



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

FINAL REPORT - APRIL 2016



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Supporting the HIV, Viral Hepatitis and Sexual Health Workforce



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Acknowledgments

SAHMRI, ASHM and the HIV Foundation of Queensland would like to acknowledge the entire ATSIHAW committee, and recognise that the *High level summit on rising HIV, sexually transmissible infections (STI) and viral hepatitis in Aboriginal and Torres Strait Islander communities* was an initiative of ATSIHAW. We also acknowledge the all the participants who attended, and contributed to, this important event.

SAHMRI, ASHM and the HIV Foundation of Queensland would also like to acknowledge the funding provided by the Department of Health.

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Key discussion points from the summit

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, Minister for Rural Health (via video message), acknowledged the increasing 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.

Day one of the program was dedicated to 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. Over the past five years rates of diagnosis have almost doubled that of non-Indigenous Australians something that has not been observed over the past 20 years of data collection. HIV exposure 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% cf to 80%), heterosexual sex (20% vs 13%), and injecting drug use (IDU - 16% vs 3%).¹ Furthermore, in 2014, 22% of Aboriginal and Torres Strait Islander people engaging in IDU, reported receptive syringe sharing.¹

Lessons to be learnt from overseas

- Particularly related to outbreaks, exposure categories, marginalised populations rural and remote populations
- Canada First Nations people particularly over represented in HIV data
- Illicit drug use injecting unsafely primary driver of HIV in Canada's First Nations population
- Inadequate service provision for PLWH and to prevent HIV once it had taken hold

Risk of outbreak

Indigenous Australians are at an increased risk of outbreaks of HIV due to the significant underlying burden of STIs as well as associated poor practices when using illicit drugs. The current syphilis outbreak across northern Australia (with almost 1000 cases notified) highlights the susceptibility of this population and underscored the importance of strong public health preparedness and response.

HIV prevention

'Combination prevention' methods should be the mainstay within Indigenous communities. This would include the provision of enhanced 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.

*It should be noted that significant work is required to ensure PrEP is available in Indigenous communities and the current cost of obtaining PrEP is a significant barrier for community members.

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.

Working groups summarised the issues for these groups as outlined in Table 1:

Table 1: Summary of HIV risk and outbreak issues for identifiable groups of Aboriginal and Torres Strait Islander people

Risk or vulnerability to an outbreak	
Group	HIV Risk factors and issues associated
Young people	<ul style="list-style-type: none">• Extensive and frequent mobility between different sexual and other networks• Risk behaviours particularly illicit drugs, and sex• Less access to health services• Need to combine with other services/strategies (domestic violence, AOD, resilience training)• Need to evaluate and promulgate what works
People who inject drugs (PWID)	<ul style="list-style-type: none">• Urban and rural differences (less equipment/NSP rurally?)• Drug of choice meth more occasions of injecting than opioids• Need to be able to get warning out• People who commence injecting in jail can learn poor practice• Particular risk issues for women (receptive sharing, injected by others)• Peer workers not in place in all AMS
MSM IDU - Vulnerability varies. MSM in rural/remote high risk of outbreak, in urban, more likely to be continual increase.	<ul style="list-style-type: none">• Need to take services to where people are• Gay community attachment• Drivers for risk are structural, homophobia, shame class• Testing for HIV• Access to ARV• Very little known of ARV uptake and UDVL• Limited access to PrEP
Women and Heterosexual: Risk is present	<ul style="list-style-type: none">• Urban and Outer regional• Alcohol and substance abuse and incarceration• Power imbalances (injecting risks)• Partners from high prevalence countries• Sex in high prevalence areas and with MSM
Torres Strait and PNG: Risk from South and North	<ul style="list-style-type: none">• Very small population mobile and dispersed across multiple communities- greater risk• Cross over from PNG and TSI increases risk

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 populations¹; Gonorrhoea rates were 69 times higher in Indigenous populations compared with non-Indigenous populations¹; and Infectious Syphilis was 304 times higher in Indigenous populations compared with non-Indigenous populations.¹ 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.² 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. Congenital Syphilis cases being diagnosed with this outbreak also highlight weaknesses in the response and an area which requires strengthening.

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. It should be noted however that single approaches to addressing STIs will not have an impact on endemic rates of STIs in those communities.

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 Australia³. 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 Australia⁵. Furthermore, mortality associated with *Hepatocellular carcinoma* (HCC) within Aboriginal and Torres Strait Islander people is far more pronounced than 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 within primary health care particularly needs to be normalised, systematic and within clinical guidelines monitoring and evaluation systems need to be implemented
- HIV testing for at-risk groups should be imbedded within continuous quality improvement (CQI) indicators
- Risk groups to be explicitly stated (MSM, IDU, Prison history, change sexual partners, partners of PWID)
- 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 prevention methods, and treatment options available
- Education and training to increase awareness of combination prevention strategies – condom access, NSPs, biomedical, education
- 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)
 - 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
- Continue to fund HIV Awareness campaigns

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
 - Acknowledge and respond to the differences between urban and rural communities
 - Acknowledge the importance of engaging local communities and ensuring responses are driven by local people/needs
 - Acknowledge the impact of shame and stigma on public health efforts
 - Acknowledge the underlying issues of alcohol and substance abuse within some communities, and the increased risk this has on potential outbreaks
 - 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
- Mass campaigns around testing and safe sex are required
- 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

2.4 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

3.3 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
 - Achieve high levels of hepatitis B vaccination
 - 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

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

1. The Kirby Institute. *Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: Surveillance and Evaluation Report 2015*. The Kirby Institute, UNSW Australia, Sydney NSW 2052.
2. Hengel B, Guy R, Garton L, Ward J, Rumbold A, Taylor-Thomson D, Silver B, McGregor S, Dyda A, Knox J, Kaldor J, Maher L. Barriers and facilitators of sexually transmissible infection testing in remote Australian Aboriginal communities: results from the Sexually Transmitted Infections in Remote Communities, Improved and Enhanced Primary Health Care (STRIVE) Study. *Sexual Health* 2015; 12: 4–12.
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Dean Smith

LIBERAL SENATOR FOR WESTERN AUSTRALIA

**Personal Message of support to attendees to the Summit on HIV, STI and HCV
Rates in Aboriginal and Torres Strait Islander Communities**

I am pleased to provide this message of support to all participants in this week's high level summit examining increasing rates of HIV, STI and HCV in our Aboriginal and Torres Strait Islander communities.

I am sorry that my parliamentary commitments in the Senate this week preclude my attendance in person.

Over many years, healthcare professionals, advocacy organisations and indigenous leaders have warned about the potentially devastating impacts of HIV in indigenous communities.

Living with HIV can be challenging for any Australian, but especially so in remote communities where access to education, information and treatment options is often limited.

I commend all participants in the Summit taking place over the next two days for their commitment and energy in helping to identify practical and innovative ways of tackling these challenges directly in communities.

I especially extend my thanks to the Australasian Society of HIV Medicine, the Queensland HIV Foundation and the South Australian Health & Medical Research Institute for taking the lead in organising this Summit, which I'm hopeful will produce invaluable discussions for stakeholders that will be to the long term benefit of indigenous communities.

My best wishes for a productive and informative Summit.



Dean Smith

NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HIV, STI AND VIRAL HEPATITIS SUMMIT

2 & 3 December 2015

Venue: Victoria Park Function Centre, Herston Rd, Brisbane



Australian Government
Department of Health

PROGRAM DAY 1: HIV



TIME	TOPIC	PRESENTER	SESSION STYLE
08:30 – 08:50	Registration		
09:00 – 09:05	Welcome	A/Prof James Ward	Introduction
09:05 – 09:10	Welcome to country	Aunty Carol Currie	Welcome
09:10 – 09:15	Address via video	Senator the Hon. Fiona Nash - Minister for Rural Health	Video Message
09:15 – 09:25	Summit opening	Hon. Cameron Dick - Queensland Minister for Health	Opening
09:25 – 09:30	Overview of Summit	A/Prof James Ward, Dr Darren Russell & A/Prof Levinia Crooks	Presentation
09:30 – 09:35	Video presentations - Neville Fazulla, Michelle Tobin	A/Prof James Ward	Video
09:35 – 09:55	Epidemiological data - Current trends & risk factors 2015	Dr Skye McGregor	Presentation
09:55 – 10:10	Lessons from abroad - relevant to Aboriginal and Torres Strait Island Australia	A/Prof James Ward	Presentation
10:10 – 10:50	What's in the HIV prevention tool-box? Review of the evidence: 1. Combination prevention 2. Testing 3. Treatment	1: Dr Marlene Kong 2: A/Prof Levinia Crooks 3: Dr Darren Russell	Presentations
10:50 – 11:10	MORNING TEA		
11:10 – 11:55	Risk matrix: - IDU - MSM - Torres Strait Islander & PNG communities - Heterosexual/Women - Young people	Facilitator: Ms Elisha McGuinness Group work leaders x 5: Ms Annie Madden Mr Brent Mackie Dr Darren Russell Dr Annie Preston - Thomas Dr Judith Dean	Facilitated Group Work
11:55 – 12:10	Risk matrix feedback from groups and discussion	Facilitator: Ms Elisha McGuinness	Group Work
12:10 – 12:55	Strengthening HIV control in existing primary health care settings	Facilitators: Dr Darren Russell & A/Prof James Ward Panel: ACCHS GPs	Panel Discussion
12:55 – 13:05	Launch of HIV Australia Special Ed.	Dr Bridget Haire	Presentation
13:05 – 13:45	LUNCH		
13:45 – 14:20	Outbreak response: Hypothetical scenarios - settings based approach - Urban, Remote & Rural	Facilitator: Dr Christine Selvey Group work leaders x 6: TBC	Facilitated Group Work

14:20 - 14:55	Outbreak response: case studies	<i>Presenters: Dr Marissa Gilles, Ms Penny Francis, Dr Mary Belfrage & Dr Darren Russell</i>	<i>Presentation</i>
14:55 - 15:20	HIV POCT	<i>Panel: A/Prof Rebecca Guy Ms Sara Bell</i>	<i>Panel Discussion</i>
15:20 – 15:45	AFTERNOON TEA		
15:45 – 16:30	Where to from here?	<i>Facilitators: Dr Darren Russell, A/Prof Levinia Crooks & A/Prof James Ward</i>	<i>Group Discussion</i>
16:30	DRINKS & CANAPES		

PROGRAM DAY 2: STIs & Viral Hepatitis

TIME	TOPIC	PRESENTER	SESSION STYLE
08:30 – 08:40	Introduction and welcome	<i>A/ Prof James Ward</i>	<i>Introduction</i>
08:40 – 09:20	STIs in Indigenous Communities	<i>A/Prof James Ward & A/Prof Rebecca Guy</i>	<i>Presentation</i>
09:20 – 09:45	Syphilis outbreak - Northern Australia	<i>Dr Nathan Ryder</i>	<i>Presentation</i>
09:45 – 10:20	What are the options in STI control?	<i>TBC</i>	<i>Presentation</i>
10:20 – 10:45	Discussion	<i>Facilitators: Dr Darren Russel & A/Prof Rebecca Guy</i>	<i>Group Discussion</i>
10:45 – 11:10	MORNING TEA		
11:10 – 11:35	STI POCT	<i>A/Prof Rebecca Guy</i>	<i>Presentation</i>
11:35 – 12:10	STI control in primary health care settings	<i>Panel: ACCHS PHMOs and GPs</i>	<i>Panel Discussion</i>
12:10 – 12:45	STIs - Where to from here?	<i>Facilitators: A/Prof James Ward & Dr Darren Russell</i>	<i>Group Discussion</i>
12:30 – 13:30	LUNCH		
13:30 – 13:50	HCV Treatment Update	<i>Dr Krispin Hajkowicz</i>	<i>Presentation</i>
13:50 – 14:25	Management issues and other aspects of treatment and care in community based/primary health care	<i>Facilitator: A/Prof Ben Cowie ACCHS GPs & others</i>	<i>Presentation Group Discussion</i>
14:25 – 14:40	HCV - Where to from here?	<i>Facilitators: Dr Krispin Hajkowicz and A/Prof Ben Cowie</i>	<i>Group Discussion</i>
14:40 – 15:00	AFTERNOON TEA		
15:00 – 15:30	HBV Guideline Update	<i>A/Prof Ben Cowie</i>	<i>Presentation</i>
15:30 – 16:30	Issues around implementation of guidelines	<i>Facilitators: Dr Krispin Hajkowicz and A/Prof Ben Cowie</i>	<i>Group Discussion</i>
16:30 – 17:00	HBV - Where to from here?	<i>Facilitator: A/Prof Ben Cowie</i>	<i>Group Discussion</i>
17:00	CLOSE		



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ATSIHAW

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

ATTENDEE LIST

Name	Organisation	Position
John Kaldor	University of New South Wales (UNSW)	Professor of Epidemiology and NHMRC Senior Principal Research Fellow
Alison Kerr	Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)	Project Officer – Viral Hepatitis
Angela Cooper	Townsville Sexual Health Services	HIV, Hepatitis & Sexual Health Coordinator, North QLD
Arun Menon	Townsville Sexual Health Unit	Sexual Health Physician
Brett Mooney	Queensland AIDS Council	Program Manager
Bridget Haire	Australian Federation of AIDS Organisations (AFAO), UNSW	President, Lecturer - Bio Ethics
Carla Gorton	Cairns Sexual Health Service	Sexual Health, HIV & Viral Hepatitis Coordinator
Daniel Gallant	South Australia Department of Health	Program Manager STIs HIV and Viral Hepatitis
Darren Russell	Cairns Sexual Health Service	Director Cairns Sexual Health
Dr David Johnson	Aboriginal Health Council of South Australia (AHCSA)	Public Health Medical Officer
Dr David Scrimgeour	Spinifex Health Service	Medical Director
Donna Ah Chee	Central Australian Aboriginal Congress Inc. (CAAC)	Chief Executive Officer
Dr Alex Hope	Aboriginal Medical Services Alliance Northern Territory (AMSANT)	PHMO - Regionalisation Development Unit
Dr Alun Richards	Queensland Health	Director
Dr Annie Preston-Thomas	Queensland Health	Public Health Medical Officer
Dr Carmel Nelson	Institute for Urban Indigenous Health	Clinical Director
Dr Caroline Harvey	Public Health Registrar	ATSICHS Brisbane
Dr Christine Selvey	Communicable Diseases Branch, Health Protection NSW	Medical Epidemiologist
Dr John Boffa	Central Australian Aboriginal Congress (CAAC)	Senior Medical Officer
Dr Marianne Wood	Aboriginal Health Council of Western Australia (AHCWA)	Public Health Medical Officer
Dr Marlene Kong	The Kirby Institute	Program Head
Dr Rae-Lin Huang	Nganampa Health Council	STI Control and HIV Prevention Co-ordinator
Dr Theo van Lieshout	Queensland Department of Health	Public Health Physician
Frida Svensson	South Australian Health and Medical Research Institute (SAHMRI)	Administration
Leonor Nacua	Department of Health	Assistant Director - BBV & STI Section, Health Protection Policy Branch
James Ward	South Australian Health and Medical Research Institute (SAHMRI)	Head Infectious Diseases Research Aboriginal Health Infection and Immunity Theme
Jill Coole	Kimberley Aboriginal Medical Services Ltd (KAMS)	Senior Manager Population Health
Linda Forbes	Australian Federation of AIDS Organisations (AFAO)	Manager Policy
Lyn Brodie	Senator the Hon Fiona Nash / Minister for Rural Health	Adviser
Michael Scott	Queensland AIDS Council Inc.	Executive Director
Morgan Dempsey	Cairns Sexual Health Service	Manager AHWs
Belinda Ford	The Kirby Institute	Project Officer – Aboriginal and Torres Strait Islander Program
Mr Victor Tawil	NSW Ministry of Health	Centre for Population Health - Aboriginal Access
Ms Megan Tapia	The Kirby Institute	Research Support Officer
Neville Fazulla	Community	Executive Indigenous Spokesperson - NAPWHA
Owain Williams	University of Queensland (Public Health)	Senior research fellow
Penny Francis	North Richmond Community Health Limited	Alcohol and Drug Team Leader
Phillip Sario	Queensland AIDS Council	Program Manager
Rebecca Guy	The Kirby Institute	Head of Surveillance

Rhondda Lewis	Cairns Sexual Health Service	Viral Hepatitis Health Practitioner
Rob Lake	Australian Federation of AIDS Organisations (AFAO)	Executive Director
Rob Page	Pius X Aboriginal Medical Service	General Practitioner
Robert Kemp	Communicable Diseases Unit, Queensland Health	Principal Policy Officer Viral Hepatitis, Blood Borne Viruses & Sexually Transmissible Infections (BBV/STI) Unit
Sallie Cairnduff	Aboriginal Health & Medical Research Council (AH&MRC)	Manager - Public Health Unit
Sam White	Hepatitis Queensland	Program Support Officer
Skye McGregor	The Kirby Institute	Surveillance officer
Vanessa Towell	Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)	Program Manager - Viral Hepatitis
Zane Roe	Princess Alexandra Sexual Health (PASH)	A&TSI Indigenous Health Worker
Dave Wild	Nunkuwarrin Yunti of South Australia Inc.	Health Promotion Team Manager Harm Minimisation
Mikael Larkin	Aboriginal Health Council of South Australia (AHCSA)	Blood Borne Virus Program Coordinator
Krispin Hajkowicz	Queensland Health	Infectious Diseases Physician
Associate Professor Benjamin Cowie	Doherty Institute, Monash University	Infectious Diseases Physician, Associate Professor
Michael West	Department of Health and Human Services	A/Manager, Sexual Health and Viral Hepatitis
Judith Dean	The University of Queensland	Post Doctoral Research Fellow
Nathan Ryder	Hunter New England Local Health District	Sexual Health Physician
James Saunders	Aboriginal Nations Torres Strait Islander HIV Youth Mob (ANTHYM)	Coordinator
Dr Stephen Lambert	Queensland Department of Health	Medical Epidemiologist
Dr Carolyn Lang	Queensland Government	Advanced Epidemiologist
Amanda Wingett/Greg Richards	Aboriginal and Torres Strait Islander Health Branch	Senior Policy and Planning Officer
Tony Majer	HIV Foundation Queensland	CEO
Dr Jeff Gow	HIV Foundation Queensland	Professor of Economics, Board Member
Andrew Redmond	HIV Foundation Queensland	ID Physician, Board Member
Melissa Warner	HIV Foundation Queensland	Principal Public Health Officer
Samuel Catling	HIV Foundation Queensland	Media and Marketing Communications Manager
Bridgette Whittle	South Australian Health and Medical Research Institute (SAHMRI)	Senior Marketing and Development Associate
Dr Clare Nourse	ANZ Paediatric Infectious Diseases	Physician
Levinia Crooks	Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)	Chief Executive Officer
Karen Price	ACON	Director HIV and Sexual Health
Nik Alexander	QuiHN (Queensland Injectors Health Network)	Senior Program Manager for Harm Reduction Services
Nicola Hayes	QuiHN (Queensland Injectors Health Network)	Senior Program Manager
Brent Mackie	ACON	Manager Community Partnership and Population Programs
Dr Mary Belfrage	Victorian Aboriginal Health Service (VAHS)	Senior Medical Officer
Lisa Bastian	WA DoH - Public Health and Clinical Services Division	Manager Sexual Health & Blood-borne Virus Program
Annie Madden	Australian Injecting and Illicit Drug Users League (AIVL)	CEO
Sione Crawford	Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)	CEO
Dr Anita Groos	Queensland Government	Principal Public Health Officer
Bill Paterson	National Association of People With HIV Australia (NAPWHA)	Operations Manager
Fiona Poeder	NSW Users and AIDS Association (NUAA)	Programs Manager
Dr Gracelyn Smallwood	James Cook University	Professor
Lisa Fitzgerald	University of Queensland	Lecturer - School of Public Health
Benny Marshall	Public Health	
Mark Saunders	National Aboriginal Community Controlled Health Organisation (NACCHO)	Research Officer
Charles Gilkes	University of Queensland	Head of School & HIV/STI Prof Chair
Dion Tatow	Queensland Aboriginal and Islander Health Council (QAIHC)	Senior Policy Officer – Mental Health
Dr Marissa Gilles	Health Department of Western Australia	Public Health Physician
Dr Michael Costello	University of New South Wales (UNSW)	Senior Lecturer - School of Women's and Children's Health
Stephanie Green	HIV Foundation Queensland	Project Support Officer