Indicators for the hepatitis B, hepatitis C, HIV and STI plans of the Victorian sexual and reproductive health and viral hepatitis strategy 2022–30.

VICTORIA State Government | Department of Health

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Except where otherwise indicated, the images in this document show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This document may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation.

Endorsed by Sexual and Reproductive Health and Viral Hepatitis Strategy Data Working Group, June 2023

Contents

Glossary of terms

ACCESS	Australian Collaboration for Coordinated Enhanced Sentinel Surveillance
ABS	Australian Bureau of Statistics
AIR	Australian Immunisation Register
ART	Antiretroviral therapy
BBV	Bloodborne virus
CSRH	Centre for Social Research in Health
DAA	Direct acting antivirals (for hepatitis C)
DH	Department of Health (Victoria)
ERP	Estimated Resident Population
GBM	Gay, bisexual and other men who have sex with men
HBIg	Hepatitis B immunoglobulin
HEP-LOGIC	Hepatitis and Liver Cancer Outcomes in General Practice Study
HCC	Hepatocellular carcinoma
HIV	Human Immunodeficiency Virus
MBS	Medicare Benefits Schedule
MGCPS	Melbourne Gay Community Period Survey
MSM	Men who have sex with men
MSW	Men who have sex with women
NIP	National Immunisation Program
NPEP	Non occupational HIV post-exposure prophylaxis
NSP	Needle and syringe program
PBS	Pharmaceutical Benefits Scheme
PHESS	Public Health Event Surveillance System
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
RNA	Ribonucleic acid
STI	Sexually transmissible infection
VHHITAL	Victorian HIV and Hepatitis Integrated Training and Learning
VIDRL	Victorian Infectious Diseases Reference Laboratory

Glossary of data sources

Data source	Custodian	Description
ACCESS	Burnet Institute	The ACCESS project is a national health surveillance network of sexually transmissible infections (STI) and blood borne viruses (BBV). ACCESS extracts de-identified data from more than 100 sexual health clinics, general practices, hospitals, community health services and pathology laboratories across Australia. Information on the number, type and distribution of sites across Victoria can be found at www.accessproject.org.au.
HEP-LOGIC	Doherty Institute	This project assesses viral hepatitis testing coverage using electronic medical records in a network of over 400 primary care clinics in Victoria, in the Eastern Melbourne, South Eastern Melbourne, and Gippsland Primary Health Networks.
Liver Cancer Linkage Project	Doherty Institute	This project generates estimates of hepatitis B adverse outcomes through linkage of notifications with cancer and hospitalisations datasets.
Medicare Benefits Scheme	Australian Government, Department of Health	Data regarding Medicare billed tests can be extracted according to relevant Medicare billing item numbers.
Melbourne Gay Community Periodic Survey	CSRH, UNSW	The Melbourne Gay Community Periodic Surveys (MGCPS) are repeated, cross-sectional surveys of gay men conducted in metropolitan Melbourne and online. They are a key part of Australia's behavioural surveillance system for HIV, monitoring sexual practices, drug use and patterns of testing for HIV and other STI.
National Surveillance for Hepatitis B Indicators Project	Doherty Institute	This project generates estimates of chronic hepatitis B prevalence, incidence and attributable mortality using a mathematical model incorporating natural history, immunisation, migration, births/deaths, and demographic and prevalence variation.
National Viral Hepatitis Mapping Project	Doherty Institute	This project generates estimates of the uptake of hepatitis B and hepatitis C treatment and monitoring using Medicare data.
PHESS	DH	The Public Health Event Surveillance System collects data from all notifiable conditions, including BBV and STI.
Stigma Indicators Monitoring Project	CSRH	This study aims to monitor indicators of stigma among priority groups identified by the five national strategies addressing BBV and STI, including men who have sex with men, people who inject drugs, people living with HIV, people living with viral hepatitis (B and C) and people who engage in sex work. The indicator is included in existing routine surveys of people who inject drugs and men who have sex with men, and in new

Data source	Custodian	Description
		surveys of people living with HIV and hepatitis C. A survey of health care providers provides a measure to monitor the expression of stigma.
SuperMIX	Burnet Institute	SuperMIX is a cohort of people who inject drugs (PWID) that has been running in various forms at the Burnet Institute since 2008. It provides important information about how injecting drug use evolves over time, focused on periods during which cohort members cease injecting drug use and if they subsequently relapse and the drivers of this cessation and relapse.

Indicator List

Background

The *Victorian sexual and reproductive health and viral hepatitis strategy 2022-30* (the Strategy) was released in October 2022. Made up of seven plans, the strategy is tailored to specific epidemics, conditions and cohorts.

In Victoria, surveillance of blood borne viruses (BBV) and sexually transmissible infections (STI) are conducted by the Department of Health (the department) in collaboration with surveillance partners.

BBV and STI data are provided to different stakeholders including the Sexual Health and Viral Hepatitis team of department, which is responsible for the development of policy, program delivery and prevention activities. BBV and STI data are also provided to the Commonwealth Department of Health and Ageing for reporting against the indicators in the national BBV and STI strategies.

The surveillance and monitoring indicators for hepatitis B, hepatitis C, HIV and STI have been refreshed and expanded by the department in consultation with the Strategy Data Working Group to monitor progress against the targets of the Victorian hepatitis B, hepatitis C, HIV and STI plans. The Data Working Group will prioritise indicators for reporting over the first years of Strategy implementation.

The indicators have been selected specifically to measure progress towards targets of the Strategy, which are quantitative in nature. We recognise that valuable qualitative data will also exist that can aid our understanding of strategy implementation and add to our ability to monitor and evaluate the Strategy.

Data to be used in this document will be obtained from a range of stakeholders. Many datasets, such as cancer and other registries, have significant lag times before providing finalised data. Some indicators, therefore, will not be reportable for more recent years.

Hepatitis B, hepatitis C, HIV and STI plans

The *Victorian hepatitis B Plan 2022-30*, the *Victorian hepatitis C plan 2022-30*, and the *Victorian HIV plan 2022-30*, and the *Victorian sexually transmission infections plan 2022-30* are components of the Strategy. The Strategy aims to achieve optimal sexual and reproductive health outcomes and reduce the impact of BBV and STI on all Victorians. Such an approach includes an elimination agenda for specific diseases, together with work to reduce stigma, racism and discrimination, strengthen workforce capacity, foster partnerships and collaboration and strengthen and support data and research.

The Strategy also contains three new plans: the *Victorian Aboriginal sexual and reproductive health plan 2022-30*, the *Victorian women's sexual and reproductive health plan 2022-30* and the *System enabler plan 2022-30*. Indicators for these plans will be developed in 2023 in partnership with key sector stakeholders in consultation with the Strategy Data Working Group.

The department is responsible for the implementation of the Strategy and its component plans, undertaken in consultation with expert representation for the hepatitis B, hepatitis C, HIV, STI, and sexual and reproductive health sectors at the Departmental Advisory Committee on sexual and reproductive health and viral hepatitis (DAC SRHVH).

Data sources and disaggregation

These indicators use data from a variety of sources. Each dataset covers a different population and can be disaggregated differently. Where available, datasets will be disaggregated by the priority

populations of the relevant Plan. The Strategy places importance on targeting prevention, testing and treatment and care services to priority populations. Some of these priority populations, such as Aboriginal Victorians , can be identified within most datasets where demographics are complete, however, other populations such as people who inject drugs (PWID) and sex workers are harder to identify within datasets.

Strengthen and support data and research

The system enabler plan outlines activities increase the quality and completeness of data and support evaluation and research. These activities include improving data collections and systems to support a comprehensive understanding of BBV and STI, improving the level of data and granularity of collected data in relation to specific priority and subpopulations and using data dashboards to inform strategy progress and support tailored responses.

As these activities are undertaken, the indicator framework will be updated to reflect improved data collection and a strengthened surveillance system.

There will be a mid-point review in 2025–26 of the Strategy to assess progress against achieving the 2025 and 2030 targets. The mid-cycle progress report, informed by the indicator framework and narrative reporting, will be used to refresh and refocus priority actions and activities outlined in the Strategy and its tailored plans.

Hepatitis B plan 2022–30

Goals, targets and priority populations

Goals:

- Victorians are supported to reduce their risk of acquiring hepatitis B
- Victorians living with hepatitis B know their status
- Victorians living with hepatitis B have the best practice evidence-based treatment and care
- Stigma, racism and discrimination are not a barrier to hepatitis B prevention, testing, treatment or care

Stepped targets for 2025:

- Reduce the number of newly acquired hepatitis B infections by 50 per cent, with a focus on priority populations
-

Priority populations

- Culturally diverse people
- People living with hepatitis B including children
- Aboriginal people
- Pregnant women with hepatitis B and their children
- Unvaccinated adults at higher risk of infection.

Focus Area 1: Prevent

Goal: Victorians are supported to reduce their risk of acquiring hepatitis B

Objectives (by 2030):

- Victorians know how to prevent hepatitis B and are supported to do so
- There is an overall and ongoing reduction in the new cases of hepatitis B in Victoria
- Vaccination coverage among Victorian children is as high as possible
- People in priority populations are vaccinated against hepatitis B.

Group 1: Reduction in newly acquired cases of hepatitis B

Targets for 2025:

- Reduce the number of newly acquired hepatitis B infections by 50%, with a focus on priority populations

Indicators:

- Annual rate of newly acquired hepatitis B

Indicator notes

Hepatitis B is a notifiable condition in Victoria. Notifications from diagnosing clinicians and laboratories are recorded in PHESS. Hepatitis B is notified as either 'newly acquired,' where evidence was available that the infection was acquired within 24 months prior to diagnosis, or 'unspecified', where the infection was acquired more than 24 months prior to diagnosis, or the period of infection is unknown.

Determination of a case as 'newly acquired' is heavily reliant on public health follow-up and the availability of previous serology test results. Notified cases over time do not solely reflect changes in disease incidence. Changes in testing policies; screening programs, including preferential testing of high- risk populations; the use of less invasive and more sensitive diagnostic tests; and periodic awareness campaigns, may influence the number of notifications that are received over time.

Another limitation of the notification and testing data is that they represent only a proportion of the total cases occurring in the community, that is, only those cases for which health care was sought, a test conducted, and a diagnosis made, followed by a notification to the department. The degree of under-representation of all cases is unknown. Modelling performed by the National Surveillance for Hepatitis B Indicators Project seeks to determine hepatitis B incidence using assumptions including the proportion of people tested and the rate of notification. Results from this project offer means of reporting estimated hepatitis B incidence.

Reporting against indicators

1. Annual rate of newly acquired hepatitis B

Component	Description	Source	Custodian	Availability
Numerator	Number of cases of newly acquired hepatitis B notified to the DH	PHESS	DH	Quarterly

Component	Description	Source	Custodian	Availability
Denominator	Victorian ERP	ABS website	ABS	Quarterly

Hepatitis C plan 2022-30

Goals, targets and priority populations

Goals:

- Victorians are supported to reduce their risk of acquiring hepatitis C
- Victorians living with hepatitis C know their status
- Victorians living with hepatitis C have the best practice evidence-based treatment and care
- Victorians living with hepatitis C are cured of the disease
- Stigma, racism and discrimination are not a barrier to hepatitis C prevention, testing, treatment and care

Stepped targets for 2025:

- Reduce the number of newly acquired hepatitis C infections, with a focus on priority populations, by 56% (compared with 2015)
- Increase the proportion of people living with hepatitis C who diagnosed to 91%

Priority populations

- People who use drugs (including people who inject drugs) and/or are accessing drug treatment programs
- People living with hepatitis C
- Aboriginal people
- People in custodial settings
- Culturally diverse people
- HIV-positive men who have sex with men
- Sex workers

Focus Area 1: Prevent

Goal: Victorians are supported to reduce their risk of acquiring hepatitis C

Objectives (by 2030):

- Victorians know what to do to prevent hepatitis C infection and reinfection and are supported to do so
- There is an overall, and ongoing, reduction in new cases of hepatitis C in Victoria
- Safe sexual and injecting practices are understood and used among priority populations
- Sterile injecting equipment is widely available to people who inject drugs, including those in regional and rural Victoria
- NSP are widely accessed by people who inject drugs

Targets for 2025:

- Reduce the number of newly acquired hepatitis C infections, with a focus on priority populations, by 56% (compared with 2015)

Indicators:

- Annual rate of newly acquired hepatitis C
- Annual rate of new unspecified hepatitis C cases

Indicator notes

Hepatitis C is a notifiable condition in Victoria. Notifications from diagnosing clinicians and laboratories are recorded in PHESS. Hepatitis C is notified as either 'newly acquired', where evidence was available that the infection was acquired within 24 months prior to diagnosis or 'unspecified', where the infection was acquired more than 24 months prior to diagnosis, or the period of infection is unknown. Determination of a case as 'newly acquired' is heavily reliant on public health follow-up and the availability of previous serology test results. As such, we report rates of all new hepatitis C notifications as well.

Notified cases over time do not solely reflect changes in disease prevalence. Changes in testing policies; screening programs, including preferential testing of high-risk populations, the use of less invasive and more sensitive diagnostic tests, and periodic awareness campaigns, may influence the number of notifications that are received over time.

A limitation of notification data is that previous testing history is often unknown if a patient has had a test at another clinic or the data is not readily available in the patient's file. ACCESS uses data from network of clinical services that specialize in the care of people who inject drugs across Victoria. Whilst this network is not comprehensive, it offers an opportunity to determine when someone diagnosed with hepatitis C had negative tests. From this information, the total time between negative and positive tests can be used to calculate the incidence of hepatitis C.

Another major limitation of the notification and testing data is that they represent only a proportion of the total cases occurring in the community, that is, only those cases for which health care was sought, a test conducted, and a diagnosis made, followed by a notification to the department. The degree of under-representation of all cases is unknown.

Reporting against indicators

2. Annual rate of newly acquired hepatitis C

Component	Description	Source	Custodian	Availability
Numerator	Number of cases of newly acquired hepatitis C notified to the DH	PHESS	DH	Quarterly
Denominator	Victorian ERP	ABS website	ABS	Quarterly

3. Annual rate of all new hepatitis C cases

Component	Description	Source	Custodian	Availability
Numerator	Number of cases of hepatitis C notified to the DH	PHESS	DH	Quarterly
Denominator	Victorian ERP	ABS website	ABS	Quarterly

Focus Area 2: Test

Goal: Victorians living with hepatitis C know their status

Objectives (by 2030):

- Victorians living with hepatitis C are aware of their status, are diagnosed early and are supported to do so
- Victorians understand the need to be tested for hepatitis C if they are at greater risk
- Testing services for hepatitis C meet the needs of priority populations
- Testing for priority populations is undertaken across community and primary care settings.

Targets for 2025:

- Increase the proportion of people living with hepatitis C who are diagnosed to 91%

Indicators:

- Proportion of people in high caseload settings who have been tested for hepatitis C

Indicator Notes

Data sources include modelling by the ACCESS clinical network. As with hepatitis B, testing rate calculations will be performed with ACCESS data sources. Note that ACCESS is targeted towards groups at higher risk of BBV and can report outcomes from clinics that see a high caseload of priority populations like PWID and HIV-positive men who have sex with men; however, ACCESS data can be disaggregated by clinical site, but not risk category. For example, it will be able to report on the proportion of people attending a clinic that specialises in the treatment of PWID, but not all the people attending that clinic inject drugs.

Reporting against indicators

4. Proportion of people in high caseload settings who have been tested for hepatitis C

Component	Description	Source	Custodian	Availability
Numerator	Number of people attending sexual health clinics, clinics specialising in care for PWID, or community health centres in ACCESS clinical network tested for hepatitis C	ACCESS	Burnet Institute	Annually
Denominator	Number of people attending sexual health clinics, clinics specialising in care for PWID, or community health centres in ACCESS clinical network	ACCESS	Burnet Institute	Annually

HIV plan 2022-30

Goals, targets and priority populations

Goals:

- Victorians are supported to reduce their risk of acquiring HIV
- Victorians living with HIV know their status
- Victorians living with HIV have access to the best practice evidence-based treatment and care
- Stigma and discrimination are not a barrier to HIV prevention, testing, treatment or care

Targets for 2025:

- The proportion of people at risk of HIV infection who use one or more forms of effective HIV prevention will be 95%
- The proportion of all people living with HIV who are diagnosed will be 95%
- The proportion of all people living with HIV who are accessing appropriate treatment will be 98%
- The proportion of all people living with HIV on treatment with an undetectable viral load will be 98%

Priority populations

- People living with HIV
- Gay, bisexual and other men who have sex with men
- Aboriginal people
- Women
- Gender diverse people
- Culturally diverse and refugee communities
- Heterosexual identifying men who intersect with a number of these priority populations
- People from, or people who travel to, high-HIV prevalence countries
- People in custodial settings
- Sex workers
- People with a blood disorder
- Young people

Focus Area 1: Prevent

Goal: Victorians are supported to reduce their risk of acquiring HIV

Objectives (by 2030):

- Victorians know what to do prevent HIV and are supported to do so
- Victorians who experience greater inequity and who are at increased risk of HIV acquisition are the focus of renewed prevention efforts
- Health professionals have the knowledge and understanding to provide contemporary prevention advice
- There is an overall and ongoing reduction in new HIV notifications in Victoria

Targets for 2025:

- The proportion of people at risk of HIV infection who use one or more forms of effective HIV prevention will be 95%

Indicators:

- Annual rate of newly acquired HIV
- Annual rate of all new HIV notifications (including unspecified cases)
- Number of people in each priority population using PrEP
- Proportion of people in each priority population using PrEP

Indicator Notes

HIV is a notifiable condition in Victoria. Notifications from diagnosing clinicians and laboratories are recorded in PHESS. HIV is notified as either 'newly acquired,' where evidence was available that the infection was acquired within 12 months prior to diagnosis through laboratory evidence or the diagnosis of a seroconversion illness by the treating doctor, or 'unspecified', where the infection was acquired more than 12 months prior to diagnosis or the period of infection is unknown, or 'child less than 18 months'.

Newly acquired infections are classified in PHESS using negative tests within 12 months of the positive test and or using evidence of seroconversion illness. However, the ACCESS network can identify all tests performed in participating services and calculate the total person-time between positive and negative tests to give an estimation of HIV incidence. As Victoria moves towards virtual elimination of HIV transmission both rates will decrease.

In April 2018, PrEP became available under the PBS throughout Australia. Prior to that, the PrEPX study run by Alfred Health was the primary way Victorians could access PrEP. Data from the ACCESS clinical network has become an important tool in assessing the degree to which PrEP is used in Victoria and by different priority populations. As ACCESS can assess denominators within the clinical network, proportion of people using PrEP can be calculated.

Prescriptions for antiretrovirals used for PrEP that receive a PBS subsidy are identified as such (and differentiated from use of the same medication for HIV treatment) by a code written on the prescription. PBS data showing the number of prescriptions dispensed for one month of PrEP does not reliably indicate the number of people taking PrEP because people sometimes wait less or more than a month before renewing their prescription, and prescriptions get lost, medication borrowed,

etc. However, the general trend in the number of prescriptions issued for PrEP does indicate the trend in number of people using it.

Reporting against indicators

5. Annual rate of newly acquired HIV

Component	Description	Source	Custodian	Availability
Numerator	Number of cases of newly acquired HIV diagnosed within Victoria	PHESS	DH	Quarterly
Denominator	Victorian ERP	ABS	ABS	Quarterly

6. Annual rate of all new HIV notifications (including unspecified cases)

Component	Description	Source	Custodian	Availability
Numerator	Number of cases of HIV notified to the DH diagnosed within Victoria	PHESS	DH	Quarterly
Denominator	Victorian ERP	ABS	ABS	Quarterly

7. Number of people using PrEP

Component	Description	Source	Custodian	Availability
Single measure	Number of people accessing PrEP overall and in each priority population	ACCESS	Burnet Institute	Annually

8. Proportion of people using PrEP

Component	Description	Source	Custodian	Availability
Numerator	Number of people overall and in each priority population in ACCESS clinical network prescribed PrEP	ACCESS	Burnet Institute	Annually
Denominator	Number of people overall and in each priority population in ACCESS clinical network	ACCESS	Burnet Institute	Annually

Focus Area 2: Test

Goal: Victorians living with HIV know their status

Objectives (by 2030):

- Victorians with HIV know their serostatus, are diagnosed early and are supported to do so
- Victorians at risk of HIV infection understand the need for regular testing
- Regular HIV testing is normalised within priority populations and is available across diverse health settings
- Testing services meet the needs of priority populations

Targets for 2025:

- The proportion of all people living with HIV who are diagnosed will be 95%

Indicators:

- Number of HIV tests performed
- Proportion of HIV tests performed that are positive
- Proportion of people who have been tested for HIV

Indicator notes

Testing is a vital step in the cascade of HIV care. The overall proportion of PLHIV who have been diagnosed is modelled by the Kirby Institute. As stated in the introduction, where possible throughout the indicators, calculations will be disaggregated by priority population. In this case, this is possible through use of ACCESS clinical data. The ACCESS clinical network is designed to include high caseload clinics that people at higher risk of HIV attend, which can be used to calculate the proportion of each priority population who are diagnosed. However, ACCESS cannot model the number of PLHIV.

An increasing proportion of new HIV diagnoses are made in low caseload GP clinics and there is currently no way to know how many tests are done in these settings. In the future, if legislation change allows this to be reported to the department, it will be included in the indicators.

CD4+ cell count is an indicator of the damage HIV has inflicted on the immune system. Levels below 200cells/uL place the person at risk of opportunistic infections; levels over 350cells/uL are considered normal. On a population level, a higher median CD4+ count, indicates earlier diagnosis of HIV. This indicator will be able to be disaggregated by population and diagnosis setting (high caseload / low caseload).

This section contains many indicators that will need to be interpreted together to give an idea of the proportion diagnosed overall and in priority populations.

Reporting against indicators

9. Proportion of HIV tests performed that are positive

Component	Description	Source	Custodian	Availability
Numerator	Number of positive HIV tests in the ACCESS clinical network	ACCESS	Burnet Institute	Annually
Denominator	Number of who had an HIV test in the ACCESS clinical network	ACCESS	Burnet Institute	Annually

10. Proportion of people who have been tested

Component	Description	Source	Custodian	Availability
Numerator	Number of Victorians (in each priority population) who had an HIV test in the ACCESS clinical network in calendar year	ACCESS	Burnet Institute	Annually
Denominator	Number of Victorians (in each priority population) in the ACCESS clinical network in calendar year	ACCESS	Burnet Institute	Annually

Focus Area 3: Treat and care

Goal: Victorians living with HIV have access to the best practice evidence-based treatment and care

Objectives (by 2030):

- Victorians living with HIV are aware of the long-term consequences of untreated HIV infection and know how to access appropriate treatment and support
- All Victorians diagnosed with HIV are linked into rapid treatment initiation and are supported to stay on treatment
- People living with HIV receive the treatment, care and support they need, including monitoring, viral load testing and antiretroviral therapy
- People living with HIV can easily access affordable care and medications in local primary and community health settings.

Group 1: Increase access and uptake of appropriate treatment

Targets for 2025:

- The proportion of all people living with HIV who are accessing appropriate treatment will be 98%

Indicators:

- Proportion of people (including in identifiable priority populations) diagnosed with HIV who are prescribed ART
- Proportion of people (including in identifiable priority populations) diagnosed with HIV who are prescribed ART within 6 months of diagnosis

Indicator notes

The different data sources used in these indicators each have various, complementary abilities to calculate the proportion of PLHIV prescribed medication. At present the mainstay of Victoria's ability to report this indicator is the ACCESS clinical network. Because many people diagnosed in low caseload GP clinics that are not part of the ACCESS clinical network are referred to high caseload clinics for HIV care, the ACCESS clinical network represents a high proportion of people in care for HIV. ACCESS is continuing to recruit new services that form part of the Victorian Sexual Health Network to improve representativeness across the state.

Although the ACCESS clinical network can identify when someone moves care to another clinic in the network, it cannot differentiate between people who have moved care to a non-ACCESS site and people who have dropped out of care.

ACCESS continues to work to link its lab network to PBS data, which will provide another source of information on prescriptions issued to PLHIV that extends to people not in the clinical network.

Fast commencement on ART stops damage to the immune system and improves individual health as well as being a crucial step in minimising the time during which a person can transmit the virus. Data from the ACCESS clinical network can provide estimates on the time from diagnosis to treatment initiation.

Reporting against indicators

11. Proportion of people diagnosed with HIV who are prescribed ART

Component	Description	Source	Custodian	Availability
Numerator	Number of Victorians in ACCESS clinical network diagnosed with HIV who are prescribed ART	ACCESS	Burnet Institute	Annually
Denominator	Number of Victorians in ACCESS clinical network diagnosed with HIV	ACCESS	Burnet Institute	Annually

12. Proportion of people diagnosed with HIV who are prescribed ART within 6 months of diagnosis

Component	Description	Source	Custodian	Availability
Numerator	Number of Victorians diagnosed with HIV who have started ART within 6 months of diagnosis	PHESS	DH	Not yet available
Denominator	Number of Victorians diagnosed with HIV	PHESS	DH	Annually

Group 2: Achieve and maintain high levels of viral suppression

Targets for 2025:

- The proportion of all people living with HIV on treatment with an undetectable viral load will be 98%

Indicators:

- Proportion of PLHIV prescribed ART with viral load <200copies/mL
- Proportion of PLHIV prescribed ART with viral load <50copies/mL

Indicator notes

When ART is used to reduce HIV viral load to undetectable levels, not only is disease progression stopped and individual health improved, but transmission is effectively eliminated. Successful treatment of HIV therefore is essential for both individual and public health. “Undetectable” viral load means that so little HIV is present in the sample that the lab cannot detect it; it is dependent on both the viral load and the lab test. As tests evolve, detection is possible at lower levels. Reporting of viral suppression at the globally accepted threshold for prevention at <200 copies/mL will be reported. Proportion with viral loads <50 copies/mL as a reflection of clinical benefit to the individuals.

Reporting against indicators

13. Proportion of PLHIV with viral load of <200copies/mL

Component	Description	Source	Custodian	Availability
Numerator	Number of Victorians diagnosed with HIV in ACCESS clinical network prescribed ART whose last viral load (taken within 12 months of analysis) was <200copies/mL	ACCESS	Burnet Institute	Annually
Denominator	Number of Victorians diagnosed with HIV in ACCESS clinical network prescribed ART	ACCESS	Burnet Institute	Annually

14. Proportion of PLHIV with viral load of <50copies/mL

Component	Description	Source	Custodian	Availability
Numerator	Number of Victorians diagnosed with HIV in ACCESS clinical network prescribed ART whose last viral load (taken within 12 months of analysis) was <50copies/mL	ACCESS	Burnet Institute	Annually
Denominator	Number of Victorians diagnosed with HIV in ACCESS clinical network prescribed ART	ACCESS	Burnet Institute	Annually

Sexually transmissible infections plan 2022–30

Goals, targets and priority populations

Goals:

- Systems support individuals and communities to enjoy positive sexual health and wellbeing
- Victorians are supported to reduce their risk of acquiring an STI
- Victorians with an STI know their status
- Victorians with an STI have access to best practice evidence-based treatment and care
- The morbidity and mortality associated with STI among Victorians is minimised
- Stigma, racism and discrimination are not a barrier to STI prevention, testing or treatment and care

Targets for 2030:

- Eliminate congenital syphilis
- Increase STI testing coverage in priority populations (compared with 2019)
- Reduce the prevalence of chlamydia, gonorrhoea and infectious syphilis (compared with 2019)

Priority populations

- Young people (15-29 years of age)
- Aboriginal people
- Gay, bisexual and other men who have sex with men
- Women of reproductive age
- Culturally diverse communities
- Trans and gender diverse people
- Sex workers
- People living with HIV (PLHIV)
- People in custodial settings

Focus Area 1: Prevent

Goal: Victorians are supported to reduce their risk of acquiring an STI

Objectives (by 2030):

- Victorians know how to prevent STI and reinfections and supported to do so
- Victorians are supported to use safe sexual practices and harm reduction strategies to reduce infection risk
- Vaccination coverage of HPV among Victorian adolescents is as high as possible
- There is an overall and ongoing reduction in new STI cases

Targets for 2030:

- Eliminate congenital syphilis
- Reduce the prevalence of chlamydia, gonorrhoea and infectious syphilis (compared with 2019)

Indicators:

- Number of cases of congenital syphilis
- Number and notification rates of chlamydia, gonorrhoea and infectious syphilis
- Number and notification rates of chlamydia, gonorrhoea and infectious syphilis by sex and 10-year age groups
- Number and notification rates of chlamydia, gonorrhoea and infectious syphilis among culturally diverse people
- Number and notification rates of gonorrhoea and infectious syphilis among Aboriginal people

Indicator notes

Chlamydia, gonorrhoea and syphilis (including infectious, late and congenital) are notifiable conditions under the Public Health and Wellbeing Regulations 2019 legislation in Victoria. Notifications from diagnosing clinicians and laboratories are recorded in PHESS. Notification data is used to calculate rate per 100,00 population, where relevant. The population data will be obtained from the ABS.

Due to the asymptomatic nature of many STI, it is important to note that notifications likely underestimate the total cases occurring in the population. The degree of under-representation of all cases is unknown; notification and testing data represent only a proportion of the total cases occurring in the community, that is, only those cases for which health care was sought, a test conducted, a diagnosis made, and notified to DH. For instance, with only about 20 per cent of cases being symptomatic, chlamydia notification rates will be considerably less than the actual rates.

Reporting against indicators

15. Number of cases of congenital syphilis

Component	Description	Source	Custodian	Availability
Single measure	Number of cases of congenital syphilis reported to the DH	PHESS	DH	Quarterly

16. Number and notification rates of chlamydia, gonorrhoea and infectious syphilis

Component	Description	Source	Custodian	Availability
Numerator	Number of chlamydia cases notified to DH	PHESS	DH	Quarterly
Numerator	Number of gonorrhoea cases notified to DH	PHESS	DH	Quarterly
Numerator	Number of infectious syphilis cases notified to DH	PHESS	DH	Quarterly
Denominator	Victorian ERP	ABS	ABS	Annually

17. Number and notification rates of chlamydia, gonorrhoea and infectious syphilis by sex and 10-year age groups

Component	Description	Source	Custodian	Availability
Numerator	Number of chlamydia cases notified to DH, by sex and 10-year age group.	PHESS	DH	Quarterly
Numerator	Number of gonorrhoea cases notified to DH, by sex and 10-year age group	PHESS	DH	Quarterly
Numerator	Number of infectious syphilis cases notified to DH, by sex and 10-year age group	PHESS	DH	Quarterly
Denominator	Victorian ERP, by sex and 10-year age group	ABS	ABS	Annually

18. Number and notification rates of gonorrhoea and infectious syphilis among culturally diverse people

Component	Description	Source	Custodian	Availability
Numerator	Number of gonorrhoea cases notified to the department among individuals born overseas	PHESS	DH	Quarterly
Numerator	Number of infectious syphilis cases notified to department among individuals born overseas, by sex and 10-year age group	PHESS	DH	Quarterly

Component	Description	Source	Custodian	Availability
Denominator	Victorian ERP of people born overseas	ABS	ABS	Annually

19. Number and notification rates of gonorrhoea and infectious syphilis among Aboriginal people

Component	Description	Source	Custodian	Availability
Numerator	Number of gonorrhoea cases notified to DH, among Aboriginal people	PHESS	DH	Quarterly
Numerator	Number of infectious syphilis cases notified to DH, among Aboriginal people	PHESS	DH	Quarterly
Denominator	Victorian ERP of Aboriginal people	ABS	ABS	Annually

Focus Area 2: Test

Goal:

- **Victorians with an STI know their status**

Objectives (by 2030):

- Victorians with an STI know their status, are diagnosed early and are supported to do so
- Regular testing for STI is normalised and offered to Victorians across local primary and community health settings, including in antenatal care
- Testing services for STI are targeted to meet the needs of priority populations
- Victorians at greater risk of an STI understand the need to be tested.

Targets for 2030:

- Increase STI testing coverage in priority populations (compared with 2019)

Indicators:

- Proportion of individuals receiving any STI testing in a calendar year
- Proportion of GBM who received complete STI testing in a calendar year
- Proportion of GBM retested for STI within three months

Indicator notes

Given the asymptomatic nature of STI, increased access to testing for the priority population groups would reach those with STI who would otherwise remain undetected. Early diagnosis and treatment of maternal syphilis improves health outcomes for the foetus or baby. Given the severity of outcomes associated with syphilis during pregnancy, the Australian Government Department of Health recommends routine testing for syphilis at the first antenatal contact. Victoria released a Chief Health Officer advisory highlighting this message as well as the importance of testing at 28 to 38 weeks, and again at delivery, to mitigate the risk of congenital syphilis.

Current guidelines recommend retesting people diagnosed with gonorrhoea 3 months after diagnosis due to the risk of reinfection. Monitoring of treatment of syphilis requires repeat testing at 3 and 6 months. Uptake of re-testing will be assessed through ACCESS.

The numerator and denominator of STI testing indicators for both GBM and young people will be obtained from the ACCESS clinical data. However, the resulting testing rates may not show the actual coverage in Victoria due to a difference in testing patterns between health facilities within the ACCESS network and those outside this network. The testing practice in the ACCESS network may not be similar to other health facilities in Victoria because ACCESS represents more people at high-risk of STI who require more frequent testing as part of routine sexual health care. For instance, those who receive PrEP for HIV in the ACCESS network may be encouraged to get tested for STI. To improve representativeness outside of high caseload services, ACCESS is continuing to recruit services participating in the expanding Victorian Sexual Health Network coordinated by the Melbourne Sexual Health Centre.

Reporting against indicators

20. Proportion of individuals receiving any STI testing in a calendar year

Component	Description	Source	Custodian	Availability
Numerator	Number of individuals who had a chlamydia, gonorrhoea or syphilis test at least once in the calendar year	ACCESS	Burnet Institute	Annually
Denominator	Number of people attending a clinical service in ACCESS in the calendar year	ACCESS	Burnet Institute	Annually

21. Proportion of GBM who received complete STI testing in a calendar year

Component	Description	Source	Custodian	Availability
Numerator	Number of GBM who received chlamydia, gonorrhoea and syphilis test at least once in the calendar year	ACCESS	Burnet Institute	Annually
Denominator	Number of GBM attending a clinical service in ACCESS in the calendar year	ACCESS	Burnet Institute	Annually

72. Proportion of GBM retested for STI within 3 months

Component	Description	Source	Custodian	Availability
Numerator	Number of GBM whose prior test was within 3 months	ACCESS	Burnet Institute	Annually
Denominator	Number of GBM tested for chlamydia, gonorrhoea and/or syphilis in ACCESS in the calendar year	ACCESS	Burnet Institute	Annually

Focus Area 3: Treat and care

Goals

- **Victorians with an STI will have access to best practice evidence-based treatment and care**
- **The morbidity and mortality associated with STI among Victorians is minimised**

Objectives (by 2030):

- Victorians with an STI receive the treatment and care they need
- Appropriate treatment in accordance with clinical guidelines reduces the risks of AMR
- Sexual partners of people diagnosed with an STI are aware, diagnosed and treated
- Victorians can easily access non-stigmatising, non-judgmental and culturally appropriate STI treatment and care in local primary and community health settings
- Treatment and care services meet the needs of priority populations through a process of co-design with communities, with effective referral pathways between primary, community and specialist care services
- Victorians living with or at greater risk of STI are aware of the long-term effects of untreated infections and know how to access appropriate treatment and support.

Indicators:

- Proportion of individuals retested for an STI within 4 months after diagnosis with an STI
- Number of notified gonorrhoea cases with high levels of resistance to ceftriaxone or azithromycin

Indicator notes

National data suggest that although a very high proportion of people diagnosed with an STI receive treatment, the majority of STI remain undiagnosed and therefore without the opportunity for treatment. Continued measurement of screening uptake will be essential to ensuring people with STI have access to treatment and care services (see Focus area 2: Test), as is assessment of the incidence of adverse outcomes due to untreated STI.

ACCESS can provide data on the individual follow-up testing and reinfections after being diagnosed and/or treated for an STI. Re-testing according to guidelines provide a marker of appropriate management. A reduction in reinfections over time could demonstrate effective management of infections and successful partner notification, testing and treatment.

Antimicrobial resistance also presents a threat to the ease with which gonorrhoea can be treated. Control of transmission of treatment resistant gonorrhoea is essential.

Reporting against indicators

22. Proportion of individuals retested for an STI within 4 months after diagnosis with an STI

Component	Description	Source	Custodian	Availability
Numerator	Number of individuals retested for chlamydia, gonorrhoea or	ACCESS	Burnet Institute	Annually

Component	Description	Source	Custodian	Availability
	syphilis 4 months after initial diagnosis in a calendar year			
Denominator	Number of individuals diagnosed with chlamydia, gonorrhoea or syphilis in a calendar year	ACCESS	Burnet Institute	Annually

23. Number of notified gonorrhoea cases with high levels of resistance to ceftriaxone or azithromycin

Component	Description	Source	Custodian	Availability
Single measure	Number of notified gonorrhoea cases highly resistant to Ceftriaxone	PHESS	DH	Quarterly
Single measure	Number of notified gonorrhoea cases with decreased susceptibility to Ceftriaxone	PHESS	DH	Quarterly
Single measure	Number of notified gonorrhoea cases with high level resistance to Azithromycin	PHESS	DH	Quarterly