Fourth National Aboriginal and Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy

2014-2017
Contents

1. Introduction ............................................................................................................. 4

2. Blood borne viruses and STIs in Aboriginal and Torres Strait Islander peoples ...................................................................................................................... 6
   2.1 Demographics ................................................................................................ 6
   2.2 Epidemiology of STIs and Blood Borne Viruses ............................................ 6

3. Measuring progress ................................................................................................. 9
   3.1 Goals ............................................................................................................. 9
   3.2 Objectives ...................................................................................................... 9
   3.3 Targets ........................................................................................................... 9
   3.4 Indicators ..................................................................................................... 10
   3.5 Implementation and Evaluation .................................................................... 12

4. Guiding principles ................................................................................................. 14
   4.1 Health Equality and a Human Rights Approach ............................................ 14
   4.2 Aboriginal and Torres Strait Islander Community Control and Engagement .............................................................................................................. 14
   4.3 Partnership ................................................................................................... 15
   4.4 Accountability .............................................................................................. 15

5. Priority groups ....................................................................................................... 16

6. Priority areas for action ........................................................................................ 17
   6.1 Prevention .................................................................................................... 17
   6.2 Testing ......................................................................................................... 21
   6.3 Management, care and support .................................................................... 23
   6.4 Workforce .................................................................................................... 25
   6.5 Removing barriers ....................................................................................... 26
   6.6 Surveillance, Monitoring and Evaluation ...................................................... 27

7. System Barriers and Enablers .............................................................................. 29
   7.1 Access ........................................................................................................... 29
   7.2 Stigma and Discrimination ............................................................................ 30
   7.3 Delivery ........................................................................................................ 31

Acknowledgements ............................................................................................................ 33
1. Introduction

Aboriginal and Torres Strait Islander people represent three per cent of Australia's population, and within this population there is significant diversity in culture, language, geographical and socio-economic influences. This diversity presents a unique challenge when addressing sexually transmissible infections (STIs) and blood borne viruses (BBVs) among Aboriginal and Torres Strait Islander communities.

Persistent very high rates of STIs and the continuing disproportionate burden of viral hepatitis affecting Aboriginal and Torres Strait Islander people underlines the urgency of addressing these infections in this population. Additionally, despite this disproportionate burden of viral hepatitis and similar rates of HIV to non-Indigenous Australians, the number of Aboriginal and Torres Strait Islander people with viral hepatitis and/or HIV on antiviral treatment appear to be extremely low.

Despite these difficulties, there are grounds for optimism. Scientific advances in preventing and treating HIV have provided us with the knowledge and the means to make dramatic reductions in new HIV infections. Ground-breaking antiviral treatments for hepatitis C will become available in Australia during the life of this strategy. These treatments are less toxic, require less complex dosing, reduce treatment duration and have been shown to significantly improve cure rates. Innovative testing technologies are creating opportunities to significantly improve testing accessibility which will lead to reduced transmission of many STIs.

This Strategy is one of a suite of five strategies which provide a framework for the coordinated effort by the Commonwealth, states and territory governments and communities, clinicians and researchers to address already high or rising rates of HIV, hepatitis B, hepatitis C, and STIs in priority populations within Australia. Management of these diseases in Aboriginal and Torres Strait Islander communities, while addressed in each of these strategies, is also drawn together in a single strategy, to reflect the particular importance in responding to BBVs and STIs among Aboriginal and Torres Strait Islander Australians.

The four disease specific strategies highlight the need to review and refresh existing approaches to ensure that the impact of traditional prevention messages, and new testing and treatment options, reach the population groups where surveillance shows that rates of BBVs and STIs are high or rising. Partners to this strategy will need to consider these approaches and options, and ensure they are implemented in an appropriate, relevant and effective way for the Aboriginal and Torres Strait Islander community.

Health promotion models traditionally focus on targeted initiatives; however there is also benefit in embedding BBV and STI activities and messages into broader Aboriginal and Torres Strait Islander health promotion programmes. A holistic approach to health will build on the strong association between well-being and health for Aboriginal and Torres Strait Islander peoples.

The health care community, both mainstream and Aboriginal medical services, need to refocus their efforts towards STI testing and timely treatment. Services need to reorient their systems to maximise opportunities to address these aspects of STI management.

Reducing the incidence of BBVs in Aboriginal and Torres Strait Islander peoples calls for a continuing emphasis on safe sex and injecting practices, combined with improvements in testing and management. Increasing the use of clean injecting equipment for every injecting episode has been highlighted as a key target for this priority population, given the higher contribution of injecting drug use to HIV transmission and higher rate of hepatitis C
diagnosis among Aboriginal and Torres Strait Islander peoples compared to non-Indigenous Australians.

For improvements in the health of Aboriginal and Torres Strait Islander peoples to be realised it is vital communities and individuals have the ability and freedom to be empowered and translate their capacity, knowledge, skills and understanding into action. This requires an integrated approach which encompasses strengthening community functioning, reinforcing positive behaviours, improving education participation, regional economic development, housing and environmental health, and spiritual healing.

This Strategy recognises a range of system enablers that impact on the health and health access for Aboriginal and Torres Strait Islander individuals and communities. These include access to health services, including addressing transport and health literacy issues; delivery of suitable and sustainable culturally appropriate management, including by supporting community engagement and workforce development and participation; social and emotional wellbeing and an enabling legal environment. Barriers to accessing health services, which must be addressed, include racism, stigma and discrimination and criminalisation.

This Strategy identifies particularly vulnerable groups of Aboriginal and Torres Strait Islander people who face additional stigma and discrimination and associated with being young, a person who injects drugs, a sex worker, gay or a man who has sex with men, or a person living with HIV or viral hepatitis.

The health sector has a role in realising necessary improvements in education and employment outcomes. The need to progress action across all these related areas has been recognised by all governments in the Closing the Gap framework - the building blocks and targets focus efforts on key areas of disadvantage and provide a framework for ongoing action to improve outcomes across social determinants of health.
2. Blood borne viruses and STIs in Aboriginal and Torres Strait Islander peoples

2.1 Demographics

In 2011, an estimated 669,900 (1) people identified as being of Aboriginal and/or Torres Strait Islander origin in Australia, representing 3% of all Australians (2). The largest Aboriginal and Torres Strait islander population was in New South Wales, followed by Queensland and Western Australia. Aboriginal and Torres Strait Islander Australians made up almost a third (30%) of the population of the Northern Territory.

The majority of Aboriginal and Torres Strait Islanders lived in major city (35%) and inner regional areas (22%). Approximately one fifth (21%) lived in remote and very remote areas, compared to only 2% of non-Indigenous Australians (2).

The Aboriginal and Torres Strait Islander population had a much younger age structure than the non-Indigenous population, with around 36% aged less than 15 years compared with 19% of the non-Indigenous population. This large proportion of young Aboriginal and Torres Strait Islander people has implications for the sexual health and wellbeing of this population. (2)

2.2 Epidemiology of STIs and Blood Borne Viruses

It is important to note that the rates of STIs, hepatitis B and hepatitis C among Aboriginal and Torres Strait Islander people are not fully understood and likely to be under reported. This results, in part, from Aboriginal and Torres Strait Islander status not always being reported with notifications. Improving reporting of Aboriginal and Torres Strait Islander status remains a priority area for BBV and STI surveillance.

In addition, notification data must be carefully interpreted because notifications and trends may not reflect true population prevalence or change, and are influenced by testing practices.

Bacterial Sexually Transmissible Infections

Rates of infection for bacterial sexually transmissible infections are much higher in the Aboriginal and Torres Strait Islander community than in non-Indigenous Australians. Rates of chlamydia are 3.5 times, gonorrhoea 30 times and infectious syphilis five times higher for Aboriginal and Torres Strait Islander people compared to non-Indigenous Australians (3). Within the Aboriginal and Torres Strait Islander populations, reported rates of STI infections are highest in those aged 15-29 years and those living in outer regional, remote and very remote locations.

The implications of ongoing high rates of untreated STIs are particularly serious for women. Untreated STIs have been associated with an increased risk of pelvic inflammatory disease, ectopic pregnancy and infertility (4). However, specific data are limited. The Prevention of Pelvic Infection (POPI) trial published in 2010 reports that almost ten percent of women with untreated chlamydia infection were diagnosed with PID by 1 year of follow-up (5), and estimated that untreated chlamydial infections increased the risk of PID by 6.5-25 fold, compared to no infection. Evidence suggests that repeated infections increases the risk of
PID, PID can develop in only a few weeks (6), severe disease is associated with an increased likelihood of ectopic pregnancy and infertility (7).

*Trichomonas vaginalis* infection is often asymptomatic but associated with adverse pregnancy outcomes and increased risk of transmission of HIV (8). While it is considered endemic in some Aboriginal and Torres Strait Islander populations, it is only notifiable in Northern Territory and as such a national picture is not available. Surveillance data from this jurisdiction show higher notification rates than chlamydia and gonorrhoea in Aboriginal women, up until 40 years of age, than in men. Limited data are available on the prevalence of *trichomonas vaginalis* in men. Donovanosis is an STI once prevalent in remote areas of Australia, however notification rates reduced significantly as a result of a targeted programme of Donovanosis eradication (3).

**Blood Borne Viruses**

The reported rate of HIV infection is comparable between the Aboriginal and Torres Strait Islander community and the non-Indigenous community, and the most frequently reported route of transmission was sexual contact between men in both Aboriginal and Torres Strait Islander people (61%) and non-Indigenous people (75%). Importantly, reports of HIV in Aboriginal and Torres Strait Islanders differ from non-Indigenous Australians in that a higher proportion of infections were attributed to injecting drug use (13% vs 2%) and a higher proportion were among women (22% vs 8%)(3). This suggests that there is a greater risk, over time, for HIV to spread more generally in the Aboriginal and Torres Strait Islander communities as opposed to the non-Indigenous population where the risk of transmission is much more concentrated in gay men and men who have sex with men.

It has been estimated that approximately 16% of the chronic hepatitis B burden in Australia occurs in Aboriginal and Torres Strait Islander people (9). In 2012, the rate of new diagnosis of hepatitis B in Aboriginal and Torres Strait Islander people was high at 86 per 100,000 (3). Furthermore, hepatitis B continues to be newly acquired by Aboriginal and Torres Strait Islander people at three times the rate than in non-Indigenous Australians (3 per 100,000 vs 1 per 100,000 (3). These new cases primarily occurred in those aged over 20 years of age (84%) and in females (male to female ratio of 0.4 to 1) in 2012.

The notification rate (per 100,000) of newly diagnosed hepatitis C in the Aboriginal and Torres Strait Islander population has gradually increased from 130 in 2008 to 166 in 2012. This compares to a decreasing rate in non-Indigenous Australians for the same time period from 51 to 40 per 100,000. New diagnoses of hepatitis C in Aboriginal and Torres Islanders most commonly occur in those aged between 20-49 years. Transmission continues to occur predominantly among people with a history of injecting drug use. Data from the Australian Needle Syringe Programme Survey reports that hepatitis C prevalence has been higher among Aboriginal and Torres Strait Islander survey respondents compared to non-Indigenous participants for most years(3).

**Emerging Issues**

Human T-cell lymphotropic virus type 1 (HTLV1) is a blood borne virus which is a distant relative of HIV but does not cause AIDS. The adverse health outcomes of infection are long term and occur in up to 5-10% of those infected, and include acute T-cell leukaemia/lymphoma and myelopathy (10). In Australia it occurs mainly in the Aboriginal populations, however prevalence estimates are varied, difficult to obtain and have important
limitations, with estimates ranging from 14% up to 40% (11,12). Improved estimates for local seroprevalence and a better understanding of the risks of infection are necessary to guide control efforts in Australia.

A more detailed breakdown of the epidemiology of STIs and BBVs among Aboriginal and Torres Strait Islander people is at Appendix 1.
3. Measuring progress

3.1 Goals

The goal of the National Aboriginal and Torres Strait Islander BBV and STI Strategy 2014–2017 is to reduce the transmission of and morbidity and mortality caused by BBV and STIs and to minimise the personal and social impact of these infections in Aboriginal and Torres Strait Islander communities.

3.2 Objectives

This strategy has the following five over-arching objectives which, in combination, are designed to support achieving the above goal:

1. Improve knowledge and awareness of STIs and BBVs

2. Reduce the incidence of STIs in Aboriginal and Torres Strait Islander people and communities
   2.1. Achieve high levels of HPV vaccination
   2.2. Reduce the risk practices associated with transmission
   2.3. Increase appropriate testing and follow-up among those at elevated risk

3. Reduce the incidence of BBVs in Aboriginal and Torres Strait Islander people and communities
   3.1. Achieve high levels of hepatitis B vaccination
   3.2. Reduce the risk practices associated with the transmission
   3.3. Decrease the number with undiagnosed BBVs

4. Increase the number of Aboriginal and Torres Strait Islander people receiving appropriate management, care and support for BBVs

5. Eliminate the negative impact of stigma, discrimination and human rights issues on Aboriginal and Torres Strait Islander health
   5.1. Increase engagement with Aboriginal and Torres Strait Islander communities through sustained and authentic action
   5.2. Improve delivery of and access to appropriate services

3.3 Targets

Targets are included for the first time in this Fourth National Aboriginal and Torres Strait Islander BBV and STI Strategy. These aspirational targets provide a specific focus for the efforts of all partners in moving towards achieving the above objectives and overall goal.

For many of these targets, the available evidence and surveillance data is insufficient to adequately inform the setting of quantitative targets. The focus of this strategy is on achieving improvements in these areas, while working towards being able to set justifiable targets for the next strategy.
Targets included in the National HIV, Hepatitis C, Hepatitis B and STI Strategies all directly apply to this priority population. These are included in Appendix 2 for reference.

The targets specifically identified in this strategy are, by 2017, in Aboriginal and Torres Strait Islander people and communities to:

1. Eliminate congenital syphilis
2. Reduce the incidence of chlamydia, gonorrhoea and infectious syphilis, accounting for testing levels, in < 30 years of age.
3. Increase the use of clean injecting equipment for every injecting episode
4. Increase treatment uptake by people with HIV, hepatitis C and hepatitis B

Congenital syphilis primarily occurs within the Aboriginal and Torres Strait Islander community in Australia, and its presence is an important indicator of a successful integrated public health response to STIs. Among Aboriginal and Torres Strait Islander populations, the national annual notifications for congenital syphilis ranged from zero to four between 2007 and 2012 (unpublished analysis as at 17 April 2014).

The high prevalence of chlamydia, gonorrhoea and infectious syphilis in some Aboriginal and Torres Strait Islander communities, particularly those aged less than 30 years of age, continues to be a significant driver of the ongoing spread of these infections. A renewed and coordinated focus to reduce STI incidence is necessary to achieving the goal of this strategy.

Reducing the incidence of BBVs in Aboriginal and Torres Strait Islander peoples requires a continuing emphasis on encouraging and supporting safe sex and injecting practices, combined with improvements in testing and management. Increasing the use of clean injecting equipment for every injecting episode is a key target, given the higher contribution of injecting drug use to HIV transmission and higher rate of hepatitis C diagnosis among Aboriginal and Torres Strait Islander peoples compared to non-Indigenous Australians.

Despite similar rates of HIV and a higher proportionate burden of viral hepatitis in Aboriginal and Torres Strait Islander populations, numbers on treatment appear to be very low. Similar opportunities must be provided for Aboriginal and Torres Strait Islander people to access culturally appropriate management for HIV, hepatitis B and C.

### 3.4 Indicators

Indicators will be used to monitor the implementation of the strategy, to report against the progress against achieving the above targets and objectives, and therefore to inform changes in the response as required.

The indicators listed below can currently be reported on. There are limitations in the ability to measure progress against many of the objectives and targets, both in the quality of the available indicators and in some cases a complete lack of available data or appropriate methodology.

There is no current indicator to report nationally against sexual health risk behaviours in Aboriginal and Torres Strait Islander people. There is also no ability to report on the treatment coverage for BBVs in Aboriginal and Torres Strait Islander people as the current administrative data set does not collect Aboriginal and Torres Strait Islander status.
Indicators which rely on general administrative datasets, such as testing levels, are dependent on Aboriginal and Torres Strait Islander status identification which varies in completeness and therefore reliability.

As with all the national BBV and STI strategies, there is no indicator currently available to measure progress in reducing the health impact of stigma, discrimination, and human rights. In this strategy, the ability to measure active engagement with the community, and delivery of and access to appropriate services is important.

These gaps and limitations are discussed further in the surveillance and monitoring section 7.6.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Sub-objective</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve knowledge and awareness of STIs and BBVs</td>
<td>Proportion of Aboriginal and Torres Strait Islander peoples giving correct answers to a knowledge and behaviour question on STIs and BBVs</td>
<td></td>
</tr>
<tr>
<td>Reduce the incidence of STIs</td>
<td>Proportion of chlamydia tests that yield a positive result in 15-29 year age group* (Target 2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual rate of notifications of infectious syphilis, chlamdia and gonorrhoea* (Target 2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of notifications of congenital syphilis annually* (Target 1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieve high levels of HPV vaccination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HPV 3 dose vaccination coverage for males and females turning 15 years of age*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduce the risk behaviours associated with transmission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase appropriate testing and follow-up among those at elevated risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of 15 to 29 year olds receiving a chlamydia test in the previous 12 months*</td>
<td></td>
</tr>
<tr>
<td>Reduce the incidence of BBVs</td>
<td>National annual rate of newly acquired hepatitis C diagnosis*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Estimated incidence of recent HIV infection*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieve high levels of hepatitis B vaccination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis B immunization coverage in children at 12 and 24 months*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduce the risk behaviours associated with the transmission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of people who inject drugs reporting re-using another person’s used needle and syringe</td>
<td></td>
</tr>
</tbody>
</table>
**3.5 Implementation and Evaluation**

The Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy sets high level directions for action over the next four years. An Implementation and Evaluation Plan will be developed in consultation with partners and will detail how priority actions will be implemented, including roles and responsibilities, timeframes and lines of accountability.

Australia’s world recognised partnership approach will remain central to our response to blood borne viruses and sexually transmissible infections. Undertaking the actions set out in this strategy by December 2017 requires Australian, state and territory governments; community organisations; service delivery organisations; professional bodies; and, research institutions to work together. In doing this, we need to ensure that infected and affected individuals and communities remain at the heart of our response and involved in activities as they are proposed, developed and implemented.

This strategy builds on its three predecessors, which have guided Australia’s response to BBVs and STIs in Aboriginal and Torres Strait Islander people between 1999 and 2013. It is one of five interrelated national strategies aiming to reduce the transmission and impact of BBVs and STIs. The other strategies are the:

- Seventh National HIV Strategy 2014–2017
- Third National Sexually Transmissible Infections Strategy 2014–2017
- Fourth National Hepatitis C Virus Strategy 2014–2017
- Second National Hepatitis B Virus Strategy 2014–2017
The five national strategies share common structural elements, designed to support a coordinated effort in addressing common concerns. Much of the prevention, health care and community responses contained in the strategies are intrinsically linked through co-infections, commonalities in risk factors and shared responsibility for the clinical management of BBVs and STIs.
4. Guiding principles

This Strategy aims to address BBV and STI in Aboriginal and Torres Strait Islander people within the framework of the following four principles:

1. Health Equality and a Human Rights Approach
2. Aboriginal and Torres Strait Islander Community Control and Engagement
3. Partnership
4. Accountability

Together with the four principles outlined above, the guiding principles outlined in the HIV, hepatitis B, hepatitis C and STI strategies also inform this strategy and are drawn from Australia’s efforts over time to respond to the challenges, threats and impacts of HIV, STIs and viral hepatitis. These are outlined in Appendix 3.

4.1 Health Equality and a Human Rights Approach

The principles of the United Nations Declaration on the Rights of Indigenous Peoples and other human rights instruments support Aboriginal and Torres Strait Islander people in attaining the highest standard of physical and mental and social health.

A rights-based approach is about providing equal opportunities for health by ensuring availability, accessibility, acceptability and quality health services. This frames both policy development and the development of goals and targets. A human rights approach helps highlight additional risks and opportunities for health and wellbeing programmes before any final decisions are made. In this way, a rights-aware approach is not necessarily about more services, but about better services through better informed policy, practice and service delivery decisions, and the processes that enable Aboriginal and Torres Strait Islander people to participate in all levels of health care decision-making.

Stewardship of health is the responsibility of each person to whom health has been entrusted. Creating the personal, environmental, and social conditions for good health is a joint responsibility—public, community, private, government, organisation and individual.

4.2 Aboriginal and Torres Strait Islander Community Control and Engagement

There is full and ongoing participation by Aboriginal and Torres Strait Islander people and organisations in all levels of decision-making affecting their health needs.

Through community consultations, individuals and communities voiced their desire to be involved in the service planning, design and implementation of policies to support their health and wellbeing. In order to enable Aboriginal and Torres Strait Islander people to participate, Government must support the development of opportunities for engagement, education and collaboration with individuals, Aboriginal and Torres Strait Islander community controlled health organisations and other health and related services.

Aboriginal and Torres Strait Islander community controlled health organisations provide unique contributions in delivering holistic, comprehensive and culturally appropriate health
care. All services delivering primary health care at the local, regional and state levels should seek to optimise their engagement and involvement with Aboriginal and Torres Strait Islander people to improve health outcomes.

4.3 Partnership

Partnership and shared ownership between Aboriginal and Torres Strait Islander people, Governments and service providers operates at all levels of health planning and delivery.

Working in partnerships to remove barriers to good health and building the evidence around health interventions is critical for improving the health and wellbeing of Aboriginal and Torres Strait Islander people. Partnerships also provide a mechanism to effectively engage with communities on their goals and priorities for health.

Partners to the implementation of this strategy are strongly encouraged to develop meaningful partnerships with local and national Aboriginal community controlled organisations or other Aboriginal and Torres Strait Islander services to ensure that programs are developed and delivered in a way that meets community needs.

The Australian Government will seek to partner with state and territory governments and Aboriginal and Torres Strait Islander people and their representatives to implement the priority action areas to ensure that their implementation will meet the diverse needs of Aboriginal and Torres Strait Islander Australians of all ages, backgrounds and locations.

4.4 Accountability

Structures are in place for the regular monitoring and review of implementation as measured against indicators of success, with processes to share knowledge on what works.

The Australian Government is committed to high quality monitoring and evaluation, and to public accountability for its efforts to address BBV and STI rates in Aboriginal and Torres Strait Islander people. Targets for this Strategy have been developed which are specific, achievable, realistic and time-bound.
5. Priority groups

While Aboriginal and Torres Strait Islander people are a priority population of their own within the other four national strategies, targeting responses to priority populations is critical to maximise the impact and sustainability of our response. The priority groups for this strategy reflect Australia’s epidemiological data and social context. Members of one priority community may also be members of other priority groups.

Priority groups for this strategy are:

- Young Aboriginal and Torres Strait Islander people
- Aboriginal and Torres Strait Islander people who inject drugs
- Aboriginal and Torres Strait Islander people in juvenile justice and adult prisons
- Aboriginal and Torres Strait Islander gay men, men who have sex with men, sistergirls and transgender people
- Aboriginal and Torres Strait Islander people living with HIV and viral hepatitis
- People living in the cross-border region of Australia and Papua New Guinea
- Aboriginal and Torres Strait Islander sex workers

Appendix 4 outlines the main reasons for priority group status and identifies specific subgroups of higher prevalence and/or higher risk. It also notes the main barriers and facilitators to effective responses, specific to priority groups.
6. Priority areas for action

Prevention is the most effective response to reducing the spread and impact of STIs and BBVs. For Aboriginal and Torres Strait Islander peoples, many factors heighten the risk of these infections, including poorer social and economic factors (social determinants), specific language and cultural issues, combined with very high existing rates of STIs. There is a critical need to sustain and improve targeted prevention efforts.

Timely testing and early detection of STIs and BBVs is important to ensure appropriate management, prevent the development of complications and limit further transmission. Many STIs and BBVs are asymptomatic and will therefore go undiagnosed and untreated unless testing occurs more frequently in at-risk individuals. Raising awareness and knowledge of STIs and BBVs and their consequences is essential to achieving this.

Timely and appropriate treatment and management for all STIs and BBVs is essential for healthy communities. Lifelong monitoring for disease progression, communities pose some particular challenges including high degree of mobility…

The comprehensive national response to STIs and BBVs in Aboriginal and Torres Strait Islander peoples addresses the following 6 priority areas:

- Prevention
- Testing
- Management, Care and Support
- Workforce
- Removing barriers, and
- Surveillance, research and evaluation.

6.1 Prevention

<table>
<thead>
<tr>
<th>Priority actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen health promotion and disease prevention activities regarding safe sex, condom availability and access, and safe injecting practices</td>
</tr>
<tr>
<td>Pilot and scale up targeted activities in young people to build knowledge and skills regarding safe sex and injecting practices through</td>
</tr>
<tr>
<td>Improve vaccination coverage for hepatitis B and HPV</td>
</tr>
<tr>
<td>Increase the coverage and accessibility of injecting equipment (NSPs) as appropriate to the local community context and specific settings</td>
</tr>
</tbody>
</table>

6.1.1 Health Promotion, Social Marketing and Education

Complex behavioural change, such as reducing unsafe sex and injecting practices, requires an integrated and sustained health promotion and disease prevention approach. Culture and cultural competency must be central to initiatives targeting Aboriginal and Torres Strait
Islander people. Health promotion that is responsive to the social, cultural and environmental context is essential to improving the health of Aboriginal and Torres Strait islander people.

Important components of a combined approach to achieve a reduction in transmission of BBVs and STIs includes communication activities designed to improve health literacy, skills, knowledge and choice (e.g. social marketing and education activities aimed at raising the age of sexual debut); improved access to information, testing, and treatment, care and support services; and availability and access to tools and equipment to support healthy behaviour choices (e.g. condoms).

A holistic approach to health will build on the strong association between well-being and health for Aboriginal and Torres Strait Islander peoples. While many health promotion models focus on targeted initiatives, embedding BBV and STI activities and messages into broader Aboriginal and Torres Strait Islander health promotion programmes.

Ensuring that interventions are practical and that health promotion initiatives link to action pathways, for example emphasising the role of testing for STIs and BBVs, and identifying where people can go to get testing, treatment and support should be supported.

Peer pressure and group behaviours have an influence on an individual’s decisions. Peer education and support have played an important role in HIV risk reduction and in reaching some hard to reach groups of people who inject drugs. Peers are credible, trusted sources of information and can reach people who are not being reached by other means and assist in overcoming physical and socio-cultural barriers(13). There would be benefit in strengthening the evidence for particular peer education models for Aboriginal and Torres Strait Islanders, as there may be considerable variation in what works with whom and where for communities in Australia.

Particular consideration should be given to targeting young Aboriginal and Torres Strait Islander people, given the high burden of STIs, the relatively higher fertility rate among Aboriginal and Torres Strait Islander teenagers and the population profile of the community. There are challenges to reaching young people in a way that is contemporary, culturally appropriate and supported by the community. Furthermore, young people outside the school environment do not have the same access to health promotion and education and therefore improved use of non-school settings is important.

Aboriginal and Torres Strait Islander peoples in correctional settings are also an important priority group. It is essential that easily accessible education be provided in Australian custodial settings as a fundamental health promotion technique to support risk reduction practices.

6.1.2 Vaccination

Vaccination remains a key prevention activity. The vaccination targets in the National STI and hepatitis B strategies align with the National Immunisation Strategy 2013-2018, where improving immunisation coverage is the first strategic priority. This strategy needs to build on the success of HBV and HPV vaccination programmes for Aboriginal and Torres Strait Islander people.

Hepatitis B vaccine is funded under the National Immunisation Programme for all Australians at birth and at 2, 4 and 6 months of age. Improvements in the timeliness of HBV
vaccination for Aboriginal and Torres Strait Islander children are required to achieve the 95% HBV childhood vaccination coverage target. The availability of funded vaccination for adults varies by jurisdiction. Aboriginal and Torres Strait Islander people of all ages are identified as a priority group for vaccination and initiatives need to be put in place to improve assessment of immune status and appropriate vaccination.

HPV vaccine is delivered to adolescent girls and boys through school-based programmes. It is important to ensure that adolescents who missed their vaccination because they were not at school can access vaccination through other services. Reaching 70% vaccination coverage nationally in Aboriginal and Torres Strait Islander peoples through the school based programme will require improved Aboriginal and Torres Strait Islander status identification in the HPV vaccination register.

6.1.3 Safe Injecting Practices

Strategies to improve access to and use of safe injecting equipment are essential. Injecting drug use contributes to a much higher proportion of HIV transmission in Aboriginal and Torres Strait Islander than in non-indigenous populations, and there is a significantly higher rate of diagnosis of hepatitis C among Aboriginal and Torres Strait Islander peoples(3). International lessons, such as the Canadian experience where the key mode of transmission of HIV in Aboriginal and Torres Strait Islander population continues to be shared injecting equipment (14), must be respected.

Strategies need to address experiences of stigma and discrimination, shame and isolation as a result of drug use, concerns regarding cultural safety and confidentiality/privacy within their community, as well as physical and socio-economic barriers such as geographical availability.

Improving safe injecting behaviours, and access to and coverage of safe injecting equipment, requires work in mainstream and Aboriginal specific centres. This may include innovative options such as incorporating NSPs within community-based health services, as appropriate to the local community context, and ‘silent’ NSPs.

The prevalence of hepatitis C infection is unevenly geographically distributed in the Aboriginal and Torres Strait Islander population(15). 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.

There continues to be a disproportionately higher number of Aboriginal and Torres Strait Islander people in correctional settings than is represented in the Australian population (16). Aboriginal and Torres Strait Islander peoples in correctional settings are an important priority group, particularly for the risk of STI and BBV transmission. It is important that a range of prevention options, including education and counselling, condoms, bleach and disinfectant, and opioid pharmacotherapy and drug rehabilitation programmes continue to be available in correctional settings. We recognise the challenges of addressing the risks of transmission in correctional settings, and this highlight the importance of strong ongoing engagement with the relevant sectors.
6.1.4 Safe Sexual Practices

Safe sexual practices rely on prevention equipment such as condoms and water based lubricant being available and accessible. Improvements are needed to address gaps which currently in such supplies for some remote communities and vulnerable groups.

Improving safe sex in young people is essential to the success of this strategy, however there are challenges to reaching young people in a way that is contemporary, culturally appropriate and supported by the community.

Sex education in schools is a highly effective strategy for decreasing sexual risk taking in young people (4). All Australian school students need to receive effective sex education. This must be supplemented by non-school based strategies for Aboriginal and Torres Strait Islander youth where school attendance is often lower. New media is an important tool to facilitate health promotion, and interactive videos, email and SMS containing health promotion messages to young people have been shown to reduce sexual risk behaviour and increase STI testing.

A significant proportion of HIV transmission in Aboriginal people is attributed to unsafe sexual practices amongst men who have sex with men (3), and some information suggests that higher risk sexual practices are a key element in transmission (17). Prevention strategies must be highly targeted to this priority group to improve awareness and knowledge and to increase the adoption of safer behaviours.

6.1.5 Prevention at the Torres Strait Islands/PNG border

The close physical distance, strong associations and high number of interactions between Indigenous Australians and Indigenous Papua New Guineans may increase the risk of ongoing transmission of BBVs and STIs between groups. The objectives of the Torres Strait Cross Border Health Issues Committee (HIC), co-chaired by the Australian Government Department of Health, are to strengthen the health service capacity in the Torres Strait and Western Province of Papua New Guinea and increase surveillance of communicable diseases in the Torres Strait Treaty Zone. It also identifies practical improvements to address cross border health concerns in the Torres Strait Treaty Zone. The HIC needs to take a key role in increasing our understanding of the risks of transmission and how these can be best managed at the border.
6.2 Testing

**Priority actions**

- Build on successful activities to improve testing rates and coverage
- Increase provider-initiated BBV and STI testing in primary care
- Explore the feasibility, accessibility and cost-effectiveness of the range of existing and emerging testing methods including point of care testing
- Identify, pilot and scale up successful activities to improve accessibility and testing in young people
- Maintain and strengthen links between STI and HIV testing

6.2.1 Blood Borne Viruses

The early detection of HIV, hepatitis C and hepatitis B infection is an essential component of the national response to reducing the impact of the BBVs in Australia. Ways in which testing and earlier diagnosis can be improved in Aboriginal and Torres Strait Islander peoples need to be explored with a focus on reviewing and addressing the barriers specific to BBV testing. An increased focus is required to identify and engage with populations at particular risk of these BBVs, and the link between STIs and BBVs, in particular HIV, needs to be highlighted.

Clinics and health professionals must be engaged to increase awareness, identify those at risk of infection, and improve action in this area. Efforts are required to maintain comprehensive STI and BBV testing in at risk individuals. Given the high prevalence of STIs in this population, improvements could be achieved by promoting the appropriate risk assessment and testing for BBVs when STIs diagnosed.

To maximise the benefits from diagnosing hepatitis B, the public health response should include appropriate testing and vaccinating of household contacts and sexual partners, and the provision of information to reduce the risk of ongoing transmission (5). A national protocol on the public health response to hepatitis B, which addresses the important role of primary care, is needed to improve national consistency.

HTLV-1 is increasingly being recognised as an important concern in some Aboriginal and Torres Strait Islander communities. There would be benefit in applying principles emerging from the public health management of HTLV-1 in international settings, such as Brazil and Japan, where it is prevalent. There is no specific treatment and no vaccine; hence the role of testing and preventing transmission is the public health focus. These countries have used a combination of antenatal testing to identify at risk mothers and breast feeding interventions to reduce the risk of transmission to children born to HTLV-1 positive mothers. The related work conducted over the last few years in Central Australia should be built on in the Australian context (10).
6.2.2 Sexually Transmissible Infections

Bacterial STIs are preventable, easily detectable and curable. Activities and tools which systematically increase the opportunities for priority groups to be tested should be explored and implemented. Health system changes that systematically increase the opportunities for testing include the integration of testing into existing health service delivery, reorienting of existing services or using outreach programmes.

Pilot projects using continuous quality improvement programmes to specifically increase testing and treatment in Aboriginal Community Controlled Health Services are providing promising results, and can be used as a basis for further work into the future.

There would be benefit in taking a holistic approach and incorporating appropriate testing into routine activities, such as visits for pap smears, contraception, Aboriginal and Torres Strait Islander health checks, and vaccinations. Testing or screening programmes may be considered, particularly in areas where there is high community prevalence of STIs. Testing programmes should be flexible and adjusting to the needs of the specific communities.

Outreach programmes are useful for targeting more difficult to reach priority groups, such as Aboriginal and Torres Strait Islander people in correctional facilities, where routine STI and BBV testing and vaccination may improve early detection and treatment.

Provider initiated opportunistic testing relies on health care professionals feeling confident and skilled in discussing sexual health. Culturally appropriate education on the importance of regular STI testing, and how to identify at-risk behaviour and symptoms, is necessary to support health care professionals to offer opportunistic testing. Toolkits and decision support materials also play an important role.

The future availability of point-of-care tests has the potential to significantly improve testing coverage and time to treatment in high prevalence population groups. This is likely to be especially useful in remote areas. Chlamydia and gonorrhoea rapid testing may reduce average time to treatment (currently 21 days for asymptomatic individuals in some remote Aboriginal communities) (6), and syphilis rapid tests improve outbreak responses providing rapid screening and immediate treatment in communities. Current trials of point-of-care tests in remote communities will be evaluated during the life of this strategy.

Health services must continue to review and improve their accessibility to Aboriginal and Torres Strait Islander peoples. This is particularly applicable for priority groups such as young people, and those services in urban settings. In addition to considering the youth friendliness of services, we need to explore models which normalise health-seeking behaviour for young people, particularly in high prevalence communities.

Current data on *Trichomonas vaginalis* indicates a very high prevalence in Aboriginal and Torres Strait Islander people compared to non-Indigenous Australians(3). Prevalence is noticeably high in females up to the age of 35 years, with particularly high rates in young Aboriginal and Torres Strait Islander women (16-24 years), and greater in remote areas compared to less remote and urban areas. Trichomoniasis infection is associated with adverse pregnancy outcomes, and an increased risk of HIV transmission. This strategy will focus on the development and implementation of consistent national guidance for testing for and management of Trichomoniasis.
While there has been some success in reducing infectious syphilis over recent years in Aboriginal and Torres Strait Islander communities, a more coordinated effort is needed in working towards the elimination of infectious syphilis in the Aboriginal and Torres Strait Islander population. Congenital syphilis primarily occurs within the Aboriginal and Torres Strait Islander community in Australia, and its presence is an important indicator of a successful integrated public health response to STIs. National annual notifications for congenital syphilis have ranged from zero to seven since 2007 (3).

6.3 Management, care and support

<table>
<thead>
<tr>
<th>Priority actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot advances and promote effective tools and activities to improve appropriate care and treatment</td>
</tr>
<tr>
<td>Explore methods to enhance contact tracing, partner notification and treatment systems</td>
</tr>
<tr>
<td>Adapt existing models of care to meet the specific needs of Aboriginal and Torres Strait Islander populations</td>
</tr>
<tr>
<td>Increase the treatment rates for people with BBVs</td>
</tr>
</tbody>
</table>

6.3.1 Blood Borne Viruses

Concern is growing about BBVs in Aboriginal and Torres Strait Islander 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 transmission, and gain access to treatment.

BBVs are increasingly being recognised as chronic diseases, and as such the management emphasis is shifting from specialist based hospital services to community based and primary health care services. HIV and chronic viral hepatitis should be considered alongside other chronic diseases in Aboriginal and Torres Strait Islander chronic care programmes.

Primary healthcare services are the chief service providers for many Aboriginal and Torres Strait Islander people. However specialist services will continue to play a vital role in BBV management and programmes will need to consider strategies, such as outreach clinics or telehealth, for improving access to specialist services while maintaining links to primary healthcare services.

Programmes that aim to improve management outcomes for people living with chronic viral hepatitis or HIV will also need to consider the high levels of mobility for some Aboriginal and Torres Strait Islander people, the impact of co-morbidities and lifestyle on treatment initiation and management, discrimination, cultural diversity and geographical spread.

Despite similar rates of HIV to the non-Indigenous population and a higher proportionate burden of viral hepatitis in Aboriginal and Torres Strait Islander populations, numbers on anti-viral treatment appear to be very low. In addition to the significant health benefits for individuals, research has confirmed that HIV antiretroviral treatments have the potential to greatly reduce the risk of HIV transmission (8). This highlights the importance of increasing
the uptake of treatment at earlier stages of infection. Providing similar opportunities for Aboriginal and Torres Strait Islander people to take advantage of advances in treatment for HIV and viral hepatitis will require a focused effort on expanding access in a safe and culturally appropriate way and reducing specific barriers such as difficulties with prescribing and dispensing of antiretroviral medicines. An improvement in data collection regarding treatment is essential to inform progress in this area and future directions.

6.3.2 Sexually Transmissible Infections

Access to timely treatment after diagnosis is critical to address the high rates of STIs among Aboriginal and Torres Strait Islander people. In some remote Aboriginal communities the time between testing and treatment for asymptomatic chlamydia/gonorrhoea is up to 3 weeks (6).

Effective tools and activities to improve treatment should be identified, adapted and promoted. Notably, several pilot studies using continuing quality improvement programmes have been conducted in primary care during the last strategy, and should lead to improved programmes and management during this strategy.

This strategy aims to build on improvements in contact tracing and partner notification and treatment, as they have the potential to reduce re-infection rates in index cases, and allow diagnosis and treatment in people who may not realise they have been exposed to an STI. Although seen as an important task of STI testing, little information is available on the models that have worked in Aboriginal and Torres Strait Islander communities. Tools currently in use should be evaluated, such as Aboriginal and Torres Strait Islander specific web-based partner notification systems, and mainstream models for specific application in Aboriginal and Torres Strait Islander communities explored. Learnings from the implementation of patient delivered partner therapy in the Northern Territory should be monitored, and the feasibility of further implementation should be explored.

While there has been some success in reducing infectious syphilis over recent years in Aboriginal and Torres Strait Islander communities, infectious syphilis is still five times higher compared to non-Indigenous population (3). Outbreaks of syphilis in remote Aboriginal communities continue to occur, requiring an ongoing focus to work towards the elimination of infectious and congenital syphilis in the Aboriginal and Torres Strait Islander population. Improvements in testing, contact tracing, follow up and education are needed, and hopefully will be seen as the recently developed guidelines for the control of syphilis in remote areas are implemented.

The availability and implementation of consistent national guidelines for the management of all relevant STIs in Aboriginal and Torres Strait Islander peoples, and priority populations should be improved. This could be specifically addressed as part of the development of the current Australian STI Management Guidelines, managed by the Australasian Sexual Health Alliance.
6.4 Workforce

<table>
<thead>
<tr>
<th>Priority actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure that STI and BBV testing and treatment providers have adequate training and support to deliver appropriate services</td>
</tr>
<tr>
<td>• Work together with relevant organisations to ensure delivery of responsive and coordinated training, continued education and professional support programmes, including in regional and remote areas and for new workforce entrants</td>
</tr>
<tr>
<td>• Improve collaboration between mental health, drug and alcohol, disability, clinical and community services to address the care and support needs of people with STIs and BBVs</td>
</tr>
<tr>
<td>• Support the capacity and role of community organisations to provide education, prevention, support and advocacy services to priority populations</td>
</tr>
</tbody>
</table>

An increase in the number of Aboriginal and Torres Strait Islander people working in health is needed, as well as improvements in the knowledge and skill level of other healthcare workers in sexual health prevention, treatment, care and support across ACCHSs and mainstream services. Building capacity through partnerships between community-controlled and mainstream health services facilitates a more holistic approach to care. Successful and effective partnerships should be identified and maintained, and their models used to develop new links. It will be important to support the establishment of stronger relationships between Aboriginal medical services and relevant professional bodies to build capacity in the management of STIs and BBVs.

Providing the Aboriginal and Torres Strait Islander health workforce with the skills needed to deal with STIs and BBVs 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. Linking such training to existing competency-based training for Aboriginal Health Workers will be explored.

Retaining staff through training, education and support is also a priority. In particular, there is a need to improve relevant public health and epidemiology training for Aboriginal and Torres Strait Islander health workers.

Non-Indigenous health care professionals play a central role in providing care to Aboriginal and Torres Strait Islander communities. Acknowledging the sometimes high turnover in this workforce and the need for awareness of relevant guidelines plus confidence to talk about sexual health with young people and other priority groups is important in planning training programs. Developing and maintaining cultural competence by all health care professionals is an ongoing priority for education and training programmes. 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.
6.5 Removing barriers

Priority actions

- Reduce racism, stigma and discrimination in community and health care settings, and empower priority populations to increase individual and community resilience
- Remove institutional, regulatory and systems barriers to equality of care for Aboriginal and Torres Strait Islander peoples infected and affected by BBVs and STIs in the health sector
- Establish a dialogue between health and other sectors to reduce stigma and discrimination against BBV and STI infected and affected Aboriginal and Torres Strait Islander individuals and communities

Enabling social and legal environments are important in ensuring access to BBV and STI prevention, treatment, care and support. HIV, viral hepatitis and STIs continues to attract stigma that can have negative consequences for psychological wellbeing and on health outcomes for people with these diseases.

People from affected communities require protection from multiple forms of discrimination (7), not only because they may be thought to be living with a BBV or STI, but also because of the primary stigma they may suffer because of their vulnerable status, such as gay men, men who have sex with men, people who inject drugs, prisoners and sex workers (18).

Stigma and discrimination relating to BBV and STI are compounded in Aboriginal and Torres Strait Islander communities by broader issues relating to racism, social and emotional wellbeing and criminalisation. These are discussed in more detail in Section 8.

Programmes that address advocacy and empowerment of individuals to access BBV and STI prevention programmes, treatment, care and support in community, education, workplace, health care and legal settings should be promoted. Approaches include awareness raising initiatives, education and training programmes, supporting advocacy and empowerment, improving access to effective complaint systems, and promoting research.

Implementation of this strategy rests within the health system. However, many of the barriers to access and equal treatment of affected individuals and communities fall outside the responsibility of the health system. For example, it could be argued that criminalisation perpetuates the isolation and marginalisation of priority populations and limits their ability to seek information, support and health care. It is important that the health sector enters into a respectful dialogue with other sectors to discuss impacts of wider decisions on the health of priority groups.
6.6 Surveillance, Monitoring and Evaluation

**Priority actions**

- Improve reporting of Indigenous identification in all relevant data collections
- Improve prevalence and incidence data for STIs and BBVs
- Improve measurement of STI testing coverage in young people
- Improve measures of treatment coverage for BBVs
- Capture the data to create a HIV treatment continuum for the Aboriginal and Torres Strait Islander population
- Research and assess emergent or changing STI issues and concerns particularly relevant to Aboriginal and Torres Strait Islander communities.
- Encourage research that informs the response to improve sexual practices and injecting drug use in communities.
- Evaluate health promotion, testing, treatment, care, support and education and awareness campaigns to ensure they are effective.

6.6.1 Surveillance and Monitoring

A core surveillance system for STIs and BBVs is the National Notifiable Disease Surveillance System (NNDSS). Notification data provided to the NNDSS by states and territories is a set of data which includes date of onset, sex, age, Aboriginal and Torres Strait Islander status and postcode of residence. Information from a number of fields is frequently incomplete, particularly Aboriginal and Torres Strait Islander status, which reduces the ability to analyse trends and inform effective interventions.

It is a priority of this Strategy to improve the completeness of surveillance data, particularly in important fields, such as Aboriginal and Torres Strait Islander status. This includes improving Indigenous identification in general practice and other primary care services. Work has been underway at a national level to respond to this deficiency.

Some important sexually transmissible infections, such as trichomoniasis, are not notified nationally, limiting the epidemiological picture to inform our response to this infection.

The development and ongoing implementation of a surveillance system to monitor the incidence of chlamydia, gonorrhoea and syphilis is prioritised in the STI strategy. Aboriginal and Torres Strait Islander specific data should be included with the development of this system.

Strengthening the surveillance of STI testing coverage in young Aboriginal and Torres Strait Islander people is a priority action area of this strategy. Additional data collection opportunities, such as STI data from prisons and juvenile detention centres, should be identified and explored. With respect to testing for BBVs, additional work is required to improve estimates to allow the undiagnosed proportion of Aboriginal and Torres Strait Islander people with HIV, hepatitis B and C to be estimated.
Improved ability to measure treatment coverage for Aboriginal and Torres Strait Islander people with blood borne viruses is also important. As an administrative dataset, the Highly Specialised Drugs Programme is unlikely to collect data on Aboriginal and Torres Strait Islander status in the near future. It is important to explore alternative mechanisms to report on this indicator. A priority is the collection of data to inform the development of a HIV care continuum specific to the Aboriginal and Torres Strait Islander population. Considering the development and application of a care continuum for hepatitis C and STIs such as syphilis may be useful.

Other gaps in surveillance include the lack of an ongoing mechanism to monitor knowledge and behaviour in Aboriginal and Torres Strait Islander peoples, and a nationally consistent framework for monitoring and reporting of syphilis testing in remote areas.

An important gap identified across all 5 strategies, is the ability to monitor the impact of stigma, discrimination, legal and human rights. Options need to be explored to develop an indicator that informs activities and strategies in a meaningful way.

6.6.2 Research and Evaluation

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

Consultative mechanisms should be established to set the agenda for research at all levels. Evaluation of research in health promotion, operational and policy areas should consider the programme within the broader health system and society, and with reference to cultural appropriateness.

More data are required on knowledge, attitudes and behaviours relating to STIs and BBVs among Aboriginal and Torres Strait Islander peoples. The wealth of data collected by NSPs could also be strengthened by including issues such as culture and identity.

More information is needed on the population characteristics of Aboriginal and Torres Strait Islander people accessing testing for HIV, hepatitis B and hepatitis C to supplement that collected through other social and behavioural data (e.g. relating to gay men and other men who have sex with men). Baseline testing rates in Aboriginal and Torres Strait Islander communities are not known; this information is crucial to identifying barriers to testing for Aboriginal and Torres Strait Islander people, and for the development of properly targeted strategies to promote testing among Aboriginal and Torres Strait Islander people who are at risk of acquiring BBVs.

Monitoring and evaluating the implementation of the priority actions, and the supporting indicators and Implementation Plan, will ensure we are progressing towards, and remain focused on, reaching the targets outlined in this strategy.

A significant number of activities and programmes have been undertaken in the First Hepatitis B Strategy and by state and territory, peak and community organisations and research centres across all six priority action areas. The opportunities for scaling up these activities and programmes to a national level should be evaluated and explored.
7. System Barriers and Enablers

System barriers impact on the health and health access for Aboriginal and Torres Strait Islander individuals and communities. These include access to health services, stigma and discrimination, and delivery of suitable, sustainable and culturally appropriate management must be addressed in conjunction with the priority action areas in this strategy. This section identifies a range of barriers and enablers to support increased health access, in order to reduce the increasing rates of BBV and STI in Aboriginal and Torres Strait Islander people.

7.1 Access

The ability to access health services, including the services of specialists and allied health professionals, is essential to improving health outcomes for Aboriginal and Torres Strait Islander people. A range of factors, both barriers and enablers, affect Aboriginal and Torres Strait Islander people’s access to health care services, including geography, cost, appropriate communication, the relationship between primary, secondary and tertiary health services (coordinated care), the availability of specialists and allied health professionals, varying levels of cultural competency across the health system, health workforce and transport.

To reduce these inequalities, health services should continue to focus on improvements to clinical care, increased access to services, better use of evidence-based guidelines and reduced systematic racism. There will continue to be a need for complementary targeted programmes to address specific areas as well as investments in population-wide health interventions, such as this strategy to reduce BBV and STI.

7.1.1 Transport

Aboriginal and Torres Strait Islander communities face various challenges in relation to transport. These challenges have a broader impact on social and economic circumstances, and specific impacts on access to health services particularly in regional and remote areas of Australia where patients may need to travel long distances to access care.

A focus on the patient journey which meets the clinical needs as well as cultural and social needs of Aboriginal and Torres Strait Islander people and their families will produce better health outcomes. This includes effective coordination and integration between health service providers, incorporating the strength and support of family and community. Stronger relationships between Aboriginal medical services and relevant professional bodies to build capacity in the management of STI and BBV is essential.

The use of regional or place-based approaches can also contribute to efficient and sustainable service delivery, based on economies of scale and sustainable service populations. This approach recognises the urban, regional, rural and remote diversity of Australia, particularly in those regions where geography, language, culture and behaviour may present obstacles to the effective access to and delivery of services.

7.1.2 Health Literacy

Health literacy is fundamental if people are to successfully manage their own health. A person’s ability to make informed health-related choices is determined by their ability to understand health information and their ability to negotiate the health care system. Access to education, particularly early childhood education opportunities, improves health literacy in an individual, and therefore their family and community.
Actions to improve health education and literacy are found across a range of related health activities such as health promotion and prevention, health protection, disease prevention, early intervention and management and health care maintenance. A particular focus of this strategy is health promotion and disease prevention activities regarding safe sex and injecting practices.

Health literacy is increasingly being recognised as an important component of safe and high quality health care.

7.2 Stigma and Discrimination

7.2.1 Racism

Racism is a key social determinant of health for Aboriginal and Torres Strait Islander people, and can deter people from achieving their full capabilities, by debilitating confidence and self-worth which in turn leads to poorer health outcomes. Evidence suggests that racism experienced in the delivery of health services contributes to low levels of access to health services by Aboriginal and Torres Strait Islander people (19).

There are numerous pathways from racism to ill-health – experiences of discrimination, linked with poor self-assessed health status, psychological distress, depression and anxiety, and health risk behaviours such as risky sexual behaviour, and alcohol and injecting drug abuse.

Racism in the lesbian, gay, bisexual, transgender and intersex (LGBTI) community contributes to Aboriginal and Torres Strait Islander LGBTI community member’s ability to make safer choices with their health and wellbeing.

Experiences of racism are compounded by the traumatic legacy of colonisation, forced removals and other past government discriminatory practices. The consequences of these events have been profound, creating historical disadvantage that has been passed from one generation to the next (20).

7.2.2 Social and Emotional Wellbeing

Social and emotional wellbeing is a holistic concept which recognises the importance of connection to the land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing can be affected by social determinants of health including homelessness, education and unemployment and a broader range of problems resulting from grief and loss, trauma and abuse, violence, removal from family and cultural dislocation, substance misuse, racism, and discrimination and social disadvantage.

Social and emotional wellbeing is the foundation for Aboriginal and Torres Strait Islander physical and mental health. It results from a network of relationships between the individual, their family and their kin and community. A positive sense of social and emotional wellbeing is essential for Aboriginal and Torres Strait Islander people to lead successful and fulfilling lives. Social and emotional wellbeing provides a foundation for effective health promotion strategies.

Culture and cultural identity is critical to social and emotional wellbeing. Practicing culture can involve a living relationship with ancestors, the spiritual dimension of existence, and connection with traditional lands and languages. Individuals and community control over their physical environment, dignity and self-esteem, respect for Aboriginal and Torres Strait
Islander people’s rights and a perception of just and fair treatment is also important to social and emotional wellbeing.

Adolescence and youth are key life stages with great personal change including physical development, the establishment of a sense of identity and values and emotional development including relationships. It as an age where health enablers, such as positive role models and health behaviours, as well as factors negatively impacting on health and wellbeing such as stigma and discrimination and limited access to education and social services, affects self-perceptions and behaviours.

Improvement in Aboriginal and Torres Strait Islander people’s social and emotional wellbeing requires effort from all levels of government and across sectors.

Self-determination contributes to positive social and emotional wellbeing of individuals and communities. Programs such as local champions or mentor programs can provide visibility for young LGBTI community members and Aboriginal and Torres Strait Islander people living with a BBV or STI. The identification of these strong people in local communities break down shame and isolation that can be associated with being a member of a priority group within this strategy.

Services at the local level should recognise the protective factors of culture, and the strong connection between culture and positive wellbeing, to help improve Aboriginal and Torres Strait Islander people’s access to timely and culturally appropriate mental health care. Aboriginal and Torres Strait Islander people with poor social and emotional wellbeing are less likely to participate in employment, consume higher levels of alcohol and other substances and are also less likely to access health services.

7.2.3 Criminalisation

For Aboriginal and Torres Strait Islander people in contact with the criminal justice, detention and care systems, incarceration can have a significant impact on health, particularly in regard to social and emotional wellbeing, with each period of contact interrupting education and employment opportunities, disrupting family life and confirming the normalcy of these outcomes. Issues with family separation and removal from one’s homeland and culture can also have a detrimental impact on wellbeing.

7.3 Delivery

7.3.1 Community Engagement

Governance is one of the key ways in which human and community capability can be strengthened. It is important in improving service delivery in raising the health and prosperity of Aboriginal and Torres Strait Islander communities(21). Aboriginal and Torres Strait Islander community controlled health organisations are an important element of the health system and provide a mechanism for Aboriginal and Torres Strait Islander people to actively lead, develop, deliver and be accountable for culturally appropriate health services.

Community governance also helps shape communities. The capability of the community, and community members, will be strengthened by supporting community decision-making and control over health organisations, and building on people’s skills, personal and collective contributions, and shared commitment to governance processes, goals and identity. It is recognised that aspects of community governance vary in different settings and it is therefore important that differing traditions and cultures are recognised and accommodated in a way that contributes to good community governance.
7.3.2 Workforce

Aboriginal and Torres Strait Islander health professionals are essential to the delivery of culturally safe care, in primary health care settings with a focus on health promotion, health education, in specialist and other health services, and the engagement of Aboriginal and Torres Strait Islander people in their own health. The employment of Aboriginal and Torres Strait Islander health professionals also contributes to the development and maintenance of culturally safe workplaces and assists in addressing institutionalised racism. Further, all health professionals delivering health care to Aboriginal and Torres Strait Islander people have the capacity to influence health policy and health professional systems and contribute to health research and infrastructure.
Acknowledgements

The Fourth National Aboriginal and Torres Strait Islander Strategy 2014-2017 was developed through a broad and inclusive consultation process with contributions from governments, community organisations, researchers and expert health professionals. Thanks go to all involved in developing this strategy.
References

2. Australian Bureau of Statistics, 2075.0 Census of Population and Housing—Counts of Aboriginal and Torres Strait Islander Australians, 2011
4. ABS 2011, Use and patient experience, Australian Social Trends
15. National Centre for HIV Epidemiology and Clinical Research (2009)


20 ABS (2010) National Aboriginal and Torres Islander Social Survey

21 Hunt, J, Smith, D, Garling, S and Sanders, W, eds 2008, Contested governance: Culture, power and institutions in Indigenous Australia, ANU ePress, Canberra
## Appendix 1: Epidemiology

<table>
<thead>
<tr>
<th></th>
<th>Comparison Rates of Aboriginal and Torres Strait Islander infection rates to non-Indigenous populations</th>
<th>Key Aboriginal and Torres Strait Islander subpopulations and sources of transmission</th>
<th>Other details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chlamydia</strong></td>
<td>3.5 times higher</td>
<td>Young people aged 15-29 years.</td>
<td>Rates of diagnosis in Aboriginal and Torres Strait Islander people are 3 times higher than the non-Indigenous population in metropolitan areas, 6 times higher in outer regional areas and 7 times higher in remote areas.</td>
</tr>
<tr>
<td><strong>Gonorrhoea</strong></td>
<td>30.6 times higher</td>
<td>Young people aged 15-29 years.</td>
<td>Transmission of gonorrhoea is mainly through heterosexual contact, whereas it is mainly through sex between males in the non-Indigenous population.</td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td>5 times higher</td>
<td>Young people aged 15-29 years including women of child bearing age.</td>
<td></td>
</tr>
<tr>
<td><strong>Trichonomiasis</strong></td>
<td>Can include overall prevalence data from STRIVE for 16-34 year olds.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Condition</strong></td>
<td><strong>Rates and Details</strong></td>
<td><strong>Key Subpopulations and Sources of Transmission</strong></td>
<td><strong>Other Details</strong></td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------</td>
<td>---------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Mycoplasma genitalium</strong></td>
<td>This organism is not well studied, and there is a need to develop standard testing protocols in order to monitor its prevalence.³</td>
<td></td>
<td>This is emerging as an important cause of pelvic inflammatory disease and urethritis, and may also be associated with increased risk of HIV acquisition.</td>
</tr>
<tr>
<td><strong>HSV-2</strong></td>
<td>18% compared with 12% in the non-Indigenous population.⁴</td>
<td></td>
<td>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.⁵</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>5.5 per 100,000 compared to 5.1 in the non-Indigenous population in 2012.⁶</td>
<td>Men who have sex with men are the primary exposure category with 55% of new infections in 2008-2012 (compared with the non-Indigenous 72%). Infections attributed to injecting drug use among Aboriginal and Torres Strait Islander people were 16% compared with non-Indigenous people 2% in 2008-2012.</td>
<td>Aboriginal and Torres Strait Islander status is reported in more than 95% of HIV notifications nationally.</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Newly acquired infection was 3 per 100,000 compared to 1 per 100,000 in the non-Indigenous population in 2012.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison Rates of Aboriginal and Torres Strait Islander infection rates to non-Indigenous populations</td>
<td>Key Aboriginal and Torres Strait Islander subpopulations and sources of transmission(^1)</td>
<td>Other details(^2)</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Newly diagnosed infection was 166 per 100 000 compared to 40 per 100 000 in the non-Indigenous population in 2012.(^3)</td>
<td>Transmission of hepatitis C continues to predominantly occur among people with a history of injecting drug use.</td>
<td>Aboriginal and Torres Strait Islander status is reported in more than 41% of hepatitis C notifications nationally.</td>
</tr>
</tbody>
</table>
Appendix 2: Related Strategy Targets

The targets of the Seventh National HIV Strategy 2014-2017 are:
   1. Reduce sexual transmission of HIV by 50 per cent by 2015
   2. Sustain the low general population rates of HIV in Aboriginal and Torres Strait Islander people and communities
   3. Sustain the virtual elimination of HIV amongst sex workers
   4. Sustain the virtual elimination of HIV amongst people who inject drugs
   5. Sustain the virtual elimination of mother-to-child HIV transmission
   6. Increase treatment uptake by people with HIV to 90 per cent
   7. Maintain effective prevention programmes targeting sex workers and for people who inject drugs.

The targets of the Second National Hepatitis B Strategy 2014-2017 are:
   1. Achieve 95% HBV childhood vaccination coverage
   2. Increase hepatitis B vaccination coverage of priority populations
   3. Increase to 80%, the proportion of all people living with chronic hepatitis B who are diagnosed
   4. Increase to 15% the proportion of people living with chronic hepatitis B who are receiving antiviral treatment.

The targets of the Fourth National Hepatitis C Strategy 2014-2017 are:
   1. 50% decrease in the incidence of new hepatitis C infections
   2. Increase the number of people receiving antiviral treatment each year

The targets of the Third National Sexually Transmissible Infections Strategy 2014-2017 are:
   1. Achieve HPV vaccination coverage of 70%
   2. Increase testing coverage in priority populations
   3. Reduce the incidence of chlamydia
   4. Reduce the incidence of gonorrhoea
   5. Reduce the incidence of infectious syphilis and eliminate congenital syphilis
Appendix 3: Guiding Principles

**Human rights:** People with HIV, STIs and viral hepatitis have a right to participate fully in society, 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).

**Access and equity:** Health and community care in Australia should be accessible to all based on need. The multiple dimensions of inequality should be addressed, whether related to geographic location, gender, sexuality, drug use, occupation, socioeconomic status, migration status, language or culture. Special attention needs to be given to working with Aboriginal and Torres Strait Islander peoples to close the gap between Aboriginal and Torres Strait Islander health status and that of other Australians.

**Health promotion:** The Ottawa Charter for Health Promotion provides the framework for effective HIV, STI and viral hepatitis health promotion action and facilitates the:
- active participation of affected communities and individuals to increase their influence over the determinants of their health; and
- formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights.

**Prevention:** The transmission of HIV, STIs and viral hepatitis can be prevented by adopting and maintaining protective behaviours. Education and prevention programmes, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures.

**Harm reduction:** Harm reduction approaches underpin effective measures to prevent transmission of HIV and viral hepatitis, including needle and syringe programmes and drug treatment programmes.

**Shared responsibility:** Individuals and communities share responsibility to prevent themselves and others from becoming infected, and to inform efforts that address education and support needs. Governments and civil society organisations have a responsibility to provide the necessary information, resources and supportive environments for prevention.

**Partnership:** An effective partnership of governments, affected communities, researchers and health professionals is characterised by consultation, cooperative effort, respectful dialogue and joint action to achieve this strategy’s goal. This includes:
- 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 and the full cooperative efforts of all members of the partnership to implement the strategy’s agreed priority actions.
## Appendix 4: Priority populations

The table below identifies the broad reasons for priority status (high prevalence - a high rate of STI within the population, and high risk - factors that could increase STI transmission among that population and/or the general community).

Broad categories of barriers to effective response, specific to these populations, are also identified. These barriers are in addition to the general barriers of stigma, discrimination and social, legal and financial framework issues. Stigma and discrimination continues to adversely affect those living with STIs and the communities affected by STIs. Social, legal, financial framework issues prevent uptake of effective prevention, testing and treatment.

<table>
<thead>
<tr>
<th>Priority Population</th>
<th>Reason for Priority Status</th>
<th>Barriers to Effective Response</th>
<th>Additional Focus</th>
</tr>
</thead>
</table>
| Young Aboriginal and Torres Strait Islander people (under 30) | High prevalence of STIs than non-indigenous youths.                                       | High risk due to:  
- Low levels of health education and health literacy  
- High rate of risk behaviours (such as partner change and risky alcohol and other drug use) and  
- High fertility rates among younger people | Young men access health services less often than young women, and are therefore an important priority subpopulation. |
<table>
<thead>
<tr>
<th>Priority Population</th>
<th>Reason for Priority Status</th>
<th>Barriers to Effective Response</th>
<th>Additional Focus</th>
</tr>
</thead>
</table>
| Aboriginal and Torres Strait Islander people who inject drugs | High prevalence of STIs in comparison to non-Indigenous people who inject drugs.  
High risk due to barriers to effective responses and higher rates of sharing injecting equipment. | • Criminalisation  
• Needle and Syringe Programme issues  
• Concerns regarding access and/or acceptance of culturally appropriate services including primary healthcare services for many communities  
• Concerns about confidentiality in service provision |  

| Aboriginal and Torres Strait Islander people in juvenile justice and adult prisons | High risk due to the overrepresentation of Aboriginal and Torres Strait islander people in the prison population (27% in a 30 June 2012 survey)  
While in prison, Aboriginal and Torres Strait Islander prisoners are at risk of HIV, hepatitis B and hepatitis C transmission (primarily through unsafe injecting practices), physical violence, sexual assault and isolation. | • Needle and Syringe Programme issues.  
• Concerns regarding access and/or acceptance of culturally appropriate services including primary healthcare services.  
• Even upon release there is increased stigmatisation, social and cultural exclusion, and further concerns regarding support networks and health and social services. |  

<table>
<thead>
<tr>
<th>Priority Population</th>
<th>Reason for Priority Status</th>
<th>Barriers to Effective Response</th>
<th>Additional Focus</th>
</tr>
</thead>
</table>
| Aboriginal and Torres Strait Islander gay men, men who have sex with men, sistergirls and transgender people | High risk due to:  
  - High levels of population mobility  
  - Low levels of HIV awareness and limited culture of safe sex negotiation  
  - Social isolation due to lack of acceptance of homosexuality and transgender status within some communities  
  - Risk behaviour such as alcohol and other drug use, and unprotected anal intercourse with casual partners  
  - A culture of violence, both generally and specifically towards Aboriginal and Torres Strait Islander gay men and sistergirls, which increases HIV, STI and viral hepatitis risk. | • Actual or perceived homophobia, racism, discrimination and cultural insensitivity. | 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. |
| Aboriginal and Torres Strait Islander people living with HIV and viral hepatitis | • Estimated 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.  
• Aboriginal and Torres Strait Islander people living with BBVs, their partners, carers, friends, families and children have complex needs. | • Fear and misunderstanding about BBVs exist in many Aboriginal and Torres Strait Islander communities, often resulting in social discrimination and isolation.  
• Issues relating to privacy and confidentiality of health status. | |
<table>
<thead>
<tr>
<th>Priority Population</th>
<th>Reason for Priority Status</th>
<th>Barriers to Effective Response</th>
<th>Additional Focus</th>
</tr>
</thead>
</table>
| People living in the cross-border region of Australia and Papua New Guinea        | High risk from HIV entering communities because of the proximity, cultural, familial and trade connections to Papua New Guinea, which has the highest rate of HIV in the Pacific region.  
   The movement of people within Torres Strait Islander and Papua New Guinea Treaty provisions has steadily increased in recent years resulting in increases in communicable diseases resulting from the free movement of traditional visitors within and around the area known as the protected zone. | • Pressure on healthcare facilities in the Torres Strait resulting from movement of people  
   • Limited access to, and poor standards of, health service facilities in the Western Province of Papua New Guinea. |                                                                                                                                                                                                                                                                                    |
| Aboriginal and Torres Strait Islander sex workers                                   | High risk associated with high number of sexual encounters  
   This risk is increased for street-based sex workers and people providing sex for favours, who have less opportunity to control the health and safety conditions of their work and are therefore at increased risk of BBV and STI transmission.  
   Aboriginal and Torres Strait Islander sex workers are overrepresented in street-based sex work and can be particularly marginalised. | • Concerns regarding access and/or acceptance of culturally appropriate services including primary healthcare services for many communities  
   • Low health literacy and perception of risk | It is acknowledged that people can transition in and out of sex work over time, and may not identify as sex workers. |
1 Kirby Institute (2013). Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: surveillance and evaluation report 2013. Kirby Institute, Sydney

2 Kirby Institute (2013). Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: surveillance and evaluation report 2013. Kirby Institute, Sydney


6 Kirby Institute (2013). Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: surveillance and evaluation report 2013. Kirby Institute, Sydney

7 Kirby Institute (2013). Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: surveillance and evaluation report 2013. Kirby Institute, Sydney