High level summit on rising HIV, sexually transmissible infections (STI) and viral hepatitis in Aboriginal and Torres Strait Islander communities

FINAL REPORT

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Key discussion

Opening remarks

The High Level Summit on Rising HIV, Sexually Transmissible Infections (STI) and Viral Hepatitis in Aboriginal and Torres Strait Islander Communities (‘The Summit’) was an initiative of Aboriginal and Torres Strait Islander HIV Awareness Week. The Summit represents one of the most important meetings in Indigenous Health, blood borne viruses (BBV) and STIs in more than 30 years.

Aboriginal and Torres Strait Islander communities are considered to be vulnerable to BBV and STIs, and examples from overseas have shown the devastating impact of outbreaks within Indigenous communities. The Summit was conducted in response to the rising rates of HIV, and the ongoing, unacceptable rates of STIs and viral hepatitis amongst Aboriginal and Torres Strait Islander people.

The Hon Fiona Nash, Minster for Rural Health, acknowledged the rising rates of STIs and BBV within Aboriginal and Torres Strait Islander communities, and highlighted the Australian Government’s commitment to improving health outcomes for Indigenous Australians. Senator Nash acknowledged the work of various organisations to date, and outlined the importance of the Summit as a platform to share ideas and promote collaborations between different organisations and government representatives.

The Hon Cameron Dick, Queensland Minister for Health and Minister for Ambulance Services, officially opened the Summit. Mr Dick highlighted the ongoing syphilis outbreak, which started in Northern Queensland and has since spread across northern Australia. Senator Dick highlighted the disproportionate burden of STIs and BBV affecting Indigenous communities and outlined the work that the Queensland Government is doing to work towards addressing these issues.

HIV

Epidemiology

The burden of HIV amongst Aboriginal and Torres Strait Islander people is increasing, and there is an increasing divergence in HIV notification rates between Aboriginal and Torres Strait Islander people and non-Indigenous people. HIV exposure risk within the Aboriginal and Torres Strait Islander population varies significantly from that of non-Indigenous people; in 2014, the highest risk factors for acquisition of HIV were male-to-male sex (MSM – 50%), heterosexual sex (20%), and injecting drug use (IDU - 16%). Furthermore, in 2014, 22% of Aboriginal and Torres Strait Islander people engaging in IDU, reported receptive syringe sharing.
Risk of outbreak
Indigenous Australians are at an increased risk of experiencing an outbreak of HIV due to the significant underlying burden of STIs and BBV. The current syphilis outbreak highlights the susceptibility of this population and underscored the importance of strong public health preparedness.

HIV prevention
‘Combination prevention’ needs to be considered within Indigenous communities. This would include: harm reduction activities (including Needle and Syringe Programs (NSPs); promotion of condom use; school based sexual health education; health promotion and community mobilisation activities; addressing shame, stigma and disadvantage; sexual health communication; and utilisation of biomedical advances, such as Pre-Exposure Prophylaxis (PrEP), point-of-care testing (POCT) and accelerating treatment for HIV positive individuals, as per the current guidelines.

Outbreak risk
Young people, women, MSM, Torres Strait Islanders and IDU were all identified as ‘high-risk’ groups; the potential for an HIV outbreak is significant, with the impact of an outbreak considered to be major. The different issues facing rural, remote and urban Indigenous communities must be considered in all public health interventions targeted towards Indigenous people.

Outbreak response
It is imperative to have adequately prepared health systems, as well as an informed health workforce, to respond appropriately to an outbreak of HIV. It is essential to develop the Indigenous health workforce’s ability to recognise risk factors around HIV transmission/acquisition within their community, so they can develop culturally sensitive responses. Within remote communities, 1-2 new HIV diagnoses should be considered an outbreak, and it is essential that the healthcare workforce is aware of this, and is prepared to respond accordingly. Underpinning all outbreak responses must be community engagement and consultation; involving local elders and community leaders in grass roots action is essential to any outbreak response within Indigenous communities.

Sexually Transmitted Infections (STIs)

Epidemiology
Indigenous communities experience a disproportionate burden of STIs. In 2014, within remote and very remote Indigenous populations, the burden of disease was further exacerbated; Chlamydia rates were 7 times higher amongst Indigenous populations compared with non-Indigenous populations\(^1\); Gonorrhoea rates were 69 times higher in Indigenous populations compared with non-Indigenous populations\(^1\); and Infectious Syphilis was 304 times higher in Indigenous populations compared
with non-Indigenous populations. The STRIVE study found that, in remote areas, 50% of Indigenous people had an STI, and 4/10 women had Chlamydia, Gonorrhoea or Trichomonas Vaginalis. The extraordinary burden of disease experienced by Indigenous Australians is unacceptable and requires an immediate, targeted public health response.

Evidence shows that increased funding and resources within Indigenous health services, as well as increased community awareness of STIs, correlates with increasing rates of STI testing, decreasing rates of STI transmission, and an increased awareness of key sexual health education messages (STRIVE study, ACCEPT study, ACCESS study).

**Syphilis outbreak**

The ongoing Syphilis outbreak - affecting young Aboriginal and Torres Strait islander people - in northern Australia, highlights the vulnerability of Indigenous communities to disastrous health outcomes. The cause of the outbreak is multi-factorial; dense sexual networks that involve interconnected partners; IDU; the significant underlying burden of STIs; and the relatively low health literacy within Indigenous communities. These factors, combined with a disengaged and un-informed affected community, have resulted in an ongoing epidemic that shows no signs of slowing.

**STI control**

Key indicators of social determinants of health within Indigenous communities remain unchanged, and contribute to the ongoing disproportionate rates of STIs within Indigenous communities. It is essential to learn from measures that have worked, and target specific interventions where ongoing issues remain.

STI POCT could be used as a crucial tool in response to ongoing burden of STIs within Indigenous communities, and has been used successfully in Western Australia. Anonymous self-testing could potentially be beneficial as it could remove some of the stigma and discrimination associated with STIs. The need to engage the affected/infected populations cannot be overstated. Currently, the Indigenous community is not engaged and is unaware of their burden of disease. They need to understand the priority issues facing their population, so as to respond to them effectively.

**Viral Hepatitis**

**Hepatitis C (HCV)**

**Epidemiology**

Whilst the incidence of HCV is decreasing nationally, the burden of disease is increasing; in 2014, HCC attributable to viral hepatitis was the only increasing cause
of cancer death in Australia\(^3\). The burden of HCV within Indigenous communities continues to rise, and in 2014, indigenous people had rates of HCV infection that were 5 times higher than non-Indigenous Australians.\(^4\)

**New HCV treatments 2016**

New HCV treatments, currently approved under the Therapeutic Goods Administration (TGA) but awaiting listing on the PBS, will revolutionise HCV care within Australia when they become available. Furthermore, Australia is set to become the only developed country to provide universal treatment to patients, irrespective of disease progression. New therapies have minimal adverse effects, are simple, and will allow patients to be treated within primary health care (PHC) settings.

**Models of care**

Considering the burden of disease amongst the incarcerated population, rapid testing of prisoners on entry to facilities - and subsequent treatment - would be a highly effective public health measure. There are a variety of current models of care, each with their own positive and negative attributes. Increasing treatment and management options within PHC settings removes some barriers around access to care, such as geographical implications. However, stigma and discrimination around HCV needs to be considered and tertiary treatment and care should always remain an option to provide client privacy.

**Hepatitis B (HBV)**

**Epidemiology**

In 2011, it was estimated that 218,000 Australians were living with chronic hepatitis B (CHB).\(^5\) Aboriginal and Torres Strait Islander people experience a disproportionate burden of disease (9.3% of the national burden)\(^5\); 21,000 Aboriginal and Torres Strait Islander people are living with hepatitis B, representing 3-4% of all Indigenous Australians, compared with <0.5% of non-Indigenous Australians born in Australia\(^5\). Furthermore, mortality associated with Hepatocellular carcinoma (HCC) within Aboriginal and Torres Strait Islander people is far more pronounced then within non-Indigenous Australians.\(^6\)

**Vaccination**

The national target for childhood vaccination is coverage >95%. Data from 2014 shows the divergence of vaccination rates between Indigenous and non-Indigenous children, with Aboriginal and Torres Strait Islander children at the 12 months age group having consistently lower vaccination rates than their non-Indigenous counterparts.\(^1\) There are increasing concerns around the efficacy of HBV vaccination within Aboriginal and Torres Strait Islander people. The National Testing Policy recommends offering HBV screening to all Aboriginal and Torres Strait Islander adults.
Recommendations

The following are agreed actions/approaches for addressing the increasing rates of blood borne BBV and STI in Aboriginal and Torres Strait Islander populations. These recommendations support achieving the objectives and targets specified in the Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy, and will produce tangible and measurable outcomes.

1. HIV

1.1 Strengthening testing

- HIV testing needs to be normalised, systematic and within guidelines of healthcare services
- HIV testing for at-risk groups (MSM, after a positive STI test) should be imbedded within continuous quality improvement (CQI) indicators
- Indicators for HIV testing should be incorporated into National KPIs
  - % of people with positive STIs (Gonorrhoea/Chlamydia/Trichomonas Vaginalis/Syphilis) who are tested for HIV and syphilis test (at first contact, and within 30 days)
- Develop a clear statement of the use of HIV Point of Care Testing - types of tests available, sensitivity specificity, risks benefits, where they could be used, when they might be used, models for rolling out

1.2 Workforce development

- Education around testing, screening, and management of HIV (including on emerging biomedical advances in PrEP, PEP and TasP) to ensure PHC and Aboriginal Community Controlled Health Service (ACCHS) staff are aware of the variety of testing options available
- Education and training to increase awareness in combination prevention strategies – condom access, NSPs
- NSPs are key to preventing HIV in Aboriginal communities - strategies needed to normalise these programs within ACCHSs
- Education around community engagement – messages around contact tracing, case management
- Education and training around outbreak response processes – targeted at PHC and ACCHSs
• Education and training around HIV for ACCHS staff – HIV exposure risk, modes of transmission, management

• Career pathways for Aboriginal Health Workers need to be improved and to include the development of skills at appropriate levels (and reward for the acquisition of these)
  o Certificate and or diploma courses which increase competency

1.3 HIV management within PHC

• Acknowledge that case management is complex and resource intensive – requires additional support and funding directed towards this

• Need for localised, and national (standardised) HIV management plans

1.4 Community Engagement

• Funding needed to resource community engagement efforts – increase awareness of HIV (risk of exposure, modes of transmission, management)

• Recognition of the crucial role elders play in community engagement and awareness activities – ensure elders are supported to be involved in STI and BBV community education

1.5 Outbreak response preparedness - reducing transmission rates

• Essential to acknowledge that vulnerability to an outbreak varies amongst ‘high-risk’ groups – young people, MSM & IDU, women and heterosexual, Torres Strait Islander and PNG – and interventions need to be targeted accordingly
  o Acknowledge and respond to the differences between urban and rural communities
  o Acknowledge the importance of engaging local communities and ensuring responses are driven by local people/needs
  o Acknowledge the impact of shame and stigma on public health efforts
  o Acknowledge the underlying issues of alcohol and substance abuse within some communities, and the increased risk this has on potential outbreaks
  o Need to combine with other services/strategies (domestic violence, AOD, resilience training)

• CDNA to develop a HIV Outbreak Response SONG (Series of National Guidelines) specific to Aboriginal communities – spectrum from initial diagnosis (potential outbreak) through to actual outbreak.
A framework that would assist communities if an outbreak does occur – outlines levels of input (high level, community responses) roles and responsibilities, activity, strategy, timeliness confidentiality and privacy issues

- Ensure healthcare workforce is equipped with the resources necessary to respond to an HIV outbreak – education, awareness of processes

1.6 Funding

- Urgent funding to be directed towards various organisations supporting/resourcing this area - NACCHO and affiliates, organisations providing workforce development, community engagement, AMSs, ACCHSs and PHC services
- Funding to support ‘combination prevention’ strategies for HIV (NSP, PrEP, PEP)

The recommendations from the Summit will support achieving the following objectives and targets from the Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy.

Objectives:

- Improve knowledge and awareness of STI and BBV
- Reduce the incidence of BBV in Aboriginal and Torres Strait Islander people and communities
  - Reduce the risk behaviours associated with transmission
  - Decrease the number of people with undiagnosed BBV
- Increase the number of Aboriginal and Torres Strait Islander people with BBV receiving appropriate management, care and support for BBV
- Eliminate the negative impact of stigma, discrimination and human rights issues on Aboriginal and Torres Strait Islander health
  - Increase engagement with Aboriginal and Torres Strait Islander communities through sustained and authentic action
  - Improve the delivery of and access to appropriate services

Targets:

- Increase the use of sterile injecting equipment for every injecting episode
- Increase the number of people with HIV, hepatitis C and hepatitis B receiving antiviral treatment

2. Sexually Transmitted Infections (STI)
2.1 Strengthening testing

- Indicators for STI testing should be incorporated into National KPIs
  - % of 15-29 year olds, who access services, screened annually for key STIs (Gonorrhoea/Chlamydia/Trichomonas Vaginalis/Syphilis)
  - % of age group tested, rates of positivity, % on treatment
- Funding allocated to support increased STI testing in endemic areas considered to be at ‘high risk’
- POCT diagnostics should be funded to enhance testing in PHC services
- Change guideline based STI screening from 12 monthly to 6 monthly
- Ensure STI screening is incorporated into adult health checks – resources and support to services to do this

2.2 Workforce development

- Education and training around the importance of patient registration and data collection, with a focus on embedding CQI into STI management
  - Essential to measure targets
- Support PHC services to deliver sexual health programs – resource/fund NACCHO and affiliates to support staff in remote settings (particularly over intensive screening periods)

2.3 Community engagement

- Ensure community engagement efforts are well resourced and funded to engage local communities in STI and BBV education
  - Trial Incentives for 2 x 6wk periods per year $30 Woolworths card for participation in STI screening
  - Education and training of Aboriginal Health Workers to promote an increase in STI testing recommendations
- Support services that provide health promotion to communities – ensure awareness of changes to clinical guidelines, as well as local burden of disease
- Recognition of the crucial role elders play in community engagement and awareness activities – ensure elders are supported to be involved in STI and BBV community education
- Evidence based early childhood programs, which are comprehensive and general (not specific STI) to allow capacity for learning/enhance health literacy – to improve the uptake of health messages. The programs should be ongoing, and age appropriate
2.3 Systems change

- Patient recall prompts, to facilitate increased frequency of testing in young people. Needs to be built into Communicare and other PMS
- Need a significant change in the system of health service delivery and funding in primary PHC services and AMS:
  - Nurse practitioners should be supported to prescribe and conduct interventions (vaccination) based on PBS number
  - AHW need to be valued for their role and to be given increased recognition for specific tasks - senior/trained AHWs to be compensated at higher level
  - Change in systems so Doctors would see patients after they have been processed by Nurse/AHW
- Guidelines for STI screening (similar to successful antenatal testing guidelines) - could suggest PAP smears and consultations for contraception as testing opportunities

2.5 Research

- Fund/support research efforts that study the per capita costing of providing appropriate STI and BBV care within Indigenous communities

The recommendations from the Summit will support achieving the following objectives and targets from the *Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy*.

**Objectives:**

- Improve knowledge and awareness of STI and BBV
- Reduce the incidence of STI in Aboriginal and Torres Strait Islander people and communities
  - Reduce the risk behaviours associated with transmission
  - Increase appropriate testing and follow up
- Eliminate the negative impact of stigma, discrimination and human rights issues on Aboriginal and Torres Strait Islander health
  - Increase engagement with Aboriginal and Torres Strait Islander communities through sustained and authentic action
  - Improve the delivery of and access to appropriate services

**Targets:**

- Eliminate congenital syphilis
• Reduce the incidence of chlamydia, gonorrhoea and infectious syphilis, accounting for testing levels, in people less than 30 years of age

3. Viral Hepatitis

It is essential to recognise the disproportionate burden of HCV infection on Indigenous communities which is increasing, and to respond accordingly.

3.1 Access to care

• Support and resource programs that provide locally-accessible care and treatment
  ○ Ensure assessment of people living with HCV - advanced liver disease/cirrhosis and HCC – Fibroscan, APRI testing and portable abdominal ultrasound are required
• Urgent access to new Direct Acting Anti-viral (DAAs) for Indigenous people living with HCV
• Ensure ACCHSs are ‘treatment-ready’ – workforce development around DAAs, community awareness of DAAs, close links with services that provide advanced care/management (fibroscan, abdominal ultrasound)
• Funding allocated towards models of care for rapid scale-up of DAAs in Indigenous communities - formation of collaborative partnerships between specialists/tertiary care centres and PHC services
  ○ PHC physicians, nurses and allied health staff education and training
• Allocate funding to ensure all susceptible Aboriginal and Torres Strait Islander adults have access to HBV vaccination
  ○ Ensure all at-risk individuals are tested for HBV and HCV

3.2 Workforce development

• Education and training for ACCHSs/AMS and PHC services to screen, treat and manage HBV and HCV
• Education and training for staff engaged in health promotion on the key messages around HBV and HCV for their local communities

3.2 Community engagement

• Funding directed towards programs that work to address viral hepatitis stigma and discrimination within Indigenous communities
• Funding of programs that promote testing for HBV/HCV
• Funding of programs that promote new DAAs and work to reduce stigma associated with previous HCV treatment
• Support and resource programs that build the capacity of Indigenous communities to advocate for their needs
• Support and resource programs that work to increase health literacy of Indigenous communities to increase their understanding of HBV and HCV

The recommendations outlined above will support achieving the following objectives and targets from the Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy.

Objectives:

• Improve knowledge and awareness of STI and BBV
• Reduce the incidence of BBV in Aboriginal and Torres Strait Islander people and communities
  o Achieve high levels of hepatitis B vaccination
  o Reduce the risk behaviours associated with transmission
  o Decrease the number of people with undiagnosed BBV
• Increase the number of Aboriginal and Torres Strait Islander people with BBV receiving appropriate management, care and support for BBV
• Eliminate the negative impact of stigma, discrimination and human rights issues on Aboriginal and Torres Strait Islander health
  o Increase engagement with Aboriginal and Torres Strait Islander communities through sustained and authentic action
  o Improve the delivery of and access to appropriate services

Targets:

• Increase the use of sterile injecting equipment for every injecting episode
• Increase the number of people with HIV, hepatitis C and hepatitis B receiving antiviral treatment

Summary

Recognising the multitude of factors that contribute to the disproportionate burden of STI and BBVs within Aboriginal and Torres Strait Islander people will ensure future public health policy is responsive and targeted. The Summit provided a platform where a variety of high-level stakeholders, from policy makers to AMS staff, could share ideas and discuss crucial issues. The summit looked at the underlying burden of STIs and BBVs within Indigenous communities, and considered the risk factors for potential outbreaks. This report outlines a suite of recommendations around HIV, STIs and viral hepatitis, which should be considered when developing future public health policy. Responding appropriately to the recommendations from the Summit will ensure measurable and tangible progress is made towards achieving the objectives and targets outlined in the Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy.
References


