Action Plan

Enhanced response to addressing sexually transmissible infections (and blood borne viruses) in Indigenous populations

NOVEMBER 2017

This Action Plan has been developed by the Australian Health Protection Principal Committee (AHPPC) Governance Group and endorsed by the AHPPC and the Australian Health Ministers Advisory Council (AHMAC).

It is expected that the Action Plan will evolve over time to meet the objectives of the *National Strategic approach for an enhanced response to the disproportionately high rates of STI and BBV in Aboriginal and Torres Strait Islander people*.

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Objectives

This Action Plan supports the *National Strategic approach for an enhanced response to the disproportionately high rates of STI and BBV in Aboriginal and Torres Strait Islander people* (the Strategic approach). The respective primary, secondary and tertiary objectives of the Strategic approach are to:

1. Control the current syphilis outbreak in northern and central Australia (primary);
2. Undertake opportunistic control efforts for other STI and BBV (secondary);
3. Consider the long-term sustainable response to STI and BBV issues in Indigenous people, in-line with the National BBV and STI Strategies for 2018-2022 (tertiary), with the ultimate goal of reducing rates of STI and BBV to a sustainably low level.

Setting the scene

In January 2011, an increase of infectious syphilis notifications among young Indigenous people was identified in the North West region of Queensland, following a steady decline at a national level in remote communities.

Subsequent increases in infectious syphilis notifications were reported in the Northern Territory in 2013, Western Australia in 2014 and South Australia in 2016, following sustained periods of low notification rates.

In April 2015, the Multijurisdictional Syphilis Outbreak Working Group (MJSO) of the Communicable Diseases Network Australia (CDNA) was formed in response to the on-going outbreak of infectious syphilis among young Aboriginal and Torres Strait Islander people residing in northern Australia.

The infectious syphilis outbreak is affecting predominately young (15-29 year olds) Indigenous people living in remote areas of northern Australia. However, the outbreak is becoming a significant issue in larger cities (most recently Darwin). The epidemiological profile of the outbreak and nature of syphilis infection has considerable public health implications:

- high rates of infection in women of child bearing age, increasing the risk of congenital syphilis;
- high risk of further spread of syphilis due to the highly mobile nature of the affected population, widespread distribution in remote areas and across jurisdictional borders, limited access to skilled and stable workforce in remote areas and limited community awareness and education; and
- increased risk of transmission and acquisition of HIV and other STI.

While much of the focus has been on syphilis, the epidemiology for other STI, particularly gonorrhoea and chlamydia, and BBV are similarly concerning.

On 1 May 2017, Minister Wyatt wrote to State and Territory health ministers articulating the need to work together more strategically on Indigenous sexual health. A comprehensive stocktake was undertaken of the actions states and territories were taking to address STI/BBV among Aboriginal and Torres Strait Islander people in their jurisdictions.

Background

On 14 July 2017, the Australian Health Protection Principal Committee (AHPPC) convened an Emergency Response Teleconference on BBV/STI in Indigenous Communities. The teleconference acknowledged that significant work has been done by State and Territory health services, Aboriginal Community Controlled Health Organisations (ACCHOs), primary health care and other community organisations, with the co-ordination of effort in syphilis through the MJSO, under the CDNA. At that teleconference, AHPPC members agreed to hold a half day workshop.

The workshop was held in Sydney on 9 August 2017 and the objectives were to:

- identify the current status of the syphilis outbreak in Indigenous populations and identify existing BBV/STI activities;
- identify the barriers to success in addressing the syphilis outbreak;
- discuss and develop solutions, including what the AHPPC led process could do to add value at the national level; and
- agree on next steps for an enhanced national response to BBVs and STIs in the Indigenous population.

The workshop agreed on a number of key priority areas, including: point of care tests; workforce; provider numbers for nurses in remote settings; standardisation of current guidelines and frequency of testing; laboratories; MBS data; standardised reporting and indicators; prisons; general practice; education awareness; antenatal care; and Indigenous identifiers on health records.

The workshop established a governance structure to oversee the progression of agreed key priority areas and actions. The workshop participants agreed to reconvene before the first AHPPC meeting in 2018 to discuss progress on the priority actions.

Priority Areas for the enhanced response

The action items identified at the workshop and through on-going discussion can be grouped into four key priority areas:

Priority Area 1: Testing and treatment

Priority Area 2: Surveillance and reporting

Priority Area 3: Education and Awareness

Priority Area 4: Antenatal Care

The importance of each Priority Area is discussed in further detail below.

This Action Plan acknowledges that significant work has been done by State and Territory Health services, ACCHOs, primary health care and other community organisations to address the syphilis outbreak.

All States and Territories have a range of interventions in place and have directed specific resources to this issue. This Action Plan identifies opportunities to scale-up these programs to a national level, where appropriate.

Workforce

Outbreak control efforts and sustained interventions to address high rates of STI and BBV in Indigenous communities are being impeded by a number of workforce issues, occurring predominately in remote health services, including:

- a lack of dedicated funding for the primary healthcare workforce for sexual health;
- high turnover and significant shortages of appropriately skilled staff; and
- gaps in education, training and professional development opportunities for health professionals.

A stable, skilled and culturally appropriate workforce is fundamental to achieving the actions outlined in this Plan. Integrated into each Priority Area are related workforce actions that will enable delivery of the overarching objective of each Priority Area and will aim to address, where possible, the significant workforce issues. These workforce actions are aimed at building capacity (including development of a surge workforce in the short-term), providing support and the tools necessary to increase health promotion, testing and treatment in areas of need.

A workforce strategy that takes into consideration current arrangements and needs of each jurisdiction will also be investigated as part of this Action Plan.

Governance and reporting structure for the enhanced response

At the Commonwealth level, there is more than one level of response, with the following areas having a role:

- Department of Health; and
- Indigenous Affairs Group, Department of Prime Minister and Cabinet (PM&C).

In addition, AHPPC and its sub-committees and technical working groups are involved in coordinating the response, including:

- CDNA, which is supported by:
  - MJSO;
  - MJSO Data Working Group;
- Public Health Laboratory Network (PHLN); and
- Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS).

Governance Group

The Office of Health Protection (OHP) in the Commonwealth Department of Health and the AHPPC has been tasked by Minister Wyatt to take a leadership role in this area. This has been formalised through the establishment of a Governance Group, which reports directly to AHPPC and whose members include representatives from the four affected jurisdictions and key advisory bodies. The Group is chaired by the Commonwealth Chief Medical Officer.

The Governance Group will oversee the enhanced national response to Indigenous sexual health priorities. The Terms of Reference for the Governance Group, including the current composition of the Group, is at Appendix A.

Reporting to the Governance Group

The Governance Group will be supported as needed by the various areas within the Commonwealth (including Health and PM&C), as well as the AHPPC sub-committees and technical working groups, as outlined below:

- CDNA: national public health coordination and leadership, including through the Series of National Guidelines (SoNGs).
- MJSO and MJSO Data Working Group (working groups of CDNA): surveillance, reporting, workforce issues related to the outbreak and guidance on antenatal care[1].
- PHLN: advice and expertise on pathology and laboratory services, including Point of Care Tests (PoCT) and improved access to laboratory data.
- BBVSS: advisory body on strategic policy, programs, and social policy activities relating to BBV and STI, including education and awareness.

The Governance Group will request advice and support as needed from key non-government agencies, including: Kirby Institute; Royal Australian College of General Practitioners (RACGP), Royal Australian College of Physicians (RACP); and Rural Doctors Association of Australia (RDAA).

Figure 1 identifies AHMAC committees and relevant organisations that will be consulted for each Priority Area.

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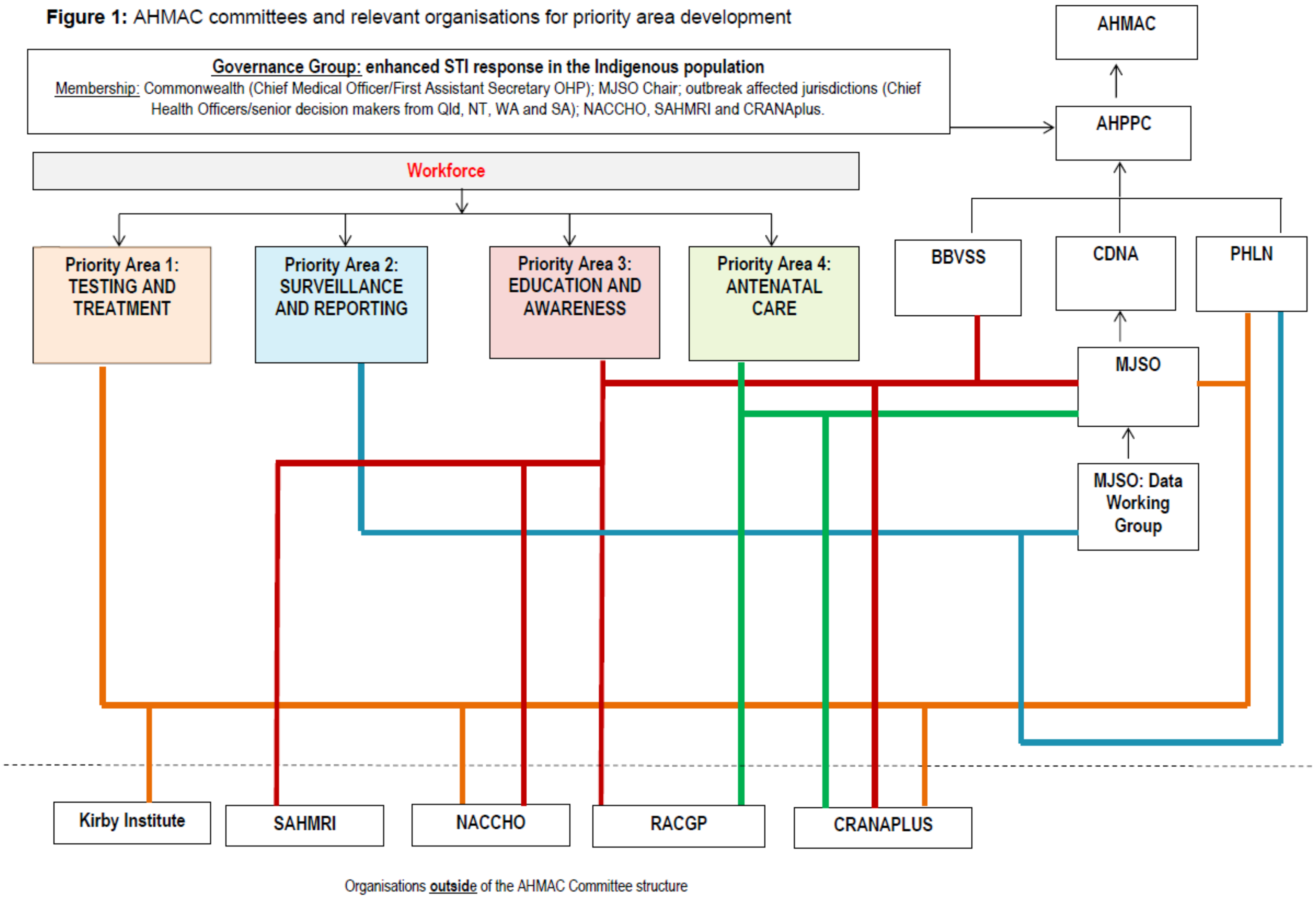
[1] As agreed by CDNA on 25 October 2017, MJSO members when providing advice to the Governance Group will seek internal approvals, including approvals from their CDNA representative prior to submission. All advice provided by the MJSO to the Governance Group will be provided to CDNA for information.

Figure 1: AHMAC committees and relevant organisations for priority area development



Governance Group: enhanced STI response in the Indigenous population

Membership: Commonwealth (Chief Medical Officer/First Assistant Secretary OHP); MJSO Chair; outbreak affected jurisdictions (Chief Health Officers/senior decision makers from Qld, NT, WA and SA); NACCHO, SAHMRI and CRANAplus.

Organisations **outside** of the AHMAC Committee structure

Action Plan

This Action Plan is expected to evolve over time as further information is gathered and actions are implemented. In developing the Action Plan and priority action areas, it is important to have the right balance of short and long term solutions. As such, the Action Plan incorporates short term actions identified at the workshop that are already underway. The Action Plan also identifies longer term actions which will be aligned to the new National BBV and STI Strategies, especially the *Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018-2022*.

The current National BBV and STI Strategies for: HIV; Hepatitis B; Hepatitis C; STI; and Aboriginal and Torres Strait Islander BBV and STI end in 2017. Consistent with previous National BBV and STI Strategies, the Commonwealth is leading the development of the next suite of National Strategies in close consultation with other jurisdictions through the BBVSS and will present the five National Strategies to AHMAC and COAG Health Council for endorsement, through the AHPPC. The 2018-2022 National Strategies will set out agreed targets and Priority Action Areas to guide BBV and STI policies and programs within government, research, medical and community based settings.

The Action Plan also acknowledges the Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* on the social and cultural determinants of health to address the causes of higher rates of BBV/STI among Indigenous people. In this regard, there continues to be significant Commonwealth investment in BBV/STI through mainstream health expenditure through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), hospitals and National Partnership Payments to jurisdictions.

It is acknowledged that a skilled, stable and culturally appropriate workforce will be critical to the success of the enhanced response. Where appropriate, actions related to workforce have been incorporated into the Priority Areas noting that each jurisdiction has different needs. As such, there will not be one national one-size-fits-all policy.

Priority Area 1: Testing and treatment

Increasing the number of people tested, frequency of testing, the subsequent treatment of those infected and contact tracing of known sexual contacts, will likely be the most effective strategy to control the current outbreak of infectious syphilis. While concentrated efforts in the immediate future are required to contain the current outbreak, sustained long term interventions are also required to ensure that there is a decline in the high rates of STI in Indigenous people more broadly, particularly in remote areas of Australia.

Short term actions

Increasing testing and treatment in the short term, and in the context of the infectious syphilis outbreak, requires action in a number of different areas to:

1. identify an appropriate syphilis point of care test (PoCT) and co-testing strategy for other STI;
2. develop PoCT and STI testing guidelines;

3. develop guidance around testing (including point of care test (PoCT), frequency of testing and treatment) for inclusion in the 2015 National Guidelines for Syphilis[2];
4. identify areas of need and frequency required for targeted testing (including consideration of immediate treatment at the time of testing);
5. develop an appropriate community engagement strategy in areas targeted for testing (and treatment where needed);
6. develop processes to ensure data can be collected to monitor and evaluate the effectiveness of increased testing (and treatment) on disease burden in targeted populations (link to Priority Area 2); and
7. identify opportunities for a ‘surge workforce’ and/or improved workforce coordination activities to undertake targeted testing (and treatment where needed) in areas of need.

Long term actions

BBV and STI control, through testing and treatment, in the long term requires sustained and intensive interventions appropriate for the population at-risk. Maintaining consistent testing practices, contact tracing, community engagement and capacity building in a stable workforce, through appropriate training, is essential in working towards reductions in STI prevalence in Indigenous communities. Actions over the long term include to:

1. identify opportunities to strengthen the existing workforce in areas of need, including the role of regional co-ordinators;
2. develop orientation resources, including STI materials, for new staff working in remote areas;
3. identify options that enable remote healthcare workers (other than doctors) to order pathology for BBV and STI;
4. review existing arrangements for the supply and or administration of medicines by nurses and Aboriginal Health Workers in remote settings and collaborate with jurisdictions to ensure mechanisms are in place to enable the supply and or administration of relevant medicines; and
5. develop resources to guide implementation of options identified in action areas 3 and 4 above (ordering pathology and administering treatment).

These short and long term actions will be progressed in consultation with AHMAC / AHPPC committees and relevant organisations: **MJSO, MJSO Data Working Group, CDNA, PHLN**, **NACCHO**, **CRANAPLUS** and the **Kirby Institute** (Figure 1).

Priority Area 2: Surveillance and reporting

Access to syphilis testing data, and that of other STI and BBV, from both private and public laboratories, continues to remain a challenge for jurisdictions and has been highlighted as an information gap in surveillance. Availability of such data enables better understanding of testing patterns and the calculation of proportion positive (notifications of a disease as a proportion of people tested for the disease). Testing data provide valuable information when evaluating interventions, for example testing rates may have increased as a result of health promotion campaigns, and providing context around notifications of infections. Indigenous identification on pathology forms is currently not mandatory, which has implications for Indigenous status completeness in the laboratory data. In the context of the outbreak, testing data where Indigenous

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[2] Series of National Guidelines: syphilis (see appendix 4) (www.health.gov.au/internet/main/publishing.nsf/Content/cdnasongs.htm)

and non-Indigenous populations cannot be differentiated may underestimate the impact of changes in testing patterns, and proportion positive, in the Indigenous population.

Access to laboratory testing data, and development of key reporting indicators would not only enhance evaluations of the effectiveness of outbreak control interventions, it would inform quality improvements that could be made within clinics in at-risk communities over the short and long term.

Short term actions

In the short term actions regarding enhanced reporting on the outbreak can leverage off existing reporting structures under the MJSO. It is acknowledged that Indigenous identification in pathology is an issue that requires long term consideration, however in the short term this issue will continue to be explored in consultation with relevant organisations. In the short term, action is required to:

1. consider indicators for outbreak monitoring, including development of new indicators and strengthening of existing measures, and consider including in the MJSO six monthly reports.

Long term actions

As noted above, Indigenous identification on pathology is an issue that requires long term consideration and will impact on a number of areas in health other than STI and BBV control. However, through this Action Plan, areas that will be addressed in the long term will include:

1. identifying opportunities to discuss, with relevant agencies/organisations, issues regarding Indigenous identification on pathology forms and results;
2. developing mechanisms to facilitate routine access to laboratory testing data;
3. investigating the development of new national KPIs for BBV and STI;
4. working with the Australian Digital Health Agency to embed Indigenous status in electronic health records; and
5. conducting a review of the voluntary Indigenous identifier on Medicare records.

These short and long term actions will be progressed in consultation with AHMAC committees and their subcommittees and relevant organisations: **MJSO Data Working Group** and **PHLN** (Figure 1).

Priority Area 3: Education and Awareness

Access to consistent and appropriate (socially, culturally and for the setting) resources for at-risk communities and the health workforce servicing these areas, is an essential element in STI control. Community education, health promotion and campaign activities focussing on safe sex practices, including condom use and normalising testing and treatment, provide tools for vulnerable people to make informed decisions about their sexual and reproductive health. Ensuring health care workers, particularly those in remote settings, are supported through orientation processes for new staff, on-going training and guidance around best practice will contribute to building capacity within the health services and retention of staff.

Short term actions

Meeting the education needs of the community and health care workers, and increasing awareness among these groups requires the following actions to be undertaken:

1. Examine existing web based resources for health professionals and if needed, develop new resources that incorporate PoC testing awareness.
2. Communicate outbreak advice, guidance on case management and other resources to doctors, Aboriginal Health Workers (AHWs) and Remote Area Nurses (RANs) through existing Commonwealth networks, including the GP Roundtable, the Young, Deadly, Syphilis Free Campaign and other professional networks.
3. Develop and implement an awareness and education strategy (taking account of existing or recent initiatives) that targets young people living in areas of need with the aim of addressing immediate outbreaks. Strategy emphasis on:
   - young women;
   - ramifications of long term infections; and
   - highlighting the importance of engagement with antenatal care (ANC) services early in pregnancy.

Long term actions

Capacity building and leveraging of the successes of historical education and health promotion campaigns will, over the long term, create efficiencies and embed effective STI control measures into health services and within at-risk communities. Education and awareness areas requiring action include:

1. Consider opportunities to improve sexual health education in schools for 13-19 year olds, with the long term plan of starting sexual health education from age 10.
2. Urgently work with content owners to align existing clinical manuals so that they are consistent across all remote areas: Remote Primary Health Care (CARPA) manuals, Silver Book and Queensland Primary Care Manual. Develop additional resources as necessary.
3. Identify opportunities to include more comprehensive education and training for GPs, AHWs and RNs, including consideration of professional qualification opportunities.
4. Undertake a comprehensive stocktake of previous sexual health campaigns and any related evaluations with the aim to develop a guiding principles document or toolbox of education/health promotion activities that have/haven't worked and guidance around education.
5. Consider the guiding principles and/or health promotion toolbox and develop ongoing health promotion resources and activities that aim to normalise testing and treatment for STI in schools and the community. Possible approaches may include:
   - use of sporting or other positive role models and/or community events as enablers (e.g. from AFL/NRL) to champion sexual health messages in communities;
   - utilisation of Indigenous community radio and television to disseminate messages about sexual health;
   - development and evaluation of peer education models to promote STI and BBV testing; and
   - provision of incentives (e.g. vouchers) for people to get tested.
6. Evaluate effectiveness of existing safe sex promotion strategies - Young Deadly Syphilis Free (campaign only launched 1 July 2017).

These short and long term actions will be progressed in consultation with AHMAC / AHPPC committees and relevant organisations: **BBVSS**, **MJSO**, **RACGP**, **SAHMRI**, **NACCHO** and **CRANAPLUS** (Figure 1).

Priority Area 4: Antenatal Care

Inconsistent antenatal guidelines for testing, including the recommendations for repeat testing in women at a high risk of infection/re-infection and management of perinatal syphilis and poorer access to antenatal care in remote communities, may have contributed to cases of congenital syphilis associated with the outbreak. To ensure national consistency and to learn from historical cases of congenital syphilis, action is required to:

1. develop interim guidance on antenatal care, including testing and treatment, and investigation of congenital syphilis cases (similar steps to those required for a sentinel event) for inclusion in the 2015 National Guidelines for Syphilis[3];
2. continue education targeted at young women on the importance of STI and BBV testing during pregnancy;
3. (*long term*) review the current National Antenatal Guidelines and include recommendations regarding frequency of testing for STI, in particular syphilis, appropriate care and follow-up in at-risk populations; and
4. *(long term*) investigate learnings from congenital syphilis cases, including circumstances under which they occurred, to identify any system-wide factors contributing to their occurrence.

These short and long term actions will be progressed in consultation with AHMAC / AHPPC committees and relevant organisations: **MJSO**, **RACGP** and **CRANAPLUS** (Figure 1).

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[3] Series of National Guidelines: syphilis (see appendix 4) (www.health.gov.au/internet/main/publishing.nsf/Content/cdnasongs.htm)

Monitoring and evaluation

This Action Plan sets high-level directions for action in both the short and long terms. Progress of key actions will be monitored by the Governance Group through its regular meetings and will be guided by the AHPPC workshop on BBV/STI in Indigenous populations. This progress will be reported to AHPPC, AHMAC and Minister Wyatt as necessary.

Ongoing monitoring and evaluation of the actions will also be undertaken through the five National BBV and STI Strategies for: HIV, Hepatitis B, Hepatitis C, STI, and Aboriginal and Torres Strait Islander BBV and STI. It is expected that Monitoring and Evaluation Plans for the new 2018-2022 Strategies will be developed in consultation with state and territory governments and partners.

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.

Appendix A: Governance Group Terms of Reference

Purpose of the Group

The purpose of the Governance Group is to oversee the enhanced national response to the current syphilis outbreak in Australia, including short term actions to address immediate priorities. The Governance Group will also take into consideration a long term approach to a sustainable response to sexually transmissible infections (STI) and blood borne viruses (BBV).

Responsibilities

The Governance Group will have the following responsibilities:

- develop a high level Strategic approach to be endorsed by AHPPC and AHMAC by the end of 2017 to guide the implementation of enhanced response activities to address sexually transmitted infections (and blood borne viruses) in Indigenous populations
- develop a culturally appropriate Action Plan to be endorsed by AHPPC and AHMAC by the end of 2017, to address the outbreak of infectious syphilis affecting Queensland, Northern Territory, Western Australia and South Australia, building on state and territory responses to date; and
- in developing the Action Plan, focus on realistic short term actions identified at the workshop that are already underway as well as longer term actions which align with the development of the new National BBV and STI Strategies, especially the *5th National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy*.

Composition

The Governance Group will consist of:

- Chair - Commonwealth Chief Medical Officer (CMO), First Assistant Secretary Office of Health Protection (FAS OHP) (proxy);
- Chair MJSO Working Group;
- Representative from National Aboriginal Community Controlled Health Organisation (NACCHO);
- Representative from the South Australian Health and Medical Research Institute (SAHMRI);
- Representative from CRANAplus; and
- Chief Health Officers or senior decision makers from Queensland, Northern Territory, Western Australia, and South Australia):

The Office of Health Protection will provide the Secretariat function for the Governance Group.

The Governance Group will be supported as needed by the various areas within the Commonwealth (including Health and PM&C), as well as the AHPPC sub-committees and technical working groups, as outlined below:

- CDNA: national public health coordination and leadership, including through the Series of National Guidelines (SoNGs);
- MJSO and MJSO Data Working Group (working groups of CDNA): surveillance, reporting, workforce issues related to the outbreak and guidance on antenatal care;
- PHLN: advice and expertise on pathology and laboratory services, including Point of Care Testing (PoCT) and improved access to laboratory data; and

- BBVSS: advisory body on strategic policy, programs, social policy activities relating to BBV and STI, including education and awareness.

The Governance Group will also request advice and support as needed from key non-government agencies, including: NACCHO, SAHMRI, Kirby Institute; RACGP, CRANAplus, RACP; and RDAA.

Reporting

The Governance Group will be responsible for reporting by the end of 2017 on progress to:
- the Australian Health Protection Principal Committee (AHPPC); and
- the Australian Health Ministers Advisory Council (AHMAC).

The Governance Group will also report to the AHPPC Workshop on BBV/STI in Indigenous Populations in April 2018.

Meeting frequency

The Governance Group will meet as needed by teleconference to agree on priorities and discuss progress.

The Governance Group will initially hold meetings in September 2017, October 2017 and February 2018.

Further meetings will be determined following the AHPPC Workshop in April 2018.

Timeframes

The Governance Group will be activated from September 2017 to April 2018.

The AHPPC Workshop in April 2018 will decide the timeframes for the continuation of the Governance Group beyond April 2018.

Conflict of Interest

Members must declare any conflict of interest, whether real or perceived, in matters being considered or about to be considered by the Governance Group.