



Australian Government

Department of Health

FOURTH  
National Aboriginal  
and Torres Strait Islander  
**Blood-borne Viruses and  
Sexually Transmissible Infections  
Strategy**

2014-2017

## **Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017**

ISBN: 978-1-74186-160-0

Online ISBN: 978-1-74186-161-7

Publications approval number: 10716

Copyright Statements:

### **Paper-based publications**

© Commonwealth of Australia 2014

This work is copyright. You may reproduce the whole or part of this work in unaltered form for your own personal use or, if you are part of an organisation, for internal use within your organisation, but only if you or your organisation do not use the reproduction for any commercial purpose and retain this copyright notice and all disclaimer notices as part of that reproduction. Apart from rights to use as permitted by the *Copyright Act 1968* or allowed by this copyright notice, all other rights are reserved and you are not allowed to reproduce the whole or any part of this work in any way (electronic or otherwise) without first being given the specific written permission from the Commonwealth to do so. Requests and inquiries concerning reproduction and rights are to be sent to the Communication Branch, Department of Health, GPO Box 9848, Canberra ACT 2601, or via e-mail to [copyright@health.gov.au](mailto:copyright@health.gov.au).

### **Internet sites**

© Commonwealth of Australia 2014

This work is copyright. You may download, display, print and reproduce the whole or part of this work in unaltered form for your own personal use or, if you are part of an organisation, for internal use within your organisation, but only if you or your organisation do not use the reproduction for any commercial purpose and retain this copyright notice and all disclaimer notices as part of that reproduction. Apart from rights to use as permitted by the *Copyright Act 1968* or allowed by this copyright notice, all other rights are reserved and you are not allowed to reproduce the whole or any part of this work in any way (electronic or otherwise) without first being given the specific written permission from the Commonwealth to do so. Requests and inquiries concerning reproduction and rights are to be sent to the Communication Branch, Department of Health, GPO Box 9848, Canberra ACT 2601, or via e-mail to [copyright@health.gov.au](mailto:copyright@health.gov.au).

FOURTH

National Aboriginal  
and Torres Strait Islander

**Blood-borne Viruses and  
Sexually Transmissible Infections  
Strategy**

2014-2017



# Foreword



Australia has made great progress in addressing blood-borne viruses and sexually transmissible infections over the last three decades. Our continued response to HIV, viral hepatitis and sexually transmissible infections over the life of the new national strategies comes at a time of both unprecedented opportunity and ongoing challenge.

Scientific advances in prevention, testing and treatment are providing us with the knowledge and the means to make dramatic reductions in new infections and significant improvements in health outcomes. At the same time, these conditions still represent a significant burden of disease in this country, with the number of people affected by blood-borne viruses and sexually transmissible infections remaining too high and, for some conditions, increasing.

Australia's five national strategies set the direction for a coordinated, national response to HIV, hepatitis B, hepatitis C, sexually transmissible infections, and blood-borne viruses and sexually transmissible infections in the Aboriginal and Torres Strait Islander population until 2017. The national strategies are endorsed by all Australian Health Ministers and, for the first time, contain targets which provide a renewed focus for action and a framework for accountability.

Achieving the targets will be challenging and will require the concerted effort of all governments, affected communities, health care providers, the community sector and researchers. Together we need to take action to overcome the barriers that impede our efforts to scale up prevention, testing, management, care and support for people living with and at risk of blood-borne viruses and sexually transmissible infections.

Each national strategy identifies the priority actions that will support achievement of the targets across the areas of prevention; testing; management, care and support; workforce; protection of human rights; and surveillance, research and evaluation.

Implementing the priority actions will see evidence-based and targeted prevention activities remaining fundamental to the national response, and efforts

to increase testing rates and early diagnosis being scaled up. The role of primary care in blood-borne viruses and sexually transmissible infections management, care and support will become increasingly important, and the workforce will need to be supported accordingly. Continuing to build an enabling environment where stigma and discrimination does not prevent people from accessing health and community services will underpin success across all areas. More effective surveillance, monitoring, research and evaluation will continue to inform our national response and measure our progress.

The strong partnership approach that has been a hallmark of Australia's response to blood-borne viruses and sexually transmissible infections to date is required now more than ever. Despite the challenges, and with concerted and collective action, I am confident that Australia is well placed to step up the pace in our response to these conditions. I will be closely monitoring our progress over the coming years.



**The Hon Peter Dutton MP**

Minister for Health

# Contents

<b>1.</b>	<b>Introduction</b>	<b>1</b>
<b>2.</b>	<b>Blood-borne Viruses and Sexually Transmissible Infections in Aboriginal and Torres Strait Islander People</b>	<b>4</b>
2.1	Demographics	4
2.2	Epidemiology of STI and BBV	4
2.2.1	Sexually Transmissible Infections	5
2.2.2	Blood-borne Viruses	6
2.2.3	Emerging Issues	7
<b>3.</b>	<b>Achievements</b>	<b>8</b>
<b>4.</b>	<b>Measuring Progress</b>	<b>10</b>
4.1	Goals	10
4.2	Objectives	10
4.3	Targets	11
4.4	Indicators	12
4.5	Implementation and Evaluation	15
<b>5.</b>	<b>Guiding Principles</b>	<b>16</b>
<b>6.</b>	<b>Priority Groups</b>	<b>19</b>
<b>7.</b>	<b>Priority Areas for Action</b>	<b>20</b>
7.1	Prevention	21
7.1.1	Health Promotion, Social Marketing and Education	21
7.1.2	Vaccination	22
7.1.3	Safer Injecting Practices	23
7.1.4	Safer Sexual Practices	24
7.1.5	Prevention at the Torres Strait Islands/ Papua New Guinea Border	25
7.2	Testing	25
7.2.1	Blood-borne Viruses	25
7.2.2	Sexually Transmissible Infections	26
7.3	Management, Care and Support	28
7.3.1	Blood-borne Viruses	28
7.3.2	Sexually Transmissible Infections	29

7.4	Workforce	31
7.5	Enabling Environment	32
7.6	Surveillance, Monitoring and Evaluation	34
	7.6.1 Surveillance and Monitoring	34
	7.6.2 Research and Evaluation	36
<b>8.</b>	<b>System Barriers and Enablers</b>	<b>37</b>
8.1	Access	37
	8.1.1 Transport	38
	8.1.2 Health Literacy	38
8.2	Stigma and Discrimination	39
	8.2.1 Racism	39
	8.2.2 Social and Emotional Wellbeing	39
	8.2.3 Criminalisation	40
8.3	Delivery	41
	8.3.1 Community Engagement	41
	8.3.2 Workforce	41
	<b>Acknowledgements</b>	<b>42</b>
	<b>References</b>	<b>43</b>
	<b>Appendix 1: Epidemiology</b>	<b>46</b>
	<b>Appendix 2: Related Strategy Targets</b>	<b>48</b>
	<b>Appendix 3: Guiding Principles Underpinning Australia's Response</b>	<b>49</b>
	Human Rights	49
	Access and Equity	49
	Health Promotion	49
	Prevention	50
	Harm Reduction	50
	Shared Responsibility	50
	Partnership	50
	<b>Appendix 4: Priority Populations</b>	<b>51</b>
	Notes to the Appendix	55



# 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, geographic and socio-economic influences. This diversity presents a unique challenge when addressing sexually transmissible infections (STI) and blood-borne viruses (BBV) among Aboriginal and Torres Strait Islander communities.

Persistently high rates of STI, the disproportionate burden of viral hepatitis, and vulnerability to an HIV epidemic underline the urgency of addressing these infections in this population.

Despite these challenges 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. Groundbreaking antiviral treatments for hepatitis C will become available in Australia during the life of this *Fourth National Aboriginal and Torres Strait Islander Blood-borne Virus and Sexually Transmitted Infection Strategy 2014–2017* (the Strategy). These treatments greatly improve the chance of being cured of hepatitis C, and future treatment generations will be less toxic and will require less complex dosing and reduced treatment duration. Innovative testing technologies are creating opportunities to significantly improve testing accessibility, which will contribute to reduced transmission of many STI and BBV.

This Strategy is one of a suite of five strategies which provide a framework for the coordinated effort by the Commonwealth, state and territory governments and communities, clinicians and researchers to address already high or rising rates of HIV, hepatitis B, hepatitis C and STI 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 in order to reflect the particular importance in responding to BBV and STI among Aboriginal and Torres Strait Islander people.

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 BBV and STI 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.

This Strategy recognises the need for health promotion in the area of STI and BBV to be both targeted toward risks or populations and also to be embedded into broader health promotion programs. A holistic approach to health will build on the strong association between wellbeing and health for Aboriginal and Torres Strait Islander people.

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

A continued emphasis on safer sex and injecting practices is essential to reduce the incidence of BBV in Aboriginal and Torres Strait Islander people, in combination with improvements in testing and management. Increasing the use of sterile 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 people compared to non-Indigenous people. This must be accompanied by improvements in BBV testing and management, in particular acknowledging the extremely low numbers of Aboriginal and Torres Strait Islander people currently on antiviral treatment.

For improvements in the health of Aboriginal and Torres Strait Islander people to be realised, it is vital that communities and individuals have the ability and freedom to be empowered and to 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
- spiritual healing.

## Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017

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 of which focus efforts on key areas of disadvantage and provide a framework for ongoing action to improve outcomes across social determinants of health.

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 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.

## 2. BBV and STI in Aboriginal and Torres Strait Islander People

### 2.1 Demographics

In 2011, approximately 669 900 [1] people were estimated to be Aboriginal and/or Torres Strait Islander in Australia, representing three per cent of all Australians [2]. The largest Aboriginal and Torres Strait Islander populations reside in New South Wales, followed by Queensland and Western Australia. Aboriginal and Torres Strait Islander Australians made up almost one-third (30 per cent) of the population of the Northern Territory (NT).

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

The Aboriginal and Torres Strait Islander population had a much younger age structure than the non-Indigenous population, with around 36 per cent aged less than 15 years compared with 19 per cent 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 STI and BBV

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

In addition, surveillance data must be carefully interpreted because notifications and trends may not reflect true population prevalence or change, and may be influenced by testing practices and access to health services.

### 2.2.1 Sexually Transmissible Infections

Rates of infection reported for bacterial STI are much higher in Aboriginal and Torres Strait Islander people than in non-Indigenous people. Rates of chlamydia are 3.5 times higher, those for gonorrhoea 30 times and for infectious syphilis five times higher for Aboriginal and Torres Strait Islander people compared to non-Indigenous people [3]. STI infections are most commonly reported among people aged 15–29 years and those living in outer regional, remote and very remote locations in Australia.

The implications of ongoing high rates of untreated STI are particularly serious for women. Untreated STI have been associated with an increased risk of pelvic inflammatory disease (PID), ectopic pregnancy and infertility [4]. The Prevention of Pelvic Infection (POPI) trial, published in 2010, reports that almost 10 per cent of women with untreated chlamydia infection were diagnosed with PID by one 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 increase the risk of PID, that PID can develop in only a few weeks [6], and that severe disease is associated with an increased likelihood of ectopic pregnancy and infertility [7].

*Trichomonas vaginalis* infection is often asymptomatic but is 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 the NT and as such a national picture is not available. Surveillance data from the NT show higher notification rates than chlamydia and gonorrhoea in Aboriginal women, up until 40 years of age, than in men [9]. While limited data are available on the prevalence of *T. vaginalis* in men, the burden is considered to be much less.

Donovanosis is an STI once prevalent in remote areas of Australia; however, notification rates have reduced significantly to a point where the infection is virtually eliminated as a result of a targeted program of donovanosis eradication [3].

### 2.2.2 Blood-borne Viruses

The population rate of newly diagnosed HIV infection is similar between Aboriginal and Torres Strait Islander and non-Indigenous populations (5.5 per 100 000 compared to 5.1 per 100 000 in 2012) [3]. The most frequently reported exposure category continues to be sexual contact between men in both Aboriginal and Torres Strait Islander people and non-Indigenous people. However, there are differences in HIV diagnoses between the two population groups: a higher proportion of infections in Aboriginal and Torres Strait Islanders was attributed to injecting drug use (13 per cent versus 2 per cent), and the population rate of diagnosis was four times higher in Indigenous women compared to non-Indigenous women (2.2 per 100 000 compared to 0.5 per 100 000) [3]. This suggests that there is a greater risk, over time, for HIV to spread more generally among Aboriginal and Torres Strait Islander people as opposed to non-Indigenous people where the risk of transmission is much more concentrated in gay men and men who have sex with men.

There are a large number of people living with chronic hepatitis B in Australia, an overall prevalence reported of approximately 1.0 per cent [3]. It has been estimated that around 9.3 per cent of this chronic hepatitis B burden occurs in Aboriginal and Torres Strait Islander people [10]. New diagnosis of hepatitis B occurs at a much greater rate in Aboriginal and Torres Strait Islander people compared to non-Indigenous people (86 per 100 000 versus 31 per 100 000) [3]. Furthermore, hepatitis B continues to be newly acquired by Aboriginal and Torres Strait Islander people at a rate three times greater than the rate in non-Indigenous people (3 per 100 000 versus 1 per 100 000) [3]. These new cases primarily occurred in those aged over 20 years of age (84 per cent) and in females (male to female ratio of 0.4 to 1) in 2012.

New diagnoses of hepatitis C have been gradually increasing in the Aboriginal and Torres Strait Islander population over the last five years, from a population rate (per 100 000) of 130 in 2008 to 166 in 2012. This compares to a decreasing rate in non-Indigenous people for the same time period, from 51 per 100 000 to 40 per 100,000. These new diagnoses of hepatitis C in Aboriginal and Torres Islanders have most commonly occurred in those aged between 20 and 49 years of age. 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].

### **2.2.3 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 per cent of those infected, and include acute T-cell leukaemia/lymphoma and myelopathy [11]. In Australia it occurs mainly in Aboriginal populations; however, prevalence estimates are varied, difficult to obtain, and have important limitations, with estimates ranging from 14 per cent to 40 per cent [12,13]. Improved estimates for local prevalence 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 STI and BBV among Aboriginal and Torres Strait Islander people is at Appendix 1.

## 3. Achievements

Over the four years 2010 to 2013, a number of milestones and achievements were reached in Australia in response to BBV and STI in the Aboriginal and Torres Strait Islander community. These achievements will be built on over the next four years to achieve the goals, objectives and targets of this Strategy.

Hepatitis B vaccination coverage in Aboriginal and Torres Strait Islander children at two years of age is similar to that of non-Indigenous children (94 per cent). Challenges, however, still remain in bridging the gap between vaccination coverage in Aboriginal and Torres Strait Islander children and non-Indigenous children at one year of age (85.05 per cent compared to 91.93 per cent), which is a focus of this Strategy.

In partnership with the Commonwealth, several states and territories commenced programs that link sexual health education with access to treatment. In addition, a range of sexual health programs in school, health and community and juvenile justice settings have been undertaken.

A range of activities implemented at the state and territory level in relation to improved partner notification for STI include the development of the Syphilis Register in Queensland, which assists in partner notification through telephone support. In Western Australia, a manual promoting appropriate strategies for partner notification has also been developed. In the Northern Territory, legislation has been passed enabling patient-delivered partner therapy.

There have been a number of successful targeted projects undertaken during 2010–13, including the GOANNA and STRIVE projects. The GOANNA project has collected the first national data on sexual health and attitudes in young Aboriginal and Torres Strait Islander people. This information will form the foundation of future models targeting young people and the transmission of BBV and STI. The STRIVE project has compiled the first comprehensive picture of *T. vaginalis* infection in remote communities, and its relationship to other STI.



## Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017

A range of Youth Demonstration Projects, aimed at improving sexual health and reducing risk behaviour in Aboriginal and Torres Strait Islander young people, have also been undertaken. These included implementing a condom, social marketing and STI early detection project in 24 Aboriginal and Torres Strait Islander communities, an STI/BBV peer-education program for young Aboriginal men in remote and urban communities in central Australia, focusing on reducing the risk of BBV transmission during ceremonial business, and promoting health seeking behaviour.

This Strategy acknowledges the achievements made in targeted and state and territory-led projects undertaken to date, and supports opportunities for scaling-up these programs to a national level where appropriate.

# 4. Measuring Progress

## 4.1 Goals

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

## 4.2 Objectives

This Strategy has the following five overarching objectives which, in combination, are designed to support achieving the above goal:

1. Improve knowledge and awareness of STI and BBV
2. Reduce the incidence of STI in Aboriginal and Torres Strait Islander people and communities
  - 2.1 Achieve high levels of human papillomavirus (HPV) vaccination
  - 2.2 Reduce the risk behaviours associated with transmission
  - 2.3 Increase appropriate testing and follow up
3. Reduce the incidence of BBV in Aboriginal and Torres Strait Islander people and communities
  - 3.1 Achieve high levels of hepatitis B vaccination
  - 3.2 Reduce the risk behaviours associated with transmission
  - 3.3 Decrease the number of people with undiagnosed BBV
4. Increase the number of Aboriginal and Torres Strait Islander people with BBV receiving appropriate management, care and support for BBV
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 the delivery of and access to appropriate services

### 4.3 Targets

Targets are included for the first time in this 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 people less than 30 years of age
3. increase the use of sterile injecting equipment for every injecting episode
4. increase the number of people with HIV, hepatitis C and hepatitis B receiving antiviral treatment.

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 STI. Among Aboriginal and Torres Strait Islander people, 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 achieve the goal of this Strategy.

Reducing the incidence of BBV in Aboriginal and Torres Strait Islander people requires a continuing emphasis on encouraging and supporting safer sex and injecting practices, combined with improvements in testing and management.

Increasing the use of sterile injecting equipment for every injecting episode is a key target, given the higher contribution of injecting drug use to HIV transmission and the higher rate of hepatitis C diagnosis among Aboriginal and Torres Strait Islander people compared to non-Indigenous people.

Despite similar rates of HIV and a higher proportionate burden of viral hepatitis in Aboriginal and Torres Strait Islander people, 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.

## 4.4 Indicators

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

There are limitations in the availability and quality of indicators to measure progress against several of the Strategy's objectives and targets. The indicators identified below have an existing national collection mechanism, and can be reported on from the initiation of this Strategy.

Further work on refining and developing indicators is required, and will be progressed in the life of this Strategy. Indicators to report against each of the targets will need to be specifically defined. An important gap to be addressed is the lack of a nationally agreed indicator for measuring progress in reducing the health impact of stigma, discrimination, and legal and human rights in the context of this Strategy. Improved measures for risk behaviours in Aboriginal and Torres Strait Islander people, testing rates and treatment coverage are needed. Further gaps and limitations are discussed in the surveillance and monitoring section 7.6 'Surveillance, Monitoring and Evaluation'.

## Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017

Objective	Sub-objective	Indicator
Improve knowledge and awareness of STI and BBV		Proportion of Aboriginal and Torres Strait Islander people giving correct answers to a knowledge and behaviour question on STI and BBV
	Reduce the incidence of STI	<p>Proportion of chlamydia tests that yield a positive result in 15–29 year age group*</p> <p>Annual rate of notifications of infectious syphilis, chlamydia and gonorrhoea*</p> <p>Number of notifications of congenital syphilis annually*</p>
	Achieve high levels of HPV vaccination	HPV three-dose vaccination coverage for males and females turning 15 years of age*
	Reduce the risk behaviours associated with transmission	
	Increase appropriate testing and follow up among those at elevated risk	Proportion of 15–29 year olds receiving a chlamydia test in the previous 12 months*
Reduce the incidence of BBV		<p>Annual rate of notifications of newly acquired hepatitis B*</p> <p>Annual rate of notifications of newly acquired hepatitis C*</p> <p>Estimated incidence of recent HIV infection*</p>
	Achieve high levels of hepatitis B vaccination	Hepatitis B immunisation coverage in children at 12 and 24 months*

Objective	Sub-objective	Indicator
	Reduce the risk behaviours associated with the transmission	Proportion of people who inject drugs reporting re-using another person's used needle and syringe in the previous month*  Number of Aboriginal and Torres Strait Islander people who are notified as newly diagnosed with HIV who report injecting drug use
	Decrease the number with undiagnosed BBV	
Increase the number receiving appropriate management, care and support for BBV		
Eliminate the negative impact of stigma, discrimination and human rights issues on Aboriginal and Torres Strait Islander health	Actively engage with the Aboriginal and Torres Strait Islander community	
	Improve delivery of and access to appropriate services	

\* Among/in Aboriginal and Torres Strait Islander people.

## 4.5 Implementation and Evaluation

This Strategy sets high-level directions for action over the next four years. Implementation and evaluation of the Strategy will be supported by an ‘Implementation and Evaluation Plan’ and a ‘Surveillance and Monitoring Plan’. These plans will be developed in consultation with state and territory governments and partners and will detail how priority actions will be implemented, including roles and responsibilities, timeframes and lines of accountability, and the ways in which the goals, targets and objectives will be monitored.

Australia’s world-recognised partnership approach will remain central to our response to BBV and STI. Undertaking the actions set out in this Strategy by December 2017 requires Commonwealth and state and territory governments, professional and 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 predecessors, which have guided Australia’s response to BBV and STI in Aboriginal and Torres Strait Islander people from 1999 to 2013. It is one of five interrelated national strategies aiming to reduce the transmission and impact of BBV and STI. The other strategies are the:

- *Seventh National HIV Strategy*
- *Fourth National Hepatitis C Strategy*
- *Third National Sexually Transmissible Infections Strategy*
- *Second National Hepatitis B Strategy.*

The five national strategies share common structural elements, designed to support a coordinated effort in addressing common concerns. Much of the prevention, healthcare 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 BBV and STI. The strategies support and align with state and territory BBV and STI strategies and provide a framework to guide coordinated action in this area by state and territory governments and other partners until 2017.

# 5. Guiding Principles

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

1. health equality and a human rights approach
2. Aboriginal and Torres Strait Islander community control and engagement
3. partnership
4. accountability.

Together with these four principles, 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, STI and viral hepatitis. These are outlined in Appendix 3.

## 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, 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 programs 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 healthcare 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.



## 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.

## 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 people of all ages, backgrounds and locations.

## 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.

# 6. 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 maximising 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 live in remote communities
- Aboriginal and Torres Strait Islander people who inject drugs
- Aboriginal and Torres Strait Islander people in custodial settings
- Aboriginal and Torres Strait Islander gay men, other men who have sex with men, and sisters 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.

## 7. Priority Areas for Action

Prevention strategies, combined with testing and appropriate management, are the most effective responses to reducing the spread and impact of STI and BBV. For Aboriginal and Torres Strait Islander people, many factors heighten the risk of these infections, including poorer social and economic factors (social determinants), and specific language and cultural issues, combined with very high existing rates of STI. There is a critical need to sustain and improve targeted prevention efforts, alongside improving broader health promotion programs.

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

The appropriate treatment and management of all STI and BBV is essential for healthy communities. There are particular challenges to achieving accessible, culturally appropriate and equitable management for all Aboriginal and Torres Strait Islander communities, and these challenges must be addressed to see the required improvements.

A well-trained and culturally appropriate workforce is fundamental to achieving the priority actions outlined in this Strategy. Meaningful partnerships and collaborations between all relevant organisations and stakeholders, including Aboriginal organisations, will be an essential part of implementing and monitoring the success of this Strategy.

## 7.1 Prevention

### Priority Actions

- Strengthen health-promotion and disease-prevention activities regarding safer sex, condom availability and access, and safer injecting practices.
- Pilot and scale-up targeted activities in young people to build knowledge and skills regarding safer sex and injecting practices.
- Improve vaccination coverage for hepatitis B and HPV.
- Increase the coverage and accessibility of injecting equipment (needle and syringe programs) as appropriate to the local community context and specific settings.

### 7.1.1 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 BBV and STI include communication activities designed to improve health literacy, skills, knowledge and choice (such as 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 wellbeing and health for Aboriginal and Torres Strait Islander people. While many health promotion models focus on targeted initiatives, BBV and STI activities and messages should also be embedded into broader Aboriginal and Torres Strait Islander health promotion programs.

Ensuring that interventions are practical and that health promotion initiatives link to action pathways (for example, emphasising the role of testing for STI and BBV, 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 connecting with 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 [14]. There would be benefit in strengthening the evidence for particular peer education models for Aboriginal and Torres Strait Islander people, 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 STI, the relatively higher pregnancy 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 people 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.

### **7.1.2 Vaccination**

Vaccination remains a key prevention activity, and this Strategy needs to build on the success of hepatitis B and HPV vaccination programs for Aboriginal and Torres Strait Islander people. The vaccination targets and priority actions in the national STI and hepatitis B strategies align with the *National Immunisation Strategy 2013–18*, in which the improvement of immunisation coverage and ensuring equity of access to immunisation services are key action areas. Under the National Partnership Agreement on Essential Vaccines, states and territories have agreed to maintain or improve vaccination coverage for Aboriginal and Torres Strait Islander people.

Hepatitis B vaccine is funded under the National Immunisation Program for all Australians at birth and at two, four and six months of age. Improvements in the timeliness of HBV vaccination for Aboriginal and Torres Strait Islander children are required to achieve the 95 per cent hepatitis B childhood vaccination coverage target. Additionally, uptake of appropriate hepatitis B vaccination should also be improved in Aboriginal and Torres Strait Islander adults, as recommended in the *Australian Immunisation Handbook* [15].

HPV vaccine is delivered to adolescent girls and boys through school-based programs. 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 per cent vaccination coverage nationally in Aboriginal and Torres Strait Islander people through the school-based program will require improved Aboriginal and Torres Strait Islander status identification in the HPV vaccination register.

### **7.1.3 Safer Injecting Practices**

Strategies to improve access to and use of sterile 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 people [3]. International lessons, such as the Canadian experience where the key mode of transmission of HIV in the Aboriginal population continues to be shared injecting equipment [16], must be heeded.

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 safer injecting behaviours, and access to and coverage of safer injecting equipment, requires work in mainstream and Aboriginal-specific centres. This may include innovative options such as incorporating needle and syringe programs (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 [17]. Mapping of 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 high number of Aboriginal and Torres Strait Islander people in correctional settings than is represented in the Australian population [18]. Aboriginal and Torres Strait Islander people in correctional settings are an important priority group, particularly for the risk of STI and BBV transmission. New drug therapies which will cure the large majority of hepatitis C cases should inform future approaches. These issues are explored in more detail in the *Fourth National Hepatitis C Strategy 2014-2017*.

#### **7.1.4 Safer Sexual Practices**

Safer sexual practices rely on prevention equipment such as condoms and water-based lubricant being available and accessible. Improvements are needed to address gaps in such supplies for some remote communities and vulnerable groups. The use of innovative methods to improve the availability and accessibility of prevention equipment is encouraged.

Improving safer 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 amongst whom 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 [19]. Prevention strategies must be highly targeted to this priority group to improve awareness and knowledge and to increase the adoption of safer behaviours.



### 7.1.5 Prevention at the Torres Strait Islands/Papua New Guinea 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 BBV and STI 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 to increase the 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 in the Torres Strait.

## 7.2 Testing

### Priority Actions

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

### 7.2.1 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 BBV in Australia. Ways in which testing and earlier diagnosis can be improved in Aboriginal and Torres Strait Islander people 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 BBV. The link between STI and BBV, including the increased risk of HIV transmission associated with the presence of an STI, needs to be highlighted.

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 STI in this population, improvements in BBV testing could be achieved through promoting the appropriate risk assessment and testing for BBV when an STI is 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 healthcare, is needed to improve national consistency.

HTLV1 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 HTLV1 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 breastfeeding interventions to reduce the risk of transmission to children born to HTLV1-positive mothers. The related work conducted over the last few years in central Australia should be built on in the Australian context [11].

### **7.2.2 Sexually Transmissible Infections**

Bacterial STI 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 programs.

Pilot projects using continuous quality improvement programs to specifically increase testing and treatment in Aboriginal community-controlled health services and primary healthcare 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 programs may be considered, particularly in areas where there is high community prevalence of STI. Testing programs should be flexible and should adjust to the needs of the specific communities.

Outreach programs 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 healthcare professionals feeling confident and skilled in discussing sexual health with people of different genders, ages and cultural backgrounds. Education appropriate to culture, gender and age on the importance of regular STI testing, and how to identify at-risk behaviour and symptoms, is necessary to support healthcare professionals to offer opportunistic testing. Toolkits and decision-support materials also play an important role.

The future availability of rapid testing in non-laboratory settings 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 by providing rapid screening and immediate treatment in communities. Current trials of rapid testing in non-laboratory settings 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 people. 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 *T. vaginalis* indicates a very high prevalence in Aboriginal and Torres Strait Islander people compared to non-Indigenous people [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. *T. vaginalis* 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 *T. vaginalis*.

## 7.3 Management, Care and Support

### Priority Actions

- Assess and implement effective tools and activities to improve appropriate care and treatment.
- Explore methods to enhance contact tracing, partner-notification and treatment systems.
- Adapt existing models of care to meet the specific needs of Aboriginal and Torres Strait Islander people.
- Increase the treatment rates for people with BBV.

### 7.3.1 Blood-borne Viruses

There is increased recognition about BBV and the need for focused prevention, diagnosis, treatment and support initiatives in Aboriginal and Torres Strait Islander communities. The personal impact of BBV 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.

BBV 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 healthcare services. HIV and chronic viral hepatitis should be considered alongside other chronic diseases in Aboriginal and Torres Strait Islander chronic care programs.

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 programs will need to consider

strategies, such as outreach clinics or tele-health, for improving access to specialist services while maintaining links to primary healthcare services.

Programs 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 people, numbers on antiviral treatment appear to be very low. In addition to the significant health benefits for individuals, research has confirmed that HIV antiretroviral treatments can 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 safer and culturally appropriate way and reducing specific barriers (such as difficulties with prescribing and dispensing of antiretroviral medicines), and access to the tools necessary for assessment of liver disease. An improvement in data collection regarding treatment is essential to inform progress in this area and future directions.

### **7.3.2 Sexually Transmissible Infections**

Access to timely treatment after diagnosis is critical to address the high rates of STI 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 three weeks [6].

Effective tools and activities to improve treatment should be identified, adapted and promoted. Notably, several pilot studies using continuing quality improvement programs have been conducted in primary healthcare during the last Strategy, and should lead to improved programs 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 to 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. Lessons learnt from the implementation of patient-delivered partner therapy in the Northern Territory should be monitored, and the feasibility of further implementation should be explored.

Rural and remote communities pose additional challenges to achieving appropriate management of STI. Difficulties in maintaining confidentiality in smaller and remote communities may impede contact tracing and other important activities.

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 people [3] and outbreaks in remote Aboriginal communities continue to occur. Reducing the incidence of infectious syphilis in the Aboriginal and Torres Strait Islander people requires a more coordinated effort. Specifically, improvements in testing and treatment, 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.

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 STI. National annual notifications for congenital syphilis have ranged from zero to seven since 2007 [3]. A sustained focus is required to achieve and maintain the elimination of congenital syphilis, including maintaining action within primary healthcare, public health, and antenatal care settings.

The availability and implementation of consistent national guidelines for the management of all relevant STI in Aboriginal and Torres Strait Islander people, 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.

## 7.4 Workforce

### Priority Actions

- Ensure that STI and BBV testing and treatment providers have adequate training and support to deliver appropriate services.
- Work together with relevant organisations to ensure delivery of responsive and coordinated training, continued education and professional support programs, including in regional and remote areas and for new workforce entrants.
- Improve collaboration between mental health, drug and alcohol, disability, clinical and community services to address the care and support needs of people with STI and BBV.
- Support the capacity and role of Aboriginal community-controlled organisations and other community organisations to provide education, prevention, support and advocacy services to priority populations.
- Build on the skills of the Aboriginal and Torres Strait Islander health workforce to drive health promotion, testing and treatment pathways in local communities.

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 and blood-borne virus prevention, treatment, care and support across Aboriginal community-controlled health services 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 STI and BBV.

Providing the Aboriginal and Torres Strait Islander health workforce with the skills needed to deal with STI and BBV 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 BBV 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 training for Aboriginal and Torres Strait Islander health workers.

Non-Indigenous healthcare 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 healthcare professionals is an ongoing priority for education and training programs. Engaging mainstream services within Aboriginal community-controlled health services 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 Aboriginal community-controlled health services.

## 7.5 Enabling Environment

### Priority Actions

- Reduce racism, stigma and discrimination in community and healthcare 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 people infected and affected by BBV and STI 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 STI continue 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 those associated with fears of contagion, but also a range of other social phobias related to sexuality, drug use, or being a sex worker or a person in a custodial setting [20].

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, 'System Barriers and Enablers'.

Programs that address advocacy and empowerment of individuals to access BBV and STI-prevention programs, treatment, care and support in the community, education, workplace, healthcare and legal settings should be promoted. Approaches include awareness-raising initiatives, education and training programs, 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, criminalisation perpetuates the isolation and marginalisation of priority groups 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.

## 7.6 Surveillance, Monitoring and Evaluation

### Priority Actions

- Improve the reporting of Aboriginal and Torres Strait Islander identification in all relevant data collections.
- Improve prevalence and incidence data for STI and BBV.
- Improve measurement of STI testing coverage in young people.
- Improve measures of treatment coverage for BBV.
- Improve the data available to inform HIV treatment continuum estimates for the Aboriginal and Torres Strait Islander people.
- 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, management, care, support and education and awareness campaigns to ensure they are effective.

### 7.6.1 Surveillance and Monitoring

The National Notifiable Disease Surveillance System (NNDSS) is the core surveillance system for STI and BBV. 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. Unfortunately, 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 healthcare services; work has been underway at a national level to respond to this deficiency.

## Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017

Some important STI, such as Trichomoniasis, are not notified nationally, limiting the epidemiological picture to inform our response to this infection. Mechanisms to collect national-level data on these infections are important to informing targeted and relevant public health actions.

The development and ongoing implementation of a surveillance system to monitor the incidence of chlamydia, gonorrhoea and infectious syphilis, accompanied by improvements in the collecting of testing data, is prioritised in the *Third National Sexually Transmitted Infections 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 custodial settings, should be identified and explored. With respect to testing for BBV, 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 BBV is also important. As an administrative dataset, the Highly Specialised Drugs Program 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 improving the collection of data to inform an HIV care continuum specific to the Aboriginal and Torres Strait Islander people. Considering the development and application of a care continuum for hepatitis C and STI such as syphilis may also be useful.

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

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

### 7.6.2 Research and Evaluation

Research provides the evidence base for the development and implementation of public policy, programs and service delivery that responds to the evolving needs of people affected by STI, 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 program within the broader health system and society, and with reference to cultural appropriateness.

More data are required on knowledge, attitudes and behaviours relating to STI and BBV among Aboriginal and Torres Strait Islander people. 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 (such as that 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 BBV.

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

A significant number of activities and programs have been undertaken in the *Third National Aboriginal and Torres Strait Islander BBV and STI Strategy* and by state and territory, professional and community organisations, Aboriginal medical services, and research centres across all six priority action areas. The opportunities for scaling-up these activities and programs to a national level should be evaluated and explored.

# 8. System Barriers and Enablers

System barriers impact on the health and health access for Aboriginal and Torres Strait Islander individuals and communities. These barriers include access to health services, stigma and discrimination. The 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.

## 8.1 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 healthcare 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 programs to address specific areas as well as investments in population-wide health interventions, such as this Strategy, to reduce BBV and STI.

### 8.1.1 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 that 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.

### 8.1.2 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 healthcare system. Access to education, particularly early childhood education opportunities, improves health literacy in an individual, and thus by extension 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 healthcare maintenance. A particular focus of this Strategy is health promotion and disease-prevention activities regarding safer sex and injecting practices.

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

## 8.2 Stigma and Discrimination

### 8.2.1 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 [21].

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 misuse.

Racism in the lesbian, gay, bisexual, transgender and intersex (LGBTI) community affects Aboriginal and Torres Strait Islander LGBTI community members' 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 [22].

### 8.2.2 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. Practising 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 is an age during which 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 the 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, are likely consume higher levels of alcohol and other substances, and are also less likely to access health services.

### **8.2.3 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. Each period of contact can interrupt education and employment opportunities, disrupt family



life and confirm 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.

### 8.3 Delivery

#### 8.3.1 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 [23]. 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.

#### 8.3.2 Workforce

Aboriginal and Torres Strait Islander health professionals are essential to the delivery of culturally safe care, in primary healthcare 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

This *Fourth National Aboriginal and Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy 2014–2017* was developed through a broad and inclusive consultation process with contributions from governments, professional and community organisations, researchers and expert health professionals. Thanks go to all involved in developing this Strategy.

# References

- 1 ABS Estimates June 2011 <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001>. [Accessed 2 June 2014]
- 2 Australian Bureau of Statistics, 2075.0 Census of Population and Housing—Counts of Aboriginal and Torres Strait Islander Australians, 2011.
- 3 Kirby Institute 2013, *Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: surveillance and evaluation report 2013*. Kirby Institute, Sydney.
- 4 ABS 2011, Use and patient experience, Australian Social Trends. <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20Mar+2011> [Accessed 2 June 2014].
- 5 Williams S, Vally H, Fielding J, Cowie B. *Hepatitis B prevention in Victoria, Australia - the potential to protect*. Euro Surveill. 2011;16(22), p. ii=19879.
- 6 Guy R, Ward JS, Smith KS, Su JY, Huang RL, Tangey A, Skov S, Rumbold A, Silver B, Donovan B, Kaldor J, 'The impact of sexually transmissible infection programs in remote aboriginal communities in Australia: a systematic review', *Sex Health* 2012, 9(3), pp. 205-212, 2012.
- 7 Malcolm A, Aggleton P, Bronfman M, Galvao J, Mane P, Verrall J, 'HIV-Related Stigmatization and Discrimination: its Forms and Contexts' (1998) 8 *Critical Public Health*, p. 347.
- 8 Kirby DB, Laris BA, Rolleri LA 2007, 'Sex and HIV Education Programs: Their Impact on Sexual Behaviors of Young People Throughout the World', *J Adoles Health* 40, pp. 206–217.
- 9 Northern Territory Health 2002 '*Trichomonas vaginalis*: Consideration of the issues that underpin testing: which way to go?' Background paper prepared by the Northern Territory AIDS/STD program, Disease Control, Darwin, March 2002.

- 10 MacLachlan J, Allard A, Towell V, Cowie, B 2013, 'The burden of chronic hepatitis B virus infection in Australia, 2011', *Australian and New Zealand Journal of Public Health Volume 37, Issue 5, pages 416–422* October 2013.
- 11 Centre of Disease Control, Northern Territory, The Northern Territory Disease Control Bulletin Vol 19, [http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/71/92.pdf&siteID=1&str\\_title=Bulletin%20March%202012.pdf](http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/71/92.pdf&siteID=1&str_title=Bulletin%20March%202012.pdf) [Accessed 2 June 2014].
- 12 Bastian I, Hinuma Y, Doherty R 1993, 'HTLV-I among Northern Territory aborigines', *MJA*, 159:12-16.
- 13 <http://www.medicalobserver.com.au/news/call-to-halt-htlv1-spread-among-indigenous> [Accessed 2 June 2014].
- 14 Wye, SQ 2006, *A Framework for peer education by drug-users organisations*, AVIL, Canberra.
- 15 Department of Health, *The Australian Immunisation Handbook*, 10th Edition 2013, Commonwealth of Australia, January 2014.
- 16 Public Health Agency of Canada 2010, *Population-Specific HIV/AIDS Status Report: Aboriginal Peoples*. Her Majesty the Queen in Right of Canada, 2010. <http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/aboriginal-autochtones/pdf/pshasrap-revspda-eng.pdf> [Accessed 2 June 2014].
- 17 National Centre for HIV Epidemiology and Clinical Research, 2009 *Annual Surveillance Report HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia*. The University of New South Wales, National Centre for HIV Epidemiology and Clinical Research, 2009.
- 18 Australian Bureau of Statistics Prisoners in Australia, 2003. <http://www.abs.gov.au/ausstats/abs@.nsf/ProductsbyReleaseDate/B7629B25B2FA BDB6CA256F7200703919?OpenDocument> [Accessed 2 June 2014]

- 19 Lea T, Costello M, Mao L, Prestage G, Zablotska I, Ward J, Kaldor J, de Wit J, Holt M, *Elevated reporting of unprotected anal intercourse and injecting drug use but no difference in HIV prevalence among Indigenous Australian men who have sex with men compared with their Anglo-Australian peers*, National Centre in HIV Social Research, The University of New South Wales, Sydney, NSW 2052, Australia, 2013.
- 20 Aggelton, P & Parker, R 2002, 'HIV and AIDS-related stigma, discrimination and human rights', *Health and Human Rights*, vol. 6, pp. 1-18, and 'HIV and AIDS-related discrimination: a conceptual framework and implications for action', *Social Science and Medicine* (2003) vol. 57, pp. 13-24.
- 21 Awofeso N, 'Racism: a major impediment to optimal Indigenous health and health care in Australia', *Australian Indigenous Health Bulletin*, vol. 11, no. 3. (2011).
- 22 ABS 2010, National Aboriginal and Torres Islander Social Survey. <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0/> [Accessed 2 June 2014].
- 23 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

	Comparison rates of Aboriginal and Torres Strait Islander infection rates to non-Indigenous populations	Key Aboriginal and Torres Strait Islander subpopulations and sources of transmission <sup>1</sup>	Other details <sup>2</sup>
Chlamydia	3.5 times higher	Young people aged under 30 years.	Rates of diagnosis in Aboriginal and Torres Strait Islander people are three times higher than the non-Indigenous people in metropolitan areas, six times higher in outer regional areas and seven times higher in remote areas.
Gonorrhoea	30.6 times higher	Young people aged under 30 years.  Transmission of gonorrhoea is mainly through heterosexual contact, whereas it is mainly through homosexual contact in the non-Indigenous people.	
Syphilis	Five times higher	Young people aged under 30 years, including women of child-bearing age.	
Trichomoniasis	Can include overall prevalence data from STRIVE for 16–34 year olds.		
Mycoplasma genitalium	This organism is not well studied, and there is a need to develop standard testing protocols in order to monitor its prevalence. <sup>3</sup>		This is emerging as an important cause of pelvic inflammatory disease and urethritis, and may also be associated with increased risk of HIV acquisition.

## Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017

	<b>Comparison rates of Aboriginal and Torres Strait Islander infection rates to non-Indigenous populations</b>	<b>Key Aboriginal and Torres Strait Islander subpopulations and sources of transmission<sup>1</sup></b>	<b>Other details<sup>2</sup></b>
HSV-2	18 per cent compared with 12 per cent in the non-Indigenous people. <sup>4</sup>		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. <sup>5</sup>
HIV	5.5 per 100 000 compared to 5.1 in the non-Indigenous people in 2012. <sup>6</sup>	Men who have sex with men are the primary exposure category, with 55 per cent of new infections in 2008–12 (compared with the non-Indigenous 72 per cent.  Infections attributed to injecting drug use among Aboriginal and Torres Strait Islander people were 16 per cent compared with non-Indigenous people, at 2 per cent, in 2008–12.	Aboriginal and Torres Strait Islander status is reported in more than 95 per cent of HIV notifications nationally.
Hepatitis B	Newly acquired infection was 3 per 100 000 compared to 1 per 100 000 in the non-Indigenous people in 2012.		
Hepatitis C	Newly diagnosed infection was 166 per 100 000 compared to 40 per 100 000 in the non-Indigenous people in 2012. <sup>7</sup>	Transmission of hepatitis C continues to predominantly occur among people with a history of injecting drug use.	Aboriginal and Torres Strait Islander status is reported in more than 41 per cent of hepatitis C notifications nationally.

# Appendix 2: Related Strategy Targets

The targets of the *Seventh National HIV Strategy 2014–2017* are to:

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 programs targeting sex workers and for people who inject drugs.*

The targets of the *Second National Hepatitis B Strategy 2014–2017* are to:

1. *achieve 95 per cent HBV childhood vaccination coverage*
2. *increase hepatitis B vaccination coverage of priority populations*
3. *increase to 80 per cent the proportion of all people living with chronic hepatitis B who are diagnosed*
4. *increase to 15 per cent 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. *a 50 per cent decrease in the incidence of new hepatitis C infections*
2. *to increase the number of people receiving antiviral treatment by 50 per cent each year.*

The targets of the *Third National Sexually Transmissible Infections Strategy 2014–2017* are to:

1. *achieve HPV vaccination coverage of 70 per cent*
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 Underpinning Australia's Response

The guiding principles informing this Strategy are drawn from Australia's efforts over time to respond to the challenges, threats and impacts of HIV, STI and viral hepatitis.

## Human Rights

People with HIV, STI 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 people 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 health, and formulation and application of law and public policy that supports and encourages healthy behaviours and respects human rights.

## Prevention

The transmission of HIV, STI and viral hepatitis can be prevented by adopting and maintaining protective behaviours. Education and prevention programs, 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 programs and drug treatment programs.

## 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 between affected communities, professional and community organisations, government, researchers and health professionals is characterised by consultation, cooperative effort, respectful dialogue, resourcing and action to achieve the goals of the strategies. It includes leadership from the Australian Government and the full cooperative efforts of all members of the partnership to implement agreed directions.

# 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 continue to adversely affect those living with STI and the communities affected by STI. Social, legal, financial framework issues prevent uptake of effective prevention, testing and treatment.

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
Young Aboriginal and Torres Strait Islander people (under 30)	<ul style="list-style-type: none"> <li>■ Higher prevalence of STI than non-Indigenous youths.</li> <li>■ High risk due to:                             <ul style="list-style-type: none"> <li>– low levels of health education and health literacy.</li> <li>– high rate of risk behaviours (such as partner change and risky alcohol and other drug use).</li> <li>– high fertility rates among younger people.</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>■ Young men access health services less often than young women, and are therefore an important priority subpopulation.</li> </ul>
Aboriginal and Torres Strait Islander people who live in remote communities	<ul style="list-style-type: none"> <li>■ Higher prevalence of STI than Aboriginal and Torres Strait Islander people in urban settings.</li> </ul>	<ul style="list-style-type: none"> <li>■ Lower levels of health literacy.</li> <li>■ Decreased accessibility to health care.</li> </ul>	

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
Aboriginal and Torres Strait Islander people who inject drugs	<ul style="list-style-type: none"> <li>Higher prevalence of STI in comparison to non-Indigenous people who inject drugs.</li> <li>High risk due to barriers to effective responses and higher rates of sharing injecting equipment.</li> </ul>	<ul style="list-style-type: none"> <li>Criminalisation.</li> <li>Needle and Syringe Program issues.</li> <li>Concerns regarding access and/or acceptance of culturally appropriate services, including primary healthcare services for many communities.</li> <li>Concerns about confidentiality in service provision.</li> </ul>	
Aboriginal and Torres Strait Islander people in custodial settings	<ul style="list-style-type: none"> <li>High risk due to the overrepresentation of Aboriginal and Torres Strait islander people in the prison population (27 per cent in a 30 June 2012 survey).</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>Needle and Syringe Program issues.</li> <li>Concerns regarding access and/or acceptance of culturally appropriate services, including primary healthcare services.</li> <li>Even upon release there is increased stigmatisation, social and cultural exclusion, and further concerns regarding support networks and health and social services.</li> </ul>	

## Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
Aboriginal and Torres Strait Islander gay men, other men who have sex with men, and sistergirls and transgender people	<ul style="list-style-type: none"> <li>■ High risk due to:               <ul style="list-style-type: none"> <li>– High levels of population mobility.</li> <li>– Low levels of HIV awareness and limited culture of safer sex negotiation.</li> <li>– Social isolation due to lack of acceptance of homosexuality and transgender status within some communities.</li> <li>– Risk behaviour, such as alcohol and other drug use, and unprotected anal intercourse with casual partners<sup>8</sup>.</li> <li>– 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.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Actual or perceived homophobia, racism, discrimination and cultural insensitivity.</li> </ul>	
Aboriginal and Torres Strait Islander people living with HIV and viral hepatitis	<ul style="list-style-type: none"> <li>■ 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.</li> <li>■ Aboriginal and Torres Strait Islander people living with BBV, their partners, carers, friends, families and children have complex needs.</li> </ul>	<ul style="list-style-type: none"> <li>■ Fear and misunderstanding about BBV exist in many Aboriginal and Torres Strait Islander communities, often resulting in social discrimination and isolation.</li> <li>■ Issues relating to privacy and confidentiality of health status.</li> </ul>	<ul style="list-style-type: none"> <li>■ The potential for self-harm from behaviours such as alcohol and other drug use is present and consideration needs to be given to co-morbidities such as mental health problems.</li> </ul>

Priority Population	Reason for Priority Status	Issues and Considerations	Additional Focus
People living in the cross-border region of Australia and Papua New Guinea	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>Pressure on healthcare facilities in the Torres Strait resulting from movement of people.</li> <li>Limited access to, and poor standards of, health service facilities in the Western Province of Papua New Guinea.</li> </ul>	
Aboriginal and Torres Strait Islander sex workers	<ul style="list-style-type: none"> <li>High risk associated with high number of sexual encounters.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>Concerns regarding access and/or acceptance of culturally appropriate services including primary healthcare services for many communities.</li> <li>Low health literacy and perception of risk.</li> </ul>	<ul style="list-style-type: none"> <li>It is acknowledged that people can transition in and out of sex work over time, and may not identify as sex workers.</li> </ul>

# Notes to the Appendix

- 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.
- 3 Weinsten SA & Stiles BG 2011, 'A review of the pidemiology, diagnosis and evidence-based management of *Mycoplasma genitalium*', *Sexual Health* 8, pp. 143–158.
- 4 Brazzale AG, Russell DB, Cunningham AL, Taylor J & McBride WJ 2010, 'Seroprevalence of herpes simplex virus type 1 and type 2 among the indigenous population of Cape York, Far North Queensland, Australia', *Sexual Health* 7, pp. 453–459.
- 5 Brazzale AG, Russell DB, Cunningham AL, Taylor J & McBride WJ 2010, 'Seroprevalence of herpes simplex virus type 1 and type 2 among the indigenous population of Cape York, Far North Queensland, Australia', *Sexual Health* 7, pp. 453–459.
- 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
- 8 Lea T, Costello M, Mao L, Prestage G, Zablotska I, Ward J, Kaldor J, de Wit J & Holt M 2013, 'Elevated reporting of unprotected anal intercourse and injecting drug use but no difference in HIV prevalence among Indigenous Australian men who have sex with men compared with their Anglo-Australian peers', *Sexual Health* 2013; 10, pp. 146–155.



**[www.health.gov.au](http://www.health.gov.au)**

All information in this publication is correct as at July 2014