

March 2010

**Third National  
Aboriginal and Torres Strait Islander  
Blood Borne Viruses and  
Sexually Transmissible Infections  
Strategy  
2010 – 2013**

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## 1. Background

This is the third National Aboriginal and Torres Strait Islander Strategy dealing with blood borne viruses and sexually transmissible infections (STIs) to be adopted in Australia. It builds on two previous strategies which guided Australia's response to blood borne viruses (BBVs) and sexually transmissible infections (STIs) in Aboriginal and Torres Strait Islander populations: The National Indigenous Australians' Sexual Health Strategy (NIASHS) 1996-97 to 2003-04<sup>1</sup> and the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2003 – 2008 (the previous Strategy)<sup>2</sup>.

This third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy is one of a suite of five strategies that aim to reduce the transmission of sexually transmissible infections (STIs) and blood borne viruses (BBVs), and the morbidity, mortality and personal and social impacts they cause. This strategy's relationship to the other four strategies is detailed in section 1.2 below.

### 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. These organisations are represented on advisory committees detailed below that have provided valuable advice during the development process.

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 Council (AHMC) and its sub-committees to facilitate national policy formulation and coordination. The Blood Borne Virus and Sexually Transmissible Infections Sub-Committee (BBVSS) of the Australian Population Health Development Principal Committee (APHDPC) includes representatives of all governments as well as the community based organisations, and provides expert advice to health ministers through the APHDPC and the Australian Health Ministers Advisory Council (AHMAC). The Australian government also seeks advice through the Ministerial Advisory Committee for Blood Borne Viruses and Sexually Transmissible Infections (MACBBVS).

These groups will work in the context of funding arrangements for the health system, to reshape existing policies and programs or to extend them where possible. These funding arrangements are provided jointly by the Commonwealth and the States and Territories under the National Health Care Agreement, which is a Schedule to the Council of Australian Government's (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. Partnerships relevant to these strategies include the Indigenous Early Childhood Development Partnership and the National Essential Vaccines Partnership.

Australian governments fund community and professional organisations, program delivery organisations and research centres to engage with, and build the knowledge base in relation to communities affected by blood borne viruses and sexually transmissible infections so that effective responses can be put into place. The involvement of these organisations has assisted in developing the response to these health challenges.

## **1.2 Relationship to other strategies**

This strategy is one of a suite of five strategies that aim to reduce the transmission of sexually transmissible infections (STIs) and blood borne viruses (BBVs) in Australia, and the morbidity, mortality and personal and social impacts they cause. The five strategies cover the period 2010-2013 and include:

- The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy (this strategy);
- The Sixth National HIV Strategy;
- The First National Hepatitis B Virus (HBV) Strategy;
- The Second National Sexually Transmissible Infections Strategy; and
- The Third National Hepatitis C Virus (HCV) Strategy.

While the latter four strategies focus on particular infections, this strategy focuses on the combined health impact these infections have on Aboriginal and Torres Strait Islander peoples in Australia. Despite each of strategy's specific history and focus, together they share many features such as:

- Some shared Guiding principles (Chapter 4 in each strategy);
- Some shared Priority populations (Chapter 5 in each strategy);
- Some shared or similar Priority action areas (Chapter 6 in each strategy); and
- Some shared issues around Surveillance, Research and Workforce development (Chapters 7, 8 and 9 in each strategy)

This strategy also includes five extra chapters (10 to 14) with issues specific to Aboriginal and Torres Strait Islander communities. The alignment of each stand-alone strategy's structure is designed to facilitate a co-ordinated effort across stakeholder groups with different focuses in recognition of common concerns.

## **1.3 Blood Borne Viruses and Sexually Transmissible Infections among Aboriginal and Torres Strait Islander people in Australia**

There remain significant public health issues and challenges for Aboriginal and Torres Strait Islander communities 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; and
- continuing new HIV infections among men who have sex with men.

Exacerbating these disease rates is the lack of access for many communities to primary health care services that are able to provide culturally appropriate treatment, care and support services. There are also significant gaps in the workforce to adequately deal with these issues. This Strategy has been developed based on the best available evidence from within Australia and internationally to address these issues.

***Four new priority action areas are identified in this Strategy:***

- Annual, routine and systematic testing, treatment and follow-up for bacterial STIs of sexually active Aboriginal and Torres Strait Islander young people;
- Increased access to treatment for Aboriginal and Torres Strait Islander young people who test positive to bacterial STIs;
- Increased primary prevention activities that seek to reduce the number of new cases of HIV and viral hepatitis among Aboriginal and Torres Strait Islander people who inject drugs; and
- Competent and accredited workforces consistent across all jurisdictions to address the scope of work outlined in this Strategy.

***Six areas from the previous Strategy are of continuing priority:***

- Continued monitoring of the HIV response in the Torres Strait Islands cross-border region with Papua New Guinea (PNG) including surveillance, community-orientated health promotion and prevention activities;
- Continued health promotion and increased community awareness of STIs, HIV and blood borne viruses (BBVs);
- Continued efforts to prevent transmission of HIV among gay men, men who have sex with men, sistergirls and transgender people;
- Continued access to treatment, care and support services for Aboriginal and Torres Strait Islander people living with BBVs;
- Continued improvement in the accuracy and completeness of Aboriginal and Torres Strait Islander status in routine STI and BBV surveillance systems across all jurisdictions; and
- Continued research activities that will guide the development and implementation of prevention, treatment and care initiatives in the Aboriginal and Torres Strait Islander community.

For the purposes of this Strategy, bacterial STIs refer to infections with 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**

Data from the Australian Bureau of Statistics<sup>3</sup> indicate that in 2006 there were just over half a million Aboriginal and Torres Strait Islander people living in Australia, representing 2.5% of the total Australian population. Over a quarter of Aboriginal and Torres Strait Islander people 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 are Aboriginal and Torres Strait Islander people, followed by less than 4% in other states and territories (Table 1).

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

State/territory	Aboriginal and Torres Strait Islander population	Total population	% of total population who are Aboriginal and Torres Strait Islander	
			By jurisdiction	Nationally
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 Indigenous status. The 2006 ABS Census data report a much younger population profile for Aboriginal and Torres Strait Islander people, with around 40% of the Aboriginal and Torres Strait Islander population aged less than 15 years compared with 19% of the non-Indigenous population. People aged 15-24 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 people was 21 years compared with 37 years in the non-Indigenous population. Recent figures from the ABS project that Australia's 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. This projected increase of almost 40% in the population aged less than 15 years has implications for the sexual health and wellbeing of young Aboriginal and Torres Strait Islander people. Consequently, STI and BBV health service planning and delivery need to acknowledge these realities and respond accordingly.

### 1.3.2 National Aboriginal and Torres Strait Islander health policy context

Under the Indigenous Early Childhood Development National Partnership (IECD NP) signed by the Council of Australian Governments in October 2008, the Commonwealth has committed funding of \$107 million to states and territories to implement strategies aimed at 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.

Action in this area will aim to deliver targeted sexual and reproductive health programs for young Aboriginal and Torres Strait Islander people (including those who are disengaged from school) and improve access to, and use of, antenatal care for young Aboriginal and Torres Strait Islander mothers.

The Indigenous Early Childhood Development National Partnership complements the objectives of the National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmitted Infections 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 people. OATSIH is a division of the Australian Government Department of Health and Ageing. OATSIH works in collaboration with Aboriginal and Torres Strait Islander communities, mainstream health providers and Aboriginal Community Controlled Health Services to achieve better health outcomes. This includes funding primary health care, substance use services and population health programs. OATSIH is committed to supporting improved management of the impact of BBVs and STIs in Aboriginal and Torres Strait Islander people. Historically, OATSIH has contributed approximately \$10-\$15 million per annum to support a range of activities including the employment of over one hundred 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 Aboriginal Community Controlled Health Services (ACCHSs), 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 STIs and blood borne viruses**

#### *Sexually transmissible infections*

Chlamydia, gonorrhoea, syphilis and trichomoniasis are curable STIs, but are often asymptomatic in those affected and can lead to serious complications if untreated for long time periods<sup>4</sup>. The consequences of genital chlamydia infection include adverse pregnancy outcomes such as premature labour and birth, low birth weight, intrauterine growth restriction, postpartum endometritis, and a range of neonatal infections such as infectious conjunctivitis, nasopharyngeal infections and pneumonia. Untreated gonorrhoea can lead to disseminated infection and illnesses such as polyarthrititis and septicaemia. Syphilis can give rise to obstetric complications and congenital disease and where untreated can be responsible for neurological and systemic late manifestations. All these infections can create discomfort and shame for affected individuals, their families and communities and can 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 that have been reported in young people from many Aboriginal and Torres Strait Islander communities provide 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 people, 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 people in the Northern Territory, South Australia, Victoria, Queensland and Western Australia. Furthermore, 14% (183 cases) of all infectious syphilis notifications in Australia in 2008 occurred among Aboriginal and Torres Strait Islander people 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 Aboriginal and Torres Strait Islander people (18%) compared with the non-Indigenous population (12%). The prevalence of HSV-2 in some Aboriginal and Torres Strait Islander communities has been found to be several-fold that in non-Indigenous people. 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 Aboriginal and Torres Strait Islander population, compared with the non-Indigenous population rate of 6 cases per 100 000. 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 in Australia<sup>5</sup>. There are suggestions that trichomoniasis is endemic in some populations and it is 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 of 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 prevailing modes of HIV transmission for newly diagnosed HIV infection between the two populations. Between 2004 and 2008 the most frequently reported route of HIV transmission among the non-Indigenous, Australian-born population was sexual contact between men (79%), followed by heterosexual contact (13%). Injecting drug use was reported as the sole exposure among 3% of cases. Over the same time period, among Aboriginal and Torres Strait Islander people, the most frequently reported route of HIV transmission was sexual contact between men (54%), followed by heterosexual transmission (23%) and injecting drug use (22%)<sup>6</sup>.

It is estimated that between 13 000 and 22 000 Aboriginal and Torres Strait Islander people are living with hepatitis C in Australia, representing 4% of all Indigenous Australians, compared with 1% in the non-Indigenous population. In 2008, 11 302 cases of hepatitis C were diagnosed in Australia. Of these, 626 (5.5%) occurred among Aboriginal and Torres Strait Islander people and 4115 (36%) among non-Indigenous people. Indigenous status was not known in a further 6561 (58%) notified cases<sup>7</sup>.

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 people, 73% among non-Indigenous people, and Indigenous status was not known in 9% cases.

In 2008, the diagnosis rate for newly acquired hepatitis B infection was between one and five times higher than that of 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 state and territory health jurisdictions. In 2008, the rates of diagnosis of newly

acquired hepatitis B infection in the Aboriginal and Torres Strait Islander population in the age group 20-49 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 Aboriginal and Torres Strait Islander populations to 8% in rural populations. 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 be a feature of ongoing management.

## 2. Goal

The goal of the 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 sexually transmissible infections and blood borne viruses and to minimise the personal and social impact of these infections.

## 3. Objectives and indicators

This section details objectives and indicators for use in monitoring progress under the strategy. Indicators are measurable targets that apply to the related objective. The primary indicators are those that have been agreed under the National Healthcare Agreement (NHCA). These have been specified and will be regularly reported 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 them. In some circumstances further data development may also be needed.

GOAL	OBJECTIVE	INDICATOR <sup>(1)</sup>
<b>To reduce the transmission of and morbidity and mortality caused by sexually transmissible infections and blood borne viruses and to minimise the personal and social impact of these infections.</b>	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 the elimination of infectious syphilis in Aboriginal and Torres Strait Islander people	Incidence of infectious syphilis in Aboriginal and Torres Strait Islander people (National Healthcare Agreement)
	Decrease the proportion of HIV and hepatitis C infections attributable to injecting drug use	Proportion of newly diagnosed HIV and newly diagnosed hepatitis C infection attributable to injecting drug use in Aboriginal and Torres Strait Islander people

	<p>Increase the level of systematic testing and treatment of sexually active 15 - 30-year olds, noting that testing is likely to lead to an increase in notifications of bacterial STIs before a reduction in notifications is evident</p>	<p>Proportion of Aboriginal and Torres Strait Islander young people who report having had an STI test in the previous 12 months</p> <p>Proportion of young Aboriginal and Torres Strait Islander people receiving a Chlamydia and gonorrhoea test in the previous 12 months</p>
	<p>Improve Aboriginal and Torres Strait Islander young people's knowledge of STIs and BBVs</p>	<p>Proportion of Aboriginal and Torres Strait Islander young people giving correct answers to STI and BBV knowledge questions</p>
	<p>Increase the number of Aboriginal and Torres Strait Islander people receiving HIV, hepatitis C and hepatitis B treatment</p>	<p>Proportion of Aboriginal and Torres Strait Islander people with HIV receiving antiretroviral treatment</p> <p>Proportion of Aboriginal and Torres Strait Islander people 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 people with chronic hepatitis B who are dispensed drugs for hepatitis B infection through the Highly Specialised Drugs Program in the previous 12 months</p>
	<p>Implement a national accreditation scheme for Aboriginal and Torres Strait Islander Sexual Health Workers, under the Council Of Australian Governments National Registration Program</p>	<p>Number of Aboriginal and Torres Strait Islander Sexual Health Workers registered under the National Registration Program</p>

(1) In areas where data are available

#### 4. Guiding principles

The 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 conditions, including as they relate to Aboriginal and Torres Strait Islander Australians, seek to minimise the transmission and impacts of these diseases on individuals and communities. The respective Strategies establish directions based on the unique epidemiology, natural history and public health imperatives of the diseases.

The guiding principles underpinning Australia's response to HIV, STIs and viral hepatitis are:

- The transmission of HIV, STIs and hepatitis C is preventable through adoption and maintenance of 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 to the adoption and application of prevention measures. Individuals and communities have a mutual responsibility to prevent themselves and others from becoming infected.
- The principles and actions described in the Ottawa Charter provide the framework for effective HIV, STI and viral hepatitis health promotion action and facilitate:
  - o the active participation of affected communities and individuals, including peer education and community ownership to increase their influence over the determinants of their health; and
  - o the 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 the needle and syringe program 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 health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.
- An effective partnership of affected communities, Government, researchers and health professionals is characterised by consultation, cooperative effort, respectful dialogue and action to achieve the Strategy's goal and includes:
  - o non-partisan support for the pragmatic social policy measures necessary to control HIV, STIs and viral hepatitis;
  - o recognition that those living with and at risk of infection are experts in their own experience and are best placed to inform efforts that address their own education and support needs;
  - o timely and quality research and surveillance to provide the necessary evidence base for action;
  - o a skilled and supported workforce; and
  - o leadership from the Australian Government, the full cooperative efforts of all members of the partnership to implement the Strategy's agreed directions, and early adoption of a framework for monitoring and evaluation action.

This Strategy is guided by the principles set out above, which are common across this Strategy and the National Hepatitis B, Hepatitis C, HIV and Sexually Transmissible Infections Strategies. Additionally, the following principles are recognised as unique to this Strategy:

- The priority and ongoing action areas in this Strategy have been articulated to provide guidance in the allocation of resources in this area of Aboriginal and Torres Strait Islander health;

- The role that Aboriginal Community Controlled Health Services (ACCHS) can play in the delivery of health programs in this area is recognised. These services should be supported in enabling outcomes and targets identified in this Strategy;
- The close family ties, kinship and strengths of cultural and social organisation within Aboriginal and Torres Strait Islander communities are recognised. Health care services are often carried out in an environment where there are significant social and cultural obligations and economic burdens occurring;
- The importance of choice between health care providers for Aboriginal and Torres Strait Islander people is recognised. Wherever possible, government services, private GPs and ACCHS should work together to ensure that Aboriginal and Torres Strait Islander people have options for confidential sexual health care and blood borne virus health care; and
- The incorporation of 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; and
  - Freedom from harms that may interfere with the sexual health and emotional wellbeing of individuals.

## 5. Priority populations

Six main population groups are priorities for this Strategy:

- Aboriginal and Torres Strait Islander people aged 15-30 years;
- Aboriginal and Torres Strait Islander people who inject drugs;
- Aboriginal and Torres Strait Islander people in juvenile justice and adult custodial facilities;
- Aboriginal and Torres Strait Islander gay men, men who have sex with men, sistergirls, transgender people;
- Aboriginal and Torres Strait Islander people living with HIV and viral hepatitis; and
- People living in the Torres Strait Islands region.

### 5.1 Aboriginal and Torres Strait Islander people aged 15-30 years

Aboriginal and Torres Strait Islander people aged between 15 and 30 years who are sexually active are considered a priority population because:

- they experience higher STI rates than non-Indigenous people of similar ages;
- their level of health education and health literacy may be lower than that of older community members;

- they 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;
- there are high fertility rates among younger people; and
- they experience serious barriers to accessing health services.

## **5.2 Aboriginal and Torres Strait Islander people who inject drugs**

There is limited information about the number of Aboriginal and Torres Strait Islander people who inject drugs<sup>8</sup>. Different sources point to evidence of increasing injecting drug use within some Aboriginal and Torres Strait Islander communities and associated increased risk of transmission of HIV and hepatitis C. The findings of these data sources require immediate attention. A range of factors continue to place Aboriginal and Torres Strait Islander people who inject drugs at risk, including:

- 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 Aboriginal and Torres Strait Islander communities;
- Concerns about confidentiality in service provision; and
- Lack of support and 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 people in juvenile justice and adult prisons**

The numbers of Aboriginal and Torres Strait Islander people in juvenile and adult corrections settings continue to increase despite recommendations of the 1991 Royal Commission into Aboriginal Deaths in Custody. Of the total prisoner population on 30 June 2008, 7% were female and 24% were Aboriginal and Torres Strait Islander people<sup>9</sup>. In June 2004, there were 785 young people in juvenile detention centres around Australia and 45% of these were Aboriginal and Torres Strait Islander people<sup>10</sup>.

While in prison, 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 challenges to Aboriginal and Torres Strait Islander prisoners' health and wellbeing. Even upon release, numerous challenges remain due to 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, men who have sex with men, sistersgirls and transgender people**

A range of factors continue to place Aboriginal and Torres Strait Islander gay men, men who have sex with men, sistersgirls and transgender people at particular risk of HIV 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 and movement between communities and 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; and
- A culture of violence, both generally towards the community and specifically towards Aboriginal and Torres Strait Islander gay men and sisters, increasing HIV, STI and viral hepatitis risk.

### **5.5 Aboriginal and Torres Strait Islander people living with HIV and viral hepatitis**

In Australia there are approximately 300 Aboriginal and Torres Strait Islander people diagnosed with HIV, approximately 28 000 with chronic hepatitis B and approximately 11 000 with chronic hepatitis C. The diversity of the lived experience of Aboriginal and Torres Strait Islander people 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 people living with HIV and viral hepatitis is supported. The role that Aboriginal and Torres Strait Islander people living with HIV and viral hepatitis play in shaping the response in Australia is recognised.

Aboriginal and Torres Strait Islander people 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 Aboriginal and Torres Strait Islander communities, often resulting in social discrimination and isolation. In such circumstances, the potential for self harm from behaviours such as alcohol and drug use is present and consideration needs to be given to co-morbidities such as mental health problems.

### **5.6 People living in the cross-border region of Australia and Papua New Guinea**

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

Under treaty arrangements that 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 Torres Strait region. The movement of people within the Treaty provisions has steadily increased in recent years. The three main health-related concerns are: increases in communicable diseases resulting from the free movement of traditional visitors within and around the area known as the protected zone; the pressure on health care facilities in the Torres Strait, resulting from such movement; and

the limited access to, and poor standards of, health service facilities in the Western Province of PNG.

## **6. Priority areas for action**

There is ample population-based and disease-based evidence that supports the three new priority action areas and six ongoing action areas to be executed over the life of the Strategy. The potential impact on Aboriginal and Torres Strait Islander communities and individuals of failure to act could be enormous. Action to address these priorities will require commitment by governments at federal, state and territory levels and concerted effort by Aboriginal and Torres Strait Islander specific and mainstream health services.

### **6.1 Testing and treatment of STIs**

Bacterial STI (gonorrhoea, chlamydia and syphilis) are preventable, easily detected and curable. Aboriginal and Torres Strait Islander young people aged 15-30 years experience chlamydia, gonorrhoea and infectious syphilis rates many times that of non-Indigenous people in the same age groups. This high rate has major implications if infections are undiagnosed, particularly 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 the elimination of infectious syphilis in the Aboriginal and Torres Strait Islander 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 may include strategies to be detailed in the Implementations 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 transmission of HIV. 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 due to a range of factors including: health

services being accessed less often by younger people than older age groups; lower health literacy among this population; and residency in hyper-endemic STI communities.

In order to address this disparity in health outcomes among young Aboriginal and Torres Strait Islander people, the implementation of routine, systematic, annual bacterial STI tests of people aged 15-30 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 of the 15-19-year-old age group who are sexually active, and have high rates of STI infection. While it is acknowledged that STI testing is one aspect of a comprehensive STI program required to reduce prevalence rates at a population level, regular opportunistic and systematic testing of those aged 15-30 years on an annual basis is seen as good public health practice as it is the main pathway to appropriate treatment and prevention of complications. This approach is clearly 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 as a strategy for increasing testing and treatment of STIs among 15-30-year olds. However it is important that screening is not seen as a stand-alone strategy but that 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 and treating the sexual partners of an individual with a STI. It is also referred to as contact tracing. The objective is reduction in the transmission of infection through early detection and treatment and promotion of behaviour change.

The need for an investigation into the models currently available for health services and clinicians to examine models of partner notification in Aboriginal and Torres Strait Islander communities is recognised. This requirement is seen as an important task of STI testing yet very little information is available on the types of models that have worked in Aboriginal and Torres Strait Islander community settings. Mechanisms to support partner notification when the index case or partners are in prison or juvenile detention also need to be explored.

Different models have been explored using patient-initiated treatment including the use of pharmacies, using 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 people 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 than other community members and the higher potential for transmission of STIs. This potential is increased for street-based sex workers (and people doing sex for favours) who have less opportunity to control the occupation health and safety conditions of their work and are therefore at increased risk of BBV and STI transmission.

##### ***Priority actions in testing and treatment of STIs***

- Build the capacity of primary health care services, the Aboriginal Community Controlled Health sector, NACCHO and GPs to initiate testing, diagnose, treat and engage in culturally appropriate partner notification strategies, particularly among 15 – 30 year olds;
- Investigate models that normalise health seeking behaviour and specifically reach the 15-19 year age group particularly in high prevalence communities including specific youth health programs within primary health care services and active outreach models, including 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 and improve systematic/integrated surveillance systems using existing patient information management systems that can report the proportions of people aged 15-30 years who are offered regular STI testing and treatment;
- Respond to high rates of syphilis in Aboriginal and Torres Strait Islander communities through a greater focus 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 aged 15-30 years including those in custodial settings, sex workers, gay men, men who have sex with men, sisters and transgender people; and
- Conduct a systematic review of the evidence base around *Trichomonas vaginalis* infection in order to develop actions to deal with this infection.

In addition, the following are important to ensure STI testing in this age group can occur. They will be considered in implementation planning for this Strategy:

- Engagement of community leaders, including those who have governance responsibilities within ACCHSs.

This is seen as an important initiative to ensure that regular STI testing is best practice in STI control improvement of the health literacy of young people, particularly through school-based education regarding the need for regular STI tests in line with broader health reforms

accessibility of advances in technology and their application in clinical treatment, particularly new point-of-care testing technology.

## **6.2 Primary prevention of BBVs 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 the population level. Despite the number of cases, the existence of risk factors for BBV transmission in the Aboriginal and Torres Strait Islander community means that primary prevention remains important.

Successful primary prevention activities for Aboriginal and Torres Strait Islander people require a focus at both the population level, and on behavioural change at the individual level. This includes: increased access for injecting drug users to needle and syringe programs (NSPs); the involvement of 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 dependent on recreational drugs to seek treatment; and participation, ownership and recognition by Aboriginal and Torres Strait Islander communities of the need for all 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 people who inject drugs is an important factor in the transmission of BBVs. Improving NSP access and availability of clean injecting equipment through mainstream NSPs and continued support and encouragement of ACCHSs 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<sup>11</sup>. Furthermore, this data does not necessarily describe where people are injecting. The mapping of injecting patterns and NSP services are important related activities to ensure that NSP service expansion occurs in communities where injecting drug use is most prevalent.

### **6.2.2 Infection control in Australian custodial settings**

Barriers to access to prevention in prison are of particular concern for Aboriginal and Torres Strait Islander people. In the correctional environment, there are often impediments to best practice BBV prevention. These problems are exacerbated by higher levels of co-infection with HIV and hepatitis C in this population. The prevalence of HIV among people in custodial settings remains low, but the potential exists for the rate to increase, particularly as the prison population increases. This is evidenced by national surveillance figures showing increases in the rates of HIV infection among new prison entrants over the past 3-4 years<sup>12</sup>. Effective HIV and other BBVs prevention and health promotion requires a whole-of-government approach enlisting those concerned with juvenile detention centres as well as 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 separate, independent systems of 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 the coordination of policy development, implementation and evaluation, research 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, the National Prison Entrants BBV & Risk Behaviour Survey, etc.

The provision of sterile injecting equipment in Australian prisons is considered a controversial issue by some in the community. An increasing number of international jurisdictions have implemented or are actively contemplating the implementation of needle and syringe programs in prisons. To date there is no evidence of adverse outcomes associated with these programs. There are however a number of positive or beneficial outcomes that have been documented from programs that have undergone evaluation including no documented increase in illicit or injecting drug use, significant reductions in equipment reusing/sharing, no documented attacks or violence, no documented seroconversion for HIV or hepatitis and acceptance by staff and prisoners of the program.

In view of the well documented return on investment and effectiveness of Australian community-based needle and syringe programs, combined with the international evidence demonstrating the effectiveness of prison needle and syringe programs it is appropriate throughout the life of this strategy for State and Territory Governments to identify opportunities for trialling the intervention in Australian custodial settings.

In addition to identifying opportunities for trialling needle and syringe programs in prisons, it is also essential that the full range of BBV and STI prevention strategies are maintained in Australian custodial settings, including:

- Increasing the provision of, and access to bleach and disinfectants where no other safer alternatives are provided for decontaminating spills, surfaces or equipment;
- Easily accessible education and counselling including peer education and support on HIV & STIs, hepatitis B and 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 been demonstrated to reduce blood borne virus 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 reduce the risk of transmission of blood borne viruses via those means in custodial settings.

### **6.2.3 Peer educators**

Peer education recognises the influence that peer pressure and peer group behaviours have on an individual's decisions. Peer education is acknowledged to be an effective education model because peer educators have the ability to reach people not being reached by other means and are credible, trusted sources of information and support<sup>13</sup>. Peer education encompasses a broad range of activities, including information provision, the development of education materials, and empowering people to take positive action in their own lives and within their communities and networks. Peer education can be conducted in both one-to-one and group settings.

Peer education is intrinsic to any health promotion activity and it must be based on the best available evidence of what is effective in Aboriginal and Torres Strait Islander communities. Highest priorities for health promotion and education in this Strategy are those people 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 require 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.

Increasing the capacity to respond to the hepatitis C epidemic in Australia will require increasing large-scale 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<sup>14</sup>.

### **6.2.4 Early detection of HIV and hepatitis C**

Early detection is also an important tool 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 ACCHSs and other primary health care facilities) is recommended as an important preventative measure to reduce transmission of BBVs, as well as increased testing based on risk in juvenile justice settings and adult custodial settings. Increasing the ability of ACCHS to provide tertiary care through the provision of visiting specialists has seen a dramatic improvement in the retention 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 is handled sensitively and that all people being tested receive 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 terms of prevention messages, detection of infection and as referral pathways for 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 of hepatitis B in Aboriginal and Torres Strait Islander communities is improved. A safe, effective and inexpensive vaccine exists and is currently recommended by the Australian Government for all infants at birth. The Aboriginal and Torres Strait Islander population is described as having intermediate-to-high endemicity of hepatitis B infection according to World Health Organization (WHO) standards and, thus, all Aboriginal and Torres Strait Islander children are strongly recommended to have the hepatitis B vaccine at birth. It is recommended also that children born to mothers who currently have hepatitis B infection should receive a dose of hepatitis immunoglobulin at birth. Hepatitis B vaccination programs are cost effective and successful and should further serve to reduce the levels of hepatitis B in the Aboriginal and Torres Strait Islander community.

The recommendations from the Hepatitis B Strategy for national consistency in groups and communities eligible for funded vaccination with priority to communities at greatest risk of hepatitis B infection and to monitor 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 people and their immediate family contacts.

### **6.2.7 Harm reduction**

Harm reduction strategies are central to preventing HIV and viral hepatitis in the community, as in the broader community. 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 can cause, both to individuals and to the community. The objective of this approach is to reduce the transmission of disease, and so reduce the personal and social impact and the loss of quality of life caused by ill health.

#### ***Priority actions in the prevention of BBVs from injecting drug use***

- Increase the coverage and accessibility of NSPs to Aboriginal and Torres Strait Islander communities particularly those in urban and regional areas of Australia;
- Facilitate the provision of high-quality, timely primary health care that will provide prevention, early detection, treatment and follow-up services for HIV, viral hepatitis, BBVs and STIs to the Aboriginal and Torres Strait Islander population;
- Promote peer education-based models and outreach as appropriate models to reach marginalised groups of the Aboriginal and Torres Strait Islander community;
- Encourage and support partnerships between ACCHSs, peer-based drug user organisations, and community-based and peak HIV and hepatitis C organisation and research bodies in the development and delivery of harm reduction strategies tailored to Aboriginal and Torres Strait Islander people; and between different health programs (e.g. drug and alcohol, mental health, sexual health, corrections) to ensure testing and treatment pathways are accessible for Aboriginal and Torres Strait Islander people;
- Strengthening evidence-based harm reduction approaches to BBV and STIs in custodial settings including drug substitution programs, 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, ACCHSs and professional bodies; and
- Promote an environment free of discrimination on the basis of sexual practice, ethnicity and drug use behaviour.

### **6.3 Torres Strait Islands cross-border region with Papua New Guinea**

Ongoing monitoring of the PNG-Torres Strait Islands cross-border region is supported. Supporting agencies already working in this region and ensuring that adequate levels of prevention and education occurs in Torres Strait Islander communities, as well as regular testing for STIs and HIV occur in the region over the life of this Strategy are seen as critical in preventing an HIV epidemic in this region.

The Torres Strait 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 within this Strategy must be ongoing, strengthened and delivered to create enabling environments, personal empowerment and increased health literacy and behaviour change to reduce STIs and BBVs. This should include efforts in health promotion and social marketing that respond to the social, cultural and environmental context in which people live. Particular emphasis should be placed on increasing health literacy among young people, people in custodial settings, gay men, men who have sex with men, sistergirls and transgender people and remote and very remote communities where English is not the first language spoken.

Australia's approach to health promotion is guided by the World Health Organisation's Ottawa Charter for Health Promotion which defines health promotion as the process of enabling people to increase control over, and thereby improve, their health. The 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 that there is limited capacity in health services and in particular, primary health care services, to develop targeted initiatives focusing on just HIV and hepatitis C. It is generally accepted that health promotion in Aboriginal and Torres Strait Islander communities should focus on all the elements essential to health. There is widespread support for ensuring the prevention activities related to HIV and hepatitis C are embedded into broader health promotion programs to ensure maximum impact.

Many health promotion campaigns for 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 localised contexts and using appropriate language and images. Preventive health education messages improving health literacy of young people and priority populations identified in this Strategy should be ongoing, and account for the cultural contexts and situational factors relevant to each group.

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 a safe environment. Education and health literacy improvements should be delivered with a greater emphasis on comprehensive approaches to sexual wellbeing, health and substance use. Furthermore, young people outside the school environment do not have the same levels of access to health promotion and education and therefore require education and health promotion that responds to their environment.

***Priority actions in health promotion and health literacy***

- Ensure comprehensive school-based and out-of-school sexual health and BBV education programs are available, with quality training attached, for delivery by all those who work with Aboriginal and Torres Strait Islander populations at risk;
- Develop social marketing campaigns in consultation with the intended target groups to ensure local relevance and support; and
- 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, men who have sex with men, sistergirls and transgender people is supported. Sex between men accounts for over half of all HIV infections in Aboriginal and Torres Strait Islander people and, as a consequence, this group will need to remain a continued focus of HIV prevention, support and care initiatives for Aboriginal and Torres Strait Islander populations.

Gay men, men who have sex with men, sistergirls and transgender people experience a range of factors resulting in them continuing to be vulnerable to BBVs and STIs. In accessing health services, they commonly experience discrimination based on race, sexuality and transgender status. Aboriginal and Torres Strait Islander gay men, men who have sex with men, sistergirls and transgender people have consistently reported difficulties accessing both specialist HIV services and Aboriginal and Torres Strait Islander community controlled health services. Actual and perceived racism on the one hand and homophobia and lack of confidentiality on the other are powerful barriers to service access and will require continued attention during this Strategy. These groups also experience high levels of sexual and other violence, exacerbating STI vulnerability.

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

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

- Continue support for mechanisms for Aboriginal and Torres Strait Islander 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 for gay men, men who have sex with men, sistergirls and transgender people;
- Improve the capacity of gay men, men who have sex with men, sistergirls and transgender people to contribute to initiatives to address the risks associated with injecting drug use;
- Support research which will help enhance sexual health responses for gay men, men who have sex with men, sistergirls and transgender people and assist them to address emerging issues; and
- Support efforts to address violence (including sexual violence) against gay men, men who have sex with men, sistergirls and transgender people.

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

There are currently around 300 people living with HIV, about 28 000 people living with chronic B and 13000 living with chronic hepatitis C in the Aboriginal and Torres Strait Islander community. There is growing concern about these blood borne viruses in the Aboriginal and Torres Strait Islander community and the need for focused prevention, diagnosis, treatment and support initiatives in this area. The personal impacts of BBVs on individuals can be severe: apart from the obvious impact on health and wellbeing, effective management of infection may require individuals to make changes to their lifestyle, modify behaviours to lower the risk of passing the virus on to others, and gain access to treatment.

The capacity of ACCHS and other primary health care services to provide adequate treatment, care and support options for Aboriginal and Torres Strait Islander people with HIV, hepatitis C and B is an ongoing issue that needs to be addressed particularly in a sector that is already under growing pressure to cope with a huge burden of disease, and where the demands are increasing in relation to these diseases.

For primary health care services to be effective in providing treatment, care and support options for Aboriginal and Torres Strait people with HIV and viral hepatitis, they need to be adequately resourced and have sufficient flexibility to accommodate changing individual needs and new treatment options. In particular, access to specialist services for the treatment of hepatitis C is needed, to complement those provided in primary health care services. The linkages between the mainstream and community-controlled health care sectors are equally important. Successful programs should be investigated as a model for further implementation in ACCHSs.

Programs that aim to increase treatment outcomes for people living with chronic viral hepatitis or HIV should understand and 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 against Aboriginal and Torres Strait Islander people, particularly gay men and people who inject drugs, affects treatment and care, both within the community sector and mainstream health services;
- Discrimination directed at people living with HIV and viral hepatitis;
- The considerable diversity of circumstances for those affected, including cultural differences and wide geographical spread, demand flexible care and treatment approaches;
- Treatment and support needs should be approached within a framework that recognises the importance of men's and women's business; and
- Real or perceived lack of confidentiality.

*Priority actions for people living with HIV and viral hepatitis*

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

## **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 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 the preventable deaths of Aboriginal and Torres Strait Islander women due to cervical cancer has been identified as an emerging

issue. 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 role of ATAGI and PBAC in making recommendations regarding eligibility for vaccine funding.

***Priority actions regarding emerging issues***

- A systematic review of the evidence will be conducted with a view to development of a national trichomoniasis action plan;
- Coverage of HPV vaccination among young Aboriginal and Torres Strait Islander women should be closely monitored. Any extension of HPV vaccination to boys and men should be evidence based and include actions that aim to reach all eligible cohorts;
- Exploration of the role of HPV immunisation in high-risk older women; and
- Continuing efforts should be made to improve Pap smear testing in older Aboriginal and Torres Strait Islander women because of the very high rates of cervical cancer and death from cervical cancer.

## **7. Developing a competent and well supported workforce**

A strong primary health care workforce that is adequately resourced in the community controlled and mainstream health sectors is a prerequisite for effective action in addressing Aboriginal and Torres Strait Islander STIs and BBVs. 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 health care workers in sexual health prevention, treatment, care and support across ACCHS and mainstream services. In considering workforce strategies in relation to Aboriginal and Torres Strait Islander sexual health and the rate of BBV infection, 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 workforce is outlined in the National Strategic Framework for the Aboriginal and Torres Strait Islander Health Workforce<sup>15</sup>. A Blueprint for Action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people<sup>16</sup> sets out a joint reform agenda endorsed by all Australian governments, with a 5-10 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 and an increase in the number of Aboriginal and Torres Strait Islander Sexual Health Workers so that there is national consistency is recognised. Furthermore, this workforce, along with the mainstream health workforce, should be provided with 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. The national registration of sexual health workers (via the

COAG national health registration process currently in development) in either clinical or public health preventive pathways that is linked to the new national Aboriginal and Torres Strait Islander Health Workers competency pathways is supported.

The recruitment, retention and continuity of sexual health-specific 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 people and acceptable to Aboriginal and Torres Strait Islander communities.

Retaining staff through the provision of 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 seen as critical aspects currently missing from the training of ASHWs.

## **7.2 Aboriginal and Torres Strait Islander Health Workers**

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

## **7.3 Other workforces**

Non-Indigenous staff, including other health care staff in ACCHS, GPs and other primary care providers have a central role in the provision of care to Aboriginal and Torres Strait Islander communities, should be provided with training in the areas of STIs and BBVs to ensure that all staff are identifying risk population groups as a priority for early detection, treatment and referrals where required. The engagement of mainstream services within ACCHS to bring specialised STI and BBVs training to clinical staff should be considered as a way of up-skilling GPs and other clinical staff within ACCHS. Custodial staff and health care workers in prison and juvenile detention settings also need access to training.

GP 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 other primary health care services are 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 which may lend extra support in the area of Aboriginal and Torres Strait Islander 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 (ASHWs) nationally and identify gaps in the workforce particularly those located in ACCHSs;
- Provide training for health service leaders and managers to develop and run organised, systematic STI programs that incorporate opportunistic and targeted screening, health education and use of data to evaluate programs;
- Improve the training, qualification and career pathways for ASHWs and generalist AHW, linked to national competency standards, encompassing STI and BBVs, public health and epidemiology; increase the number of ASHWs in jurisdictions where there are very few ;
- Collaborate with new initiatives and other national strategies and programs to advocate for increased ASHW positions in ACCHS and mainstream services nationally;
- Employ gender-specific workers, where necessary, using women's and men's health workers to offer a wide range of services;
- Explore any barriers to workforce development and approaches to addressing these barriers; and
- Improve the effectiveness of training, recruitment and retention for both Aboriginal and Torres Strait Islander and non-Indigenous staff in Aboriginal and Torres Strait Islander primary health care services.

## 8. Surveillance

Improvements in the accuracy and completeness of Aboriginal and Torres Strait Islander status in routine STI and BBV surveillance systems across all jurisdictions will improve the understanding of STIs in Aboriginal and Torres Strait Islander people, facilitating prevention and clinical management strategies and providing tools for monitoring and evaluation.

There remain considerable gaps in the accuracy of reportable data for Aboriginal and Torres Strait Islander people. In 2008, 52% or over 30 000 cases of notified chlamydia in Australia did not report Aboriginal and Torres Strait Islander status, similarly 2178 cases or 28% of all gonorrhoea did not report Aboriginal and Torres Strait Islander status. These missing data have the potential to underestimate the true prevalence and morbidity associated with these STIs in Australia among this population. 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 people have arisen from routine notifications required by public health legislation in Australia. Despite this, there remain considerable gaps in information related to Aboriginal and Torres Strait

Islander people living in regional and urban areas of Australia where the majority of this population reside. This is a particular issue in relation to reporting of Aboriginal and Torres Strait Islander 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 people. For example the Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS) reports on chlamydia infections outcomes in 90 clinical services across Australia and provides data specifically related to Aboriginal and Torres Strait Islander people. A data linkage project will be undertaken in 2010 to improve accuracy and completion of STI and BBV data in NSW. These types of initiatives should be extended and supported in the absence of an incomplete national surveillance system that cannot report for Aboriginal and Torres Strait Islander status.

Improving completeness and accuracy of Aboriginal and Torres Strait Islander status within the NNDSS will require a number of agencies coming together to identify, develop and implement strategies that may increase notification data. It is recommended that NACCHO, the Royal Australasian College of Physicians (RACP), the Royal Australian College of General Practitioners (RACGP) and the Royal College of Pathologists of Australia (RCPA) take a collaborative lead on this issue. An Office for Aboriginal and Torres Strait Islander Health (OATSIH) commissioned report - Improving Indigenous Identification in Communicable Disease Reporting Systems (IICDRPSC, 2004) - on strategies to improve Aboriginal and Torres Strait Islander identifiers in communicable disease notifications also highlights this need. Data also assist in the monitoring and evaluation of interventions and increase our understanding about prevalence and incidence of infections to 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 to accuracy and completeness of indigenous status 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: support the extension of enhanced sentinel surveillance programs such as the ACCESS project, investigating data linkage as a mechanism to improve data sets with regard to completeness and accuracy of Aboriginal and Torres Strait Islander status and following up the implementation of the CDNA Improving Indigenous Identification in Communicable Disease Reporting Systems. NACCHO, RACP, RACGP, RCPA and other stakeholders should identify, develop and implement strategies that will improve completeness and accuracy of Aboriginal and Torres Strait Islander status in NNDSS.

## **9. Research**

Research provides an evidence base for the development 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 appropriate 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 Research<sup>17</sup> will provide opportunities for addressing some of the knowledge gaps in relation to Aboriginal and Torres Strait Islander STIs and BBVs.

The formation of partnerships in research, particularly between the community sector and the national research centres will provide opportunities for addressing research gaps in relation to Aboriginal and Torres Strait Islander sexual health and BBVs, as well as for complementary capacity building in research.

***Priority actions in research***

- Identify specific research priorities in relation to primary health care access, epidemiological surveillance and health promotion needs for responding to priority population groups;
- Develop strategies and partnerships to actively involve local Aboriginal and Torres Strait Islander people in the collection, analysis and interpretation of research data related to their experiences of sexual health and BBVs and ensure the communication of findings to communities and others, including policy makers and planners;
- Continue partnerships with the national research centres to maximise the development, conduct 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; and
- Enable evaluation of strategies and interventions aimed at reducing risk behaviours.

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