



Australian Government
Department of Health and Ageing

THIRD
NATIONAL

Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections

STRATEGY
2010–2013



Third National
Aboriginal and Torres Strait Islander
Blood Borne Viruses and
Sexually Transmissible Infections
Strategy

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Acronyms

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
BBV	blood borne viruses
COAG	Council of Australian Governments
HPV	human papillomavirus
HSV	herpes simplex virus
NAAT	nucleic acid amplification tests
NACCHO	National Aboriginal Community Controlled Health Organisation
NSPs	needle and syringe programs
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PNG	Papua New Guinea
STI	sexually transmissible infections
WHO	World Health Organization

1. Background

This is the third national Aboriginal and Torres Strait Islander strategy dealing with blood borne viruses (BBVs) and sexually transmissible infections (STIs) to be adopted in Australia. It is one of a suite of five strategies aiming to reduce the transmission of STIs and BBVs, and the morbidity, mortality and personal and social impacts they cause. The relationship of the Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013 (this strategy) to the other four is detailed in section 1.2.

1.1 Roles and responsibilities of parties to this strategy

While governments are the formal parties to this document, a partnership approach has been central to the development of this strategy. This has included significant consultation with, and input from, community organisations, researchers, clinicians and health sector workforce organisations. A number of people who contributed are members, or representative members, of the advisory committees detailed further below.

The priority actions identified in this strategy will be progressed through a continuation of this partnership between governments and the community sector, representing people with the infections and their communities, researchers, clinicians and health sector workforce organisations.

Leadership is provided by the Australian Government which works through the Australian Health Ministers' Conference and its sub-committees to facilitate national policy formulation and coordination. The Blood Borne Virus and Sexually Transmissible Infections Sub-Committee of the Australian Population Health Development Principal Committee includes representatives of all governments as well as community based organisations. It provides expert advice to health ministers through the principal committee and the Australian Health Ministers' Advisory Council.

The Australian Government further seeks advice from the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections.

These groups will work in the context of funding arrangements for the health system, reshaping existing policies and programs or extending them where possible. These funding arrangements are provided jointly by the Commonwealth and the states and territories under the National Healthcare Agreement, which is a Schedule to the Council of Australian Governments (COAG) Intergovernmental Agreement on Federal Financial Relations (which came into effect on 1 January 2009). Related national partnership agreements provide the broad basis for funding reform in the Australian health system. The partnerships relevant to these strategies include the Indigenous Early Childhood Development Partnership and the National Essential Vaccines Partnership.

The Australian Government also funds community and professional organisations, and program delivery organisations and research centres to engage with, and build a knowledge base for, communities affected by BBVs and STIs—to put effective responses in place. The involvement of these organisations and research centres helped develop the overall response to these health challenges.

1.2 Relationship to other strategies

This strategy is one of a suite of five strategies aiming to reduce the transmission of STIs and BBVs in Australia, and the morbidity, mortality and personal and social impacts they cause. The five strategies, which cover the period 2010–13, are the:

- Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy (this strategy)
- Sixth National HIV Strategy
- National Hepatitis B Strategy

- Second National Sexually Transmissible Infections Strategy
- Third National Hepatitis C Strategy.

While the last four strategies listed focus on individual infections, this one focuses on the combined health impact these infections have on Aboriginal and Torres Strait Islander peoples in Australia. Despite their specific focus, each strategy shares common structural elements. This is designed to support a coordinated effort and pinpoint common concerns. The shared structural elements are:

- guiding principles (Chapter 4 in each strategy)
- priority populations (Chapter 5)
- similar priority action areas (Chapter 6)
- issues around surveillance, research and work force development (later chapters).

1.3 Blood borne viruses and sexually transmissible infections among Aboriginal and Torres Strait Islander peoples in Australia

Aboriginal and Torres Strait Islander communities continue to face significant public health issues and challenges around BBVs and STIs including:

- sustained and unacceptably high rates of bacterial STIs
- the rate of acquisition of HIV and viral hepatitis through injecting drug use
- continued new HIV infections among men who have sex with men.

Exacerbating these challenges is that many communities lack access to culturally appropriate treatment, care and support through primary healthcare services. There are also significant gaps in the workforce to adequately deal

with this reality. This strategy has been developed based on the best available national and international evidence to address these issues.

For the purposes of this strategy:

- bacterial STIs refer to the infections of *chlamydia trachomatis* (chlamydia), infectious syphilis and gonorrhoea
- other STIs include trichomoniasis, HIV and hepatitis B
- BBVs refer to HIV, hepatitis B and C
- Hepatitis B and HIV are recognised as both STIs and BBVs.

1.3.1 *Aboriginal and Torres Strait Islander population*

Australian Bureau of Statistics (ABS)¹ data indicate that in 2006 there were just over half a million Aboriginal and Torres Strait Islander peoples living in Australia, representing 2.5% of the total population. More than a quarter reside in remote or very remote areas, compared with 2.3% of the non-indigenous population. Nearly one third (30%) of the Northern Territory population is Aboriginal and Torres Strait Islander peoples, followed by less than 4% in other states and territories (Table 1).

Table 1: Aboriginal and Torres Strait Islander population in Australia in 2006, national/state/territory (2006 ABS Census)

National/ state/ territory	Aboriginal and Torres Strait Islander population	Total population	% of total population who are Aboriginal and Torres Strait Islanders	
			By jurisdiction	National
Australia	516 810	21 017 222		2.5
NT	64 005	214 975	29.8	12.4
Tas.	18 415	493 341	3.7	3.6
Qld	144 885	4 182 062	3.5	28.0
WA	70 966	2 105 783	3.4	13.7
NSW	152 685	6 889 072	2.2	29.5
SA	28 055	1 584 513	1.8	5.4
ACT	4 282	339 865	1.3	0.8
Vic.	33 517	5 205 216	0.6	6.5

There are significant differences in the age distributions of the Australian population by Aboriginal and Torres Strait Islander status. The 2006 ABS Census data report a much younger population profile for Aboriginal and Torres Strait Islander peoples, with around 40% aged less than 15 years compared with 19% of the non-indigenous population. People aged 15 to 24 years comprised 19% of the Aboriginal and Torres Strait Islander population compared with 14% in the non-indigenous population. Furthermore, the median age of Aboriginal and Torres Strait Islander peoples was 21 years compared with 37 years in the non-indigenous population. Recent figures from the ABS Census project that the Aboriginal and Torres

Strait Islander population will reach between 713 300 and 721 100 in 2021, from its level of almost 517 000 in 2006. The projected increase of almost 40 per cent in the population aged less than 15 years has implications for the sexual health and wellbeing of young Aboriginal and Torres Strait Islander peoples. STI and BBV health service planning and delivery must acknowledge these realities and respond accordingly.

1.3.2 National Aboriginal and Torres Strait Islander peoples health policy context

Under the Indigenous Early Childhood Development National Partnership, signed by the COAG in October 2008, the Australian Government committed \$107 million to states and territories to implement strategies for reducing the high rate of early pregnancy in the Aboriginal and Torres Strait Islander population, and to educate young people on sexual and reproductive health issues. This includes aiming to deliver targeted sexual and reproductive health programs for young Aboriginal and Torres Strait Islander peoples (including those disengaged from school) and improve access to, and use of, antenatal care for young mothers.

The Indigenous Early Childhood Development National Partnership complements the objectives of this strategy for young people.

In a broader sense, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) aims to improve the health status of Aboriginal and Torres Strait Islander peoples. OATSIH is a division of the Australian Government Department of Health and Ageing. It works in collaboration with Aboriginal and Torres Strait Islander communities, mainstream health providers and Aboriginal Community Controlled Health Services (ACCHS) to achieve better health outcomes. This includes funding primary healthcare, substance use services and population health programs. OATSIH supports improved management of the impact of BBVs and STIs on Aboriginal and Torres Strait Islander peoples. It has so far contributed approximately \$10 to \$15 million per year for activities such as the employment of more than 100

Aboriginal and Torres Strait Islander sexual health workers, investment in new pilot programs for increased education and awareness, and support for testing programs. Future OATSIH investment will be guided by the objectives of this strategy and epidemiological trends.

The partnership with and participation of ACCHS, through the provision of culturally appropriate healthcare services to Aboriginal and Torres Strait Islander communities, is acknowledged as an essential factor in the success of this strategy.

1.3.3 Epidemiology of sexually transmissible infections and blood borne viruses

Sexually transmissible infections

While chlamydia, gonorrhoea, syphilis and trichomoniasis are curable STIs, they are often asymptomatic in those affected and can lead to serious complications if untreated for long periods².

The consequences of long-term untreated genital chlamydia infection include adverse pregnancy outcomes such as premature labour and birth, low birth weight, intrauterine growth restriction, postpartum endometritis, and neonatal infections such as infectious conjunctivitis, nasopharyngeal infections and pneumonia.

The consequences of long-term untreated gonorrhoea include disseminated infection and illnesses such as polyarthritis and septicaemia.

The consequences of long-term untreated syphilis can give rise to obstetric complications and congenital disease and, where untreated, can be responsible for neurological and systemic late manifestations.

These infections can create discomfort and shame for affected individuals, their families and communities. They can also play a role in relationship

breakdown and cultural dysfunction. Furthermore, untreated STIs have the potential to enhance the sexual transmissibility of HIV infection, which so far has remained a confined epidemic in Aboriginal and Torres Strait Islander communities.

The unacceptably high rates of STIs reported in young people from many Aboriginal and Torres Strait Islander communities is compelling evidence of the need to engage in sexual health literacy and STI prevention education. In 2008, 11% of all chlamydia notifications reported from the Northern Territory, South Australia, Tasmania, Victoria and Western Australia occurred among Aboriginal and Torres Strait Islander peoples, despite representing 2.3% of the total population in these jurisdictions. Similarly 55% of all gonorrhoea notifications in 2008 occurred among Aboriginal and Torres Strait Islander peoples in the Northern Territory, South Australia, Victoria, Queensland and Western Australia. Furthermore, 14 per cent (183 cases) of all infectious syphilis notifications in Australia in 2008 occurred among Aboriginal and Torres Strait Islander peoples compared with 1111 cases among non-indigenous people.

Along with other STIs, Aboriginal and Torres Strait Islander communities may be vulnerable to herpes simplex virus (HSV), particularly HSV-2. A recent national seroprevalence study noted higher rates of HSV-2 among the Aboriginal and Torres Strait Islander population (18%) compared with the non-indigenous population (12%). Indeed, the incidence of HSV-2 in some Aboriginal and Torres Strait Islander communities has been found to be considerably higher. HSV-2 is an important factor for increased potential transmission of HIV.

The age-specific standardised rate of diagnosis of infectious syphilis in 2008 was 34 per 100 000 in the Aboriginal and Torres Strait Islander population, compared with six cases per 100 000 in the non-indigenous population. Syphilis in Aboriginal and Torres Strait Islander peoples is most frequently evidenced in younger people, including women of child-bearing age. Remote and very remote communities continue to experience significantly higher rates of chlamydia, gonorrhoea and infectious syphilis compared

with regional and metropolitan communities across Australia.³ There are suggestions that trichomoniasis is endemic in some populations and associated with adverse pregnancy outcomes. Hepatitis B remains a significant health burden in Aboriginal and Torres Strait Islander communities.

Blood borne viruses

Between 2004 and 2008, population rates for HIV diagnosis among the Aboriginal and Torres Strait Islander population (3.8 per 100 000) were similar to those in the non-indigenous population (4.8 per 100 000). However, available data suggest that differences exist in the prevailing modes of HIV transmission for newly diagnosed HIV infection between the two populations. Between 2004 and 2008 the most frequently reported mode of transmission among non-indigenous, Australian-born, was sexual contact between men (79%), followed by heterosexual contact (13%). Injecting drug use was the sole exposure among 3% of cases. Over the same time period, the most frequently reported route of HIV transmission among Aboriginal and Torres Strait Islander peoples was sexual contact between men (54%), followed by heterosexual transmission (23%) and injecting drug use (22%).⁴

It is estimated that between 13 000 and 22 000 Aboriginal and Torres Strait Islander peoples are living with hepatitis C in Australia, representing 4% of all Indigenous Australians, compared with 1% of non-indigenous Australians. In 2008, 11 302 cases of hepatitis C were diagnosed in Australia. Of these, 626 (5.5%) occurred among Aboriginal and Torres Strait Islander peoples and 4115 (36%) among non-indigenous people. Indigenous status was not known in 6561 (58%) of notified cases.⁵

It should also be noted that injecting drug use is a risk factor for hepatitis B infection, although the route of transmission is not systematically recorded. Of the total newly acquired hepatitis B infections in 2008, 9% occurred among Aboriginal and Torres Strait Islander peoples and 73% among non-indigenous people. The Indigenous status was not known in 9% of cases.

In 2008, the diagnosis rate for newly acquired hepatitis B infection in the Aboriginal and Torres Strait Islander population was between one and five times higher than in the non-indigenous population in New South Wales, the Northern Territory, South Australia, Victoria, Queensland and Western Australia. In the non-indigenous population, the rate of diagnosis of newly acquired hepatitis B infection remained low in all states and territories. In 2008, the rates of diagnosis of newly acquired hepatitis B infection in the Aboriginal and Torres Strait Islander population in the age group 20 to 49 years were 4.73 and 4.5 times that of non-indigenous males and females respectively. In 2007, 2.5% of the Australian population identified as Aboriginal and Torres Strait Islander but accounted for an estimated 16% of the Australian population living with chronic hepatitis B infection. Estimated prevalence of chronic hepatitis B infection in the Aboriginal and Torres Strait Islander population ranged from 2% for urban to 8% for rural. Remote Aboriginal and Torres Strait Islander communities are likely to have even higher prevalence rates. Vaccination is a primary measure to control the transmission of hepatitis B and routine screening of people with chronic hepatitis B should feature in ongoing management.

2. Goal

The goal of the Third National Aboriginal and Torres Strait Islander Sexually Transmissible Infections and Blood Borne Viruses Strategy 2010–2013 is to reduce the transmission of, and morbidity and mortality caused by, STIs and BBVs and to minimise the personal and social impact of these infections.

3. Objectives and indicators

This section details the objectives and indicators that will be used to monitor progress. Indicators are measurable targets that apply to the related objective.

The primary indicators are those that have been agreed under the National Healthcare Agreement. These have been specified and will be regularly reported on during the life of the agreement. Additional indicators have been included for the more specific objectives relevant to this strategy. Further work will be undertaken during the implementation phase to develop a surveillance and monitoring plan. This will include further work on specifications for the indicators, and development of an agreed process for reporting on them. In some circumstances further data development may also be needed.

GOAL	OBJECTIVE	INDICATOR ⁽¹⁾
To reduce the transmission of, and morbidity and mortality caused by, STIs and BBVs, and to minimise the personal and social impact of these infections in Aboriginal and Torres Strait Islander communities.	Reduce hepatitis B infections	Coverage of hepatitis B vaccination among Aboriginal and Torres Strait Islander children and adolescents (Essential Vaccines National Partnership Agreement)
	Work towards eliminating infectious syphilis in Aboriginal and Torres Strait Islander peoples.	Incidence of infectious syphilis in Aboriginal and Torres Strait Islander peoples (National Healthcare Agreement)
	Decrease the proportion of HIV and hepatitis C infections caused by injecting drug use	Proportion of newly diagnosed HIV and newly diagnosed hepatitis C infection caused by injecting drug use in Aboriginal and Torres Strait Islander peoples

GOAL	OBJECTIVE	INDICATOR ⁽¹⁾
To reduce the transmission of, and morbidity and mortality caused by, STIs and BBVs, and to minimise the personal and social impact of these infections in Aboriginal and Torres Strait Islander communities.	Increase the level of systematic testing and treatment of sexually active 15 to 30-year-olds, noting that testing will likely increase the notifications of bacterial STIs in the short term—before a reduction in the long term	<p>Proportion of young Aboriginal and Torres Strait Islander peoples who report having had an STI test in the previous 12 months</p> <p>Proportion of Aboriginal and Torres Strait Islander young people receiving a chlamydia and gonorrhoea test in the previous 12 months</p>
	Improve Aboriginal and Torres Strait Islander young people's knowledge of STIs and BBVs	Proportion of Aboriginal and Torres Strait Islander peoples giving correct answers to knowledge questions on STIs and BBVs
	Increase the number of Aboriginal and Torres Strait Islander peoples receiving treatment for HIV, hepatitis C and hepatitis B	Proportion of Aboriginal and Torres Strait Islander peoples with HIV receiving antiretroviral treatment
		<p>Proportion of Aboriginal and Torres Strait Islander peoples with chronic hepatitis C who are dispensed drugs for hepatitis C infection through the Highly Specialised Drugs Program in the previous 12 months</p> <p>Proportion of Aboriginal and Torres Strait Islander peoples with chronic hepatitis B who are dispensed drugs for hepatitis B infection through the Highly Specialised Drugs Program in the previous 12 months</p>

GOAL	OBJECTIVE	INDICATOR ⁽¹⁾
To reduce the transmission of, and morbidity and mortality caused by, STIs and BBVs, and to minimise the personal and social impact of these infections in Aboriginal and Torres Strait Islander communities.	Implement a national accreditation scheme for Aboriginal and Torres Strait Islander sexual health workers, under COAG's National Registration Program	Number of Aboriginal and Torres Strait Islander peoples registered under the National Registration Program

(1) In areas where data are available

4. Guiding principles

The guiding principles informing this strategy are drawn from Australia's efforts over time to respond to the challenges, threats and impacts of HIV, STIs and hepatitis C. Strategies addressing each of these diseases, including as they relate to Aboriginal and Torres Strait Islander peoples, seek to minimise their transmission and impacts on individuals and communities and establish directions based on their unique epidemiology, natural history and public health imperatives.

The guiding principles underpinning Australia's response to these diseases in this strategy, and in the individual strategies on national hepatitis B, hepatitis C, HIV and STIs, are:

- The transmission of HIV, STIs and hepatitis C can be prevented by adopting and maintaining protective behaviours. Vaccination is the most effective means of preventing the transmission of hepatitis B. Vaccination, education and prevention programs, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures. Individuals and communities have a mutual responsibility to prevent themselves and others from becoming infected.
- The Ottawa Charter for Health Promotion⁶ provides the framework for effective HIV, STI and viral hepatitis health promotion action and facilitates the:
 - ~ active participation of affected communities and individuals, including peer education and community ownership, to increase their influence over the determinants of their health
 - ~ formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights as this protects those who are vulnerable or marginalised, promotes confidence in the system and secures support for initiatives.

- Harm reduction principles underpin effective measures to prevent transmission of HIV and viral hepatitis, including through the needle and syringe programs (NSPs) and drug treatment programs.
- People with HIV, STIs and viral hepatitis have a right to participate in the community without experience of stigma or discrimination, and have the same rights to comprehensive and appropriate healthcare as do other members of the community (including the right to the confidential and sensitive handling of their personal and medical information).
- An effective partnership of governments, affected communities, researchers and health professionals is to be characterised by consultation, cooperative effort, respectful discussion and action to achieve this strategy's goal. This includes:
 - ~ non-partisan support for the pragmatic social policy measures needed to control HIV, STIs and viral hepatitis
 - ~ recognition that those living with, and at risk of, infection are experts in their own experience and are therefore best placed to inform efforts that address their own education and support needs
 - ~ timely and quality research and surveillance to provide the necessary evidence base for action
 - ~ a skilled and supported workforce
 - ~ leadership from the Australian Government, but also the full cooperative efforts of all members of the partnership struck to implement this strategy's agreed directions and early adoption of a framework for monitoring and evaluation.

This strategy is unique in that it also recognises the following five main principles:

1. The priority and ongoing action areas in this strategy have been articulated to guide resource allocation in the area of Aboriginal and Torres Strait Islander health.
2. The role that ACCHS can play in the delivery of health programs in this area is recognised. Services should be supported in enabling outcomes and targets identified in this strategy.
3. Close family ties, kinships and strengths of cultural and social organisation exist within Aboriginal and Torres Strait Islander communities. Healthcare services are often carried out in an environment where there are significant social and cultural obligations and economic burdens occurring.
4. The importance of choice between healthcare providers for Aboriginal and Torres Strait Islander peoples is recognised. Wherever possible, government services, private general practitioners and ACCHS should work together to ensure Aboriginal and Torres Strait Islander peoples have options for confidential sexual healthcare and BBV healthcare.
5. The following aspirations in Aboriginal and Torres Strait Islander peoples' health and wellbeing is recognised:
 - ~ enjoyment and control of consensual sexual (and potentially) reproductive behaviour in accordance with cultural values, kinship practices and individual ethics
 - ~ freedom from shame, guilt, myths about sexual orientation and sexual behavioural choices that do not harm individuals or their sexual partners

- ~ freedom from infectious diseases that are preventable and treatable, and that may interfere with sexual life
- ~ freedom from harms that may interfere with the sexual health and emotional wellbeing of individuals.

5. Priority populations

This strategy covers six main priority Aboriginal and Torres Strait Islander population groups:

1. people aged 15 to 30 years
2. people who inject drugs
3. people in adult and juvenile corrections settings
4. gay men, other men who have sex with men, sisters and transgender people
5. people living with HIV and viral hepatitis
6. people living in the Torres Strait Island region.

5.1 Aboriginal and Torres Strait Islander peoples aged 15 to 30 years

Aboriginal and Torres Strait Islander peoples aged 15 to 30 years who are sexually active are considered a priority population because they:

- experience higher STI rates than non-indigenous people of similar ages
- may have levels of health education and health literacy that are lower than that of older community members
- may engage in risk behaviours because they lack the maturity to negotiate safe sex, may not recognise their own vulnerability and may not value their sexual health
- have high fertility rates
- experience barriers to accessing health services.

5.2 Aboriginal and Torres Strait Islander peoples who inject drugs

Information is limited on the number of Aboriginal and Torres Strait Islander peoples who inject drugs.⁷ Different sources point to evidence of increasing injecting drug use within some communities and associated increased risk of transmission of HIV and hepatitis C. These findings require immediate attention.

The factors that continue to place those who inject drugs at risk include:

- lack of access to culturally appropriate BBV prevention education and primary health services, particularly in rural and remote regions
- discrimination and stigmatisation associated with injecting drug use, within and outside of communities
- concerns about confidentiality in service provision
- lack of support for, and the capacity to address, the large number of other health issues, and more pressing and immediate social and legal concerns, which prevent action to confront BBV-related health issues.

5.3 Aboriginal and Torres Strait Islander peoples in adult and juvenile corrections settings

The number of Aboriginal and Torres Strait Islander peoples in adult and juvenile corrections settings continues to increase despite the recommendations of the 1991 Royal Commission into Aboriginal Deaths in Custody. Of the total prisoner population on 30 June 2008, for example, 7% were female and 24% were Aboriginal and Torres Strait Islander peoples.⁸ In June 2004, there were 785 young people in juvenile detention centres around Australia and 45 per cent of these were Aboriginal and Torres Strait Islander peoples.⁹

Aboriginal and Torres Strait Islander prisoners are at increased risk of BBV transmission (especially viral hepatitis), physical violence, sexual assault and isolation. Limited access to confidential and culturally appropriate health services exacerbates these problems. Even upon release, numerous challenges that can prevent health and wellbeing remain. These include stigmatisation, social and cultural exclusion, and inadequate access to support networks and health and social services.

5.4 Aboriginal and Torres Strait Islander gay men, other men who have sex with men, sistergirls and transgender people

A range of factors continue to place Aboriginal and Torres Strait Islander gay men, other men who have sex with men, sistergirls and transgender people at particular risk of infection, including:

- barriers to accessing some health services, including testing services, for reasons of actual or perceived homophobia, racism, discrimination and cultural insensitivity
- high levels of population mobility, including movement between communities and between urban, rural and remote settings
- low levels of HIV awareness, including prevention, treatment and care options
- lack of acceptance of homosexuality and transgender status within some Aboriginal and Torres Strait Islander communities
- alcohol and other drug use
- where there is a culture of violence towards Aboriginal and Torres Strait Islander gay men and sistergirls.

5.5 Aboriginal and Torres Strait Islander peoples living with HIV and viral hepatitis

In Australia approximately 300 Aboriginal and Torres Strait Islander peoples are diagnosed with HIV, approximately 28 000 with chronic hepatitis B and approximately 16 000 with chronic hepatitis C. The diversity of the lived experience of Aboriginal and Torres Strait Islander peoples living with HIV and viral hepatitis is noted. Accordingly, the importance of providing the best possible advocacy, support and information dissemination to Aboriginal and Torres Strait Islander peoples living with HIV and viral hepatitis is supported. The role that they play in shaping Australia's overall response is recognised.

Aboriginal and Torres Strait Islander peoples living with BBVs, their partners, carers, friends, families and children have complex needs, including the right to confidentiality of their health status. Fear and misunderstanding about BBVs exist in many communities, often resulting in social discrimination and isolation. In such circumstances, the potential for self harm through alcohol and drug use, as well as other behaviours, is present and consideration needs to be given to co-morbidities such as mental health problems.

5.6 People living in the Torres Strait Island region

People living in the Torres Strait Island region are a priority population in this strategy. There is a continuing potential risk of HIV entering communities in the region because of the proximity, cultural, familial and trade connections to PNG, which now has the Pacific region's highest rate of HIV/AIDS.

Under the treaty arrangements Australia has with PNG, the importance of protecting the traditional way of life and the livelihood of Torres Strait Islanders and Papua New Guineans living in the coastal area adjacent to Torres Strait is recognised and protocols exist for the conduct of the relationship between Australia and PNG in the region. The movement of

people under the treaty arrangements has steadily increased in recent years. The three main health-related concerns resulting from this are:

1. increases in communicable diseases resulting from the free movement of traditional visitors within and around the area known as the protected zone
2. the pressure on healthcare facilities in the Torres Strait, resulting from such movement
3. the limited access to, and poor standards of, health service facilities in PNG's Western Province.

6. Priority action areas

Ample population-based and disease-based evidence supports the four new priority action areas and six ongoing action areas to be implemented over the life of this strategy. The potential impact of Aboriginal and Torres Strait Islander communities failing to act could be enormous. Implementation requires the commitment of national, state and territory governments and concerted effort by health services, both Aboriginal and Torres Strait Islander specific and mainstream.

6.1 Testing and treatment of sexually transmissible infections

Bacterial STIs (gonorrhoea, chlamydia and syphilis) are preventable, easily detected and curable. Aboriginal and Torres Strait Islander young people aged under 30 years experience much higher rates of these diseases than do non-indigenous people in the same age groups. These higher rates have major implications when infections are undiagnosed, especially for young women's reproductive health (including pregnancy). More is known about rates of infection among remote and very remote communities yet little is known among Aboriginal and Torres Strait Islander young people living in more urban settings, particularly for gonorrhoea and chlamydia, because accurate and complete data do not exist in all jurisdictions on Aboriginal and Torres Strait Islander status.

While there has been some success in reducing infectious syphilis over recent years in Aboriginal and Torres Strait Islander communities (such as downward trends in the Northern Territory, Queensland and South Australia), a greater national focus is required to work towards eliminating infectious syphilis in this population. Given the diversity within Aboriginal and Torres Strait Islander communities and service settings, a jurisdiction-led response that strengthens comprehensive sexual health programs in the primary care setting will be developed for communities affected by syphilis. This response

may include strategies to be detailed in implementation plans to improve syphilis testing, contact tracing and follow up, as well as health-provider and community education.

In some Aboriginal and Torres Strait Islander populations, data suggest that trichomonal infections are endemic. While it is usually asymptomatic in men, this readily treatable infection causes under-reported, localised, genital symptoms in women and is associated with adverse pregnancy outcomes and increased risk of HIV transmission. The development of testing treatment guidelines for trichomonas based on a literature review is supported. Targeted interventions will also be considered to reduce the burden of this infection on Aboriginal and Torres Strait Islander women in remote communities. The literature review will also make recommendations on the development of the evidence base around this infection for Aboriginal and Torres Strait Islander women living in urban areas.

6.1.1 Annual, routine and systematic testing programs

Many STIs are asymptomatic and there are many difficulties associated with partner notification. High rates of STI infection are caused by factors such as: health services being accessed less often by younger people than older people; lower health literacy among this population; and residency in hyper-endemic STI communities.

To address this disparity in health outcomes among young Aboriginal and Torres Strait Islander peoples, the implementation of routine, systematic, annual bacterial STI tests of people aged 15 to 30 years is supported. Routine STI and BBV screening and vaccination for hepatitis A, hepatitis B and human papillomavirus (HPV) where indicated should also be conducted in prison and juvenile detention centres. Furthermore, where local epidemiology suggests high community prevalence, the program response should be flexible and the frequency of testing and the age group should be extended.

In addition, specific strategies are required to increase access to STI testing at least annually for those aged 15 to 19 years who are sexually active and

have high rates of STI infection. While it is acknowledged that STI testing is only one aspect of the comprehensive program required to reduce STI prevalence rates at population level, regular opportunistic and systematic testing of this younger age group annually is good public health practice. It is the main path towards appropriate treatment and prevention of complications as well as an important long-term preventive strategy.

6.1.2 Provider-initiated testing programs

Provider-initiated testing or screening for STIs has been an important initiative in sexual health activities for some Aboriginal and Torres Strait Islander communities. Testing or screening has been largely delivered through organised population-based programs in communities where prevalence rates of bacterial STI are considerably high. Scope exists for increasing activity in this area of testing and treating STIs among those aged 15 to 30 years. However it is important that screening not be a stand-alone strategy—regular opportunistic testing and follow up must occur concurrently to have an impact on STI prevalence rates.

6.1.3 Partner notification

Partner notification involves finding, informing and treating the sexual partner of an individual with a STI. This is referred to as 'contact tracing'. The objective is to reduce the transmission of infection through early detection and treatment and to promote behaviour change.

The need to investigate the models currently available for health services and clinicians on partner notification in Aboriginal and Torres Strait Islander communities is recognised. Although seen as an important task of STI testing, little information is available on the models that have worked in these communities. Ways to support partner notification when the individual with an STI or their partner is in prison or juvenile detention also need to be explored.

Different models have been explored using patient-initiated treatment, including the use of pharmacies, email or SMS. The process of partner notification should be confidential and undertaken with appropriate and culturally sensitive support for both the index case and partners. Cultural sensitivity is particularly important when working with Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds.

6.1.4 Testing and treatment of Aboriginal and Torres Strait Islander sex workers

Despite the occupational risks, the incidence of STIs in sex workers in Australia is among the lowest in the world. This has largely been through the establishment of safe-sex as a norm, the availability of safe sex equipment and community-driven health promotion and peer-based interventions. Sustaining this achievement will require continuing support of prevention initiatives to minimise transmission of STIs and BBVs.

Sex workers are a priority population because of their significantly higher number of sexual encounters and the higher potential for transmission of STIs. The risk increases for street-based sex workers (and people engaging in sex for favours) who have less opportunity to control the occupation health and safety conditions of their work and who are therefore at increased risk of BBV and STI transmission.

Priority actions for testing and treating sexually transmissible infections

- Build the capacity of primary healthcare services, the ACCHS, National Aboriginal Community Controlled Health Organisation (NACCHO) and general practitioners to initiate testing, diagnosing, treating and engaging in culturally appropriate partner notification strategies, particularly among those aged 15 to 30 years.

- Investigate models that normalise health-seeking behaviour and specifically reach those aged 15 to 19 years, particularly in high prevalence communities. Models could include:
 - ~ specific youth health programs within primary healthcare services
 - ~ active outreach models
 - ~ uptake of the Adult Health Check and other such initiatives.
- Integrate provider-initiated STI testing and treatment into routine health checks provided in primary care.
- Improve systematic, integrated surveillance systems using existing patient information management systems that can report on the proportions of people aged 15 to 30 years who are offered regular STI testing and treatment.
- Respond to high rates of syphilis in Aboriginal and Torres Strait Islander communities through greater emphasis on comprehensive sexual health programs in the primary care setting (that may include syphilis testing, treatment, contact tracing and follow up), as well as healthcare provider and community education.
- Improve partner notification initiatives in communities that encompass cultural and social considerations.
- Encourage the development of testing, treatment and care guidelines for specific target groups:
 - ~ those aged 15 to 30 years
 - ~ those in custodial settings
 - ~ sex workers
 - ~ gay men, other men who have sex with men, sistergirls and transgender people.

- Conduct a systematic review of the evidence base around trichomonas vaginalis infection to develop actions to deal with it.

In addition, it is important to ensure that STI testing among those aged 15 to 30 years occurs. The engagement of community leaders, including those who have governance responsibilities with ACCHSs, is also an important strategy to ensure that testing among those aged 15 to 30 years occurs.

This is seen as an important initiative to ensure that regular STI testing is best practice in STI control.

6.2 Primary prevention of blood borne viruses attributable to injecting drug use

The prevailing modes of transmission of BBVs may vary between the Aboriginal and Torres Strait Islander population and the non-indigenous population. While existing data collection systems may be capable of quickly and reliably detecting changes in the mode of transmission, the numbers of new cases are not always high enough to draw conclusions at population level. However, the existence of risk factors for BBV transmission in the Aboriginal and Torres Strait Islander community means primary prevention remains important.

Successful primary prevention activities for Aboriginal and Torres Strait Islander peoples require a focus on both population level, and on behavioural change at individual level. This includes:

- increasing access for injecting drug users to NSPs
- involving injecting peers to prevent transmission of BBVs; increasing appropriate drug education and health promotion programs within communities
- delaying or preventing the onset of drug use

- encouraging those who are dependent on recreational drugs to seek treatment
- ensuring that Aboriginal and Torres Strait Islander communities participate in, develop ownership of and recognise the need for all of these programs.

6.2.1 Needle and syringe programs in Aboriginal and Torres Strait Islander communities

The coverage, availability and accessibility of new injecting equipment for Aboriginal and Torres Strait Islander peoples who inject drugs is an important factor in the transmission of BBVs. Improving access to and the availability of clean injecting equipment through mainstream NSPs and continued support and encouragement of ACCHS to distribute clean injecting equipment is therefore an important continuing priority action for this strategy. The prevalence of hepatitis C infection is unevenly geographically distributed in the Aboriginal and Torres Strait Islander population.¹⁰ Mapping injecting patterns and NSP services are important related activities for ensuring that NSP services expand in communities where injecting drug use is most prevalent.

6.2.2 Infection control in Australian custodial settings

Barriers to accessing prevention in prison are of particular concern for Aboriginal and Torres Strait Islander peoples. The correctional environment often has impediments to best practice BBV prevention. These impediments are exacerbated by the higher levels of co-infection with HIV and hepatitis C in custodial settings. The prevalence of HIV remains low, but the potential exists for it to increase, particularly as the prison population increases (national surveillance figures reveal that the rates of HIV infection among new prison entrants has increased over the past three to four years¹¹). Effective HIV and other BBV prevention and health promotion require a whole-of-government approach for juvenile detention centres and adult prisons.

In this context, it is recognised that people in custodial settings are a priority population at risk of HIV, hepatitis B and hepatitis C infections, primarily through unsafe injecting practices, and that there are available and effective evidence based approaches to the prevention of blood borne infections in the context of injecting drug use.

Each state and territory has its own independent systems for police, courts, prisons and juvenile institutions. Health services are provided variously by health or justice jurisdictions and supplied directly, or contracted, by public and private custodial facilities. Australia's prison systems are relatively small and isolated from each other. This presents challenges for coordinating research and policy development, implementation, evaluation and education. However, these challenges have been overcome within the custodial environment to enable effective responses to a number of key public health issues including BBV and STI initiatives such as provision of condoms, access to bleach, provision of opioid pharmacotherapies, and the National Prison Entrants BBV & Risk Behaviour Survey.

Providing sterile injecting equipment in Australian prisons is controversial in some parts of the community, even though an increasing number of international jurisdictions have implemented this approach, or are actively contemplating doing so. To date there is no evidence of adverse outcomes associated with providing an NSP. A number of positive or beneficial outcomes have emerged from evaluated programs including: no documented increase in illicit or injecting drug use; significant reductions in equipment reusing and sharing; no documented attacks or violence in prisons; no documented seroconversion for HIV or hepatitis; and acceptance by staff and prisoners. In view of the well documented return on investment and the effectiveness of Australian community-based NSPs, it is appropriate throughout the life of this strategy for state and territory governments to identify opportunities for trialling this approach in Australian custodial settings. This is also supported by the international evidence demonstrating the effectiveness of prison NSPs.

In addition, it is essential that the full range of BBV and STI prevention strategies be maintained in Australian custodial settings, including:

- increasing the provision of, and access to, bleach and disinfectants where no safer alternatives are provided for decontaminating spills, surfaces or equipment
- easily accessible education and counselling—including peer education and support on HIV and STIs, hepatitis B, hepatitis C and injecting drug use—as a fundamental health promotion technique to support risk reduction practices
- increasing access to drug treatment programs, including opioid pharmacotherapy programs which have reduced BBV transmission in custodial settings, as well as detoxification and drug rehabilitation programs.

Strategies should also be explored for developing and promoting Australian infection control standards for tattooing and body art to further reduce the risk of BBV transmission in custodial settings.

6.2.3 *Peer educators*

Peer education is important because of the influence peer pressure and peer group behaviours have on individual decisions. Peer education is effective because peer educators can reach those who are not being reached by other means—they are also credible, trusted sources of information and support.¹² Peer education encompasses a broad range of activities, including providing information, developing education materials, and empowering people to take positive action in their own lives and within their communities and networks. Peer education is conducted in one-to-one and group settings.

Peer education in Aboriginal and Torres Strait Islander communities—intrinsic to any health promotion activity—must be based on the best evidence of what is effective. The highest population priorities for health promotion and

education in this strategy are those who are most at risk of acquiring HIV and hepatitis C.

Peer education has been fundamental to improving the distribution of injecting equipment and providing information to people with, or at risk of, hepatitis C infection. The range of peer education models requires further evidence to support their implementation within this vulnerable population in Australia, as there may be considerable variation in what works with whom and where.

Building the capacity to respond to the hepatitis C epidemic in Australia will require investment in training and support for peer educators, which should be accompanied by additional resources to strengthen, evaluate and promulgate good practice in peer education.¹³

6.2.4 Early detection of HIV and hepatitis C

Early detection is also important for diagnosing and assessing the prognosis for people with HIV and hepatitis C and for preventing transmission of disease. Incorporating testing based on risk (for example as part of an Adult Health Check in ACCHS and other primary healthcare facilities) is recommended as an important preventative measure to reduce transmission of BBVs. This applies also in juvenile justice and adult custodial settings. Increasing the ability of ACCHS to provide tertiary care through visiting specialists has improved the retention rate of clients accessing treatment for viral hepatitis in at least one ACCHS in Australia since 2006. This model should be assessed for further implementation in other settings.

The diagnostic event shapes how people with HIV and hepatitis C understand their infection. It is essential that diagnosis be handled sensitively and that everyone being tested receives information about hepatitis C treatment options and the support services available. The national HIV and hepatitis C testing policies provide a framework for these activities.

6.2.5 *Connecting related services*

Making connections between sexual health services and drug and alcohol services is important, particularly given the role of injecting drug use in the transmission of HIV and hepatitis C. Greater collaboration is required between these two sectors in developing and disseminating prevention messages, detecting infection and in referring people to access treatment for drug use and treatment for HIV and hepatitis C.

6.2.6 *Immunisation*

The high levels of hepatitis B infection demand that prevention in Aboriginal and Torres Strait Islander communities be improved. A safe, effective and inexpensive vaccine is recommended by the Australian Government for all infants at birth. The Aboriginal and Torres Strait Islander population has intermediate-to-high endemicity of hepatitis B infection, according to World Health Organization (WHO) standards and, thus, it is strongly recommended that all children be vaccinated at birth. It is also recommended that children born to mothers who have hepatitis B should receive a dose of hepatitis immunoglobulin at birth. Hepatitis B vaccination programs are cost effective and successful and should further serve to reduce levels among Aboriginal and Torres Strait Islander peoples.

The following recommendations from the National Hepatitis B Strategy 2010–2013 are supported:

- a national consistency in groups and communities eligible for funded vaccination with priority to communities at greatest risk of hepatitis B infection.
- monitoring hepatitis B vaccine uptake at a population level and among populations at greater risk of acute infection are supported.

This approach will prioritise the vaccination of Aboriginal and Torres Strait Islander peoples and their immediate family contacts.

6.2.7 Harm reduction

Harm reduction strategies are central to preventing HIV and viral hepatitis. Harm reduction underpins Australia's public health response to the transmission of HIV and other BBVs, particularly through injecting drug use. Public health measures should be designed to reduce the harm that drug use causes, both to individuals and the community. The objective is to reduce the transmission of disease, the personal and social impact and the loss of quality of life caused by ill health.

Priority actions in preventing blood borne viruses from injecting drug use

- Increase the coverage and accessibility of NSPs to Aboriginal and Torres Strait Islander communities, particularly in urban and regional areas where most injecting drug users are.
- Facilitate the provision of high-quality, timely, primary healthcare that will provide prevention, early detection, treatment and follow-up services for HIV, viral hepatitis, BBVs and STIs.
- Promote peer education-based models and outreach to reach marginalised groups.
- Encourage and support partnerships between ACCHS, peer-based drug user organisations, community-based and peak HIV and hepatitis C organisations, and research bodies in developing and delivering tailored harm reduction strategies; and between different health programs (e.g. drug and alcohol, mental health, sexual health, corrections) to ensure testing and treatment pathways are accessible.
- Strengthen evidence-based harm reduction approaches to BBV and STIs in custodial settings, including through drug substitution programs, the availability of condoms and lubricant, exploring the feasibility of implementing access to safe tattooing and piercing programs, and state and territory governments identifying opportunities to pilot regulated needle and syringe distribution.

- Consider issues around re-entry into the community for those leaving custodial settings such as prevention, testing, treatment and completion of vaccination courses.
- Ensure initiatives are fully evaluated and the findings disseminated as widely as possible to community partners, health departments, research centres, ACCHS and professional bodies.
- Promote an environment free of discrimination on the basis of sexual practice, ethnicity and drug use behaviour.

6.3 People living in the Torres Strait Island region

Ongoing monitoring of the PNG–Torres Strait Island cross-border region is supported. Supporting agencies already working in this region to ensure that adequate levels of prevention and education occurs in Torres Strait Islander communities and that regular testing for STIs and HIV occurs over the life of this strategy are seen as critical in preventing an HIV epidemic in this region.

The Torres Strait Island region is in the process of implementing a focused public health program that includes health promotion, surveillance, screening, treatment and management. The Australian and Queensland governments, in partnership with key stakeholders from the Torres Strait Island region and PNG, continue to develop plans and allocate resources to deal with the potential risks in the region.

Priority action in cross border issues

- Continue the multi-agency and systematic response in the Torres Strait Island region to ensure the potential for HIV to escalate in the region does not occur.

6.4 Health promotion, community awareness and health literacy

Health promotion and education initiatives for the priority population groups identified in this strategy should be strengthened and delivered on an ongoing basis to create the enabling environments, personal empowerment and increased health literacy and behaviour change needed to reduce STIs and BBVs. This should include health promotion and social marketing that respond to the social, cultural and environmental context in which people live. Emphasis should be on increasing health literacy among young people, people in custodial settings, gay men, other men who have sex with men, sisters, transgender people, and remote and very remote communities where English is not the first language spoken.

Current models of health promotion provide a rationale for the shift from broad-based prevention activities to targeted initiatives. The overwhelming burden of chronic disease morbidity and mortality in Aboriginal and Torres Strait Islander communities means there is limited capacity in health services and, in particular, primary healthcare services, to develop targeted initiatives focusing on just HIV and hepatitis C. It is therefore generally accepted that health promotion in these communities should focus on all elements essential to health. There is widespread support for ensuring that prevention activities related to HIV and hepatitis C are embedded into broader health promotion programs to ensure maximum impact.

Many health promotion campaigns targeted at the general population in Australia have adopted social marketing techniques to deliver health messages designed to influence the behaviours of specific target groups. Social marketing has been used in health promotion activities targeting Aboriginal and Torres Strait Islander communities with some success, particularly when adapted to local contexts with appropriate language and images. Preventive health education messages improving the health literacy of young people and other priority populations identified in this strategy should be ongoing, and account for relevant cultural contexts and situational factors.

Special consideration should be given to the preventive messages that young people receive given the burden of STIs in this group, the relatively higher fertility rate among Aboriginal and Torres Strait Islander teenagers and because of the population profile of the community. Culturally-specific preventive health and education programs should commence at the age of 10 years, and continue to be delivered within a school or other safe environment. Education and health literacy improvements should place greater emphasis on comprehensive approaches to sexual wellbeing, health and substance use. Furthermore, young people outside of the school environment do not have the same levels of access to health promotion and education and so require to be taught in a way that suits them and responds to their environment.

Priority actions in health promotion and health literacy

- Ensure that comprehensive school-based and out-of-school sexual health and BBV education programs are available, with quality training attached, for delivery by those who work with populations at risk.
- Develop social marketing campaigns in consultation with target groups to ensure local relevance and support.
- Link sexual health education with access to testing and treatment.

6.5 Gay men, other men who have sex with men, sistergirls and transgender people

The continued targeting of health promotion activities to Aboriginal and Torres Strait Islander gay men, other men who have sex with men, sistergirls and transgender people is supported. Sex between men accounts for more than half of all HIV infections in Aboriginal and Torres Strait Islander peoples and, as a consequence, this group need to remain a focus of HIV prevention, support and care initiatives.

Gay men, other men who have sex with men, sistergirls and transgender people have experiences that result in them continuing to be vulnerable to BBVs and STIs. For example, in accessing health services, they commonly experience discrimination based on race, sexuality and transgender status. Aboriginal and Torres Strait Islander gay men, other men who have sex with men, sistergirls and transgender people consistently report difficulties accessing specialist HIV services and community-controlled health services. Actual and perceived racism on the one hand, and homophobia and lack of confidentiality on the other hand, are powerful barriers to service access that require continued attention during this strategy. These groups also experience high levels of sexual and other types of violence, which exacerbates their vulnerability to STIs.

These factors can also contribute to these groups seeking refuge through drug use and injecting drug use has been noted as an emerging issue for these groups. The efforts of communities to develop and implement their own responses to the health issues with which they are confronted are supported.

Priority actions for gay men, other men who have sex with men, sistergirls and transgender people

- Continue support for mechanisms for communities affected by HIV to identify emerging priorities and refine HIV and BBV responses.
- Continue support for peer-based, nationally co-ordinated prevention and health promotion initiatives.
- Improve the capacity of these groups to contribute to initiatives that address the risks associated with injecting drug use.
- Support research that will help enhance sexual health responses for these groups and help them address emerging issues.
- Support efforts to address violence (including sexual violence).

6.6 Treatment, care and support for people living with HIV and viral hepatitis

Around 300 people in the Aboriginal and Torres Strait Islander communities currently live with HIV, about 28 000 live with chronic hepatitis B and 16 000 live with chronic hepatitis C. Concern is growing about these BBVs in these communities and the need for focused prevention, diagnosis, treatment and support initiatives. The personal impacts of BBVs on individuals can be severe. Apart from the effects on health and wellbeing, effective management of infection requires individuals to make lifestyle changes, modify behaviours to lower the risk of passing the virus on, and gain access to treatment.

To be effective in providing treatment, care and support options for Aboriginal and Torres Strait Islander peoples with HIV and viral hepatitis, primary healthcare services need to be adequately resourced and sufficiently flexible to accommodate changing individual needs and new treatment options. In particular, access to specialist services to treat hepatitis C is needed, to complement those being provided through primary healthcare services. The links between mainstream and community-controlled healthcare sectors are equally important. Successful programs should be investigated as a model for further implementation in ACCHS.

Programs that aim to increase treatment outcomes for people living with chronic viral hepatitis or HIV should respond to these factors:

- high levels of mobility between urban and provincial centres and communities
- the impact of co-morbidities such as mental health and alcohol misuse, and the impacts these have on treatment initiation and management
- discrimination, particularly against gay men and people who inject drugs, that affects treatment and care, in the community sector and mainstream health services

- general discrimination against people living with these diseases
- the considerable diversity of circumstances for those affected, including cultural differences and wide geographical spread, which demand flexible care and treatment approaches
- treatment and support, which needs to be approached within a framework that recognises the importance of men's and women's business
- real or perceived lack of confidentiality.

Priority actions for people living with HIV and viral hepatitis

- Explore options to increase the number of people with viral hepatitis accessing and completing treatment.
- Increase assessment of hepatitis B status, hepatitis B immunisation coverage for those at risk, and management of those who have chronic hepatitis B.
- Ensure that people living with HIV have adequate access to treatment options at a range of health services, including through ACCHS.

6.7 Emerging issues

6.7.1 Testing issues associated with gonorrhoea

Develop and encourage laboratory participation in an ongoing quality assurance mechanism to validate currently used gonorrhoea nucleic acid amplification tests (NAAT) against appropriate comparisons including gonococcal cultures. This is necessary to ensure the validity of currently used gonorrhoea NAAT.

6.7.2 *Trichomoniasis*

In some Aboriginal and Torres Strait Islander populations, data suggest that trichomonal infections are endemic. While it is usually asymptomatic in men, this readily treatable infection causes under-reported, localised genital symptoms in women and is associated with adverse pregnancy outcomes and increased transmission of HIV. There is no commercially available diagnostic test for trichomoniasis in Australia. NAAT testing has been validated in adult women in Australia, but not in men or young people.

6.7.3 *Human papilloma virus immunisation*

The disproportionate rate of cervical cancer death among Aboriginal and Torres Strait Islander women is well reported and the need to address this preventable issue is an emerging problem. In particular a targeted vaccination program for girls, health promotion about and accessible services for Pap tests and local availability of treatment are action areas identified in this strategy. Consideration could also be given to reviewing the data in order to determine whether the funding of suitable vaccines should be extended to include Aboriginal and Torres Strait Islander men and boys as a priority population. Any review would have to be consistent with the roles of the Australian Technical Advisory Group on Immunisation and the Pharmaceutical Benefits Advisory Committee in making recommendations regarding eligibility for vaccine funding.

Priority actions regarding emerging issues

- Conduct a systematic review of the evidence and develop a national trichomoniasis action plan.
- Closely monitor coverage of HPV vaccination among young women. Any extension of HPV vaccination to boys and men should be evidence based and include actions that aim to reach all eligible cohorts.
- Explore the role of HPV immunisation in high-risk older women.

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Continue with efforts to improve Pap smear testing in older women because of the very high rates of cervical cancer and death from cervical cancer in this group.

7. Developing a competent and well supported workforce

A strong primary healthcare workforce that is adequately resourced in both community-controlled and mainstream health sectors is a prerequisite for effective action in addressing STIs and BBVs in Aboriginal and Torres Strait Islander communities. This strategy builds on the need to increase the number of Aboriginal and Torres Strait Islander health workers and to improve the knowledge and skill level of other healthcare workers in sexual health prevention, treatment, care and support across ACCHS and mainstream services. In considering workforce strategies for Aboriginal and Torres Strait Islander sexual health and the rate of BBV infection in these communities, there is a need for action and shared responsibility in community-controlled and mainstream health services.

7.1 Aboriginal and Torres Strait Islander sexual health workers

The need for a competent healthcare workforce is outlined in the National Strategic Framework for the Aboriginal and Torres Strait Islander Health Workforce.¹⁴ A Blueprint for Action: Pathways into the health workforce for Aboriginal and Torres Strait Islander peoples¹⁵ sets out a joint reform agenda endorsed by all levels of government in Australia, with a five to 10 year plan to build a competent health workforce to address the needs of Aboriginal and Torres Strait Islander peoples.

The need for a comprehensive mapping process of sexual health workers and an increase in the number of Aboriginal and Torres Strait Islander sexual health workers to provide national consistency is recognised. This workforce, along with the mainstream health workforce, should have ongoing support and professional development opportunities. There is inconsistency across jurisdictions about the roles of sexual health workers, particularly in the clinical and preventive areas. Linking the national registration of sexual

health workers (through the COAG national health registration process being developed) in clinical or public health preventive pathways to the new national Aboriginal and Torres Strait Islander Health Workers competency pathways is supported.

The recruitment, retention and continuity of designated sexual health worker positions pose different challenges in different settings. For example, designated positions for sexual health may lead to stigmatisation and narrow roles, and positions may lack long-term funding or may be drawn on for other priorities. Tailored approaches are therefore needed to increase the Aboriginal and Torres Strait Islander workforce in sexual health. These may include both sexual health specialist as well as innovative work roles, including integrating sexual health provision into more generalist roles that are attractive to Aboriginal and Torres Strait Islander peoples and acceptable to Aboriginal and Torres Strait Islander communities.

Retaining staff through adequate training and education is also seen as an ongoing action item for this strategy. In particular, public health and sexual health epidemiology training are critical aspects missing from Aboriginal and Torres Strait Islander Sexual Health Worker training.

7.2 Aboriginal and Torres Strait Islander Health Workers

The Standing Committee on Aboriginal and Torres Strait Islander Health report (2002) noted that providing the general Aboriginal and Torres Strait Islander health workforce with the skills needed to deal with STIs and BBVs—in the absence of specialised staff—is a continuing requirement. In particular, Aboriginal Health Workers in youth roles, in primary healthcare services, and drug and alcohol workers are priority groups to be skilled in STI and BBVs prevention, testing, treatment and care. This training should be linked to competency-based training for Aboriginal Health Workers.

7.3 Other workforces

Non-indigenous staff, including other healthcare staff in ACCHS, general practitioners and other primary care providers, play a central role in providing care to Aboriginal and Torres Strait Islander communities. They should be provided with training in STIs and BBVs to ensure they can identify risk population groups as a priority for early detection, treatment and referrals where required. Engaging mainstream services within ACCHS to provide specialised STI and BBV training to clinical staff should be considered as a way of up-skilling general practitioners and other clinical staff within ACCHS. Custodial staff and healthcare workers in prison and juvenile detention settings also need access to these types of training.

General practitioner registrars and overseas trained doctors, who comprise a significant portion of doctors working within ACCHS and in rural and remote settings, and who bring different sets of values and often little knowledge in the areas of Aboriginal and Torres Strait Islander culture and sexual health, are identified as a priority group within the workforce which requires training in STI and BBV clinical care and management. It is recommended that overseas trained doctors working in ACCHS and in other primary healthcare services be provided with cross-cultural and specific training in the area of STIs and BBVs relevant to Aboriginal and Torres Strait Islander communities, as part of their ongoing training.

7.4 Collaborating with new workforce initiatives

The current opportunities to cross-reference this strategy's primary workforce with new workforces arising from the health reform agenda, to lend extra support with STIs and BBVs—given the burden of disease in the Aboriginal and Torres Strait Islander community—are recognised.

Priority actions in workforce development

- Map the workforce of Aboriginal and Torres Strait Islander sexual health workers nationally and identify gaps, particularly in ACCHS.
- Provide training for health service leaders and managers to develop and run organised, systematic STI programs incorporating opportunistic and targeted screening, health education and use of data to evaluate programs.
- Improve the training, qualification and career pathways for Aboriginal and Torres Strait Islander sexual health workers and generalist Aboriginal Health Workers, by linking them to national competency standards, encompassing STI and BBVs and encompassing public health and epidemiology.
- Increase the number of Aboriginal and Torres Strait Islander sexual health workers in jurisdictions where there are few.
- Collaborate with new initiatives and other national strategies and programs to advocate for increased Aboriginal and Torres Strait Islander sexual health workers positions in ACCHS and mainstream services.
- Employ gender-specific workers, where necessary, using women's and men's health workers to offer a wide range of services.
- Explore barriers to workforce development and approaches to addressing them.
- Improve the effectiveness of training, recruitment and retention for both Aboriginal and Torres Strait Islander staff and non-indigenous staff in primary healthcare services.

8. Surveillance

Improvements in the accuracy and completeness of the status of Aboriginal and Torres Strait Islanders in routine STI and BBV surveillance systems across all jurisdictions will improve the understanding of STIs and BBVs in these communities, facilitate prevention and clinical management strategies, and provide tools for monitoring and evaluation.

There are considerable gaps in the accuracy of reportable data for Aboriginal and Torres Strait Islander peoples. In 2008, for example, 52 per cent or more than 30 000 cases of notified chlamydia in Australia did not report Aboriginal and Torres Strait Islander status. Similarly, 2178, or 28 per cent, of all gonorrhoea cases did not report Aboriginal and Torres Strait Islander status. This missing data has the potential to underestimate the true prevalence and morbidity associated with these STIs in Australia among this population group. Accurate and complete reporting of Aboriginal and Torres Strait Islander status on communicable disease notifications is critical to improving the quality of data available. For almost two decades the main sources of information on the occurrence of STIs and BBVs among Aboriginal and Torres Strait Islander peoples have arisen from routine notifications required by public health legislation in Australia. Despite this, considerable gaps exist in the information available for Aboriginal and Torres Strait Islander peoples living in regional and urban areas (which is where the majority of this population group resides). This is especially true with reporting status on hepatitis C notifications, gonorrhoea and to a lesser extent chlamydia.

A number of initiatives have been recently introduced or are planned to provide a more comprehensive picture of trends in STI and BBVs in Aboriginal and Torres Strait Islander peoples. For example, the Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance reports on chlamydia infections outcomes in 90 clinical services across Australia and provides data specifically related to Aboriginal and Torres Strait Islander peoples. A data linkage project will be undertaken in 2010 to improve the

accuracy and completion of STI and BBV data in New South Wales. These types of initiatives should be extended and supported, especially given the absence of a complete national surveillance system that can report on Aboriginal and Torres Strait Islander status.

Improving completeness and accuracy of Aboriginal and Torres Strait Islander status within the National Notifiable Diseases Surveillance System requires a number of agencies coming together to identify, develop and implement strategies to increase notification data. It is recommended that NACCHO, the Royal Australasian College of Physicians, the Royal Australian College of General Practitioners and the Royal College of Pathologists of Australia take a collaborative lead on this issue. The OATSIH-commissioned report—Improving Indigenous Identification in Communicable Disease Reporting Systems (2004)—on strategies to improve Aboriginal and Torres Strait Islander identifiers in communicable disease notifications also highlights this need. Complete and accurate data will also help with monitoring and evaluating interventions and increasing understanding about the prevalence and incidence of infections. This, in turn, will support strategic approaches to improving sexual health and reducing BBVs.

Priority action in surveillance

- Support enhancement of existing data collection and surveillance strategies to improve the accuracy and completeness of Aboriginal and Torres Strait Islander and other demographic information required to underpin program development, monitoring and evaluation.
- As part of the implementation planning process the following specific issues should be considered:
 - ~ supporting the extension of enhanced sentinel surveillance programs such as the Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance project

- ~ investigating data linkage as a mechanism for improving the completeness and accuracy of data sets on Aboriginal and Torres Strait Islander status
- ~ following up the implementation of the Communicable Diseases Network Australia's Improving Indigenous Identification in Communicable Disease Reporting Systems
- ~ ensuring that NACCHO, the Royal Australasian College of Physicians, the Royal Australian College of General Practitioners, the Royal College of Pathologists of Australia and other stakeholders identify, develop and implement strategies that will improve the completeness and accuracy of Aboriginal and Torres Strait Islander status in the National Notifiable Diseases Surveillance System.

9. Research

Research provides the evidence base for the development and implementation of public policy, programs and service delivery that responds to the evolving needs of people affected by STIs, HIV and hepatitis C. Improvements in planning and decision making can be linked to the collection, analysis and dissemination of accurate and meaningful data.

Epidemiological, basic scientific, clinical, social, and behavioural research contributes to addressing sexual health and BBVs in the Aboriginal and Torres Strait Islander population.

The second National Health and Medical Research Council Roadmap for Aboriginal and Torres Strait Islander Health Research¹⁶ will provide opportunities for addressing some of the knowledge gaps in Aboriginal and Torres Strait Islander STIs and BBVs.

Forming research partnerships, particularly between the community sector and national research centres will help address research gaps in Aboriginal and Torres Strait Islander sexual health and BBVs. It will also support capacity building in research.

Priority actions in research

- Identify specific research priorities in relation to primary healthcare access, epidemiological surveillance and health promotion needs for responding to this strategy's priority population groups.
- Develop strategies and partnerships to actively involve local Aboriginal and Torres Strait Islander peoples in the collection, analysis and interpretation of research data related to their experiences of sexual health and BBVs, and ensure the findings are communicated to their communities and other interested parties, such as policy makers and planners.

- Continue with established partnerships with national research centres to maximise the development and implementation of Aboriginal and Torres Strait Islander sexual health and BBV-related research.
- Encourage research that examines behaviours associated with sexual practices and injecting drug use in the Aboriginal and Torres Strait Islander community.
- Evaluate strategies designed to, and interventions aimed at, reducing risk behaviours.

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