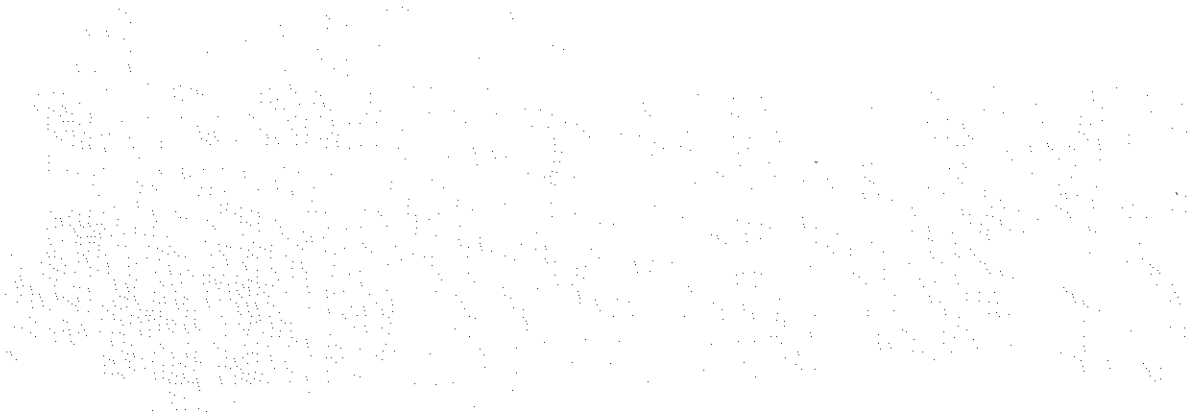
AIDS IN QUEENSLAND

Information Circular No. 14

QUEENSLAND HEALTH

EPIDEMIOLOGY AND HEALTH INFORMATION BRANCH
AIDS MEDICAL UNIT



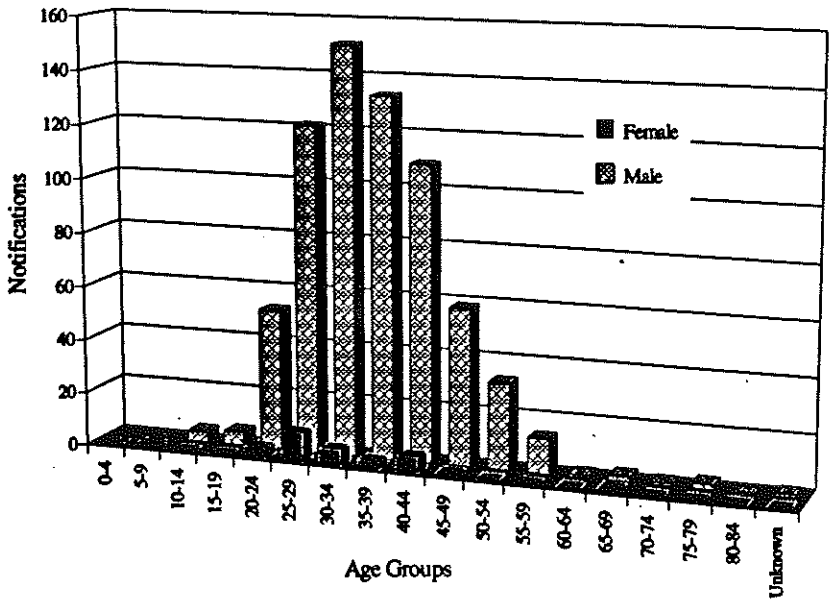
Queensland

- 1388 Cases of HIV had been diagnosed in Queensland as at 30 September 1992; 74.3% were alive and 21.2 % had died.
- 522 of the cases had progressed to AIDS; 52.5% of these cases had died.
- HIV/AIDS is mainly an urban infection but it is also found in small communities.

Age/Sex Distribution

- HIV infection has predominantly affected adult males to date.
- There were 718 people with HIV living in Queensland on 30th September, 1992. 84% were males aged 25-54 years and 8.5% were males and females aged 15-24 years (Figure 1).
- The risk taking and relative indifference to health issues by young people present special challenges for HIV prevention programs.

Figure 1: NOTIFICATIONS, QUEENSLAND, BY AGE GROUP
ALIVE AT 30/9/92, QUEENSLAND



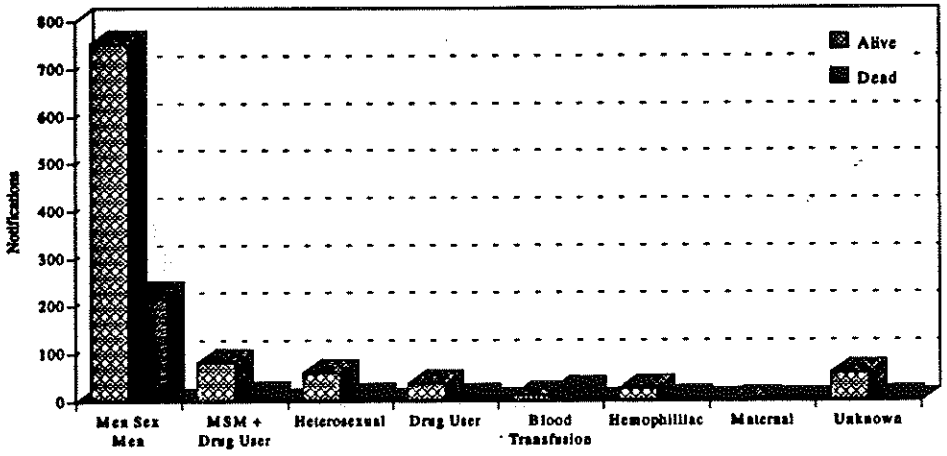
Source : AIDS Medical Unit, Queensland Health

Risk Groups

- In Queensland, 73% of infections have been acquired by men who have sex with men (MSM), 7% by MSM who also inject drugs, 3.7% by injecting drug use (DU) and 5.3% by heterosexual contact (Figure 2.).

- 53% of the 66 female cases diagnosed in Queensland were acquired heterosexually and 19.7% were associated with drug use.

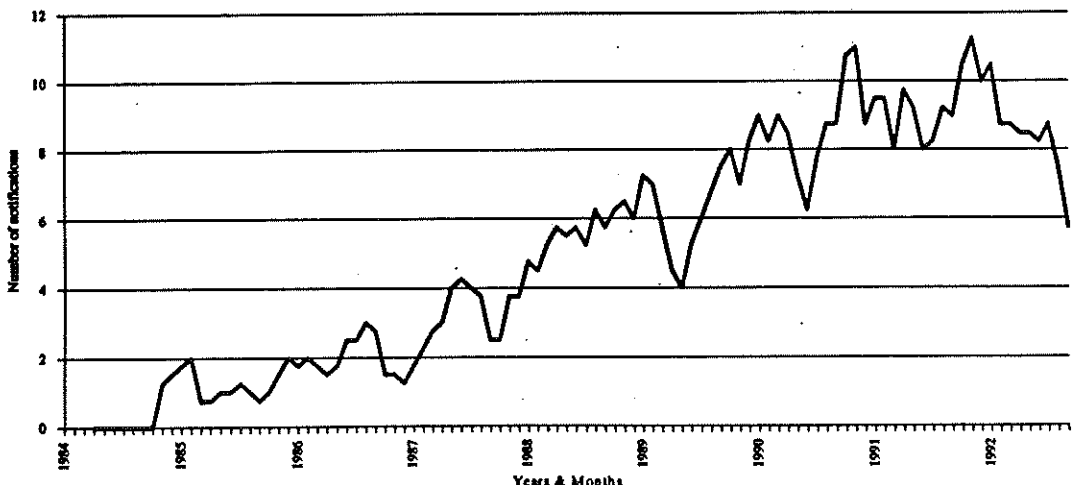
Figure 2: TOTAL HIV NOTIFICATIONS, TRANSMISSION CATEGORY, 30/9/92, QUEENSLAND



Trends

- Although HIV/AIDS remains a problem of men who have sex with men, the rate of increase of new cases of AIDS has decreased since 1990 and appears to be plateauing in Queensland (Figure 3) as well as Australia.

Figure 3: TOTAL AIDS* NOTIFICATIONS** BY MONTH, 30/9/92, QUEENSLAND



- In recent years, the number of female infections has increased although it is too early to interpret a trend (Table 1).

Table 1: FEMALE HETEROSEXUAL TRANSMISSION BY YEAR OF HIV DIAGNOSIS, 30/9/92, QUEENSLAND

Year	Females
'85	1
'86	0
'87	2
'88	1
'89	7
'90	8
'91	9
'92(Sep)	8

Source : AIDS Medical Unit, Queensland Health

- A WHO report in February 1992 noted that on a worldwide scale 90% of newly infected adults were contracting their infection heterosexually[1]. In the US, 33% of HIV infected women became so via heterosexual contact. In New York City, AIDS has become the leading cause of death for women aged 20-40 years[2].

- There is no evidence of a rising trend among injecting drug users in Queensland but again there is a warning in the overseas experience.

- Trends in some cities overseas have shown the potential for the combination of injecting drug users (DU) and prostitution to be associated with a rapidly rising HIV incidence rate with the potential for transmission to the wider community. Over 40% of people attending one Bangkok drug clinic in 1990 became infected in the preceding 18 months. By 1988 in New York, injecting drug use caused more new cases of AIDS than homosexual transmission[3].

- International bodies note an alarming increase in HIV infection in SE Asia, Thailand, Burma, and India[4]. The practice of sex tours to SE Asia by Australian men has been raised as a growing concern. Cases of Australian tourists being infected overseas have been reported.

STRATEGIES

1. Prevention

- There is little likelihood of a vaccine for HIV in the short-term future.

- Queensland Health in collaboration with other GovernmentDepartments, the community based organisations and the regional health providers are reporting successes and challenges in prevention and education (refer "Queensland: State HIV/AIDS Story"[5]).

- A 90% reduction of sexually transmitted diseases in the gay population and sex industry workers in Australia has been cited as evidence of the success of prevention programs. However, some young gay men still don't regard themselves as being at risk.

- There is a need to promote condom use amongst heterosexuals who have had more than one sexual partner. High levels of STD's (e.g. chlamydia, herpes, warts) in young women are of concern.

- Bisexual men may not regard themselves at risk and are less likely to use a condom in a regular relationship with a woman.

- Needle and Syringe Exchange programs operate from 70% of pharmacies Statewide in conjunction with several community based programs. Some subgroups (MSM who also inject drugs) are hard to reach.

- Aboriginal and Torres Strait Islander programs are tackling difficult issues of safer sexual practices (e.g. condom use), young Aboriginals in prison, STD and alcohol services.

- Workplace training programs have been very successful.

- Multirisk youth programs have been developed in Brisbane, Townsville and Cairns.

- No seroconversions have occurred in prisons in part due to screening and segregation policies introduced in 1986.

2. Screening

- Screening needs to be more targeted. The proportion of positive tests due to screening has remained 1 in a 1000 over the last 5 years. HIV testing in Queensland currently consumes about 25% of the total HIV/AIDS budget.

- The Red Cross Blood Transfusion service must continue to test blood. From May 1985 to June 1992, 12 new cases of HIV had been detected by the transfusion service in Queensland. Four of these cases were detected in 1991/992[6].

3. Treatment

- There is no cure for HIV but treatment with zidovudine and prophylactic treatments (e.g. Bactrim for pneumocystis pneumonia) are increasing survival.

- With increased awareness of improved survival and quality of life, there will be demand for earlier diagnosis and earlier use of zidovudine.

Goals and TargetsGoals and Targets

State and National bodies have proposed that prevention, education and treatment programs for Sexually Transmitted Diseases (STD) and HIV/AIDS be further integrated and enhanced.

Proposed **national targets** for the year 2000 include:

- reducing the incidence of HIV in sexually active people and injecting drug users to an annual rate of less than 2 per 100,000.
- reducing the incidence of HIV infection in men who have sex with men (particularly those aged under 25 years) from the 1992 level of 91 per 100,000 per annum.
- reducing the incidence of HIV through needle sharing by drug users.
- increasing the proportion of HIV positive injecting drug users who do not engage in risk behaviours.
- increasing the proportion of HIV positive opiate injecting drug users who are enrolled in a methadone maintenance program.

The relevant **targets** for **Queensland Health** for the next 3 years include:

- Statewide STD surveillance through a minimal data set and common case definitions.
- reduce the incidence of all forms of STD in the general population.
- reduce the incidence of STDs in subpopulations currently suffering the burden of very high incidence (e.g. Aboriginal and Torres Strait Islanders and others).

For further information contact:

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Material for this circular was provided by the AIDS Medical Unit.

DEFINITIONS

1. **H.I.V. (Human Immunodeficiency Virus) Case.**

   A person who is infected with HIV as detected by a positive blood test. The person remains essentially asymptomatic in the early years of the infection except for a "glandular fever type" illness following primary infection.

2. **AIDS (Acquired Immune Deficiency Syndrome) Case.**

   A person develops certain recognised diseases (opportunistic infections, neoplasms or neurologic disease) indicative of the underlying cellular immune deficiency caused by HIV infection.

REFERENCES

1. WHO. Over a million new HIV infections in eight months. *AIDS weekly* 1992; 24 February: 4-5.

2. Yale University. Scientists show changing face of AIDS in first comprehensive review of research on infected women. *AIDS Weekly* 1992; 27 January: 6-7.

3. Queensland Health. *A practical approach to management of HIV & STDs in your patients*. GP Course, May 1991.

4. Global AIDS Policy Coalition. AIDS in the world 1992: a global epidemic out of control? *AIDS Weekly* 1992; 15 June: 7.

5. HIV/AIDS and Sexual Health Section. *Queensland State HIV/AIDS Story*. Queensland Health, July 1992. (Ph 234 1296).

6. National Centre in HIV Epidemiology and Clinical Research. *Australian HIV Surveillance Report* 1992; 8(3): 22.