIV transmission, as well as experiencing specific barriers to accessing health care.

The ongoing centring of people living with HIV (including, and as well as, people from priority populations) in the development of prevention, diagnosis, treatment and ongoing care models is critical to ensure these are as effective as possible.¹

Current situation



At the end of 2024, an estimated 30,890 people were living with HIV in Australia.

Of the 757 HIV notifications made for first-time diagnosis in 2024:

- GBMSM continue to experience the **highest HIV risk exposure** in Australia (62%).
- Over a third (38%) were classified as **late diagnosis** (CD4+ <350 cells/uL), which indicates these people **acquired HIV at least 4 years prior to diagnosis**.
- **Heterosexual sex was attributed to 27% of HIV notifications**, an increase from 20% in 2015, with almost half of these (49.6%) classifying as late diagnoses.
- While the **rate of HIV notifications among Australian-born people declined** – 53% between 2015 and 2024 (from 4.4 to 2.1 per 100,000) – HIV notifications among people born in the Pacific (excluding Australia) **increased by 77%** (from 3.6 to 6.4 per 100,00), and there was **an increase of 50%** (from 9.1 to 13.6 per 100,000) among people from Latin America.²

AUSTRALIA: HIV notifications made in 2024 (first-time diagnosis)			
62%	38%	27%	50%
among GBMSM population	classified as late diagnosis	acquired via heterosexual sex	of notifications attributed to heterosexual sex classified as late diagnosis
53%	77%	50%	
rate of HIV notification among Australian-born people	increase of HIV notifications among Pacific-born people	increase of HIV notifications among people from Latin America	

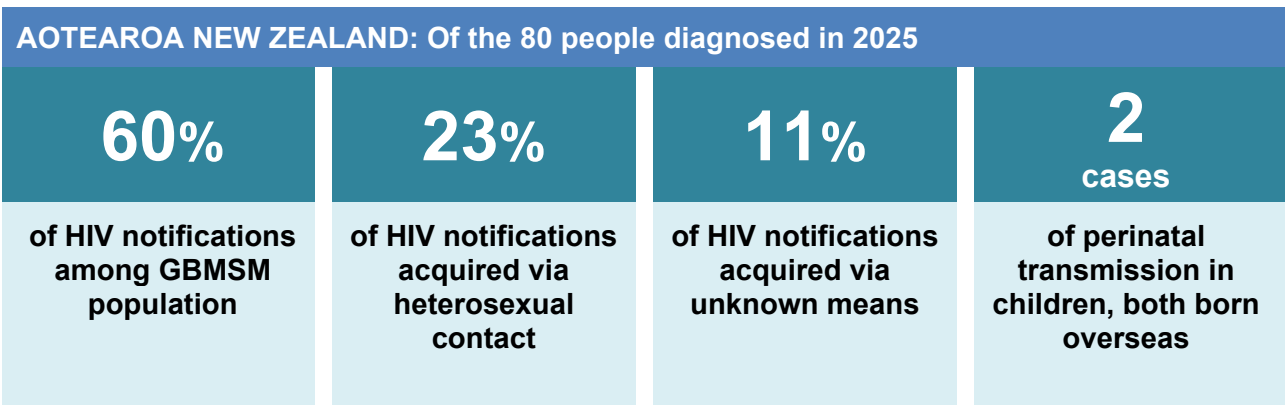


Aotearoa New Zealand

Data indicates that 3,534 people living in Aotearoa New Zealand were receiving HIV treatment at the end of March 2025.

Of the 80 people diagnosed with HIV in Aotearoa New Zealand in 2025:

- 48 (60%) were among the **GBMSM population**.
- 18 (23%) people acquired HIV through **heterosexual contact** and nine (11%) through **unknown means**.
- There were **2 cases of perinatal transmission**, both of which involved babies born overseas.¹²



Prevention measures

The World Health Organization (WHO) recommends a combination prevention approach, encompassing biomedical, behavioural and structural interventions that are tailored to the local population and respond to the epidemiology of the location.²¹

Effective HIV transmission prevention is crucial for reducing the incidence of HIV transmission

Biomedical interventions

These involve clinical and medical approaches to reduce the risk of HIV transmission.²² Examples include:

- Treatment as Prevention (TasP) or Undetectable=Untransmittable (U=U), involving the use of antiretroviral treatment to achieve and maintain viral suppression in people living with HIV.
- Needle exchange programs.
- Use of preventive HIV medication to reduce the risk of HIV infection in people at elevated risk of exposure.²³

There are currently two (2) types of preventive HIV treatment options available for people at high risk of HIV exposure:

1. Pre-exposure prophylaxis (PrEP): an antiretroviral therapy used by HIV negative individuals to reduce their risk of acquiring HIV.²⁴ PrEP can be taken daily, on-demand or periodically during periods of increased exposure.²⁵

2. Post-exposure prophylaxis (PEP): a method of taking a short course of antiretroviral therapy to prevent HIV infection following suspected exposure.²⁶

PrEP and PEP can be prescribed by medical practitioners or accredited nurse practitioners.

Behavioural interventions

These address the behaviours of individuals and communities that increase the risk of HIV transmission through educational, motivational, skill-building and community normative approaches.²⁷

Community partnerships and working with people living with HIV in the development and delivery of resources is crucial to their effectiveness

Examples include:

- Provision of information, e.g. comprehensive sexual and reproductive health education.
- Resources to reduce the risk of HIV transmission, e.g. needle and syringe programs, and access to free condoms.

Structural interventions

HIV prevention programs that are rights-based, evidence-informed, and community-owned have the greatest sustained impact on reducing HIV transmission.²⁸

Structural interventions address the social, economic, political or environmental factors that may increase the risk of acquiring or transmitting HIV by creating an environment that is more supportive and enabling of prevention actions²²

Examples include:

- Access to free or subsidised medication and healthcare
- Access to free HIV testing
- Needle exchange programs
- Decriminalising sex work
- Providing clinics in geographically accessible locations (including considerations to public transport) and with accessible opening hours
- Reducing stigma related to gender, sexuality, sexual expression and behaviours, as well as the stigma of HIV infection itself
- Providing culturally safe services.

A comprehensive approach to HIV prevention is the use of a combination of interventions tailored to the needs of individuals and communities.

Testing

HIV testing that is convenient and accessible is crucial for identifying people with HIV and reducing rates of HIV transmission. It is critical to achieving UNAID's 95-95-95 targets.²⁹

HIV testing is cost-effective, even when the prior likelihood of positivity is as low as 1 in 1,000.³⁰ HIV testing enables people to know their status and adopt behaviours that minimise transmission. It also supports early diagnosis and commencement of treatment, which is important in achieving a healthy and improved quality of life for people living with HIV.

There are several HIV testing and sampling options available to suit individual circumstances and preferences. These include:³¹



Laboratory-based testing: the traditional method of HIV testing where a blood test is requested by a healthcare practitioner and sent to the laboratory for testing. Traditional HIV testing can take days to provide a result.



HIV point-of-care tests (POCTs)/self-testing: commonly known as 'rapid tests', POCTs and self-testing are quick screening tests for HIV, generally used outside clinical settings, e.g. by peer testers or for self-testing at home. POCTs use either a finger-prick blood sample or saliva testing. POCTs are conducted on the spot, with results available in around 20 minutes or less. A reactive (positive) result is only preliminary and must be followed by confirmatory blood tests in a laboratory. There is some level of risk of false negative and false positive results with POCTs.



Dried Blood Spot (DBS) sampling: another self-performed process that involves collecting a few drops of blood on a test card before mailing it to a laboratory for testing.³² Results are usually received in a week, with any reactive (positive) result to be followed by a laboratory-based test to confirm an HIV diagnosis. This technology is not routinely available in Aotearoa New Zealand.

HIV testing is recommended for:

People who request HIV testing	After a non-consenting sexual encounter
People undergoing any STI test	People with a STI or blood-borne virus (BBV) (e.g. hepatitis B or C), or possible signs or symptoms
Priority populations at increased risk of HIV	
People with HIV clinical indicator conditions	
People identified in contact tracing	People presenting to healthcare settings with recreational drug related mental health conditions, or mental health conditions causing risk taking behaviour, or methamphetamine-related illness. ³³
People commencing PrEP	
People commencing PEP	
Pregnant people	

While testing is recommended for these groups, it should be noted that clinicians should not require knowledge of 'risk behaviours for HIV' to conduct a HIV test. It also is important to avoid assuming people are not at-risk of HIV, as this can lead to missed opportunities to identify people with HIV who are undiagnosed.³⁴

People should be made aware if they are being tested for HIV and appropriate support should be provided to anyone who tests positive, including post-test discussion and a referral to a local HIV service. Contact tracing is also required to manage possible transmission.³⁵

HIV clinical indicator conditions

HIV often manifests through subtle clinical cues that may go unnoticed without deliberate attention

These conditions are known as 'HIV clinical indicator conditions' and include the well-known 'AIDS defining illnesses', as well as conditions that are often seen in primary and tertiary care but are lesser known as clinical indicators for HIV testing.⁵

HIV clinical indicator conditions include:³⁶

Conditions which are **AIDS defining**, e.g. oesophageal candidiasis, non-Hodgkin lymphoma.

Conditions where the **background prevalence of HIV is >0.1%**, e.g. thrombocytopenia, persistent unexplained diarrhoea, multidermatomal shingles, loss of weight.

Conditions where **not testing for HIV could result in poorer outcomes**, e.g. prior to commencing chemotherapy or immune modulating therapy.

AChSHM and RACP affiliated [specialty society ASHM](#) are working with medical colleges and other healthcare organisations to embed clinical indicator conditions in education, training and practice, which will lead to improved levels of HIV testing and diagnosis.

Treatment

While there is no cure for HIV, excellent treatment options are available to support people living with HIV, as well as to prevent HIV infection in those at increased risk.

Antiretroviral therapy (ART)

ART is a combination of medications used to treat HIV by limiting HIV replication causing viral suppression (sustained viral load of less than 200 copies/mL). Viral suppression allows immune recovery, prevents complications, and stops HIV transmission.

Consistent use of ART by people living with HIV to maintain an undetectable viral load is a highly effective strategy to prevent the sexual and perinatal transmission of HIV

Lifelong use of ART is required to maintain viral suppression to prevent HIV disease progression.³⁷

Access to health care

In Australia, HIV testing and health care for people living with HIV is available free (or for a small co-payment in some jurisdictions) via public hospitals and sexual health clinics. In Aotearoa New Zealand, health care for people diagnosed with HIV is publicly funded, including the supply of ART through pharmacies. These arrangements apply for all people in Australia and Aotearoa New Zealand, regardless of eligibility to Medicare or publicly funded health care.^{38 39}

While funding arrangements support equitable access to HIV treatment and care for all people living with HIV in Australia and Aotearoa New Zealand, there are **still barriers** to access, including distance to services, stigma and lack of culturally appropriate and safe services, particularly for Aboriginal, Torres Strait Islander, Māori and Pacific communities.

Issues in Australia

While HIV rates in Australia have improved, there are several continued and emerging issues that require action.

Provision of culturally safe HIV care to Aboriginal and Torres Strait Islander communities

While the number of Aboriginal and Torres Strait Islander people diagnosed with HIV has declined 54% between 2015 and 2024², **this group continues to be disproportionately affected by HIV due to a range of structural and social barriers**. This includes geographic, financial or other barriers to culturally safe and stigma free healthcare services.

When compared with non-Indigenous populations, Aboriginal and Torres Strait Islander people are more likely to have acquired HIV through heterosexual transmission and transmission from intravenous drug use. In addition, the ongoing national syphilis outbreak in Australia creates another critical risk for HIV virtual elimination for Aboriginal and Torres Strait Islander peoples.⁴⁰

The culturally safe, effective and comprehensive approach to HIV prevention, testing and care provided by the Aboriginal Community Controlled Health Organisation (ACCHO) sector is a crucial element to addressing the disproportionate levels of HIV infections in Aboriginal and Torres Strait Islander communities.⁴¹ Increased funding to the sector is required across all jurisdictions to ensure these services continue and can expand their current service delivery models.

Rising rates of HIV diagnoses in the heterosexual population

Data from 2024 indicates that male-to-male sex continues to be the major HIV risk exposure in Australia, accounting for 62% of all HIV notifications (including those reporting male-to-male sex and injection drug use). However, heterosexual sex was attributed to 27% of all HIV notifications that same year, with almost half (49.6%) classified as late diagnosis.²

The fact that these rates are increasing contrary to the overall decline, as well as the high proportion of late diagnoses, raises **significant concerns regarding delayed testing and diagnosis in this population group**.² It indicates that HIV prevention strategies, including public education campaigns, must **increase focus to target all population groups, including heterosexual men and women**.

AUSTRALIA: Of all HIV notifications in the heterosexual population		
62%	27%	Almost half
of HIV notifications attributed to male-male sex	of HIV notifications attributed to heterosexual sex	of all notification attributed to heterosexual sex classified as late diagnosis

Number of people living with undiagnosed HIV

Undiagnosed HIV is a major barrier to achieving virtual elimination of HIV. In 2024, an estimated 1,950 (6%) of people living with HIV in Australia were unaware of their HIV status.²

The proportion of people with undiagnosed HIV was lower among Australian-born GBMSM (2%) than in overseas born GBMSM (11%), and in people with heterosexual exposure risk (13%).² This reflects the elevated proportion of late diagnosis amongst these groups and is of particular concern as people who receive a late diagnosis of HIV are more likely to transmit HIV to sexual partners, require hospitalisation, and have an increased risk of AIDS or death.⁴²

AUSTRALIA: People living with undiagnosed HIV			
6%	2%	11%	13%
of people living with undiagnosed HIV in Australia	of people living with undiagnosed HIV among Australian-born GBMSM population	of people living with undiagnosed HIV among overseas born GBMSM population	of people living with undiagnosed HIV attributable to heterosexual exposure risk

Issues in Aotearoa New Zealand

Similarly, there are several continued and emerging issues that require action in Aotearoa New Zealand.

Provision of culturally safe HIV care to Māori and Pacific peoples

Of the number of GBMSM who have acquired HIV locally in Aotearoa New Zealand, there has been a decline among European GBMSM. However, **the number of GBMSM in other ethnic groups with HIV diagnoses has either increased or remained stable**. In particular, the number of new HIV diagnoses in Māori GBMSM have increased, with more Māori GBMSM receiving a diagnosis (n=16, or 33%) than GBMSM of European descent (n=10, or 21%) in 2025. This reflects a change over the last 5 years, in which the annual average proportion of Māori GBMSM receiving a diagnosis was 19%, compared to 35% for European GBMSM.^{43 44 45 46 47} This highlights the **need to ensure access to culturally safe prevention and testing services**.⁴³

In addition, there are ongoing inequities in the number of Māori and Pacific peoples remaining engaged in care following a HIV diagnosis. For example, in 2024 viral suppression among all people on ART was 91.7%, however, among Māori and Pacific peoples on ART these levels are lower (82.9% and 88.0% respectively).⁴⁸ This again highlights the need for **access to treatment services that are culturally safe**, which is crucial to ensuring Māori and Pacific Islander people living with HIV remain engaged in care and treatment.

Primarily, this can be addressed through supporting and funding whānau-centred initiatives that prioritise Indigenous voices and knowledge systems to improve health outcomes of Māori and Pacific peoples living with HIV.⁴⁹ In addition, **ensuring that mainstream services are culturally safe is also crucial**⁵⁰ to supporting Māori and Pacific peoples living with HIV to achieve the best health outcomes at an individual level (including U=U), as well as among the broader Māori and Pacific communities by reducing further transmission.

AOTEAROA NEW ZEALAND: HIV notifications among Māori and Pacific peoples		
33%	82.9%	88%
Rate of diagnosis among Māori GBMSM compared to 21% GBMSM of European descent	Viral suppression rate among Māori people on ART compared to 91.7% of all people on ART	Viral suppression rate among Pacific peoples on ART compared to 91.7% of all people on ART

Perinatal transmission

Two children were diagnosed with perinatally acquired HIV, both of whom were born overseas, in 2025. In addition, four women were diagnosed with HIV through antenatal testing.¹² Another two children were diagnosed with perinatally-acquired HIV in 2024, the first cases of perinatally-acquired HIV since 2007. These are **important reminders of the importance of antenatal screening for all pregnant people.**⁴³

HIV notifications of people first diagnosed overseas

In 2025, there were 137 people notified with HIV in Aotearoa New Zealand, who were first diagnosed overseas. Most of these people (85%) had an undetectable viral load indicating they were on antiretroviral therapy and therefore cannot pass HIV on sexually.¹² Ensuring ongoing access to appropriate and culturally safe treatment and care for this cohort is important to maintaining this level of engagement with care.

AOTEAROA NEW ZEALAND: Perinatal transmission and overseas diagnosed			
2	4	137	85%
Child HIV diagnoses acquired perinatally	Women diagnosed through antenatal testing	HIV notifications where first diagnosis occurred overseas	Proportion of people with undetectable viral load among the 137 HIV notifications first diagnosed overseas

Common issues for both Australia and Aotearoa New Zealand

Late diagnosis

The proportion of newly diagnosed people with HIV in Australia with a late diagnosis, in which an individual's CD4⁺ cell count indicates they likely acquired HIV at least four years before receiving a diagnosis, increased from 27.3% in 2015 to 38.4% in 2024. The proportion of HIV notifications with late diagnosis in 2024 was particularly high among migrant populations, particularly people from Southeast Asia, Oceania (outside Australia) and Sub-Saharan Africa.²

Similarly, the impact of late diagnosis on health outcomes and HIV transmission in Aotearoa New Zealand warrants continued efforts to reduce rates of late diagnosis, increase HIV testing rates and identify HIV infection early.⁵¹

Late diagnoses are a significant concern, and actions such as increased access to testing, treatment and prevention that are targeted at affected cohorts and populations, are required to address this issue⁵²

Many of these people have presented in the previous few years to primary and tertiary care, often with a clinical indicator condition, and there have been missed opportunities for testing and earlier detection.

This highlights the importance of all healthcare workers understanding clinical indicator conditions, as well as the need to consider more generalised approaches to increase testing levels, such as investigating options for opt-out testing in hospital and primary care facilities

The implementation of an opt-out HIV testing program in emergency departments and key areas of the United Kingdom indicates that opt-out testing is a cost-effective strategy to identify people with HIV who are undiagnosed.⁵³

Limited access to face-to-face sexual health services in regional, rural and remote areas

It is well established that people living in rural and remote communities experience poorer health outcomes compared to those living in metropolitan areas.⁵⁴

People living in rural and remote areas face barriers to sexual health care, such as availability of healthcare services, transport, knowing healthcare workers socially, or fear of judgement within a small community.⁵⁵ **Many regional, rural and remote areas also lack specialist sexual health services**, meaning some people living with HIV may have to travel for several hours to access in-person specialist care.

Greater access to appropriate care is vital to ensuring ongoing engagement in care among people living with HIV in regional, rural and remote areas

Access to HIV services by people who were born overseas

The rate of HIV notifications among Australian-born people declined 53% between 2015 and 2024 (from 4.4 to 2.1 per 100,000). HIV notification rates among most people born overseas have declined or fluctuated in this period, however for some populations they have increased. **HIV notifications among people born in Latin America increased by 50%** (from 9.1 to 13.6 per 100,000) and **people born in the Pacific (excluding Australia) saw an increase in HIV notification of 77%** (from 3.6 to 6.4 per 100,000).²

In addition, GBMSM receiving a HIV notification are now more likely to have acquired HIV after migration (48% of HIV notification among migrants to Australia attributed to male-to-male sex in 2024, up from 24% in 2016), compared to those who were likely to have acquired HIV before migration (35% in 2024, down from 63% in 2016). The proportion of people born overseas who receive a **late diagnosis is also significantly higher than for people born in Australia**.² Similarly, in Aotearoa New Zealand the rates of HIV notifications amongst GBMSM in ethnic groups other than European have **either stayed the same or increased**.²

This suggests inequitable access to effective HIV prevention and testing services and the need for targeted intervention and prevention strategies. Services should be designed in consultation with relevant communities to ensure they are culturally safe and linguistically appropriate and be targeted at settings likely to be visited by new arrivals in the countries.¹

Increases in the number of people diagnosed with HIV in Asia and the Pacific may also affect the need for culturally safe services in Australia and Aotearoa New Zealand, particularly in relation to testing and prevention, due to immigration patterns and policies across the region.^{56 57} For

example, Fiji’s escalating HIV epidemic has seen the number of new HIV case notifications in the country rise by a multiple of twelve over the last seven years, from 131 in 2018 to 1,583 in 2024.⁵⁸ Given the levels of tourism and migration between Fiji, Aotearoa New Zealand and Australia, as well as the rest of the Pacific, it is important to ensure **HIV information and education campaigns as well as testing and treatment services are co-designed and culturally safe** for these communities.

HIV notifications among overseas-born people			
50%	77%	48%	35%
Increase in HIV notifications among Latin America born people living in Australia	Increase in HIV notifications among Pacific-born people living in Australia	Rate of HIV notifications among migrants to Australia attributed to male-to-male sex	Rate of HIV notifications among migrants to Australia likely acquired prior to migration

Awareness of and access to PrEP

Despite recent improvements to funding for access to PrEP, there continue to be a range of **barriers to the use of PrEP to prevent transmission**. At an individual level, barriers relate to knowledge and risk perception of HIV. Other systemic and societal barriers include cost, discrimination, and health system navigation as well as perceptions and stigma.⁵⁹

For people **ineligible for Medicare or publicly funded health care**, access to PrEP and related testing and care **is generally more expensive**. PrEP can be accessed with a private prescription or through personal importation of PrEP which is generally more expensive, and the cost of consultation fees as well as monitoring testing are at the individual’s expense, which can be significant.^{60 61}

In addition, **targeted and tailored education campaigns** are required to address the **lack of awareness or misconceptions about PrEP**, particularly among people born overseas.⁵⁹ While developments in **new forms of treatments**, such a **long-acting injectable therapies**, are likely to improve access and use of PrEP, it will be important to ensure the equitable provision of such therapies.⁶²

Finally, **implementing expanded PrEP prescribing rights to pharmacists and all nurse practitioners** would increase access to prescribers and supply of PrEP, particularly in regional and remote areas. This expansion should occur within **appropriate frameworks for training and testing in line with current standards to ensure a safe model of care**. It should be accompanied by increased education and resources about efficacy and safety of the medications in conjunction with appropriate health professionals, such as clinical pharmacologists.⁶²

Efforts to virtually eliminate HIV transmission globally

HIV is one of the most serious health challenges across the world, and the **virtual elimination of transmission requires a global effort**. Certain regions of the globe are disproportionately affected by HIV, including Australia and Aotearoa New Zealand's close neighbours. In 2024, there **were 6.9 million people living with HIV in Asia and the Pacific**,⁶³ and rising rates of people receiving HIV diagnoses in Pacific countries such as Fiji are of particular concern, given the significant challenges such countries have in addressing these increases in transmission.⁶⁴

In the face of **major cuts to international funding to the global HIV response**,⁶³ continued support for initiatives to virtually eliminate HIV transmission in the Pacific and other areas is crucial. Eighty percent of prevention programs in low- and middle-income countries are delivered through international funding, and if the funding permanently disappears modelling shows there could be an additional 6 million HIV infections and an additional 4 million AIDS-related deaths by 2029.⁶⁵

Stigma

HIV-related stigma is still very prevalent. For many people the effects of HIV-related stigma and discrimination are much more harmful than the infection itself. **HIV-related stigma can impact access to HIV prevention tools, testing and treatment**, and cause overall worse health outcomes.⁶⁶ In addition, HIV-related stigma can be further compounded by intersecting stigmatised identities such as people who inject drugs, trans and gender diverse people, people who have been incarcerated and people from multicultural communities.⁶⁷

Continued and expanded **education campaigns** and **policy and legislative protections aimed at addressing HIV stigma and discrimination** are still required to address stigma in our community. In addition, improving the awareness and understanding of U=U (Undetectable = Untransmittable) in the broader community has been proven to reduce HIV stigma.⁶⁸

People living with HIV who are lost to follow up care

People living with HIV are generally considered to be lost to follow up care if they have not attended a medical service in the last 12 months, and this loss represents interrupted clinical care which can affect long term health outcomes.⁶⁹

The rates people living with HIV who are lost to follow up care in both Aotearoa New Zealand and Australia are relatively low, particularly compared international standards

The incidence of lost to follow up care in Australia is indicated to be 3.6 per 100 person-years.⁷⁰ In Aotearoa New Zealand, approximately 98.5% of people diagnosed with HIV since 2006 were on

ART as of 2023.⁴⁸

Despite the low rates of loss to follow up care, continued effort is needed to ensure retention in care is maintained for as many people as possible. Factors contributing to loss to follow up care include stigma and discrimination, financial and logistical challenges, mental ill health and substance use.⁷¹ Some people are particularly at risk of loss of follow up care, including Indigenous peoples, young people, and people who are unemployed and/or experiencing homelessness.⁶²

Identifying risk factors for loss of follow up care and providing appropriate support to mitigate these factors is crucial. Measures to be taken include developing positive therapeutic relationships, providing HIV education and providing psychosocial support including the use of peer navigators.³⁷

Living longer with HIV

The life expectancy of Australians living with HIV has been steadily increasing and is approaching that of the general population, and non-AIDS related causes are now the major cause of death for more people living with HIV than AIDS-related complications.⁷² Over 61% of people living with HIV in Aotearoa New Zealand are now over the age of 50 years. Future projections estimate that by 2030 this will rise to 72%.^{73 74} It is therefore **important that the wider health needs of people ageing with HIV continue to be met to enhance ongoing quality of life and wellbeing.**

However, while ART has increased the longevity of people living with HIV it has not enabled a complete return to normal health, and it is well recognised that people living with HIV **experience increased rates of chronic conditions compared to the general population.**⁷⁵ A range of factors, including the effect of persistent HIV infection, ART toxicity as well as harmful lifestyle behaviours may contribute to HIV-associated immune activation and chronic inflammation. This in turn is implicated in an **increase in the number of people living with HIV who are also living with co-morbidities**, including neurocognitive disorders, cardiovascular disease, chronic kidney disease, metabolic syndrome, type 2 diabetes mellitus, osteoporosis and cancers.⁷⁵

Living longer with HIV		
Increased life expectancy	Over 61%	72%
Life expectancy of Australians living with HIV approaching that of general population	of people in Aotearoa New Zealand living with HIV are over the age of 50	Estimate of people in Aotearoa New Zealand living with HIV will be over the age of 50 by 2030

Given this increased longevity and greater risk of comorbidities experienced by people living with HIV, **guidance and standards to help direct the optimal clinical management of older people living with HIV** are likely have a positive impact on both the sexual health sector and the broader health system.⁷⁵

Pragmatic and functional shared care models for people living with HIV allow best-practice care of non-HIV chronic conditions, for example by a regular GP and other health care professionals, alongside the continued expert management of HIV by sexual health physicians. Physicians of all specialties, including aged care, are likely to care for people living with HIV.⁷⁶



Successful implementation of shared and other collaborative care models relies on clear communication channels, addressing fragmentation in healthcare systems, establishing protocols for care coordination, and ongoing education for all health care professionals involved in the person's care⁷⁶

Preventive approaches such as immunisation against specific conditions, lifestyle modification, smoking cessation and cancer screening should be emphasised for people living with HIV.⁷⁷ Increased risks of comorbidities mean that consideration should be given to referring people living with HIV to specialists for review and management.

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