

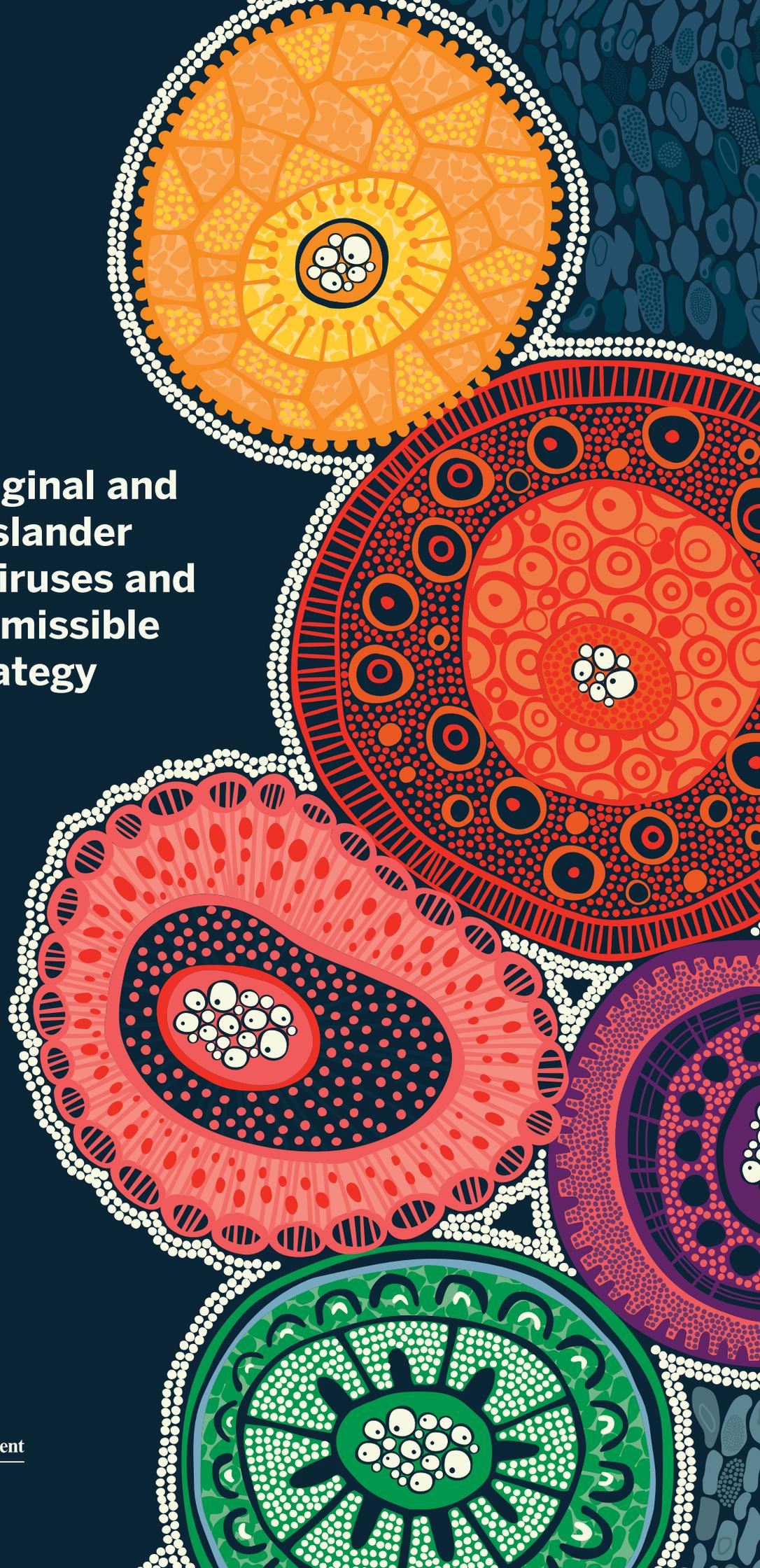
FIFTH

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

2018–2022



Australian Government
Department of Health



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Contents

1	Introduction	04
2	Guiding principles	08
3	Snapshot of Aboriginal and Torres Strait Islander BBV and STI in Australia	10
4	About this strategy	14
5	Measuring progress	20
6	Priority groups and settings	23
7	Key areas for action	32
8	Implementing this strategy	52
	Appendix A: National BBV and STI guiding principles	54
	Appendix B: References	56





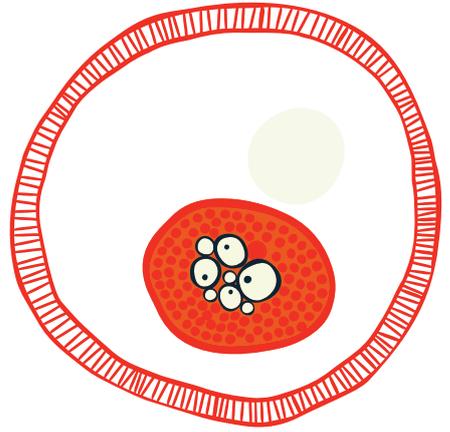
1.

Introduction

Acknowledgement

We acknowledge the Traditional Owners of country throughout Australia, and Aboriginal and Torres Strait Islander people's continuing connection to culture, land, sea, waters and community. We pay our respects to Elders both past, present and emerging.

We would like to thank Aboriginal and Torres Strait Islander communities and stakeholders for their assistance in the development of this Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018–2022. The development of this strategy involved the commitment of many people. Your time and contribution is greatly appreciated.



Aboriginal and Torres Strait Islander peoples continue to be disproportionately impacted by blood borne viruses (BBV) and sexually transmissible infections (STI). While some communities have had considerable success in responding to BBV and STI, this is not a common experience across communities and much more needs to be done.

With the advent of more effective prevention methods, testing and treatments, there is a significant opportunity to close the gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians in relation to BBV and STI, reduce associated morbidity and mortality and greatly improve health outcomes.

Rates of STI, hepatitis C and Human Immunodeficiency Virus (HIV) are substantially higher in Aboriginal and Torres Strait Islander peoples than in non-Indigenous Australians. While there has been a decline in newly diagnosed cases of hepatitis B due to the success of childhood and adolescent vaccination programs, chronic hepatitis B significantly impacts Aboriginal and Torres Strait Islander people in older age groups. Without proper treatment and care, BBV can cause a range of serious long-term health problems and can be fatal. If left untreated, STI can lead to acute and chronic health consequences, including infertility and infant fatalities if transmitted from mother to child.

Of particular concern is the ongoing syphilis outbreak in northern and central Australia. A nationally coordinated enhanced response is currently underway to control this outbreak by addressing barriers and collectively developing

sustainable solutions. This enhanced response also provides an opportunity to address other BBV and STI. The actions taken under this enhanced response, and its lessons, will be used to inform the implementation of this strategy.

There are a range of barriers and challenges which may contribute to the disproportionate impact of BBV and STI on Aboriginal and Torres Strait Islander peoples. The traumatic legacy of colonisation and the profound consequences of the Stolen Generations, racism and other past discriminatory practices have created historical disadvantage passed on from one generation to the next.¹ Complex social and cultural determinants, lower health literacy, a lack of culturally respectful health education and prevention services, sub-optimal clinical care, over-representation in custodial settings, and shame, cultural issues (especially a paucity of appropriately gendered care or services for men's and women's business), stigma and discrimination mean that Aboriginal and Torres Strait Islander peoples experience heightened risks and burden of BBV and STI.

Despite this, there has been resilience demonstrated by Aboriginal and Torres Strait Islander peoples in the face of adversity and a continued willingness to work in cultural partnerships to improve life and health outcomes for Aboriginal and Torres Strait Islander communities.

This strategy identifies priority groups of Aboriginal and Torres Strait Islander peoples who are particularly at risk of BBV and STI and for whom responses must be unique and tailored.

Coordinated, comprehensive and sustained actions are needed to build community knowledge and awareness of safe sex and how to prevent BBV and STI, the importance of regular testing, the effectiveness and availability of treatment, and the long-term consequences of untreated BBV and STI. Supporting equitable access to the various means of prevention and harm reduction; increasing and sustaining vaccination coverage; increasing access to BBV and STI testing among priority groups; and ensuring early access and adherence to treatment, ongoing management and care are all critical areas for focus.

While this strategy contains actions across priority groups, it includes a strong focus on young Aboriginal and Torres Strait Islander people, who experience higher rates of STI, particularly in remote and very remote areas. These rates are many times greater than those of young non-Indigenous people. Young people are also impacted by BBV. Hepatitis C notification rates increased substantially more in young Aboriginal and Torres Strait Islander people (15–24 years) than in other age groups over the past five years. Improved access to culturally responsive education, needle and syringe programs and evidence-based opioid treatment programs (OTP), as well as improved diagnosis and treatment rates, are all critical aspects of the response to hepatitis C.

HIV among Aboriginal and Torres Strait Islander people is of growing concern. Notifications of newly diagnosed HIV cases have doubled since 2011. Tailored approaches are needed to build community awareness and strengthen prevention efforts, including improving awareness and access to pre-exposure prophylaxis (PrEP) for Aboriginal and Torres Strait Islander people at medium and high risk of HIV infection. Greater effort is also needed to ensure people with HIV are diagnosed early and receive ongoing treatment and support. Research to date has found that people with HIV who take antiretroviral treatment daily as prescribed and achieve and maintain sustained viral suppression^a have effectively no risk of sexually transmitting the

virus to a HIV-negative partner. This is known as undetectable equals untransmittable (U=U) and Treatment as Prevention (TasP)^{2,3,4,5}

There are a number of other specific issues that require further research to improve knowledge and understanding of how to respond to BBV and STI among Aboriginal and Torres Strait Islander peoples, including Human T-lymphotropic virus 1 (HTLV-1), *Mycoplasma genitalium* and trichomonas, all of which have been shown, in separate studies, to be present at high rates in some Aboriginal communities.

The diversity of Aboriginal and Torres Strait Islander cultures, languages, and specific geographic and socio-economic influences within different Aboriginal and Torres Strait Islander communities requires unique and tailored approaches. Strong connections between communities, organisations and service providers are vital to the success of this strategy. This includes the leadership and ongoing participation of Aboriginal and Torres Strait Islander peoples and Aboriginal and Torres Strait Islander community controlled organisations at the national and local levels. Evidence-based approaches which successfully identify and address the issues and barriers experienced by priority groups and communities are needed, and these must be supported by a culturally safe and highly skilled multidisciplinary workforce, including Aboriginal and Torres Strait Islander Health Workers (AHWs), sexual health workers and peer educators with lived experience.

This strategy is one of a suite of five national BBV and STI strategies^b which provide a framework for the coordinated effort by all stakeholders to address BBV and STI within Australia. While actions to respond to the high rates of BBV and STI in Aboriginal and Torres Strait Islander peoples are included in each of these strategies, they are drawn together and expanded in this strategy, reflecting the importance of a dedicated and targeted response for Aboriginal and Torres Strait Islander

^a Currently defined as a sustained viral load of less than 200 copies/mL

^b Third National Hepatitis B Strategy 2018-2022; Fourth National STI Strategy 2018-2022; Fifth National Hepatitis C Strategy 2018-2022; and Eighth National HIV Strategy 2018-2022.

peoples. This strategy also supports the goals and objectives of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

Australian governments acknowledge the significant contribution of Aboriginal and Torres Strait Islander communities and organisations, national and state-based community and health peak organisations, other community organisations, researchers and the health workforce over the course of the previous Aboriginal and Torres Strait Islander BBV and STI strategies. The continued commitment and work of all partners means that Australia is well placed to achieve the ambitious goals and targets set out in this strategy.

BBVSS is a key advisory body reporting to the Australian Health Ministers' Advisory Council through the Australian Health Protection Principal Committee on strategic policy, programs, social issues and activities related to HIV, viral hepatitis and sexually transmissible infections (STIs).

Gratitude is expressed to those who participated in the stakeholder consultations and contributed to the strategy development process, including the members and organisations represented on the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (see Figure 1).

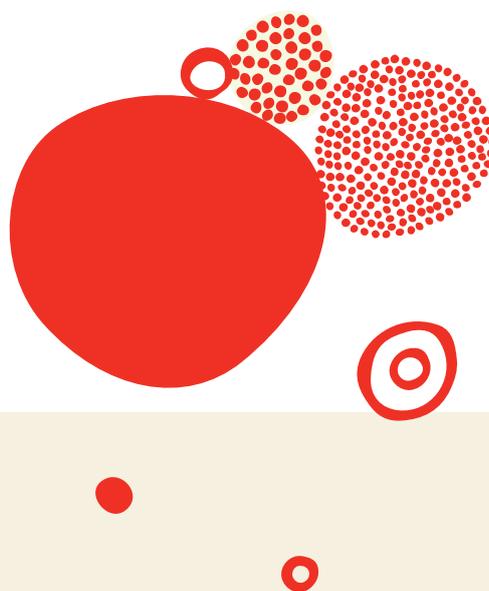


Figure 1: Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS)

Peak organisations

-
- Australian Indigenous Doctors' Association (AIDA)
-
- Australian Federation of AIDS Organisations (AFAO)
-
- Australian Injecting & Illicit Drug Users League (AIVL)
-
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)
-
- Hepatitis Australia
-
- National Association of People with HIV Australia (NAPWHA)
-
- Scarlet Alliance, Australian Sex Workers Association
-

State and territory governments

-
- ACT Health
-
- NSW Ministry of Health
-
- NT Department of Health
-
- Queensland Health
-
- SA Department for Health and Wellbeing
-
- Tasmanian Department of Health and Human Services
-
- Victorian Department of Health and Human Services
-
- WA Department of Health
-
- Australian Government Department of Health
-

2.

Guiding principles

The Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018–2022 includes four guiding principles to support high-quality, evidence based and equitable responses to BBV and STI in Aboriginal and Torres Strait Islander peoples. Together with the general guiding principles included in each of the five national BBV and STI strategies (see Appendix A), these are drawn from Australia’s efforts over time to respond to the challenges and impacts of HIV, hepatitis B, hepatitis C and STI.

1. 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 consistently voice their desire to be involved in the service planning, design and implementation of policies to support their health and wellbeing. Government must support the development of local responses to local issues by building on the strength of Aboriginal and Torres Strait Islander culture and communities, engendering local leadership, and building trust and strong relationships. Opportunities for engagement, education, capacity building, knowledge translation and collaboration with individuals, Aboriginal and Torres Strait Islander community-controlled health organisations, BBV and STI organisations, and other health and related services are all critical.

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

2. 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, including the International Strategic Plan on HIV & AIDS For Indigenous Peoples and Communities from 2011–2017 and the HIV Toronto Charter 2006, 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 the development of policy, 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-based approach is not necessarily about more services but about better services through more 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.

3. Partnership

Partnership and shared ownership between Aboriginal and Torres Strait Islander peoples, 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.

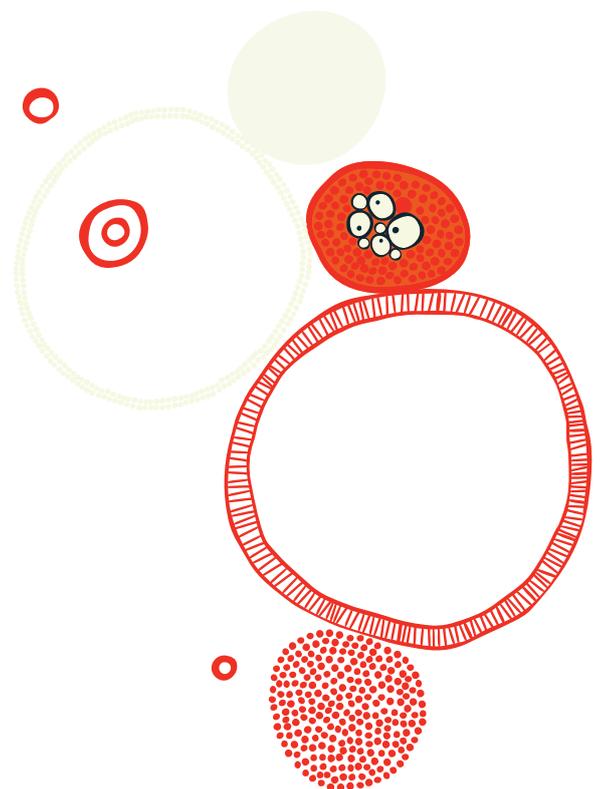
Partners to the implementation of this strategy—including mainstream health services, BBV and STI organisations, and other services, that work to support Aboriginal and Torres Strait Islander peoples—are strongly encouraged to develop meaningful partnerships with local and national Aboriginal and Torres Strait Islander organisations and 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 peoples and their representatives to implement the priority actions of this strategy to ensure implementation meets the diverse needs of Aboriginal and Torres Strait Islander peoples—all ages, backgrounds and locations—including a focus on the unique needs of the priority groups of this strategy.

4. Accountability

Structures are in place for the regular monitoring and review of implementation as measures 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. This strategy includes targets to drive progress and measure effectiveness. These actions are specific, achievable, realistic, measureable and time-bound.



3.

Snapshot of Aboriginal and Torres Strait Islander BBV and STI in Australia

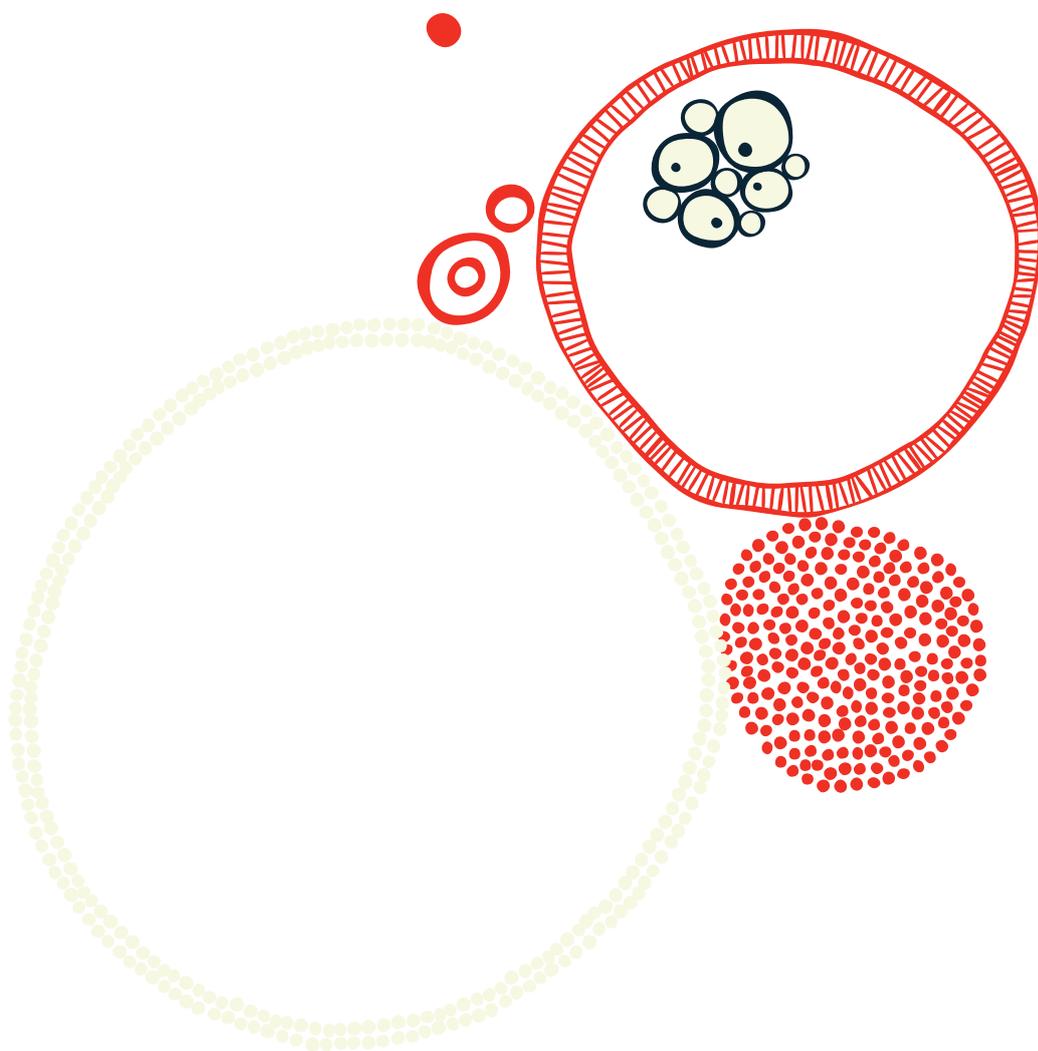


Figure 2: Snapshot of Aboriginal and Torres Strait Islander BBV and STI in Australia ^{6,17}



What are BBV and STI?

BBV are viruses which may be transmitted when blood infected with the virus enters into the bloodstream of another person via a break in the skin or mucous membrane. BBV include HIV, hepatitis B and hepatitis C, which are all nationally notifiable, and HTLV-1*. Depending on the virus, transmission may also occur via other routes, such as sexually or during breastfeeding.

STI are bacterial, viral and parasitic infections that are transmitted by bodily fluids and direct contact. The primary mode of transmission is through sexual contact.

There are four nationally notifiable STI including gonorrhoea, chlamydia, syphilis and donovanosis, and a range of non-notifiable STI, including HTLV-1*, human papilloma virus (HPV), *Mycoplasma genitalium* and trichomoniasis*.

**Notifiable in the Northern Territory*



What health issues can they cause?

BBV and STI vary in terms of health impact and impact on quality of life. Without treatment, hepatitis B and hepatitis C can cause liver damage and be fatal. Without treatment, HIV damages the immune system which can lead to serious infections and cancers that can be fatal over time.

Among STI, congenital syphilis can be fatal, while other STI such as chlamydia and gonorrhoea can lead to serious acute and chronic health consequences including joint swelling and pain, infertility and pelvic inflammatory disease. Many BBV and STI can be asymptomatic and remain undetected until complications ensue.



How are they managed?

Management varies across BBV and STI. Some are vaccine preventable, such as hepatitis B and HPV. HIV and hepatitis B can be managed through antivirals which suppress the virus and prevent disease progression; however, treatment of hepatitis B is only required where clinically indicated. In the case of chronic hepatitis C, treatment with direct acting antivirals (DAAs) results in a cure for over 90% of people.

Research to date has found that people with HIV who take ART and achieve and maintain sustained viral suppression[#] have effectively no risk of sexually transmitting the virus to a HIV-negative partner.

Bacterial and parasitic STI, such as chlamydia, gonorrhoea and *T. vaginalis* are treated with antibiotics; however, this has been impacted by the emergence of antimicrobial resistance.

[#]Currently defined as a sustained viral load of less than 200 copies/mL

New Diagnoses

Hepatitis B: In 2016, there were **176** notifications, with a rate of **31 per 100 000** compared to 23 per 100 000 in the non-Indigenous population. At the end of 2016, it is estimated that over 24 000 Aboriginal and Torres Strait Islander people were living with chronic hepatitis B infection, an estimated prevalence of 3.7%.

Hepatitis C: In 2016, there were **1122** notifications, with a rate of **173 per 100 000** compared to 45 per 100 000 in the non-Indigenous population.

HIV: In 2016, there were **46** newly diagnosed notifications, with a rate of **6 per 100 000** compared to 3 per 100 000 in the non-Indigenous population. At the end of 2016, it is estimated that 574 Aboriginal and Torres Strait Islander people were living with HIV in Australia, including an estimated 20% undiagnosed, compared to 7% of Australian-born non-Indigenous people with HIV.

Chlamydia: In 2016, there were **6925** notifications, with a rate of **1194 per 100 000** compared to 419 per 100 000 in the non-Indigenous population.

Gonorrhoea: In 2016, there were **3779** notifications, with a rate of **582 per 100 000** compared to 84 per 100 000 in the non-Indigenous population.

Syphilis: In 2016, there were **530** notifications of infectious syphilis among Aboriginal and Torres Strait Islander people, with a rate of **67 per 100 000** (compared to 12 per 100 000 in the non-Indigenous population); a threefold increase on 2010 notification rates. These high rates reflect the ongoing **outbreak** affecting Aboriginal people residing in remote areas of northern and central Australia.

Congenital syphilis: In the last 10 years, **24 of 43 cases** were in Aboriginal and Torres Strait Islander children. In 2016, the notification rate was 5.4 per 100 000 live births; **18 times as high** as the rate in the non-Indigenous population.

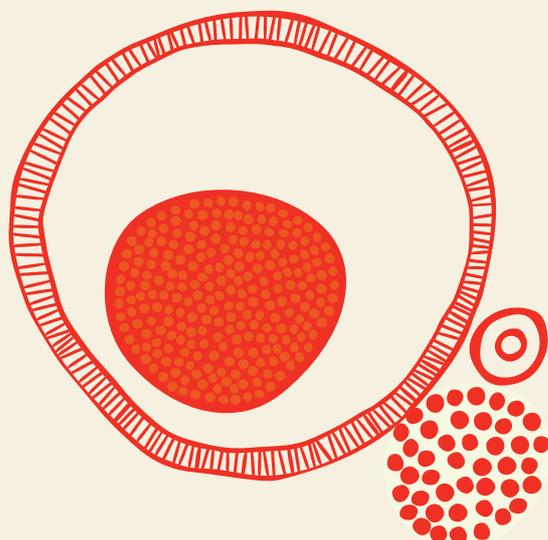
Testing and care

There is limited information on the uptake of testing and treatment for BBV in this population. Data is taken from the Australian Needle and Syringe Program Survey, and are only available for Hepatitis C and HIV (testing only).

Hepatitis C: The proportion of Aboriginal and Torres Strait Islander people who inject drugs reporting a recent hepatitis C test was **higher than the non-Indigenous participants** between 2011 and 2014; however, it declined between 2014 and 2016 to close to the non-Indigenous proportion.

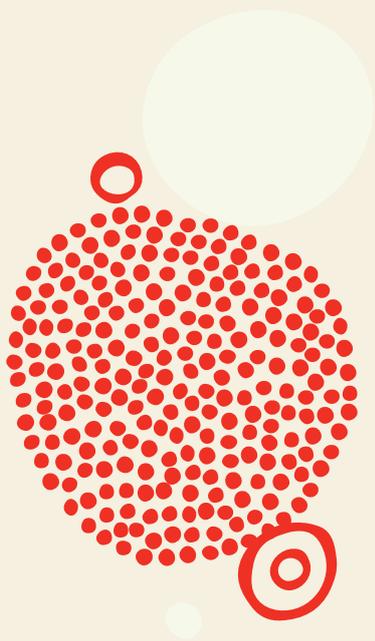
In 2016, **19%** of Aboriginal and Torres Strait Islander participants in the survey reported **treatment in the last 12 months, an increase from 3%** in 2015. However, lifetime and recent uptake of treatment was lower in 2016 compared to non-Indigenous participants.

HIV: The proportion of Aboriginal and Torres Strait Islander people who inject drugs reporting a recent HIV test was **higher than the non-Indigenous population** between 2012 to 2016.



Prevention

There are a **broad range of preventative strategies** for BBV and STI. These include education—delivered through schools, clinical, community and peer-based settings—condoms, vaccination (human papillomavirus and hepatitis B), access to sterile syringes and needles, screening of blood donors, treatment as prevention, pre and post-exposure prophylaxis, harm reduction, early detection and treatment, and antenatal care.



Routes of transmission

BBV transmission routes in Australia vary but include **blood contact, receptive needles and syringe sharing, sexual contact**, vertically from **mother to child, close household contact**, and **unsterile tattoos and piercings**.

Standard infection control procedures have virtually eliminated the risk of transmission in medical settings.

The primary route for transmission of STI is through **sexual contact**.

Some STI can also be transmitted vertically from **mother to child**, through **blood contact** and **orally**.

Notes:

Surveillance data must be interpreted with care, as notifications and trends may be influenced by community and targeted testing levels, data capture and access to health services. It therefore may not truly represent the incidence of disease in a population. In addition, while notification data provides important information about changing rates of BBV and STI in a community, it does not measure the broader implications of BBV and STI, such as the psychosexual, acute, chronic effects, comorbidities and reproductive impacts of STI and the long-term health implications associated with BBV.

Notification data for BBV and STI highlight the disproportionate rates of each STI and BBV relative to non-Indigenous Australians, recognising that some of this data lacks information to determine the true extent of infection and burden of disease. Incompleteness of Aboriginal and Torres Strait Islander status in notification data arising from some clinical services is a contributing factor, and there is no available estimate on the prevalence of hepatitis C amongst Aboriginal and Torres Strait Islander people. The data presented does not include all state and territories, as 50 per cent completeness of Aboriginal and Torres Strait Islander status was required for analysis and presentation of each BBV and STI.⁶ Improving the collection and reporting of this field remains a priority area for BBV and STI surveillance.

Further details on the Aboriginal and Torres Strait Islander priority groups that are predominantly impacted by BBV and STI can be found in Section 4, 'About this strategy', and Section 6, 'Priority groups and settings'. Data on the national rates and characteristics of BBV and STI can be found in the associated national BBV and STI strategies for 2018–2022.

4.

About this strategy

The Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy sets the direction for Australia's continuing response to BBV and STI in Aboriginal and Torres Strait Islander peoples for 2018 to 2022 and builds on achievements and lessons learned from the implementation of previous strategies.

This strategy aims to provide a framework for the efforts of all partners in the response to BBV and STI in Aboriginal and Torres Strait Islander peoples, guide resourcing decisions and monitor progress. It is informed by evaluation of progress made under the [Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2014–2017](#); the effectiveness of current and past responses in Australia and internationally; the identification of gaps and opportunities; and consultation with Aboriginal and Torres Strait Islander people, governments, community organisations, researchers, health professionals and other stakeholders across the country. This strategy is also informed by a range of surveillance data and research on BBV and STI in Aboriginal and Torres Strait Islander peoples and its impact on priority groups.

It is one of five national strategies that, together, outline a framework for a high-quality and coordinated national response to BBV and STI in Australia. These strategies are:

1. Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018–2022 (this strategy)

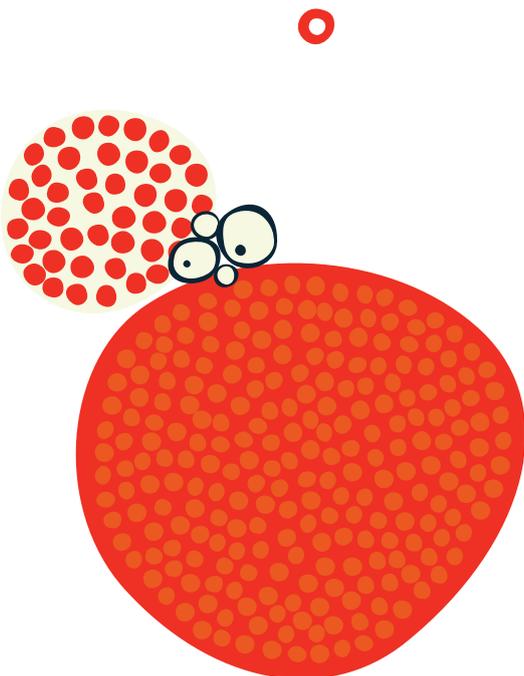
2. Third National Hepatitis B Strategy 2018–2022

3. Fourth National STI Strategy 2018–2022

4. Fifth National Hepatitis C Strategy 2018–2022

5. Eighth National HIV Strategy 2018–2022.

Each strategy has a specific focus but shares some structural elements, including guiding principles, goals, targets, priority areas (see Section 5, 'Measuring progress'), and defined priority populations/groups. Also, all five national BBV and STI strategies have key priority areas for



action, including education and prevention, testing, treatment and management, equitable access and coordination of care, workforce, improving data and surveillance, and stigma and discrimination.

Aboriginal and Torres Strait Islander peoples are identified as a priority population in each of the BBV and STI strategies. The Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy reinforces and builds on the targets and actions set out in each of the other four strategies in response to the need for focused effort and commitment in addressing BBV and STI among Aboriginal and Torres Strait Islander communities.

This strategy complements other jurisdictional, national and international policy instruments that all contribute to the national response to BBV and STI in Aboriginal and Torres Strait Islander peoples and supports the achievement of existing commitments. These include:

- state and territory Aboriginal and Torres Strait Islander BBV and STI strategies and action plans
- [National Aboriginal and Torres Strait Islander Health Plan 2013–2023 and Implementation Plan](#)
- [Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026](#)
- [National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023](#)
- [Closing the Gap](#)
- [National strategic approach and action plan](#) for an enhanced response to the disproportionately high rates of sexually transmissible infections (and blood borne viruses) in Indigenous populations, Australian Health Protection Principal Committee, 2017
- [Australian Health Ministers AIDS 2014 Legacy Statement](#)

- [National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023](#)
- [National Drug Strategy 2017–2026](#)
- [Aged Care Diversity Framework](#)
- [World Health Organization \(WHO\) Global Health Sector Strategies for HIV, Viral Hepatitis and STI](#)
- [WHO Western Pacific Region Regional Action Plan for Viral Hepatitis in the Western Pacific 2016–2020](#)
- [United Nations Declaration on the Rights of Indigenous Peoples](#)
- [The Toronto Charter—Indigenous Peoples Action Plan on HIV/AIDS 2006](#)
- International Indigenous Working Group on HIV & AIDS, [International Indigenous Strategic Plan on HIV and AIDS for Indigenous Peoples and Communities from 2011–2017](#)
- 2016 United Nations [Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030](#)
- Regional Action Plan on the Triple Elimination of Mother-to-Child Transmission of HIV, Hepatitis B and Syphilis.

This strategy also supports progress towards [Sustainable Development Goal 3](#) ('Ensure healthy lives and promote well-being for all at all ages') of the United Nations 2030 Agenda for Sustainable Development.

This strategy acknowledges that some states and territories have set or may set different targets to drive progress, and the national goals and targets of this strategy are intended to facilitate jurisdictional efforts. Jurisdictions are encouraged to match or exceed the targets of this strategy.

Further detail on the implementation of this strategy,

Figure 3:
Key achievements under the Fourth National Aboriginal and Torres Strait Islander BBV and STI Strategy 2014–2017, ^{c,6,7,8,9,10}



Sexual health education and STI control programs contributed to a stabilisation of **chlamydia notification rates** and a 17% decline in **gonorrhoea notification rates** from 2012 to 2016



The incidence of genital warts, once the most common STI managed at sexual health clinics, has declined by **88% in Aboriginal and Torres Strait Islander men** and **100% in Aboriginal and Torres Strait Islander women** at their first visit since the introduction of a national vaccination program for human papillomavirus (HPV) in 2007



Continued decline in **hepatitis B notification rates** in younger age groups, reflecting the impact of Aboriginal and Torres Strait Islander childhood and adolescent vaccination programs



Donovanosis, a bacterial infection that causes genital ulcers, was once a frequently diagnosed STI among remote Aboriginal and Torres Strait Islander populations. Donovanosis is **close to elimination** in Australia, with only two cases detected from 2011 to 2016



Uptake of sexual health services by young Aboriginal and Torres Strait Islander people **increased**, indicating that improvements have been made in the delivery of more accessible health services. This may also indicate improved health literacy among young Aboriginal and Torres Strait Islander people



The proportion of respondents from an Aboriginal and Torres Strait Islander background participating in the Australian Needle and Syringe Program Survey increased from **11% in 2007 to 18% in 2017**. However, it must be noted that during this period the prevalence of receptive needle and syringe sharing by Aboriginal and Torres Strait Islander program participants increased from 18% to 28%



There was progress in efforts to integrate sexual health services with **primary health care**, including through **Aboriginal Community Controlled Health Services**



Highly successful STI control programs delivered by **Nganampa Health Council** in the Anangu Pitjantjatjara Yankunytjatjara lands and health services in the **Ngaanyatjara Lands**, and **Tiwi Islands** has kept STI testing comprehensively embedded in community controlled primary care in these remote communities

^cRates in this figure relate to BBV and STI in the Aboriginal and Torres Strait Islander population.

including the associated action plan, is provided under Section 8, 'Implementing this strategy'.

Progress under the Fourth National Aboriginal and Torres Strait Islander BBV and STI Strategy 2014–2017

It is important to reflect on the progress that has been made under the Fourth Aboriginal and Torres Strait Islander BBV and STI Strategy 2014–2017 (see Figure 3), acknowledging that much more needs to be done. These achievements reflect the joint efforts of governments, Aboriginal and Torres Strait Islander communities and organisations, BBV and STI and other community organisations, researchers, general practice and clinicians through the partnership approach.

The Aboriginal Community Controlled Health (ACCH) sector, including Aboriginal Community Controlled Health Services (ACCHS) and ACCH sector support organisations and broader community organisations at the national, state and territory level are central to this partnership approach. They continue to play a vital role in the national response through coordination, capacity building, resource development and provision, policy translation and being a facilitator between government and priority Aboriginal and Torres Strait Islander sub-populations.

While progress under the Fourth National Aboriginal and Torres Strait Islander BBV and STI Strategy 2014–2017 has been notable in some areas, there are significant challenges remaining that still need to be addressed and overcome. Over the past five years new diagnoses for several BBV and STI, including HIV, hepatitis C and syphilis, have increased significantly among Aboriginal and Torres Strait Islander communities. These increases in new diagnoses may reflect an increase in testing—a key achievement of the previous strategies—but are a very concerning trend.

The following summarises progress over the period of the Fourth National Aboriginal and Torres Strait Islander BBV and STI Strategy 2014–2017, including (where relevant) progress against the specific targets set in this previous strategy:

- Due to an ongoing outbreak of **infectious syphilis** in northern and central Australia, the notification rate in Aboriginal and Torres Strait Islander people increased by 193 per cent between 2012 and 2016.² The previous strategy's target of decreasing the notification rate of syphilis in Aboriginal and Torres Strait Islander people and communities was not achieved.
.....
- Between 2012 and 2016, there were 10 cases of congenital syphilis in the Aboriginal and Torres Strait Islander population, representing more than half (63 per cent) of total **congenital syphilis** cases reported in Australia during this period. This is of significant concern. The majority of these cases were related to an ongoing outbreak of infectious syphilis affecting Aboriginal and Torres Strait Islander communities and reflect the high rates among Aboriginal and Torres Strait women of child-bearing age.
.....
- A reduction in the notifications of **chlamydia** in people under 30 years of age was achieved. Between 2012 and 2016 the notification rate in Aboriginal and Torres Strait Islander people declined by 11 per cent in people aged 15 to 19 years and by 6 per cent in those aged 20 to 29 years. However, the chlamydia notification rate was approximately three times higher in Aboriginal and Torres Strait Islander people in 2016 when compared with the non-Indigenous population.
.....
- Since 2012, the **gonorrhoea** notification rate in Aboriginal and Torres Strait Islander people declined 20 per cent in people aged 15 to 19 years and 28 per cent in people aged 20 to 29 years, which was in line with the target of reducing gonorrhoea among people under 30 years of age. However, in 2016 the rate in Aboriginal and Torres Strait Islander people was nearly seven times greater than the rate in the non-Indigenous population (which itself increased 125 per cent between 2012 and 2016).
.....

- Rates of STI in Aboriginal and Torres Strait Islander people are also significantly higher in **remote/very remote areas**. The syphilis notification rate for Aboriginal and Torres Strait Islander populations living in remote/very remote areas is 50 times higher than that of the non-Indigenous notification rate. This is also the case for the notification rate for gonorrhoea (30 times) and chlamydia (five times).
- The target of the previous strategy to increase the **use of sterile injecting equipment** for every episode was not met, with rates of receptive syringe sharing increasing from 18 per cent in 2007 to 28 per cent in 2016 among Aboriginal and Torres Strait Islander respondents to the Australian Needle and Syringe Program Survey.⁶
- There is currently limited data on **treatment uptake** among Aboriginal and Torres Strait Islander people living with hepatitis B, hepatitis C and HIV. However, there was an increase in the proportion of Aboriginal and Torres Strait Islander people who inject drugs and attended needle and syringe programs (NSPs) reporting hepatitis C treatment, with lifetime history of treatment increasing from 9 per cent in 2012 to 19 per cent in 2016, and treatment in the last 12 months increasing from 3 per cent to 18 per cent, reflecting the increased availability of direct-acting antiviral (DAA) treatment from March 2016.⁶
- Between 2012 and 2016, the number of notifications per year of newly diagnosed **HIV** infections in the Aboriginal and Torres Strait Islander population increased from 33 notifications in 2012 to 46 in 2016. This is in contrast with the non-Indigenous population, where, since 2012, HIV notifications have remained relatively stable at just over 1000 notifications each year. In 2016 the notification rate in the Aboriginal and Torres Strait Islander population was 2.2 times as high as in the Australian born non-Indigenous population.⁶
- During the 10-year period 2007 to 2016, male-to-male sex was the most common exposure risk for HIV infection in Aboriginal and Torres Strait Islander people (51 per cent) in 2016, as was the case in the Australian-born non-Indigenous population

(74 per cent). In the five-year period between 2012 and 2016, heterosexual sex and injecting drug use exposure risks were reported in higher proportions in Aboriginal and Torres Strait Islander people compared to the Australian-born non-Indigenous population (20 per cent versus 15 per cent; 14 per cent versus 3 per cent respectively).

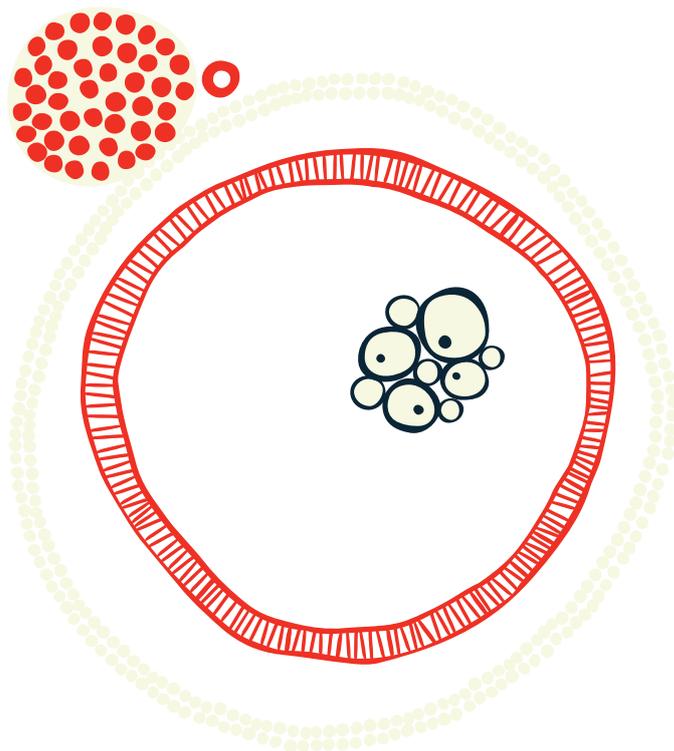
- Over the five-year period of 2012–2016, there was a 25 per cent increase in the notification rate of new **hepatitis C** diagnoses in the Aboriginal and Torres Strait Islander population, increasing from 138 per 100 000 in 2012 to 173 per 100 000 in 2016. The rate in the non-Indigenous population remained stable over this period (at 44 per 100 000 in 2012 and 45 per 100 000 in 2016). In Aboriginal and Torres Strait Islander people aged under 25 years, there has been a 50 per cent increase in the hepatitis C notification rate over the past five years but a decrease in the rate in non-Indigenous people in this age group.⁶
- Although the notification rate of newly diagnosed **hepatitis B** infections halved from 2012 to 2016 in the Aboriginal and Torres Strait Islander population, in 2016 it was 1.4 times greater than the rate in the non-Indigenous population, at 31 per 100 000 compared with 23 per 100 000. At the end of 2016, 11 per cent of the total number of people living with chronic hepatitis B in Australia were Aboriginal and Torres Strait Islander despite composing 3 per cent of the national population.⁶
- Recent research has documented very high prevalence rates of HTLV-1 in certain Aboriginal and Torres Strait Islander communities, particularly in central Australia.^{11,12} HTLV-1 is a retrovirus which causes lifelong infection and may cause adverse health outcomes in a small percentage of people many years later. International research shows that, in a small proportion of people, HTLV-1 causes a rare form of leukaemia (adult T-cell leukaemia/lymphoma) and/or a spinal cord disease (HTLV-1 associated myelopathy / tropical spastic paraparesis).¹³ Studies have suggested associations with other diseases (including bronchiectasis or skin disease), but it is not yet known whether the relationship is causal.^{14,15} Transmission can occur

from mother-to-child via breastfeeding, through sexual contact and blood exposure. Studies on the incidence and prevalence of HTLV-1 infection and associated outcomes in Australia are limited. Further research is required to understand the true burden of HTLV-1 associated disease, including among Aboriginal and Torres Strait Islander populations.

• In many remote Aboriginal and Torres Strait Islander communities, the prevalence of **trichomonas** and ***Mycoplasma genitalium*** is high.¹⁶ In an analysis of multiple studies examining the health of 30 111 Aboriginal and Torres Strait Islander people, the overall prevalence of trichomonas was estimated at 23 per cent, with the greatest rate of those studied (25 per cent) in pregnant women.¹⁶ This analysis identified that, over the last 10 years, prevalence has been higher in older women in remote areas and lower in urban locations. However, these were all clinic-based studies, with all but one conducted in remote locations, increasing the risk of selection bias.¹⁶ Little is currently known about the prevalence of *M. genitalium* in Australia. Treatment is available; however, it appears that *M. genitalium* is becoming increasingly resistant to azithromycin, which is the usual first-line treatment. At present, trichomonas, HTLV-1 and *M. genitalium* are not nationally notifiable, although the first two are notifiable in the Northern Territory.

The limited progress demonstrated against the targets of the previous national strategy—including an increase in rates of syphilis, congenital syphilis, HIV and hepatitis C among Aboriginal and Torres Strait Islander people; an increase in receptive needle and syringe sharing; and a lack of data to estimate diagnoses and treatment coverage for BBV in this population—indicates that a revitalised response is needed. Sustained efforts are also needed to further reduce the disproportionately high rates of chlamydia and gonorrhoea and to build on approaches that are proving successful.

Responses must be tailored and informed by the evidence base, including data on significant transmission routes which may differ from the non-Indigenous population. An understanding of the social determinants that lead to this greater impact is also required to ensure high-risk priority groups are effectively engaged.



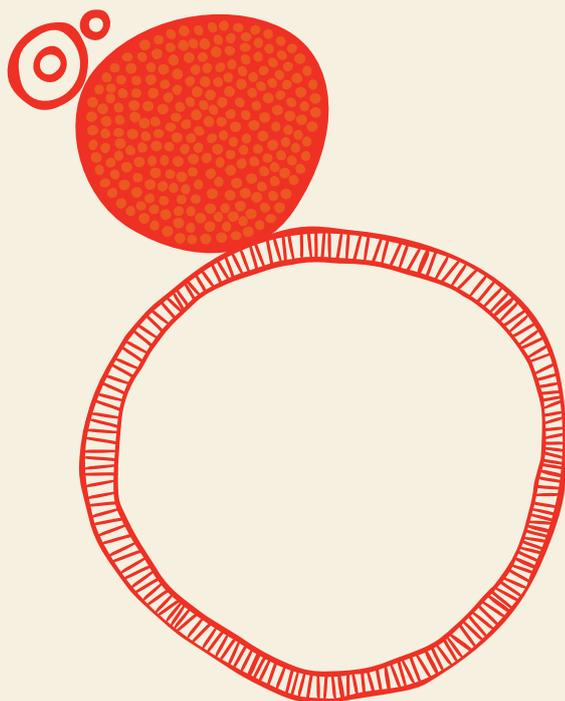
5.

Measuring progress

This strategy has overarching goals, targets and priority areas which will guide the national response to BBV and STI in Aboriginal and Torres Strait Islander people for 2018–2022. Indicators and associated data sources for measuring progress towards each target are included in the surveillance and monitoring plan for the five national BBV and STI strategies.

Goals^d

- Significantly reduce the transmission of BBV and STI among Aboriginal and Torres Strait Islander people
- Close the gap in BBV and STI incidence, prevalence, testing and treatment rates between Aboriginal and Torres Strait Islander and non-Indigenous populations
- Reduce morbidity and mortality related to BBV and STI
- Minimise the personal and social impact of BBV and STI
- Minimise the negative impact of stigma, racism, discrimination, and legal and human rights issues on Aboriginal and Torres Strait Islander people's health



Targets^d

By 2022:

- 1.** Achieve and maintain hepatitis B childhood vaccination coverage of 95 per cent at 12 and 24 months

- 2.** Achieve and maintain HPV adolescent vaccination coverage of 80 per cent

- 3.** Increase STI testing coverage^e with a focus on areas of highest need

- 4.** Increase the use of sterile injecting equipment for every injecting episode^e

- 5.** Reduce the incidence and prevalence of infectious syphilis,^{e,f} with a particular focus on areas of highest disease burden

- 6.** Eliminate congenital syphilis^g

- 7.** Reduce the incidence and prevalence of gonorrhoea and chlamydia,^{e,f} with a focus on young people

- 8.** Reduce the number of newly acquired hepatitis C infections by 60 per cent^e

- 9.** Reduce the incidence of HIV transmissions^e

- 10.** Achieve the 95–95–95 HIV diagnosis and treatment targets:
 - a. Increase to 95 per cent the percentage of people with HIV who are diagnosed
 - b. Increase to 95 per cent the percentage of people diagnosed with HIV on treatment
 - c. Increase to 95 per cent the percentage of those on treatment with an undetectable viral load

- 11.** Increase the proportion of people living with hepatitis C who are diagnosed to 90 per cent and the cumulative proportion who have initiated direct acting antiviral treatment to 65 per cent

- 12.** Increase the proportion of people living with hepatitis B who are diagnosed to 80 per cent; receiving care to 50 per cent; and on antiviral treatment to 20 per cent

- 13.** Reduce hepatitis C attributable mortality by 65 per cent^e

- 14.** Reduce hepatitis B attributable mortality by 30 per cent^e

- 15.** Reduce the reported experience of stigma among Aboriginal and Torres Strait Islander people with BBV and STI, and the expression of stigma, in relation to BBV and STI status

^d Goals and targets are specific for the Aboriginal and Torres Strait Islander population. Some of these targets will require the development/further development of data sources to monitor progress. This will be progressed through the action plan.

^e Compared with 2016 data.

^f Accounting for testing levels

^g No new cases of congenital syphilis nationally notified (as defined by the global surveillance case definition) for two consecutive years.

Priority areas^h

- Implement, support and evaluate a range of community (co)-designed and led, evidence-based and multi-faceted BBV and STI education and prevention initiatives across priority settings to build community knowledge and awareness, and effectively target and engage priority groups
- Support sexual health education in schools and community settings to improve knowledge and awareness of healthy relationships and STI, reduce risk behaviours associated with the transmission of STI, and highlight the importance of regular STI testing once sexually active
- Build knowledge and awareness of the various means of prevention for BBV and STI, including reinforcing the central role of condoms, the importance of vaccination, the effective use of biomedical tools such as post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP) and treatment as prevention for HIV and hepatitis C, and the need for sterile injecting practices
- Support widespread and equitable access to all means of STI and BBV prevention across the country, in combination with STI and BBV prevention education and regular testing and treatment services
- Build on successful approaches to improve testing rates and coverage to reduce the number of undiagnosed BBV and STI and decrease rates of late diagnosis
- Support health professionals to provide culturally responsive and safe, current, innovative and effective BBV and STI testing, treatment, monitoring and care
- Increase early and appropriate treatment of BBV and STI to reduce transmission, improve health outcomes and enhance quality of life
- Increase testing and treatment for BBV and STI in custodial settings, including youth detention, that is respectful of and responsive to the needs of Aboriginal and Torres Strait Islander people
- Implement a range of initiatives to address stigma and discrimination and minimise their impact on the health of Aboriginal and Torres Strait Islander people at risk of or living with BBV and/or STI
- Continue to work towards addressing the legal, regulatory and policy barriers which affect Aboriginal and Torres Strait Islander priority groups and influence their health-seeking behaviours
- Continue to work towards addressing negative and culturally unsafe experiences of individuals and communities with the healthcare system and other institutions which influence health-seeking behaviours
- Identify and implement novel multidisciplinary, culturally safe and inclusive coordinated and sustainable programs which successfully address the barriers experienced by communities and significantly increase the uptake of BBV and STI services
- Facilitate and support a highly skilled and stable multidisciplinary health workforce that is respectful of and responsive to the needs of Aboriginal and Torres Strait Islander people in the provision of high-quality BBV and STI services
- With a focus on identified gaps, continue to build a strong evidence base for effectively responding to existing and emerging BBV and STI issues and challenges among Aboriginal and Torres Strait Islander communities, informed by high-quality, timely data and surveillance systems
- Enhance systems and capacity to monitor and respond to changes in BBV and STI incidence among Aboriginal and Torres Strait populations, including enhanced surveillance and rapid responses to potential outbreaks among priority populations and in geographic locations

^h Links to section 7, 'Priority areas for action': Priority groups and settings are described in Section 6, 'Priority groups and settings.'

6.

Priority groups and settings

BBV and STI disproportionately impact on Aboriginal and Torres Strait Islander peoples across settings, communities and sub-populations. There are a number of factors, barriers and challenges which continue to contribute to this impact and which may prevent individuals from accessing vital services for prevention, testing and treatment.

There are a range of factors that mean that Aboriginal and Torres Strait Islander peoples are more frequently exposed to environments and situations where there is an increased risk of BBV and STI. These include a lack of tailored and culturally responsive BBV and STI services which effectively engage high-risk priority groups; complex social and medical factors; concerns around privacy; confidentiality, stigma and shame; and over-representation in custodial settings.¹⁷ Experiences of the Stolen Generations, racism and the ongoing impacts of colonisation also contribute to an increased burden of disease. In addition, the higher prevalence of BBV and STI in Aboriginal and Torres Strait Islander communities means that individuals have an increased exposure risk. This is because it is more likely that a person will come into contact with an individual who has a BBV or STI either in a sexual or other risk context.

This strategy identifies priority groups within the Aboriginal and Torres Strait Islander population who are particularly impacted by BBV and STI and whose needs must be specifically considered in the response. This strategy acknowledges that many

Aboriginal and Torres Strait Islander people may identify with multiple priority groups (such as gay men and other men who have sex with men (MSM), and/or people who inject drugs and/or sex workers) and priority settings (see Figure 4). This results in a diverse variety of intersecting characteristics and risk factors unique to each individual.

In accordance with the guiding principle of 'access and equity' (see Appendix A), the unique challenges and experiences within all priority groups and communities need to be considered in the response. This includes, but is not limited to, all gender expressions and experiences, disabilities and sexual orientations and across different geographic settings.

Aboriginal and Torres Strait Islander peoples—population data (Census, 2016)

In 2016, Aboriginal and Torres Strait Islander peoples represented 2.8 per cent of the Australian population. Of the 649 200 people who identified as being of Aboriginal and/or Torres Strait Islander origin, 90.9 per cent were of Aboriginal origin, 5.0 per cent were of Torres Strait Islander origin and 4.1 per cent identified as being of both Aboriginal and Torres Strait Islander origin.

New South Wales had the highest count of Aboriginal and Torres Strait Islander people (33 per cent of the national total), followed by Queensland (29 per cent) and Western Australia (12 per cent). The Northern Territory had the highest proportion of the population who identified as being of Aboriginal and Torres Strait Islander origin (26 per cent), while Victoria had the lowest at less than 1 per cent of the state total.

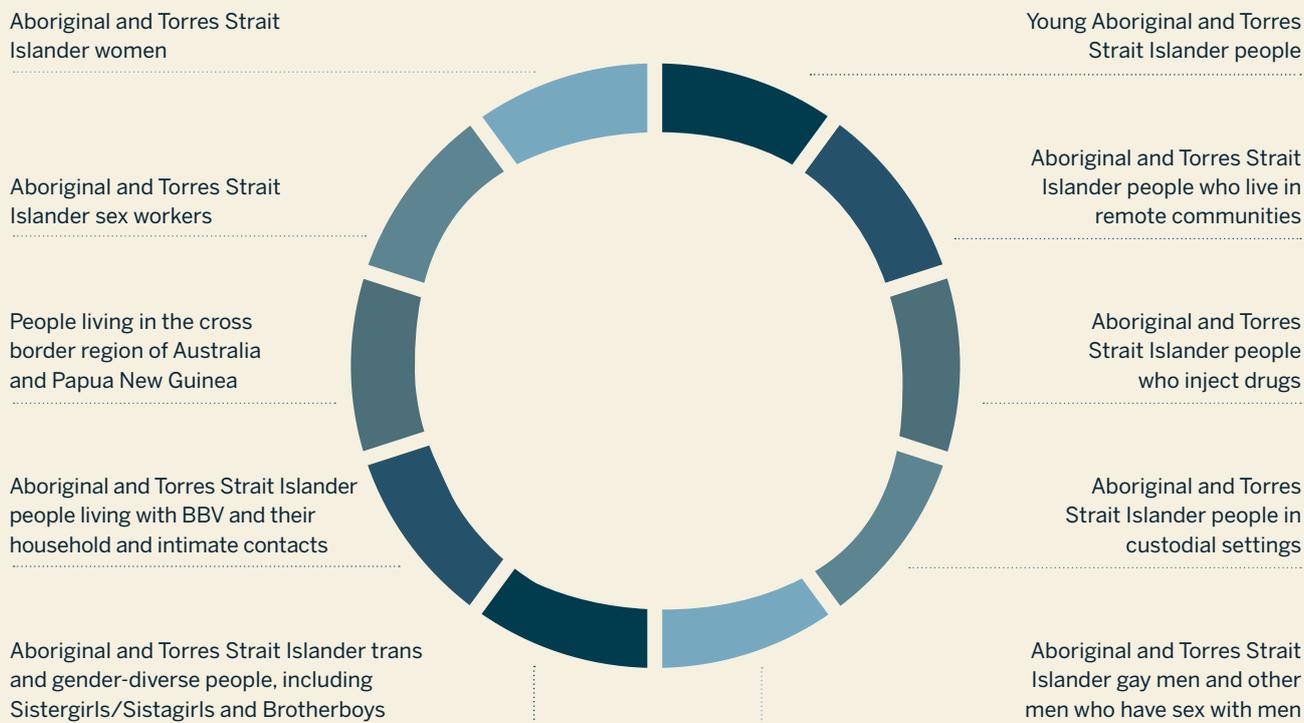
Aboriginal and Torres Strait Islander people are increasingly living in urban areas, with 79 per cent of people living in urban areas in 2016 and 30 per cent in capital cities (increased from 73 per cent and 30 per cent in 1996). The Northern Territory has the highest proportion of Aboriginal and Torres Strait Islander people living in rural areas.

In 2016, more than half (53 per cent) of Aboriginal and Torres Strait Islander people were under the age of 25 years, compared with 31 per cent in non-Indigenous people.

Source: **Australian Bureau of Statistics (2017) 2011.0—Census of Population and Housing: Reflecting Australia—Stories from the Census, 2016.**

Figure 4:
Priority groups and settings for the Fifth National Aboriginal and Torres Strait Islander BBV and STI Strategy 2018–2022

Priority groups



Priority settings



Geographic locations with high prevalence and incidence of BBV and STI, including remote communities



Places where Aboriginal and Torres Strait Islander priority populations live, work and socialise



Aboriginal Community Controlled Health Services

Community, primary, antenatal care and other health services



Custodial settings



Other services that support Aboriginal and Torres Strait Islander priority populations, including community and peer-based services, homelessness services and mental health services



Needle and syringe programs



Alcohol and other drug services

Note: This graphic is not intended to reflect equal priority or prevalence among groups

Aboriginal and Torres Strait Islander people living with BBV and their household and intimate contacts

Aboriginal and Torres Strait Islander people with HIV and/or living with hepatitis C and/or hepatitis B and their families have complex needs that must be addressed in the diagnosis, treatment and management of these conditions.

A lack of appropriate service provision, including geographic and distance barriers for remote communities, decreases accessibility to services for HIV, hepatitis C and hepatitis B.

Available data suggests that there is a greater prevalence of BBV in Aboriginal and Torres Strait Islander people when compared with the non-Indigenous population. This difference could be even greater when considering the low reporting of Indigenous status nationally.

In 2016, there were an estimated 574 Aboriginal and Torres Strait Islander people living with HIV in Australia. Of these, it was estimated that 20 per cent (approximately 111 people) were undiagnosed compared with 7 per cent (approximately 1158 people) in the Australia-born non-Indigenous population.⁶ From 2012 to 2016, the age-standardised rate of HIV notifications in the Aboriginal and Torres Strait Islander population increased by 33 per cent compared with a 22 per cent decline in the Australia-born non-Indigenous population.⁶ Over the period from 2011 to 2016, HIV notification rates increased by 90 per cent in Aboriginal and Torres Strait Islander males compared with a 15 per cent decrease in the Australia-born non-Indigenous male population.⁶ Access to testing and treatment is essential to prevent the development of Acquired Immunodeficiency Syndrome (AIDS) and associated morbidities, achieve viral suppression, enhance individual health outcomes and prevent onward HIV transmission.

There were an estimated 24 287 Aboriginal and Torres Strait Islander people living with chronic hepatitis B in 2016, representing 11 per cent of people living with chronic hepatitis B nationally.⁶ This equates to 4 per cent prevalence in the

Aboriginal and Torres Strait Islander population compared with less than 1 per cent prevalence in the total Australian population. Hepatitis B is associated with significant morbidity and mortality; therefore, it is essential that access to appropriate services for the management of chronic hepatitis B is available for this population.

Over the past 10 years, for every year except 2010, hepatitis C antibody prevalence has been higher in Aboriginal and Torres Strait Islander respondents to the Australian Needle and Syringe Program Surveys compared with non-Indigenous respondents.¹⁰ In addition, the hepatitis C notification rate in Aboriginal and Torres Strait Islander people increased by 25 per cent between 2012 and 2016. This highlights the importance of equitable access to hepatitis C DAA treatment and evidence-based harm reduction, including culturally respectful and safe NSPs, for this population as key actions.

Further research is needed to understand the drivers of the transmission of HTLV-1, its impact on the health outcomes of Aboriginal and Torres Strait Islander people and how best to support Aboriginal and Torres Strait Islander communities and the health workforce to inform an effective, evidence-based response.

Young Aboriginal and Torres Strait Islander people

In Australia, people aged 15 to 29 years experience higher rates of diagnosed STI compared to other age groups.¹⁸ While STI rates are also high in young non-Indigenous people, rates are substantially higher in young Aboriginal and Torres Strait Islander people. Recent studies have found young Aboriginal and Torres Strait Islander people display similar risk-taking and health-seeking behaviours to non-Indigenous young people, suggesting that a lack of accessibility of services is a key issue in STI management for this priority group.^{19,20,21} Barriers faced by young Aboriginal and Torres Strait Islander people in accessing health services include stigma, shame, confidentiality concerns and the absence of age-responsive or culturally responsive services.²⁰ A lack of access to both male and female health professionals across the clinical workforce limits

the ability of young people to access professionals of the appropriate gender and can impact on their engagement with services.

Services and approaches must be designed and delivered in ways that are youth friendly and effectively respond to the diversity of needs and experiences within this priority group. Research has highlighted the potential benefits of evidenced-based peer support systems and education strategies, which effectively harness the lived experience of young Aboriginal and Torres Strait Islander people, in delivering prevention education and in better engaging young people with services.^{22,23,24} Age at sexual debut has also been associated with STI; therefore, the commencement of prevention education needs to be appropriately timed.²⁵

The newly diagnosed HIV notification rate in young Aboriginal and Torres Strait Islander people has been variable over the past five years. In the five-year period from 2012 to 2016, there were 72 newly diagnosed cases of HIV among 15- to 29-year-old Aboriginal and Torres Strait Islander people.²⁶ This represents 40 per cent of newly diagnosed HIV cases among Aboriginal and Torres Strait Islander people in that period. Between 2013 and 2016, the number of notifications in young Aboriginal and Torres Strait Islander people increased by 171 per cent (compared with relatively stable rates in the non-Indigenous population). Although year-on-year changes should be interpreted with caution due to the small number of notifications, this data highlights the importance of this priority group in the HIV response. The high rates of STI in young Aboriginal and Torres Strait Islander people also increase the risk of HIV infection.

The rate of newly diagnosed hepatitis C is greater in young Aboriginal and Torres Strait Islander people when compared with non-Indigenous young people. In the period from 2012 to 2016, the notification rate in Aboriginal and Torres Strait Islander people aged 15 to 24 years increased by 49 per cent from 159 per 100 000 population in 2012 to 237 per 100 000 in 2016.⁶ This is compared with an increase of 13 per cent in the 25- to 39-year age group and 20 per cent in people over 40 years. Amongst the

non-Indigenous population, the notification rate remained stable for each of these age groups across the same time period.

The rate of newly diagnosed hepatitis B has declined in Aboriginal and Torres Strait Islander people aged under 30 years between 2012 and 2016, with no cases recorded in individuals aged 15 to 19 years of age in this population in 2016.⁶ This reflects the positive impact of Aboriginal and Torres Strait Islander childhood and adolescent vaccination programs.

While there have been small declines in the notification rates of chlamydia and gonorrhoea in Aboriginal and Torres Strait Islander people aged between 15 and 29 years, rates remain higher than in non-Indigenous people of the same age. In 2016, the rate of chlamydia in people aged between 15 and 19 years was 5522 per 100 000 (compared with 1316 in the non-Indigenous population) and 3681 per 100 000 (compared with 1632) in those aged between 20 and 29 years. In 2016, the rate of gonorrhoea in people aged between 15 and 19 years was 2202 per 100 000 (compared with 93 in the non-Indigenous population), and 1449 per 100 000 (compared with 262) in those aged between 20 and 29 years.⁶ The rate of chlamydia and gonorrhoea in this age group (15 to 29 years) is also greater when compared with older age groups, indicating that the burden in Aboriginal and Torres Strait Islander people is primarily among young people.

The rate of syphilis notifications in young Aboriginal and Torres Strait Islander people is of particular concern and is largely attributable to the ongoing outbreak of infectious syphilis in northern and central Australia. In 2016, 60 per cent of the notifications in this population were among people aged 15 to 29 years, with the greatest increase over five years in the 20- to 29-year age group.⁶ In contrast with the high proportion of males diagnosed with syphilis in 2016 in the non-Indigenous population (94 per cent), only 54 per cent of notifications in the Aboriginal and Torres Strait Islander population were among males. This suggests that heterosexual transmission is a more predominant route of transmission than in the non-Indigenous population. Among Aboriginal

and Torres Strait Islander women aged between 15 and 39 years, there were 205 notifications in 2016. Syphilis in young women is of particular concern given the risk of mother-to-child transmission.

Aboriginal and Torres Strait Islander people in remote communities

According to the 2016 Census of Population and Housing, 20 per cent of the Aboriginal and Torres Strait Islander population live in remote or very remote areas compared with only 2 per cent of the non-Indigenous population.²⁷ Aboriginal and Torres Strait Islander people living in remote communities generally experience higher rates of STI than their counterparts in urban settings. This is likely to be due to the underlying social determinants of health, decreased availability of health services and community education, and a hesitance in accessing services due to privacy and confidentiality concerns.

In 2016, the chlamydia notification rate in Aboriginal and Torres Strait Islander people living in remote and very remote areas was two and a half times higher when compared with Aboriginal and Torres Strait Islander people living in major cities; and four and a half times higher when compared with the non-Indigenous population living in remote and very remote areas.⁶

The disparity was even greater for infectious syphilis, where the overall notification rate in Aboriginal and Torres Strait Islander people in remote and very remote areas was nearly six and a half times the rate in Aboriginal and Torres Strait Islander people living in major cities and 50 times that of the non-Indigenous population living in remote and very remote areas.⁶

Similarly, the rate disparity was also substantial when comparing notification rates for gonorrhoea, where the overall rate in Aboriginal and Torres Strait Islander people was nearly twice that in the non-Indigenous population, 10 times as high in inner/outer regional areas and 30 times as high in remote/very remote areas.²

In 2016, the hepatitis B notification rate in Aboriginal and Torres Strait Islander people was greatest in regional areas, at 41.9 per 100 000 population,

followed by remote (28.4 per 100 000) and major cities (28.1 per 100 000).⁶

While new diagnoses of HIV in the Aboriginal and Torres Strait Islander people are greatest in urban regions, the rate in regional and remote areas has been increasing since 2012. However, it should be noted that these data only represent a small number of notifications. The prevention of the interaction of this trend with the ongoing outbreak of infectious syphilis in remote communities in northern and central Australia remains an area of particular concern.

Access to culturally responsive health services, prevention education and methods of prevention (such as condoms, sterile injecting equipment, PEP, PrEP and Treatment as Prevention (TasP)) requires particular consideration within regional and remote Australia. The ability of health services to respond effectively to an increase in BBV and STI in remote areas to prevent the occurrence of an outbreak is also essential but may be limited by several factors, including workforce capacity, funding and access to community-led, peer-based initiatives for priority groups.

Aboriginal and Torres Strait Islander gay men and other men who have sex with men

Aboriginal and Torres Strait Islander gay men and other MSM may be at greater risk of social isolation and exclusion and engagement in higher risk behaviours, which increases the risk of acquiring HIV, STI, hepatitis C or hepatitis B.²⁸

They may also experience heightened levels of stigma, discrimination, homophobia and racism.

As with the non-Indigenous population, Aboriginal and Torres Strait Islander gay men and other MSM carry the greatest burden of HIV. Over half of new notifications in Aboriginal and Torres Strait Islander people can be attributed to male-to-male sex as the risk exposure and a further 10 per cent to both male-to-male sex and injecting drug use.⁶ Gay men and other MSM are therefore a priority group for reducing new HIV transmissions in Aboriginal and Torres Strait Islander people. A 2016 survey of

young Aboriginal and Torres Strait Islander people (16 to 29 years of age) found that, for men, being gay or bisexual was a predictor of previous STI diagnosis.²⁹

Given the high burden of HIV experienced by Aboriginal and Torres Strait Islander gay men and other MSM, the increased risk of STI and heightened stigma and discrimination, it is essential that targeted, effective prevention, testing and support programs are available for this priority group.

Alongside HIV TasP, access to PEP and the listing of PrEP on the Pharmaceutical Benefits Scheme (PBS) provide opportunities to reduce HIV transmission among Aboriginal and Torres Strait Islander people. Equitable access to these biomedical interventions for this population must be ensured. It must also be accompanied by access to condoms; culturally responsive HIV and STI prevention education, including peer education; regular and comprehensive HIV and STI testing; ongoing commitment to partner notification; and sterile injecting equipment. This also applies to other priority groups listed in this strategy that are at risk of HIV.

Aboriginal and Torres Strait Islander women

Aboriginal and Torres Strait Islander women face unique challenges, experiences and consequences, including reproductive risks, which need to be addressed and incorporated in the response to BBV and STI. For these reasons, Aboriginal and Torres Strait Islander women are a priority group in this strategy as well as being recognised across most of the other priority groups.

BBV and STI have a potentially devastating impact on unborn children and neonates, pregnant women and women of child-bearing age, so a focus on prevention, high-quality antenatal care and ongoing support is required.

The rate of hepatitis B and syphilis in pregnant women is of particular concern given the risk of mother-to-child transmission and the morbidity and mortality associated with hepatitis B and congenital syphilis. Children born to hepatitis B

positive mothers who contract the infection before or at birth are at very high risk (90 per cent) of developing chronic hepatitis B.³⁰ In 2016, the rate of newly diagnosed hepatitis B in Aboriginal and Torres Strait children and in women under 30 years was lower than in the non-Indigenous population; however, continued maintenance of activities and monitoring is important given the risks associated with maternal transmission of hepatitis B.

Over the last 10 years, 24 of the 43 congenital syphilis national notifications were in Aboriginal and Torres Strait Islander people.⁶ The notification rate of congenital syphilis in the Aboriginal and Torres Strait Islander population was 5.4 per 100 000 live births in 2016, which is 15 times the rate in the non-Indigenous population. Congenital syphilis can have severe and lifelong impacts on infants and can result in neonatal death.

In 2016, the notification rates for both chlamydia and gonorrhoea were substantially higher in Aboriginal and Torres Strait Islander women aged 15 to 29 years than in all other age groups and the non-Indigenous population.⁶ The overlap of these age groups with childbearing years is of serious concern, as STI can result in infertility, still birth, premature birth and eye disease.³¹

Between 2007 and 2016, the notification rates of newly diagnosed HIV infection among Aboriginal and Torres Strait Islander females were two to 12 times as high as among the non-Indigenous Australian-born female population.⁶ Although specific data is not available for Aboriginal and Torres Strait Islander people in relation to mother-to-child transmission, among 223 women with HIV who gave birth in the five-year period from 2012 to 2016, the transmission rate to newborns was 2 per cent compared with 39 per cent in the period from 1985 to 1991 and 28 per cent between 1992 and 1996.¹⁸ There were no cases notified in 2016. It is important that high-quality education is provided to all Aboriginal and Torres Strait Islander women of child-bearing age and that high-quality antenatal care is available to all pregnant Aboriginal and Torres Strait Islander women in to help maintain this achievement.

Increasing access to culturally responsive antenatal care and education on the importance of antenatal BBV and STI testing, vaccination, treatment and care for Aboriginal and Torres Islander women is integral to preventing mother-to-child transmission of BBV and STI within this population.

Aboriginal and Torres Strait Islander trans and gender-diverse people

BBV and STI prevalence among Aboriginal and Torres Strait Islander transgender and gender diverse people, including Sistagirls/Sistergirls, Brotherboys and other two-spirit people, is unknown in Australia due to a paucity of data. However, this population may be at greater risk due to high levels of population mobility, social isolation and exclusion.^{32,33} Aboriginal and Torres Strait Islander trans and gender-diverse people may also experience heightened levels of stigma, discrimination, homophobia/transphobia and racism, which can negatively impact on health-seeking behaviour and access to services.

Many trans and gender-diverse people are part of other priority groups (such as trans MSM, trans men, trans women and non-binary sex workers; and injecting drug users) and share some of the same risk exposures. However, it is important that the specific sexual health needs of trans and gender-diverse people and the unique barriers to prevention, treatment and care they experience are taken into consideration in the response to BBV and STI.

Increased community engagement and consultation and improved data and research are needed to better understand how Aboriginal and Torres Strait Islander trans and gender-diverse people are impacted by BBV and STI and their unique experiences and needs. This would better inform the provision of culturally competent peer-based approaches and identify opportunities for more effective inclusion in the broader BBV and STI response.

Aboriginal and Torres Strait Islander people who inject drugs

There is a higher prevalence of BBV in Aboriginal and Torres Strait Islander people who inject drugs when compared with the non-Indigenous population. A number of factors may increase exposure risks in this population, including lack of access to, or uptake of, culturally competent services and NSPs.

In the five-year period from 2012 to 2016, injecting drug use accounted for a higher proportion of new HIV notifications among the Aboriginal and Torres Strait Islander population when compared with the non-Indigenous population (14 per cent compared with 3 per cent).^{6,10}

Since 2007, for all years except 2010, the Australian Needle and Syringe Program Surveys have demonstrated that hepatitis C antibody prevalence (indicating current or past infection) is higher in Aboriginal and Torres Strait Islander respondents when compared with non-Indigenous respondents.⁶ This survey has also demonstrated a significant increase in receptive syringe sharing amongst Aboriginal and Torres Strait Islander respondents, increasing from 18 per cent in 2007 to 28 per cent in 2016 (compared with an increase of 15 per cent to 17 per cent amongst non-Indigenous respondents).⁶ In this same period, the number of participants identifying as Aboriginal and/or Torres Strait Islander also increased. To inform effective responses, it is important to understand the drivers behind changing this data. This priority group will continue to be a significant focus in the BBV and STI response.

Co-designed and tailored approaches are needed to ensure this priority group has equitable access to safe prevention methods, including evidence-based harm reduction, and testing and treatment services. Aboriginal and Torres Strait Islander people who inject drugs are a priority group for hepatitis C treatment, as successful treatment prevents onward transmission. This also applies to Aboriginal and Torres Strait Islander people with HIV who inject drugs. The development of such responses needs to acknowledge the impact of

stigma and discrimination as a barrier to accessing both mainstream and ACCHS; and include a focus on the provision of culturally competent peer-based services and interventions as a means of reaching these key groups.

In addition to the BBV transmission risks associated with injecting drug use, research suggests that the use and misuse of some illicit and licit drugs may increase the likelihood of high-risk sexual contact and STI transmission.^{34,35,36,37} The correlation between methamphetamine use and increased risk of STI has been well documented, and there is increasing evidence that this may also apply more widely to injecting drug use, non-medical use of prescription drugs and other illicit drug use.^{38,39,40} It is important that the response considers and addresses the unique challenges and experiences of Aboriginal and Torres Strait Islander people who use drugs. Aboriginal and Torres Strait Islander people are recognised as one of the priority populations in the National Drug Strategy 2017–2026, which outlines a range of strategies to prevent and minimise the associated harms among individuals, families and communities.⁴¹

Aboriginal and Torres Strait Islander people in custodial settings

There is evidence that people in custodial settings are at heightened risk of BBV and STI transmission and encounter barriers to prevention, testing and treatment. Causes include barriers to accessing preventative measures and healthcare services, a lack of continuity of care and support, a lack of access to sterile injecting and tattooing equipment, sexual assault, incarceration of Sistagirls/Sistergirls and Brotherboys in facilities inappropriate for their gender, and stigma and discrimination.

Aboriginal and Torres Strait Islander people are over-represented in custodial settings. Although Aboriginal and Torres Strait Islander adults make up around 3 per cent of the national population, they constitute 27 per cent of the national prison population.⁴² In a 2017 report, young Aboriginal and Torres Strait Islander people aged between 10 and 17 years were identified as being 24 times as likely as non-Indigenous young people to be in detention.⁴³

Limited data are available on BBV and STI exposure in custodial settings. While data on the percentage tested for BBV and STI on entering and leaving the prison system are available, the results of these tests are not available.¹⁷ This highlights a significant gap in our understanding of BBV and STI in Aboriginal and Torres Strait Islander people in custodial settings.

In 2016 the prevalence of chronic hepatitis B was 6 per cent in Aboriginal and Torres Strait Islander prison entrants and 2 per cent in non-Indigenous entrants.⁴⁴ Twenty-one per cent of Aboriginal and Torres Strait Islander people in prison are positive for the hepatitis C antibody (compared with 23 per cent in non-Indigenous people) and just under a third have the hepatitis B core-antibody (compared with 8 per cent in non-Indigenous people), indicating previous or current infection with these viruses. There were no identified cases of HIV transmission in Australian prisons in 2016. However, the risk of transmission in the context of undiagnosed HIV or detectable viral load is significant given the nature of risk exposures occurring in custodial settings.^{25,45,46}

Opportunities for improved access to preventive measures in custodial settings need to be prioritised and explored. This includes vaccination, condoms, and addressing gaps in access to other important prevention measures. There are currently limitations on the delivery of evidence-based harm reduction and demand reduction programs in custodial settings, such as provision of sterile needles and syringes, sterile tattooing and body piercings, and evidence-based OTP. Opportunities for greater harm reduction and demand reduction services need to be explored. Care coordination for people living with or at risk of BBV, ensuring continuity of access to medication, and engagement with medical care and community supports following release from custody are all crucial to reduce morbidity and transmission risk.

Appropriate and effective BBV and STI education, prevention, testing and treatment for this priority group require a strong, whole-of-government partnership approach involving those concerned with Aboriginal and Torres Strait Islander people in juvenile detention centres as well as adult prisons.

Aboriginal and Torres Strait Islander sex workers

Sex workers are a priority group due to the potential higher exposure risk associated with sex work. Australia's strong and sustained health promotion programs among sex workers mean that rates of BBV and STI in this group continue to be among the lowest in the world when compared with sex workers in other countries. However, the prevalence of BBV and STI among Aboriginal and Torres Strait Islander sex workers is unknown in Australia due to a paucity of data, signalling a need for research in this area.

Sex workers experience specific barriers to accessing health services, including stigma and discrimination and regulatory and legal issues—criminalisation, licensing, registration and mandatory testing in some jurisdictions.⁴⁷ These barriers are heightened for Aboriginal and Torres Strait Islander sex workers, who can also be impacted by racism; a lack of cultural respect regarding their sex work; incarceration and criminalisation; and a lack of appropriately targeted services, including culturally competent peer education and outreach. These barriers can impede access to evidence-based prevention, testing, treatment and support services and can result in increased risk of STI, loss of livelihood, and risk to personal and physical safety.⁴⁸ This can be further exacerbated for Aboriginal and Torres Strait Islander sex workers if they are highly mobile and by experiences of social isolation and exclusion. Additional layers of stigma are also experienced by sex workers who identify with other priority groups, such as sex workers who inject drugs, sex workers with BBV and trans and gender-diverse sex workers.

The risk of exposure to BBV and STI is greater for sex workers who have less opportunity to control the health and safety aspects of their work. This includes street-based sex workers, who are more heavily criminalised and policed. Aboriginal and Torres Strait Islander sex workers are over-represented in street-based sex work and may be particularly marginalised.⁴⁹ Evidence that has emerged since the previous strategy definitively shows that decriminalisation of sex work is linked to the reduction of HIV risk and rates.⁴⁸

There is a need to identify and expand culturally competent peer-based responses for Aboriginal and Torres Strait Islander sex workers as well as for Aboriginal and Torres Strait Islander people who provide sexual services but may not identify as being a sex worker.

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

For Aboriginal and Torres Strait Islander people living in the cross-border region of Australia and Papua New Guinea, there is an elevated risk of HIV, BBV and STI entering communities. This is because of proximity and cultural, familial and trade connections to Papua New Guinea, which has high rates of STI, including the highest rate of HIV in the Pacific region.^{50,51} The movement of people has steadily increased in recent years, increasing the risk of transmission and the pressure on healthcare facilities both in Australia and in Papua New Guinea. In response to managing this risk the Australian Government has funded Torres and Cape Hospital and Health Service, Queensland Health, over several years to further support its health services to specifically target these issues. Data shows that the incidence of these diseases is declining, with the exception of HIV⁶ and an outbreak of syphilis in northern Australia, including the Torres Strait, and for which a national enhanced response is underway.

7.

Key areas for action

This strategy includes a set of priority areas for action designed to support the achievement of the goals and targets. Each priority area for action relates to one or more of the targets. It is the interaction of these actions as a whole that is essential to the achievement of this strategy.

Australia's response to BBV and STI in Aboriginal and Torres Strait Islander people builds on the lessons learned over previous decades and is shaped by a number of significant challenges and opportunities. Some of these have been around for considerable time and others are new and reflect changes in epidemiology and other aspects of the response as well as biomedical advances in prevention and treatment. This strategy is designed to address these while recognising the need to maintain key aspects of the response that remain pivotal to its success and respond flexibly to other issues as they arise.



Education and prevention

- *Implement, support and evaluate a range of community (co)-designed and led, evidence-based and multifaceted BBV and STI education and prevention initiatives across priority settings to build community knowledge and awareness and effectively target and engage priority groups*
- *Support sexual health education in schools and community settings to improve knowledge and awareness of healthy relationships and STI, reduce risk behaviours associated with the transmission of STI, and highlight the importance of regular STI testing once sexually active*
- *Build knowledge and awareness of the various means of prevention for BBV and STI, including reinforcing the central role of condoms, the importance of vaccination, the effective use of biomedical tools such as PEP, PrEP and treatment as prevention for HIV and hepatitis C, and the need for sterile injecting practices*
- *Support widespread and equitable access to all means of STI and BBV prevention across the country in combination with STI and BBV prevention education and regular testing and treatment services*

Sustained education and prevention initiatives are critical in reducing the spread of BBV and STI among Aboriginal and Torres Strait Islander people. Education and prevention approaches that target gaps in knowledge and misconceptions, and build on the strength of community and effective peer networks, can significantly reduce stigma, increase rates of testing and treatment, and reduce the overall impact of BBV and STI.

Education and prevention approaches must successfully engage priority groups to improve knowledge of transmission pathways and effective methods for reducing risk to better inform decision-making and health behaviour choices. The most effective education and prevention approaches are those based on a sound understanding of the

behaviours, knowledge, beliefs and practices that they are trying to influence.⁵² Efforts should include a strong focus on engaging higher risk priority groups, including younger people, pregnant women, people in remote areas, gay men and other MSM, people who have a current or previous BBV or STI, people who inject drugs, sex workers and people in high-prevalence communities. Due to the greater prevalence of HIV and STI transmitted through heterosexual contact in Aboriginal and Torres Strait Islander people, this exposure route should be a focus of education and prevention activities.

Education and prevention initiatives must be culturally safe and linguistically appropriate, co-designed, co-developed and led by the community, and responsive to the social, cultural and environmental context in which they are being implemented. It is important that BBV and STI education and prevention efforts sit within a community-wide approach to build general knowledge and awareness, minimise the stigmatisation of priority groups and ensure messaging is effective in reaching the broader community.⁵³ Embedding BBV and STI prevention and education activities into broader Aboriginal and Torres Strait Islander health promotion and comprehensive primary healthcare programs supports a more holistic approach to health and wellbeing.

Opportunities to learn from, and build on, successful education and prevention approaches should be identified. Formalised peer-based approaches, which are community-led and involve well-supported community members with lived experience, are considered an effective way of supporting the provision of culturally responsive education and health promotion and engaging communities.^{54,55,56} The evaluation of existing BBV and STI programs, including those targeting other priority populations, is important to build a robust evidence base, inform the design and delivery of new programs and identify opportunities for program adaptation and scale-up.

Health professionals play a critical role in prevention education, including through the contact they have with patients and families and, more broadly, with people of influence in their communities. Programs delivered using multiple mechanisms and mediums achieve maximum engagement, impact and reach. This includes ACCHS, other primary health services, sexual health services, education institutions, youth services, BBV and STI organisations, peer-based services, alcohol and other drug (AOD), mental health services, and services in custodial and other settings. Reporting back to affected communities on research and emerging issues is also an important part of community engagement and can assist prevention efforts.

Prevention education needs to be coupled with ready access to the means of prevention, including vaccination, condoms and dams, water-based lubricant, PrEP, PEP and treatment as prevention for HIV and hepatitis C, sterile needles and syringes and evidence-based OTP. Opportunities for improved access to these preventive measures in custodial settings need to be explored and advanced, with an emphasis on evidence-based harm reduction and demand reduction measures, including NSPs and AOD treatment.

Education and prevention initiatives must be supported by accessible and acceptable culturally competent clinical services. Approaches must also improve knowledge and skills in how to access and navigate the available local health services and assist in addressing some of the barriers faced by Aboriginal and Torres Strait Islander people in accessing health services. Studies have shown that young Aboriginal and Torres Strait Islander people often face barriers in accessing health services due to stigma, confidentiality concerns, lack of age-appropriate services and lack of health professionals of the same gender.^{20,57,58}

Education programs in primary and secondary schools have been shown to support young people in managing risks and engaging in positive health-seeking behaviours.^{59,60} Support is also required in non-school settings for young people not engaged in the school environment. Evidence suggests that

community-led peer education may be an effective way of engaging young Aboriginal and Torres Strait Islander people in STI prevention interventions, particularly to address some of the social and cultural barriers and influences on sexual health.²⁴

It has been recommended that STI prevention strategies combine safe sex education with AOD harm reduction education for young Aboriginal and Torres Strait Islander people.⁶¹ This call for combined messaging is supported by the results of the GOANNA survey of 2877 young Aboriginal and Torres Strait Islander people, which found that illicit drug use was higher among respondents compared with the similar-aged non-Indigenous populations and was associated with risky sexual behaviours and STI diagnosis. International research has also suggested that the use and misuse of some illicit and licit drugs and risky alcohol consumption may increase the likelihood of high-risk sexual contact and STI transmission.^{34,36,37}

Education and prevention initiatives need to provide accurate and comprehensive information on the possible long-term consequences of BBV and STI. Emphasising the ramifications of untreated or undertreated infections on reproductive health, and the perinatal and neonatal impacts of infections, may build community support for BBV and STI initiatives and improve the engagement of pregnant women with antenatal care services.

In the case of HIV, while prevalence among Aboriginal and Torres Strait Islander people in Australia is low, rates of newly diagnosed HIV are increasing. While HIV notification rates have been highest in urban areas in most years, rising HIV notifications in remote areas is also a concern.⁶ Remote areas are often associated with high rates of untreated bacterial STI, which increases the risk of HIV transmission. Prevention messages which effectively engage those at risk are needed across all priority settings and geographic areas. To effectively reverse recent rate increases, this must be coupled with increased access to HIV and STI testing, improved uptake of PrEP, PEP and TasP, and culturally responsive clinical management and support for people living with HIV.^{62,63}

Education for health professionals and Aboriginal and Torres Strait Islander people with, or at risk of, HIV should outline the benefits of having an undetectable viral load. Raising awareness in those with HIV and their partners of the significance of having an undetectable viral load in HIV prevention may also assist in addressing HIV-related stigma. The subsidisation of PrEP for people at medium and high risk of HIVⁱ through the PBSⁱ as of 1 April 2018 is a significant development that needs to be capitalised on. A lack of awareness about the role of PrEP among relevant priority groups and not having a general practitioner or other clinician who is familiar with PrEP are some of the identified barriers that need to be addressed. Improving the targeted education about the benefits of PrEP to support its uptake is important. Recognising the role of PEP in the prevention 'toolbox' for individuals who have been exposed (or suspect they have been exposed) to HIV is also important,^{64,65} as is promoting awareness and accessibility to this medication.

Vaccination

Vaccination is a critical aspect of the response to BBV and STI. Improving awareness and education on the importance of vaccination and available catch-up programs is critical in preventing transmission.

Continued effort is needed to maintain and build on the success of the hepatitis B and HPV vaccination programs for Aboriginal and Torres Strait Islander people. Supporting improved and sustained immunisation coverage as outlined in the National Immunisation Strategy 2019–2024 is essential.

Despite high infant vaccination coverage, improved timeliness of hepatitis B vaccination (as part of efforts to improve vaccination timeliness more broadly) for Aboriginal and Torres Strait

Islander children is required to achieve the 95 per cent hepatitis B vaccination coverage target. All individuals up to 19 years of age are eligible for catch-up vaccines through the National Immunisation Program, including for hepatitis B. Targeted catch-up programs for Aboriginal and Torres Strait Islander people aged 20 years and older who missed or were not included in childhood vaccination, in line with the recommendations of the *Australian Immunisation Handbook*, would further reduce transmission rates.^{66,67}

Community education needs to contextualise hepatitis B as a family health and cancer prevention issue. It also needs to reinforce the need for antenatal screening to prevent vertical transmission. Antenatal and neonatal prevention and vaccination protocols need to be implemented alongside management and care for women living with hepatitis B. This is particularly important due to the greater health consequences that follow from infection at birth.

Following the introduction of HPV vaccination in 2007, there were marked declines in diagnosis of genital warts in Aboriginal and Torres Strait Islander women and men attending sexual health clinics for the first time.² HPV vaccination has been shown to protect a high proportion of Aboriginal and Torres Strait Islander women against vaccine-targeted HPV types that are associated with the development of cervical cancer.⁶⁸ The introduction of Gardasil[®]9, which protects against nine types of HPV, to the National Immunisation Program in 2018 is expected to further reduce cervical and other HPV-related cancer rates.⁶⁹ Sustained high HPV vaccine coverage rates are needed to close the gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians in the rates of cervical and other HPV-related cancers.⁷⁰

ⁱAs defined in the PrEP guidelines published by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. Available at: http://viruseradication.com/journal-details/Australasian_Society_for_HIV_Viral_hepatitis_and_Sexual_Health_Medicine_HIV_pre-exposure_prophylaxis:_clinical/guidelines/

ⁱThe closing the Gap PBS Co-payment Measure for Aboriginal and Torres Strait Islander People reduces the cost of PBS medicines for eligible Aboriginal and Torres Strait Islander people. Information available at: <http://www.pbs.gov.au/info/publication/factsheets/closing-the-gap-pbs-co-payment-measure>

Given that the primary delivery method of the national HPV adolescent immunisation program is through secondary schools, greater efforts need to be implemented to support Aboriginal and Torres Strait Islander students and their parents/ carers to participate in the program. To reach young Aboriginal and Torres Strait Islander people not engaged in the school environment, additional programs must be implemented and supported outside the school setting to increase access and catch up on missed HPV vaccine doses.

Harm reduction

NSPs remain the primary tool to prevent BBV transmission among people who inject drugs and have proven to be highly effective.⁷¹ Despite their proven efficacy, harm reduction and NSPs are not widely available or accessible in many parts of Australia for Aboriginal and Torres Strait Islander people who use drugs. Increased receptive syringe sharing, as well as the over-representation of this population in custodial settings, further increases the risk of BBV transmission. Ensuring greater focus on treatment as prevention for HIV and hepatitis C, as well as access to evidence-based OTP, are also important factors in minimising BBV transmission across priority settings.

There is a need for intensified evidence-based harm reduction efforts, coupled with culturally responsive peer-based education, across both community and custodial settings. Improving awareness that harm reduction is safe and highly effective is important, as it remains contentious in some communities due to fear it may encourage drug use.⁷² Messaging and engagement strategies need to incorporate cultural respect and involve strong engagement with community leadership in order to overcome these barriers and foster this change.

KEY AREAS FOR ACTION

1. Ensure meaningful engagement with community members and organisations that represent priority groups in the design and delivery of BBV and STI education prevention initiatives and services for their community

2. Identify and implement culturally safe, innovative, multifaceted education and prevention initiatives, including community-led, peer-based approaches, for priority groups to improve knowledge and awareness, address stigma related to BBV and STI, reduce risk behaviours and transmission and facilitate early testing and treatment

3. Evaluate existing education and prevention programs, including those targeting other priority populations, to inform the design and delivery of new programs and identify opportunities for program adaptation and scale-up

4. Implement comprehensive relationships and sexuality education in primary and secondary schools to improve knowledge, attitudes, skills and behaviours which support young Aboriginal and Torres Strait Islander people to engage in respectful relationships, reduce risky behaviours and increase health-seeking behaviour

5. Implement BBV and STI education and prevention initiatives for young Aboriginal and Torres Strait Islander people outside the school setting to improve knowledge, attitudes, skills and behaviours

6. Facilitate the development of partnerships between ACCHS, mainstream health services, schools, educational institutions and BBV and STI organisations to improve the delivery, availability and accessibility of sexual health education and services for all young Aboriginal and Torres Strait Islander people and strengthen linkages to BBV and STI testing and treatment

7. Develop initiatives to support further increases in vaccination coverage for HPV in adolescents, in and outside of school settings, in support of the actions of the National Immunisation Strategy

8. Develop options to improve access to hepatitis B catch-up programs for adolescents who were missed in infant vaccination programs in line with national and state and territory based immunisation programs

9. Promote the consistent and effective use of condoms and other prevention methods, including PrEP, PEP and TasP, and support widespread access across priority settings
10. Improve knowledge and awareness of the benefits of hepatitis C DAA treatment and support widespread access across priority settings
11. Promote the importance of evidence-based harm reduction and demand reduction (for example, NSPs and OTP) in preventing the transmission of BBV among people who inject drugs, including through community-led peer education; and support wide availability and equitable access to these prevention measures across priority groups, settings and geographic areas
12. Ensure education and prevention services, including NSPs, are linked to BBV and STI testing and treatment services and other relevant services, such as AOD services, youth services, peer-based services and mental health services
13. Support and foster community leadership to reduce the sharing of injecting equipment and increase access to NSPs and harm reduction approaches
14. Increase prevention education, evidence-based harm reduction and demand reduction for BBV and STI in custodial settings, including youth detention
15. Ensure consistent implementation of evidence-based antenatal and neonatal protocols for BBV and STI for pregnant women and women considering pregnancy to prevent vertical transmission and infant mortality

Testing, treatment and management

- *Build on successful approaches to improve testing rates and coverage to reduce the number of undiagnosed BBV and STI and decrease rates of late diagnosis*
- *Support health professionals to provide culturally responsive and safe, current, innovative and effective BBV and STI testing, treatment, monitoring and care*
- *Increase early and appropriate treatment of BBV and STI to reduce transmission, improve health outcomes and enhance quality of life*
- *Increase testing and treatment for BBV and STI in custodial settings, including youth detention, that is respectful of and responsive to the needs of Aboriginal and Torres Strait Islander people*

The disproportionate impact of BBV and STI on Aboriginal and Torres Strait Islander people is due in part to higher rates of late diagnosis.^{6,19} Late diagnosis contributes to poorer treatment outcomes and increases the risk of further transmission and outbreaks occurring. Inadequate levels of treatment and monitoring as well as partner notification and partner treatment may also contribute to this impact.⁷³ Sustained and intensive approaches tailored for the community and priority groups are essential to improve BBV and STI testing rates and treatment uptake and adherence. Given the high prevalence of STI among young Aboriginal and Torres Strait Islander people, comprehensive and regular STI testing is part of best-practice routine health care for all sexually active young people.^{74,75}

Integration of comprehensive BBV and STI testing and treatment programs into primary health protocols and guidelines, including opportunistic testing and adult health checks, can improve testing coverage and treatment outcomes.^{76,77} Additional intensive clinic-based strategies are needed where testing coverage remains low. In certain circumstances, and following local guidance, other approaches, such as outreach, targeted engagement of priority groups in non-clinical settings and community screening to further expand reach, may also be needed to

supplement routine clinic-based testing. It is important that strategies to strengthen partner notification/contact tracing are also implemented. A combination approach is most likely to have the greatest success at maximising testing coverage across a region,⁷⁸ with widespread community screening being particularly important in responding to emerging or current outbreaks. Simultaneous testing for other BBV and STI is also an important consideration due to the potential for co-infection. This includes the increased risk of HIV transmission associated with an STI, and HIV and hepatitis B and/or C co-infection.

Australia has national testing policies⁷⁹ and guidelines⁷⁵ which cover testing for STI, HIV, hepatitis B and hepatitis C. These include details on indications for testing, diagnostic strategies and quality assurance as well as specific guidance on offering testing to Aboriginal and Torres Strait Islander people. Guidelines provide advice to clinicians on recording sexual history and establishing the presence of known risk factors and behaviours associated with BBV and STI acquisition and transmission. Where required, local guidelines also need to be developed and/or maintained to address the specific needs of the community, ensuring cultural and language appropriateness.

Efforts to increase the frequency and coverage of BBV and STI testing must be based on the principles of quality testing in Australia—that all testing is voluntary with informed consent (including in custodial settings), accessible, non-discriminatory, confidential and of clear benefit to the patient being tested.

Engagement with Aboriginal and Torres Strait Islander people may be improved by using a variety of BBV and STI testing options, including rapid testing and point-of-care (POC) testing as these become increasingly available. The second phase of the Test, Treat and Go Trial (TTANGO2) is integrating POC testing for gonorrhoea, chlamydia and trichomonas into a routine program and expanding its availability at trial sites. The Enhanced Response to the syphilis outbreak in northern and central Australia is utilising syphilis POC testing to increase the options available to health professionals in areas

with high numbers of cases. These tests can provide clinical services with a rapid laboratory result, allowing, in many circumstances, treatment and the partner notification process to begin without delay.

Improving the diagnosis of BBV and STI requires increased access to testing through multiple settings, focusing on those commonly used by Aboriginal and Torres Strait Islander people. The design and delivery of BBV and STI testing services should be informed by available evidence on the predictors for and patterns of testing and patterns of health service access. Research has indicated a greater use of services by young Aboriginal and Torres Strait Islander women than young Aboriginal and Torres Strait Islander men. Developing approaches that effectively engage young men in health services is important, as well as delivering innovative outreach testing and education services in the community.^{23,24} Testing services that are tailored to the needs of communities and utilise well-supported peer educators in a nonstigmatising and non-discriminatory environment are more likely to be utilised. Incentives, including financial and non-financial, have been shown to achieve a sustained increase in STI testing rates in some Aboriginal and Torres Strait Islander communities.^{80,81,82,83}

Improvements in contact-tracing activities need to be built on, with a particular focus on innovative partner notification and treatment systems. Effective partner notification has the potential to reduce reinfection rates and allow diagnosis and treatment in people who may not realise they have been exposed. There are particular challenges associated with this depending on location, including in remote and very remote areas, and where communities are more mobile. Testing for hepatitis B is critical in confirming hepatitis B status and establishing the need for vaccination in individuals, and household/ sexual contacts, as well as treatment and care for people with hepatitis B.

Testing options that support early diagnosis of STI and BBV need to be linked with the provision of early treatment and care, including in the antenatal period, and treatment which is culturally responsive and safe. Rapid patient follow-up is

needed to minimise the time between diagnosis and commencement of treatment, with active patient management to support adherence to treatment and, where applicable, confirmation of cure.

For Aboriginal and Torres Strait Islander people who are diagnosed with HIV, early uptake of treatment and ongoing treatment adherence are critical. This requires rapid patient follow-up, strong coordination of care and active case management of people who are at risk of 'loss to follow-up'. Aboriginal and Torres Strait Islander people with HIV need to be supported and empowered to achieve and maintain sustained viral suppression to both improve individual health outcomes and for effective TasP.

In relation to hepatitis B, routine monitoring (including biannual blood tests) is the cornerstone of appropriate hepatitis B care and is critical to prevent associated morbidity and mortality. Access to appropriate hepatitis B monitoring services (including liver ultrasonography) remains a challenge in remote communities. Innovative flexible solutions are required to address service gaps. An example is the Far North Queensland Liver Health Champions project, which is training and mentoring AHWs and practitioners in providing liver health monitoring within communities and in creating 'Liver Health Champions' at the local level.⁸⁴

Regular hepatitis C testing among priority populations and in priority settings enables not only early diagnosis but also access to curative treatment and education to prevent transmission. Hepatitis C DAA treatments are well tolerated, are of short duration, and provide a cure for well over 90 per cent of people treated. The prescribing arrangements for the new DAAs are expanded beyond specialists to include general practitioners (GPs) and authorised nurse practitioners, providing the opportunity to greatly increase treatment coverage.

Ensuring adequate importance is placed on the effective management of BBV and STI can be challenging if what are considered more urgent health priorities exist or where high rates of STI have become normalised. HIV and hepatitis B are increasingly being recognised as chronic diseases

and, as such, HIV and chronic hepatitis B should be considered alongside other chronic diseases in Aboriginal and Torres Strait Islander chronic disease management programs. Accordingly, the management emphasis is shifting from specialist-based hospital services to community-based and primary healthcare services. Agreed care pathways and shared care models between primary and specialist services are therefore important. However, they have been identified as being deficient in some settings. Patient information management systems provide opportunities to enhance data quality on patient immunity and test results as well as support the provision of treatment and care for Aboriginal and Torres Strait Islander people living with or at risk of BBV or STI. Recall and reminder systems are important to support consistent, guideline-based care for patients post-diagnosis. Peer-based models which include Aboriginal and Torres Strait Islander people with lived experience providing advice and support for individuals post diagnosis also play an important role in linking people with ongoing treatment and care.⁸⁵

The provision of medical services in custodial settings is an opportunity for improved BBV and STI testing and management. These services are generally the responsibility of state and territory governments, although some medicines, including HIV, hepatitis B and hepatitis C treatments, are also available to people in prison under the Highly Specialised Drugs Program for patients who meet eligibility criteria. Nurse-led programs have been successful in custodial settings in supporting the scaling-up of treatment and reducing hepatitis C prevalence.⁸⁶ These programs are currently implemented in specific prisons in some jurisdictions,^{87,88} and should be considered in other areas. Post-release transition programs are also critical in supporting the seamless continuation of treatment and follow-up testing and in preventing reinfection. Given many people in prison are on remand or incarcerated for short periods of time, timely testing and treatment, along with post-release transition programs, are essential to ensure people are effectively treated before or soon after release.

KEY AREAS FOR ACTION

16. Identify areas of need for improved BBV and STI testing and treatment coverage and target efforts accordingly

17. Explore the development of key performance indicators for organisations providing health services to Aboriginal and Torres Strait Islander peoples in relation to BBV and STI testing, treatment and care to inform continuous quality improvement cycles

18. Develop and integrate peer support models where Aboriginal and Torres Strait Islander people with lived experience of BBV and STI are peer navigators in diagnosis, treatment and care

19. Improve the knowledge and awareness of Aboriginal and Torres Strait Islander Health Workers, other health professionals, and community-based health workers of risk factors and indications for BBV and STI testing

20. Include a greater emphasis on sexual health and BBV/STI testing in routine primary health protocols and guidelines where appropriate, including in antenatal care and adult health checks

21. Further develop and implement innovative evidence-based testing approaches across priority settings and geographic areas which address barriers to access and include strong linkages to well-coordinated treatment, monitoring and care

22. Explore the use of rapid testing and point of care technologies, where appropriate, to improve access to testing and treatment

23. Increase the capacity of health professionals to undertake culturally safe, rapid contact tracing and partner treatment which builds on established networks and local partnerships; and explore the use of incentives for individuals at risk of 'loss to follow-up'

24. Regularly update, maintain and promote the use of evidence-based clinical guidelines and resources for health professionals to guide high-quality testing, treatment, monitoring and care; and identify opportunities to better integrate these guidelines into routine clinical practice

25. Develop systems to ensure active patient management and strong coordination of care to support adherence to treatment and reduce 'loss to follow-up' to ensure hepatitis C cure and, in the case of hepatitis B and HIV, support the achievement and maintenance of sustained viral suppression

26. Support community- and peer-based organisations and primary health services to develop the capacity of Aboriginal and Torres Strait Islander people living with chronic BBV to effectively manage their condition

27. Identify and trial opportunities to increase access to prevention, testing and treatment of BBV and STI for people in custodial and youth detention settings, including nurse-led and other treatment programs/approaches, as well as strengthened systems for improving continuity of treatment and care for people upon re-entry into the community

Addressing stigma and creating an enabling environment

- *Implement a range of initiatives to address stigma and discrimination and minimise their impact on the health of Aboriginal and Torres Strait Islander people at risk of or living with BBV and/or STI*
- *Continue to work towards addressing the legal, regulatory and policy barriers which affect Aboriginal and Torres Strait Islander priority groups and influence their health-seeking behaviours*
- *Continue to work towards addressing negative and culturally unsafe experiences of individuals and communities with the healthcare system and other institutions which influence health-seeking behaviours*

The health and wellbeing of Aboriginal and Torres Strait Islander people continues to be challenged by experiences of stigma, racism and discrimination not only in health but also in community and other settings.⁸⁹ Stigma specifically associated with BBV and STI remains a major barrier to uptake of testing and treatment services. This can be exacerbated in regional and remote areas due to distance, confidentiality concerns and sparse service availability in some localities.

A strong enabling and culturally safe environment is required to support increased access to BBV and STI prevention, testing and treatment, reduce risk-taking behaviours, empower priority populations, and improve overall health outcomes for Aboriginal and Torres Strait Islander people.

Acknowledging the profound impact of the social determinants of health is fundamental in the design of any program or health service initiative. This is particularly evident where there is socio-economic disadvantage, food insecurity, poor housing and low health literacy.

Programs for Aboriginal and Torres Strait Islander populations that aim to address the burden of BBV and STI are currently delivered in communities in a range of forms and through a network of services. However, multiple and overlapping sources of stigma experienced by Aboriginal and Torres Strait

Islander priority groups present barriers to the effectiveness of these, and more work needs to be done.

Racism is a key social determinant of health for Aboriginal and Torres Strait Islander people. It can deter people from achieving their full capabilities by damaging self-confidence and self-worth. It can result in poorer mental health and lead to reduced health-seeking behaviours. Evidence demonstrates that racism experienced in the delivery of health services is associated with increased psychological distress and contributes to lower levels of health service access by Aboriginal and Torres Strait Islander people.⁹⁰ Conscious efforts must be made to counter racism in the design and delivery of health services, through inclusive health promotion messaging, employment practices and cultural awareness training for service providers.

Stigma and discrimination experienced by Aboriginal and Torres Strait Islander people may be influenced by intersecting characteristics. This includes sexual orientation, gender and gender identity, disability, a history of substance abuse or injecting drug use, or being a sex worker or a person in a custodial setting. It is important to recognise that stigma and discrimination also occurs within Aboriginal and Torres Strait Islander communities. Transphobia towards Sistagirls/Sistergirls and Brotherboys has been well documented and has been associated with serious physical and mental health impacts. These may relate to ostracism from community, relocation, and loss of identity. These impacts are amplified because community and country are such essential aspects of Aboriginal and Torres Strait Islander people's sense of self, wellbeing, and spirituality.^{32,33}

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 assists the breakdown of shame and isolation that can be associated with being a member of a priority group identified in this strategy. The use of well-supported peer educators from priority groups can also assist in breaking

down stigma and discrimination, empowering individuals, strengthening communities and engendering better health outcomes.

Aboriginal and Torres Strait Islander peoples and organisations have a holistic view of health that focuses on the physical, cultural, emotional and social wellbeing of the individual, family and community. Actions to address BBV and STI must be responded to within this context. Approaches need to respect the cultural rights, values, beliefs, knowledge, aspirations and expectations of Aboriginal and Torres Strait Islander people.

Specific barriers, including the lack of access to culturally responsive health services and concerns over confidentiality in accessing these services, need to be addressed. Confidentiality concerns are particularly relevant in small communities where a member of the close or extended family may work in the local health service. Other barriers include a lack of male health workers for male patients; cost barriers in seeking advice or treatment; and transport, especially in rural and remote locations. These barriers are also underpinned by issues of cultural dislocation, personal and intergenerational trauma and ongoing stresses associated with disadvantage.

This highlights the importance of strong community involvement and sustainable leadership from community Elders and new and emerging leaders in the planning, design and implementation of services and programs. This ensures effective engagement with priority groups and supports their health and wellbeing.

Studies have found that removing legislative and non-legislative barriers, and reducing stigma and discrimination, increased the rates of testing and treatment and contributed to a decrease in incidence and prevalence of various BBV and STI.^{47,91} The removal of these barriers would offer a proportionally beneficial impact on health outcomes for Aboriginal and Torres Strait Islander people, who are subject to higher levels of criminalisation and incarceration than the non-Indigenous population.

KEY AREAS FOR ACTION

28. Incorporate messaging to counteract stigma, racism and discrimination into prevention education programs and initiatives

29. Work to eliminate stigma, racism and discrimination, including prejudice against Aboriginal and Torres Strait Islander people and priority groups, in the health workforce and wider community through evidence-based education and training programs

30. Provide culturally safe services which support the elimination of stigma and discrimination in Aboriginal and Torres Strait Islander communities and healthcare settings

31. Encourage partnerships and joint action between Aboriginal and Torres Strait Islander organisations, community organisations representing priority groups, health services and other services providers to reduce the experience of stigma and discrimination for individuals and communities

32. Commit to strengthen the coordination efforts across governments, Aboriginal and Torres Strait Islander Community Controlled Health Services and the non-government sector through a shared responsibility for reducing stigma and discrimination

33. Further develop partnerships between governments, Aboriginal and Torres Strait Islander Community Controlled Health Services, BBV and STI organisations, and other key partners in the response, to identify opportunities to reduce the barriers (institutional, regulatory, systems and legal) to accessing BBV and STI testing and treatment

Culturally responsive, coordinated and accessible services

- *Identify and implement novel multidisciplinary, culturally safe and inclusive coordinated and sustainable programs which successfully address the barriers experienced by communities and significantly increase the uptake of BBV and STI services*

Accessible, high-quality, culturally responsive and regionally based services are essential to reducing the prevalence and impact of BBV and STI on Aboriginal and Torres Strait Islander people. Evidence has repeatedly shown that Aboriginal and Torres Strait Islander people are more likely to access health services where service providers communicate respectfully, have an understanding of culture and build good relationships with Aboriginal and Torres Strait Islander people; and where Aboriginal or Torres Strait Islander staff are part of the healthcare team.⁹² Research has highlighted how readily Aboriginal and Torres Strait Islander people attend services where they do not feel negatively judged and that stigma decreases people's access to healthcare services.⁹³ Delivery of services in a friendly, culturally respectful, non-judgmental environment that makes clients feel comfortable increases the likelihood they will return to the service at a later date.

Barriers to accessing BBV and STI services include remoteness of many communities, financial barriers, shame and stigma. Other barriers include misunderstandings among non-Indigenous staff of how health is holistically perceived in Aboriginal and Torres Strait Islander cultures; acute health issues taking precedence over non-acute health care; the adequacy and effectiveness of services, including in maintaining client confidentiality; and staff capacity to offer testing (impacted by staffing turnover, constraints with workload and concerns about managing positive results).⁹⁴

The complexity of issues emphasises the importance of local community control and participation in the development and delivery of programs and the critical role of Aboriginal and Torres Strait Islander staff within both community controlled and mainstream services. It is also

important to ensure that health care is provided in a cultural context and issues such as kinship, gender and appropriate health service layout are all recognised and considered.

The primary healthcare STI and BBV services available to Aboriginal and Torres Strait Islander people include ACCHS and mainstream general practice clinics. They are also provided through specialised sexual health and family planning clinics as well as public hospitals in regional and remote areas and peer-based services.

Efforts to build the organisational capacity of primary healthcare services, including ACCHS and mainstream services,⁹⁵ have improved BBV and STI screening, testing and treatment rates in several health services. Studies have shown that ACCHS are the preferred health service for the majority of young Aboriginal and Torres Strait Islander people and are where most STI testing and diagnosis occur.^{23,29} ACCHS are also viewed as playing an important role in providing advice on alcohol and other drug use.²³ Continuing to build capacity in services that are frequently utilised by Aboriginal and Torres Strait Islander people is critical. Mainstream services also play an essential role in the delivery of BBV and STI services to Aboriginal and Torres Strait Islander people, providing choice and reach so that Aboriginal and Torres Strait Islander people can access services that best suit their individual needs and situations.

The success that many organisations and programs have had in providing high-quality, consistent primary healthcare and sexual health services has been a result of dedicated capacity to maintain the provision of BBV and STI services amid a wide range of other complex and challenging health priorities.

The experience of health services in the Anangu Pitjantjatjara Yankunytjatjara Lands, Ngaanyatara Lands and Tiwi Islands provides important lessons for delivery of STI control programs in primary healthcare services. While STI prevalence among Indigenous people in remote areas is very high overall, these regionally coordinated health services have maintained comparatively low STI prevalence in their communities. This indicates that regional coordination of STI control programs in remote

communities, with support from jurisdictions and laboratories, is an effective model. Effective STI control programs in these health services feature strong leadership, high levels of engagement with local communities, monitoring of testing and treatment data, and use of sexual health coordinators. Robust clinical systems, integration of comprehensive BBV and STI programs into primary health protocols and services and rapid access to diagnosis and treatment are also important elements.^{96,97}

It is important to identify novel multidisciplinary approaches which address the specific barriers experienced by communities and increase their engagement with BBV and STI services is important. This includes learning from trials and studies and scaling up successful approaches, ensuring they are adapted to the local context by, or in collaboration with, communities.

Locating programs and services close to where Aboriginal and Torres Strait Islander people meet has been found to be useful in making attendance easier and allows staff to build relationships with the community.⁹³ The benefits of a walk-in, one-stop shop model of care for BBV and STI have been described as increasing ease of access, community adoption and program reach; providing a gateway to sexual health awareness and BBV and STI screening; promotion of harm reduction in relation to injecting drug use; and a potential avenue for supporting the uptake of hepatitis C DAA treatments.

To reach priority populations effectively requires strong connections between organisations that support and provide services to these populations. Building capacity and reach through partnerships between ACCHS, mainstream health services, BBV and STI organisations, AOD services, harm reduction and peer-based service providers, schools, youth services and mental health services are all critical and support a more coordinated and holistic approach to prevention and care. Effective partnerships should be identified and maintained and their models applied to develop new links and referral pathways.

It is important to ensure there is a focus on capacity building in community organisations, including ACCH Sector Support Organisations as well as peer-based organisations, is important, as these organisations possess a unique understanding of affected communities, capacity to mobilise community members through their networks and ability to reach hidden populations far more effectively and efficiently than mainstream service providers.⁹⁸

KEY AREAS FOR ACTION

- 34.** Support models of care that provide effective and culturally responsive prevention, testing, treatment and care at a local level, including mobile services, with strong links and pathways to access multidisciplinary and specialist services
- 35.** Ensure meaningful local community participation and control in the development and delivery of BBV and STI programs and services for their community, including to ensure that gaps in programs and services are identified and addressed
- 36.** Support partnerships between Aboriginal and Torres Strait Islander organisations, mainstream health services, BBV and STI organisations, AODs, youth services, mental health services and other service providers to build capacity, reach and referral pathways for BBV and STI service access
- 37.** Identify opportunities to improve patient management systems to better support the primary healthcare workforce in promptly identifying and providing ongoing treatment and care for people with HIV and hepatitis B
- 38.** Develop mechanisms for strong regional coordination of BBV and STI responses in remote areas, involving local primary healthcare services and with support from specialist services and laboratories

Workforce

- *Facilitate and support a highly skilled and stable multidisciplinary health workforce that is respectful of and responsive to the needs of Aboriginal and Torres Strait Islander people in the provision of high-quality BBV and STI services*

A skilled, stable, multidisciplinary and culturally respectful workforce is fundamental to an effective response to BBV and STI among Aboriginal and Torres Strait Islander people. Increasing the Aboriginal and Torres Strait Islander health workforce and building workforce capacity are critical to ensuring that health professionals have the confidence, skills and knowledge to recognise and deliver culturally responsive BBV and STI services. This is needed for staff working in ACCHS, ACCH Sector Support Organisations, BBV and STI organisations and mainstream health services.

The quality of BBV and STI services is impeded by a number of workforce issues. These include a lack of dedicated funding for the primary healthcare workforce for sexual health; high turnover; vacancy rates; significant shortages of appropriately skilled staff; gaps in education, training and professional development opportunities for health professionals; and competing and more urgent health priorities. These issues predominate outside of metropolitan areas and are particularly felt in remote areas.

It is critical to ensure that the health workforce is supported to deliver care by continuing education and training, evidence-based clinical guidelines, and appropriate resources and tools. To respond effectively, the health workforce needs clear clinical pathways and guidelines for the clinical management of specific BBV and STI models of care that are systematic, sustainable, agreed and coordinated. These pathways and guidelines are important in supporting staff to provide high-quality care. Building workforce capacity in research and research translation is also important in supporting the delivery of best-practice BBV and STI care.

The [National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023](#),⁹⁹ along with jurisdictional Aboriginal and Torres Strait Islander health workforce strategies

and action plans, sets out a broad range of actions for building workforce capacity. A key outcome is ensuring Aboriginal and Torres Strait Islander people are strongly represented across all health disciplines to support culturally safe and responsive health care. Increasing the number of Aboriginal and Torres Strait Islander people working in BBV and sexual health primary and specialist care management and services, surveillance and research will ensure cultural capability is evident in service design and provision and in the development and translation of the evidence base. This also assists in improving the knowledge and skills of non-Indigenous health workers. However, the additional workload and expectation that this may place on Aboriginal and Torres Strait Islander staff needs to be considered and closely monitored, and it must be matched by continuing effort on the part of the non-Indigenous workforce.

Cultural safety is being incorporated into codes of conduct for various health professions to promote and provide culturally safe care.¹⁰⁰ Comprehensive orientation processes, including ongoing cultural safety training for staff, are also important. Studies have suggested that staff should be educated on the role that social disadvantage plays in clients' lives and how this affects health.⁸² Due to the often emotionally challenging work associated with the provision of BBV and sexual health services, it has been recommended that the mental and physical health of workers be monitored and supported through debriefing programs and ongoing primary care.⁹³

Providing the skills and knowledge necessary to competently deal with BBV and STI not only supports good health outcomes but also assists in improving staff job satisfaction and retention. This is particularly important for AHWs, who play a crucial role in improving health outcomes of Aboriginal and Torres Strait Islander people. AHWs in youth support roles and primary healthcare services and AOD workers are priority groups that need to be skilled in BBV and STI prevention, testing, treatment and care. Studies have found that AHWs often struggle to gain sufficient educational attainment or professional career opportunities.¹⁰¹ Perceptions

of being undervalued and poorly supported at the health system and facility level have also been identified as a common theme. Identifying opportunities for workforce capacity building, knowledge sharing, upskilling and innovation is critical for improved service delivery, staff retention and career pathways.

With the appropriate training, support and guidance, there may be opportunities to better utilise a range of health professionals to provide BBV and STI services. Improving the utilisation of the primary health workforce is particularly important in remote areas with high BBV and STI prevalence, as high levels of workforce instability are common. Ensuring health professionals have access to the necessary tools and resources to support high-quality care is imperative, as is timely referral and advice between specialist and primary healthcare services.

In relation to the ongoing challenge of workforce recruitment and retention in rural and remote areas, research has found that 'bundled' incentives are likely to be most effective and that strategies (for example, financial and non-financial—housing, support and career pathways) should be flexible to target the specific needs of health workers practising in different contexts.¹⁰² The provision of rural training opportunities and recruitment of professionals from rural areas are also important retention strategies. The likelihood that general practitioners will choose to work in rural practice is strongly associated with rural training pathways and rural origin.¹⁰³

Key areas for action

39. Support an increase in the Aboriginal and Torres Strait Islander health workforce trained in BBV and STI and strengthen their role in the provision of services, including prevention education, client support and recall

40. Develop the capacity of health professionals and organisations providing BBV and STI services, including ACCHS, ACCH Sector Support Organisations, BBV and STI organisations and mainstream health services, to deliver effective health promotion and prevention education and testing, treatment, management and care, particularly in areas of high BBV and STI prevalence

41. Improve the cultural awareness of health professionals through cultural safety training, including education regarding the importance of sensitively asking for and recording a patient's Aboriginal and/or Torres Strait Islander origin; using culturally respectful partner notification, testing and treatment; and understanding the intersecting issues experienced by Aboriginal and Torres Strait Islander priority groups

42. Implement targeted initiatives to improve the education, training, resources and tools provided to health professionals, including the use of digital platforms and face-to-face learning opportunities, to facilitate and support a highly skilled clinical and community-based workforce

43. Continue to regularly update, maintain and make accessible evidence-based clinical guidelines, tools and support for BBV and STI prevention, testing, treatment and antenatal care; and ensure consistent applications across jurisdictions

44. Provide a range of BBV and STI professional development, networking opportunities and supports to Aboriginal and Torres Strait Islander Health Workers and other health professionals, including through existing accredited programs

45. Ensure ACCH Sector Support Organisations are supported to employ staff focused on the provision of BBV and STI services

46. Promote the engagement of Aboriginal and Torres Strait Islander people with lived experience of BBV as peer navigators to provide support in diagnosis, treatment and care services

Data, surveillance, research and evaluation

- *With a focus on identified gaps, continue to build a strong evidence base for effectively responding to existing and emerging BBV and STI issues and challenges among Aboriginal and Torres Strait Islander communities, informed by high-quality, timely data and surveillance systems.*
-

Surveillance and data

It is important to improve data collections and systems to support a more comprehensive understanding of BBV and STI among Aboriginal and Torres Strait Islander people across Australia.

Opportunities to improve the level of detail in collected data to better identify trends and issues of concern need to be explored. The recording and reporting of Aboriginal and Torres Strait Islander status in clinical and pathology settings remains low and is a key area for improvement. There is also a need to improve the timeliness and consistency of data collection across Australia to better support completeness and comparability.

Data collection and surveillance varies between jurisdictions and there are opportunities to improve consistency. There are also opportunities to improve data linkages and increase sharing of data between jurisdictions, laboratories and service providers. Timely reporting of data is critical to inform local and national responses, particularly in the case of a potential outbreak. The opportunities brought by the national rollout of My Health Record and existing jurisdictional eHealth solutions (such as the well-established Northern Territory My eHealth Record) need to be considered for their potential to improve continuity of patient care across settings. Privacy and confidentiality considerations are important. Perceived risks associated with data sharing and the secondary uses of data could potentially discourage people from accessing sexual health services, particularly if people believe their information is not secure. Ensuring a clear understanding of informed consent, the privacy regulations governing electronic health records and the opportunities to opt out will be crucial to ensure that trust is maintained. The use of translation services, where

required, is encouraged to support informed consent.

Surveillance data are currently only collected for four notifiable STI at the national level. This limits the understanding of the full impact of STI in Australia, including the rates of STI diagnoses among Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people are known to experience high rates of non-nationally notifiable STI, such as the high rates of *Trichomonas vaginalis* and high endemic rates of HTLV-1 among some remote communities.

With respect to BBV, there is currently limited data on prevalence, testing and treatment uptake among Aboriginal and Torres Strait Islander people. This limits our understanding of disease impact and inhibits targeting and monitoring the effectiveness of responses. There are additional privacy considerations for data collection within Aboriginal priority groups where the potential for re-identification may be greater.

For all data and surveillance activities, it is important to balance the benefit of additional data with the right to privacy of the person accessing the service and the effort required to collect and report on the data.

Research and evaluation

Maintaining a strong research agenda to inform and support the implementation of this strategy is essential. Social, behavioural, epidemiological, clinical and basic research are all important in developing a strong evidence base for managing and preventing BBV and STI in Aboriginal and Torres Strait Islander communities. This includes research to identify and examine key changes in the epidemiology and behaviours of priority groups, emerging issues and concerns; influences on people's decisions in regard to risk taking; and the ability to seek and access testing, care and treatment. It is also important to inform the development of targeted responses in priority groups and settings.

It is critical that core values and other ethical principles are applied to ensure research is ethically conducted and produces positive outcomes and benefits for Aboriginal and Torres Strait Islander

peoples and communities. Communities must have a central role in the identification of research priorities, and findings need to be accessible to communities to inform knowledge translation and local decision-making.

Community organisations, peer-based organisations and health professionals with strong links to Aboriginal and Torres Strait Islander priority groups and communities are often able to identify early changes in behaviours, social interactions and demographics.^{105,106} Collaborative efforts between communities, organisations, researchers and health professionals offer opportunities to combine the strengths of all partners to identify research priorities of most value to communities, policy and practice.

There are known research gaps including the need to better identify and examine the knowledge and attitudes about sexual health and sexual health behaviours among priority groups. We also need to improve our understanding of patterns of sex work, mobility and migration; drivers of high-risk behaviours (such as alcohol and other drug use); and barriers and enablers to accessing evidence-based prevention, testing and treatment across different priority groups and communities. Further understanding is also needed about how cultural values support sexual health; the influences on young men's attitudes to STI prevention and access to sexual health services; and the experiences for same-sex attracted and gender-diverse Aboriginal and Torres Strait Islander people. This information would better inform the design and delivery of culturally safe and acceptable sexual health services and programs.¹⁰⁷ Research and evaluation is required to provide a more definitive evidence base in relation to the programs and approaches that most effectively reduce BBV and STI prevalence for Aboriginal and Torres Strait Islander people.

Dedicated research effort is needed to develop a better understanding of the prevalence of HTLV-1 in remote communities. To inform an effective public health response, research is needed to characterise this virus, its prevalence, its disease associations and its impact on health outcomes. Research also indicates that some Aboriginal and Torres Strait Islander communities in northern Australia are

affected by a more aggressive strain of hepatitis B that may impact on efficacy of vaccination and influence long-term outcomes. Further research is needed to better understand the public health implications of this distinct hepatitis B subtype.^{108,109,110}

The National BBV and STI Surveillance and Monitoring Plan 2018–2022 will be developed to measure and monitor the implementation of this strategy through the identification and development of indicators to measure progress towards achieving the strategy's targets. The assessment of existing and the development of new BBV and STI activities and programs will aim to maximise their contribution to the priority areas for action set out in this strategy.

Cross-border responses

Close surveillance of HIV, hepatitis B and hepatitis C and STI in cross-border regions is particularly important to identify and respond to new cases and prevent further transmission. Efforts to address the risk of BBV and STI transmission in cross-border regions is guided by a joint steering committee—the Torres Strait Cross Border Health Issues Committee (HIC), which was formed to consider health issues arising in the region. In addition, the Australian Government provides specific funding to Queensland Health towards the additional costs incurred by Queensland to provide health services in this region.

KEY AREAS FOR ACTION

47. Identify and prioritise strategies that address gaps in data to support the implementation and monitoring of this strategy. Identified areas include the development of a hepatitis C prevalence estimate; improved data on risk behaviours, healthcare access, testing, treatment and care cascades; a valid quality of life tool to measure the impact of BBV and STI; and appropriate stigma and discrimination indicators

48. Improve recording and reporting of Aboriginal and Torres Strait Islander status across all relevant data and administrative collections, including pathology request forms, laboratory results and disease notifications

49. Identify opportunities and mechanisms to partner with community organisations, laboratories and service providers in data collection and surveillance activities

50. Collaboratively identify and address research gaps, with reference to the priority actions of this strategy and specific community priorities, to support a strong evidence-based response

51. Strengthen research translation to guide interventions at the local and national level

52. Support research on the public health implications of the distinct strain of hepatitis B that affects some Aboriginal and Torres Strait Islander communities, and on the epidemiology and public health implications of HTLV-1 in remote communities, in order to better inform responses

53. Evaluate health promotion, prevention, testing and treatment programs and activities for Aboriginal and Torres Strait Islander people and communities and support continuation of those found to be effective

54. Ensure ongoing surveillance of HIV, hepatitis B, hepatitis C and STI, and responses to new notifications, in the cross-border region of Australia and Papua New Guinea

55. Explore opportunities for assessing the impact of legislation and regulation on access to health services

Outbreak detection and response

- *Enhance systems and capacity to monitor and respond to changes in BBV and STI incidence among Aboriginal and Torres Strait Islander populations, including enhanced surveillance and rapid responses to potential outbreaks among priority populations and in geographic locations*

As well as having access to high-quality, timely surveillance data, it is critical that opportunities to improve the capacity to respond to current and emerging BBV and STI issues are explored. The ongoing syphilis outbreak in northern and central Australia demonstrates the need for an improved response.

To support effective responses to increased incidence, it is necessary to enhanced patient management and notification systems, along with clear roles, responsibilities and accountabilities at all levels. Comprehensive follow-up treatment, effective contact tracing and treatment of sexual partners to prevent further transmission, and review of BBV and STI treatment guidelines are all essential elements of an effective response.

State and territory disease control operations play a critical role as the first-line response to serious outbreaks of infectious disease. These centres are responsible for identifying outbreaks and mounting a rapid response in collaboration with local primary healthcare service providers. Partnership arrangements involving ACCHS and mainstream general practice, sexual health services and pathology providers, as well as peer-based services, may be needed to support active case finding, testing and contact tracing in high-prevalence areas in order to minimise time between infection and treatment and to reduce incidence and prevalence. In some instances, dedicated local or regional staff may also be needed to support the quality and organisation of responses.

A well-coordinated, rapid and intensive outbreak response is essential to control current outbreaks and prevent future ones. An enhanced and decisive response to the current syphilis outbreak is

important in the short term. In the long term, there is a need to strengthen the public health STI and BBV outbreak response capacity generally.

Difficulties in preventing and managing STI, together with international and local experience with HIV, indicate a HIV cluster would be difficult to control and manage and have a strong impact on affected communities. Poorer access to services, lower frequency of HIV testing and lower treatment uptake amplify this risk. The higher prevalence of HIV among Aboriginal and Torres Strait Islander gay men and other MSM, and the efficiency of transmission through injecting drug use, provide conditions for potential clusters. There is also a heightened risk of an HIV cluster in the Aboriginal and Torres Strait Islander population as a result of a high prevalence of STI, given the associated increased risk of HIV acquisition and transmission and higher rates of receptive needle and syringe sharing when compared with the non-Indigenous population.^{6,95} Rapid responses to increased HIV transmission and clusters are essential. However, in the absence of a vaccine or cure, and given HIV is a lifelong infection, rapid action must be coupled with sustained, long-term, community-based approaches to reduce the prospects for continued transmission.

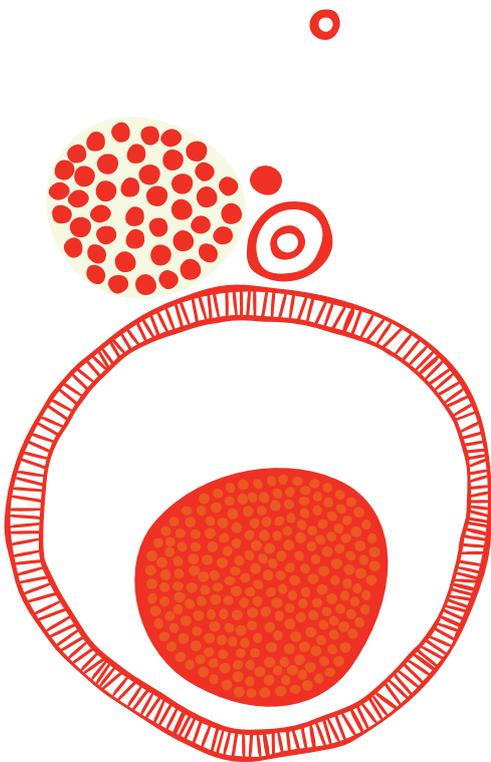
KEY AREAS FOR ACTION

- 56.** Enhance systems and capacity to monitor and respond to changes in BBV and STI incidence among Aboriginal and Torres Strait populations, including rapid identification and response to outbreaks and clusters among priority populations and in specific locations
- 57.** Develop processes to support increased STI testing in outbreak situations and ensure that testing data is collected to monitor and evaluate the effectiveness of increased testing and treatment
- 58.** Ensure that the implementation of the National strategic approach and action plan for an enhanced response to the disproportionately high rates of STI (and blood borne viruses) in Indigenous populations is integrated with and supported by the actions under this strategy
- 59.** Continue collaborative jurisdictional and national level support for effective responses to BBV and STI incidence, including in averting and responding to outbreaks, and develop agreed responsibilities and procedures at a jurisdictional and national level to support these responses



8.

Implementing this strategy



Leadership, partnership and connections to community

Australia's response to BBV and STI in Aboriginal and Torres Strait Islander peoples is built on a model of partnership between communities, priority groups, government, community-based organisations, researchers and health professionals. The partnership approach depends on clear leadership roles and accountability for all involved.

The Australian Government is committed to providing strong national leadership by working across portfolios and jurisdictions to achieve the goals of this strategy. The Australian Government Department of Health leads the coordination of the national response to BBV and STI in Aboriginal and Torres Strait Islander people under the National Aboriginal and Torres Strait Islander BBV and STI Strategy. However, the success of this strategy is contingent on productive partnerships between Australian, state and territory governments and partners, including peak bodies representing communities, health professionals, researchers and others including service providers. In the case of research on BBV and STI, it is imperative that this is conducted in partnership with communities and aligned with the priorities of the five national strategies.

National community and health peak organisations, and other organisations, representing communities and the clinical workforce remain at the forefront of the response in Australia. Organisations including the National Aboriginal Community Controlled Health Organisation and affiliates; ACCHS; the Australian Federation of AIDS Organisations; the Australian Indigenous Doctor's Association; the Australian Injecting and Illicit Drug Users League; the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine; Hepatitis Australia; the National Association of People with HIV Australia; Scarlet Alliance, Australian Sex Workers' Association; and the Anwernekenhe National HIV

Alliance, Positive Aboriginal Torres Strait Islander Network, and the relationship these organisations have with their members, have a critical role to play in the implementation of this strategy.

Action plan

The National BBV and STI Strategies Action Plan 2018–2022 provides the detail of specific actions for governments and partners. The action plan outlines the roles and responsibilities of governments and partners and the time frames for implementation of the actions. Indicators for measuring the progress towards achievement of the strategies' targets will also be developed. The action plan will be reviewed as required during the lifetime of the strategies.

The five national BBV and STI strategies share a number of key actions related to areas such as workforce, improving data and surveillance, education programs, and stigma and discrimination. The action plan will focus on encouraging connections between existing programs and policies, and build on previously successful approaches, to minimise duplication of effort. It will also look for opportunities to learn from and adapt responses used for other diseases where relevant.

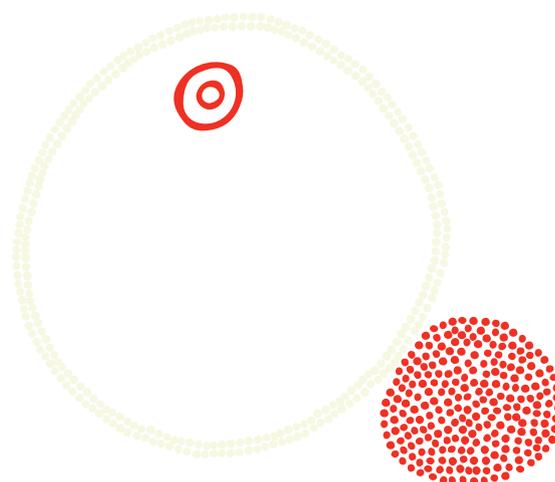
Governance, reporting and evaluation

The five national BBV and STI strategies are endorsed by Australia's Health Ministers and governed through relevant committees of the Australian Health Ministers' Advisory Council (AHMAC). The Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS) coordinates implementation efforts across jurisdictions and reports to the Australian Health Protection Principal Committee (AHPPC) on progress in the implementation of the national strategies. BBVSS and the Communicable

Diseases Network Australia (CDNA) will jointly monitor progress towards the targets of each strategy and identify emerging issues and opportunities for action.

Surveillance and monitoring plan

The National BBV and STI Surveillance and Monitoring Plan 2018–2022 supports the five national BBV and STI strategies and informs and monitors progress on achieving the goals and targets of each strategy. A subcommittee of the CDNA is responsible for overseeing the surveillance and monitoring plan and reporting on progress to the CDNA and BBVSS.



Appendix A

National BBV and STI guiding principles

1. Centrality of people with BBV and meaningful involvement of priority populations^b

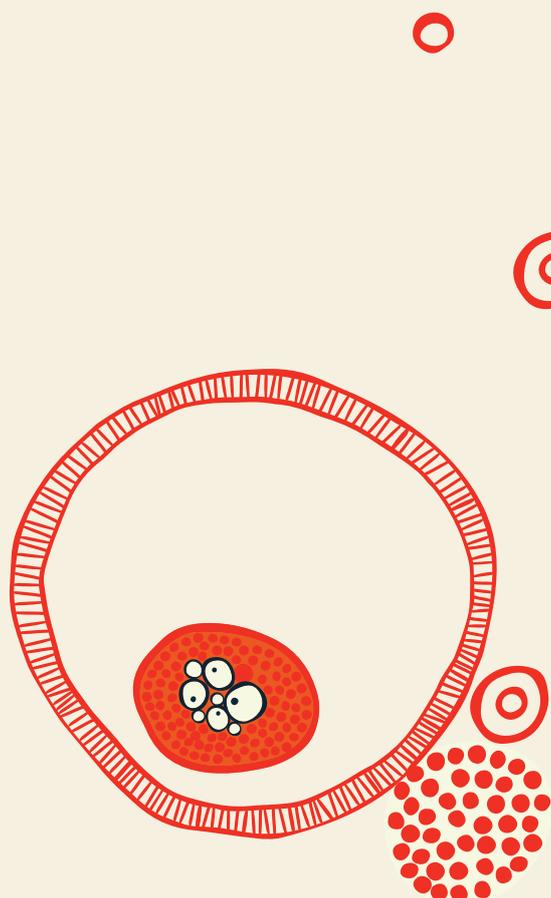
The centrality of Aboriginal and Torres Strait Islander people with HIV in accordance with the MIPA/GIPA principle, and people living with hepatitis C and/or B and their meaningful participation along with other priority populations is essential to the development, implementation, monitoring and evaluation of effective programs and policies.

2. Human rights

Aboriginal and Torres Strait Islander people with a BBV or STI have a right to participate fully in society, without experience of stigma or discrimination. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.

3. 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 gender, sexuality, disease status, drug use, occupation, socioeconomic status, migration status, language, religion, culture or geographic location, including custodial settings. 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.



4. Health promotion

The Ottawa Charter for Health Promotion provides the framework for effective action under this Strategy. It facilitates the active participation of affected communities and individuals to increase their influence over the determinants of their health, and the formulation and application of laws and public policies to support and encourage healthy behaviours and respect for human rights.

5. Prevention

The transmission of BBV and STI can be reduced through the appropriate combination of evidence-based biomedical, behavioural and social approaches within a supportive enabling environment. Education and prevention programs, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures.

6. Quality health services

A strong multidisciplinary workforce of motivated, trained and regularly updated health professionals, community and peer-based workers from, and who work with, priority populations are vital to delivering culturally appropriate, high quality services across Australia. Coordination and integration of health services across a number of settings is essential in order to respond to new technologies, best practice, and to best support Aboriginal and Torres Strait Islander people with or at risk of BBV and STI to make informed choices about their treatment and prevention.

7. Harm reduction

Harm reduction approaches underpin effective measures to prevent transmission of BBV. Approaches include needle and syringe programs, alcohol and other drug treatment programs, counselling and mental health support, and measures to address social determinants of health.

8. Shared responsibility

Individuals and communities share responsibility to prevent transmission, and to inform efforts that address education and support needs. Governments and community organisations have a responsibility to provide the necessary information, resources and supportive environments for prevention.

9. Commitment to evidence-based policy and programs

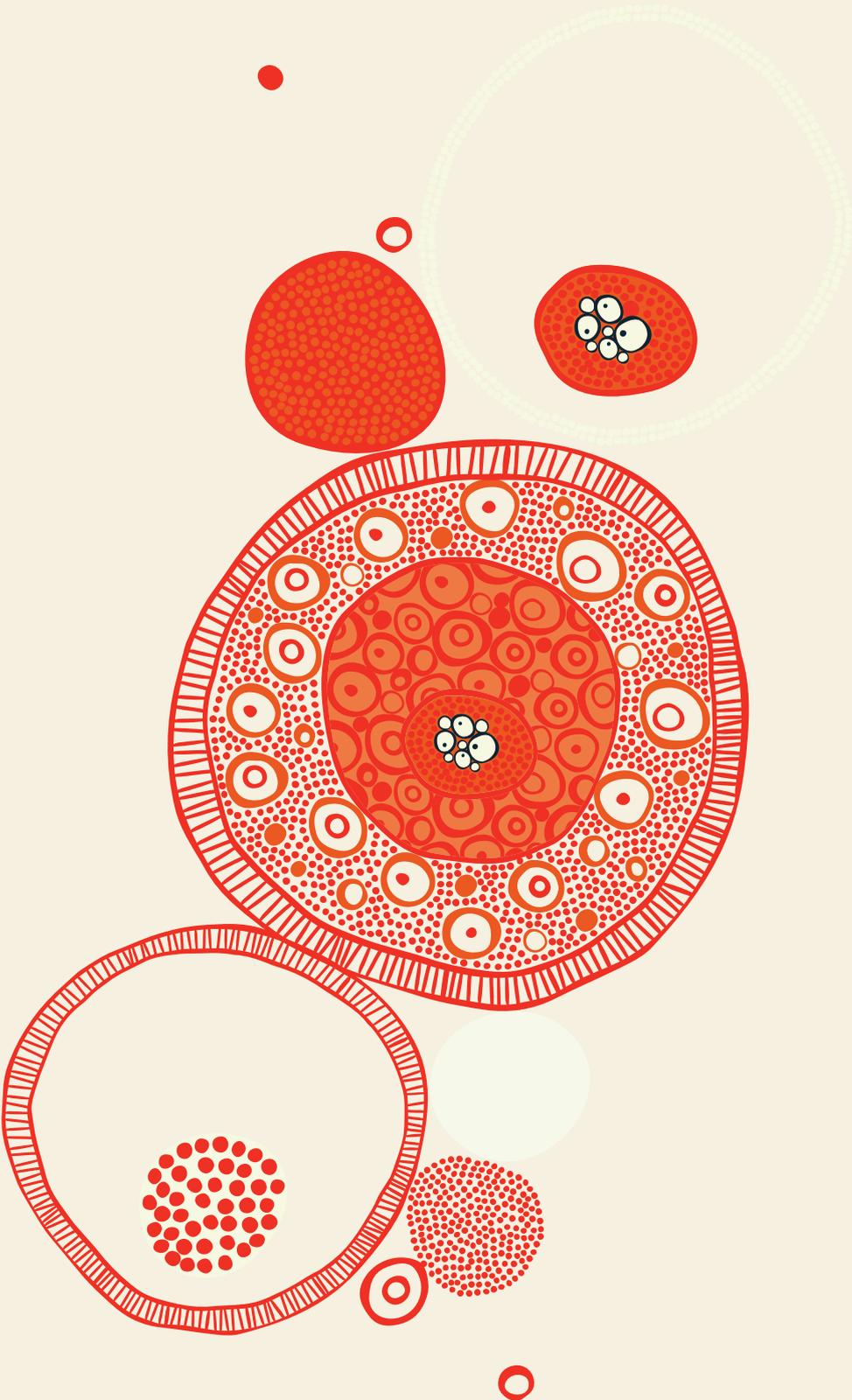
The national response to BBV and STI has at its foundation an evidence base built on high quality research and surveillance, monitoring and evaluation. A strong and constantly refining evidence base is essential to meet new challenges, evaluate current and new interventions and develop effective social policy. The development and dissemination of evidence-based national clinical guidelines and other information resources on testing, treatment, care and support is critical.

10. Partnership

Effective partnerships exist between affected communities, national peak organisations representing the interest of communities, and the clinical workforce, government and researchers. These relationships are characterised by consultation, cooperative effort, clear roles and responsibilities, meaningful contributions, empowerment, respectful dialogue and appropriate resourcing to achieve the goals of the strategies. It includes leadership from the Australian, State and Territory Governments and the full cooperative efforts of all members of the partnership to implement agreed directions.

Appendix B

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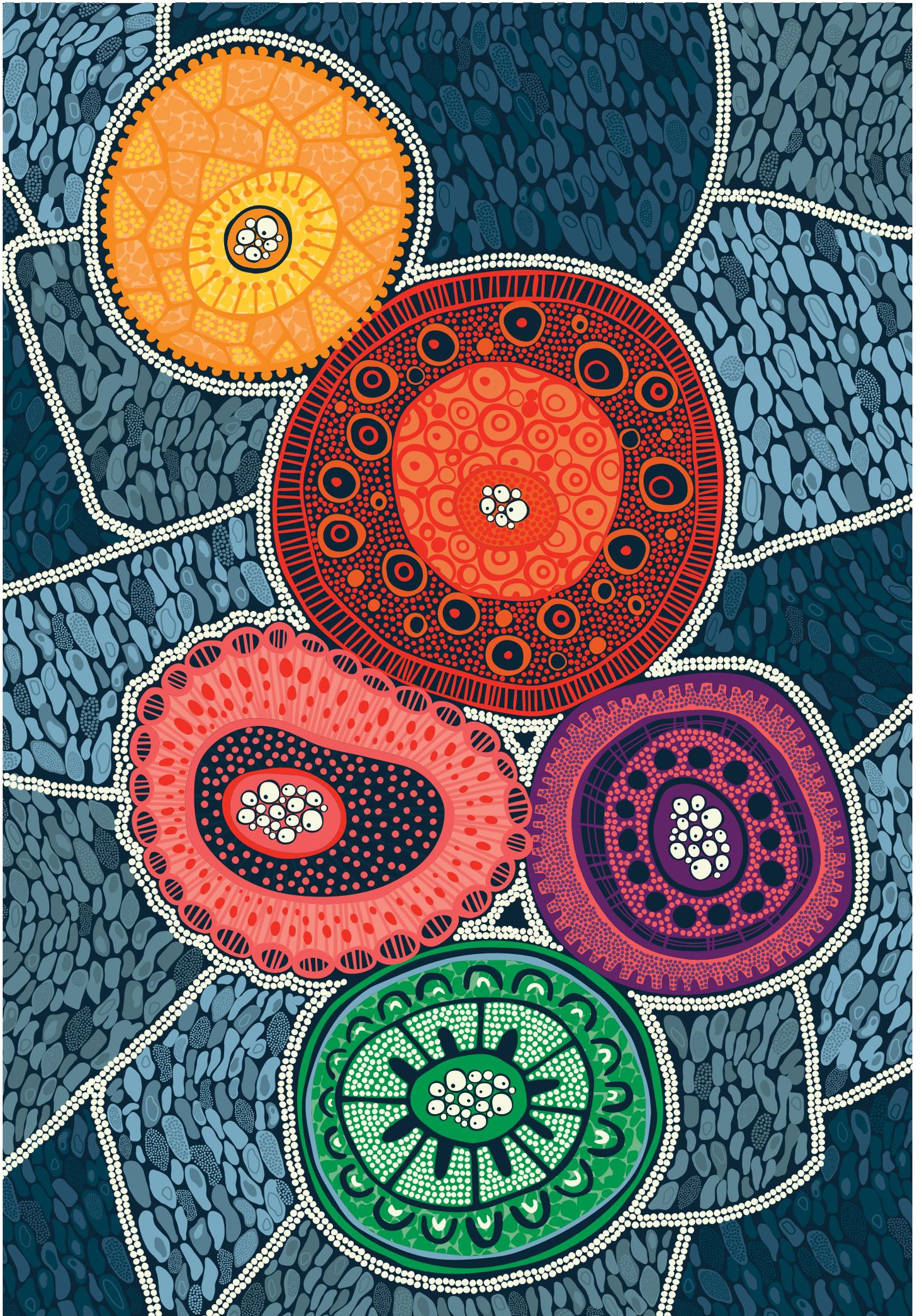
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Healing Culture by *Keisha Thomason*

The overall artwork is part of the 'biology' of culture. Each circle symbol represents the five health strategies. Each strategy is bound and strengthened by the community, culture and the land. These elements work together to minimise the negative individual and social impact of these health issues. By putting these strategies in place, the community can heal, contributing to cultural healing.

The background consists of the flow of information and health education throughout mainstream and Indigenous communities. The dot work around the artwork and throughout the background represent the Indigenous and mainstream health strategies—that work together to maintain the health of the community and greater cultural healing.

About the artist

Keisha Thomason is a Brisbane-based Indigenous Graphic Designer. Keisha is a proud Waanyi & Kalkadoon woman from Mount Isa, Queensland. Her artwork merges the handmade with the digital landscape, influenced by both her culture and the modern world.

FIFTH

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



Australian Government
Department of Health

2018–2022