Western Australian Aboriginal Sexual Health Strategy 2005–2008

October 2005

FOREWORD

The *Western Australian Aboriginal Sexual Health Strategy 2005-2008* is the first of its kind in Western Australia (WA). The Strategy recognises the importance of a comprehensive approach to sexual health, and outlines a framework for engaging communities and service providers to bring about improvements in sexual health.

Sexually transmitted infections (STIs) pose serious risks to reproductive health, yet are preventable, and most are easy to treat with antibiotics. This Strategy provides an opportunity to concentrate and coordinate efforts in prevention and treatment in order to reduce the unacceptably high rates of STIs which burden the health of Aboriginal people. Of particular concern is the high incidence of STIs in young Aboriginal people, and the Strategy gives prominence to working across sectors to engage with this high risk group.

The WA Strategy will complement the *National Aboriginal and Torres Strait Islander Sexual Health and Blood-borne Virus Strategy 2005-2008* and the *National Sexually Transmitted Infections Strategy 2005-2008*. All three Strategies recognise the importance of partnerships between communities, health care providers and other agencies to address the complex issues related to sexual health.

There is already much valuable work being undertaken in Aboriginal sexual health, and this Strategy seeks to build on this. I would like to acknowledge the support of, and valuable contributions made by, people across WA in the development of the Strategy, including community members and those working in government departments and non-government organisations. The generosity and interest shown are signs that there is a real willingness to work together, and I am optimistic that this spirit of engagement will carry through to successful implementation of the Strategy.

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MINISTER FOR HEALTH

GLOSSARY OF NAMES AND TERMS

ACCHS	Aboriginal Community Controlled Health Services
AFAO	Australian Federation of AIDS Organisations
AHW	Aboriginal Health Worker
AIDS	Acquired Immune Deficiency Syndrome
BBV	Blood-borne Virus
CDCD	Communicable Disease Control Directorate
DAO	Drug and Alcohol Office
DCD	Department for Community Development
DIA	Department of Indigenous Affairs
DoET	Department of Education and Training
DOH	Department of Health
DoJHS	Department of Justice Health Service
EPS	Explicit Performance Standards
FPWA	Family Planning WA
GP	General Practitioner
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
IASHC	Indigenous Australians' Sexual Health Committee
IDU	Injecting Drug Use
MSM	Men who have Sex with Men
NATSISHBBVS	National Aboriginal and Torres Strait Islander Sexual Health and Blood-borne Virus Strategy 2005-2008
NIASHS	National Indigenous Australians' Sexual Health Strategy
NHMRC	National Health and Medical Research Council
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OCYA	Office of Children and Youth Affairs
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PHCAP	Primary Health Care Access Program
PHU	Population Health Unit
PID	Pelvic Inflammatory Disease
PLWHA	People Living with HIV/AIDS
SHBBVP	Sexual Health and Blood-borne Virus Program
STI	Sexually Transmitted Infection
WA	Western Australia(n)
WACHAS	WA Committee on HIV/AIDS and Sexually Transmitted Infections
WAAC	Western Australian AIDS Council Inc.
WAISHAC	Western Australian Indigenous Sexual Health Advisory Committee
WANIDD	Western Australian Notifiable Infectious Disease Database
WHO	World Health Organization

CONTENTS

EXECUTIVE SUMMARY

Background

Despite the efforts of many individuals and agencies, and a State-wide review of sexual health services in the mid 1990s, rates of sexually transmitted infections (STIs) in Aboriginal people in Western Australia (WA) have remained unacceptably high for many years.

Recognising the need for a better coordinated population health response, in December 2003, the WA Indigenous Sexual Health Advisory Committee (WAISHAC) requested that the Sexual Health and Blood-borne Virus Program (SHBBVP) within the WA Department of Health (DOH) develop a WA Aboriginal Sexual Health Strategy. The WA Strategy, along with the National Aboriginal and Torres Strait Islander Sexual Health and Blood-borne Virus Strategy 2005-2008 (NATSISHBBVS) provides a framework that will guide policy makers, planners and those involved in sexual health service provision in WA.

The WA Aboriginal Sexual Health Strategy 2005-2008 outlines a comprehensive approach to primary health care and population health to improve sexual health indicators for Aboriginal people living in WA. The Strategy aims to guide government action over the next three years and beyond through the provision of a coordinated, collaborative and multi-sectoral approach to sexual health policy development and service provision that is supported by Aboriginal health-care providers and other stakeholder organisations.

Development

One of the major achievements in WA to date has been the development of effective partnerships between the Commonwealth and WA Governments, Aboriginal Community Controlled Health Services (ACCHS) and other relevant organisations. These partnerships have become the cornerstone of the development of the Strategy and will provide a solid base for its implementation.

The WAISHAC has representation from the State and Commonwealth Departments of Health, ACCHS, and other government and non-government organisations involved in sexual health policy development and service provision. The Committee guided the development of successive drafts of the Strategy and advised on consultation processes.

A *Draft for Discussion* was released in January 2005, outlining the principles of partnerships and comprehensive programs, proactive community responses, and primary health care approaches. The SHBBVP coordinated an extensive state-wide consultation process which generated considerable interest and participation from Aboriginal community organisations and human services sectors across government, including corrective services, welfare organisations and educational institutions. Importantly, youth services showed particular interest and support for the Strategy.

Evidence Base

STIs can cause infertility in both men and women. The presence of STIs enhances the spread of HIV, itself a sexually transmitted virus, and can also have serious consequences on the health of newborn infants. All STIs are preventable and some are easily treated with antibiotics.

Of particular concern is the continuing high incidence of STIs in Aboriginal youth. In 2004, those aged 15 to 19 years were 158 times more likely to be notified with gonorrhoea and 15 times more likely to be notified with chlamydia than non-Aboriginal youth of the same age.

The limited published material available on effective sexual health programs for Aboriginal people indicates that the most effective strategies include enhanced primary care services and comprehensive approaches. A reduction in high rates of STIs in Central Australia on the Anangu Pitjantjatjara Lands in the mid 1990s was attributed to a comprehensive sexual health program known as the 'Eight Way Model'. This model has been replicated, with good results, in the Ngaanyatjarra Lands in WA, and is used as the framework for this Strategy. The full engagement of communities is essential to the success of this model, requiring ongoing efforts in all areas of culturally appropriate service delivery, including:

1. Planning and management
2. Health promotion and community education
3. Data collection and monitoring
4. Health hardware
5. Clinical services
6. Training
7. Research
8. Evaluation.

Commitment

The Strategy is a plan to guide sexual health services for Aboriginal people living in WA over the next three years, and has been endorsed by WAISHAC and the WA Committee on HIV/AIDS and Sexually Transmitted Infections (WACHAS). Successful implementation of the Strategy will require contributions from agencies in both the government and non-government sectors, including the Departments of Justice, Community Development and Education, as well as ACCHSs, FPWA (formerly Family Planning WA), and youth agencies such as those funded through local government. The main aims of the Strategy are to:

- improve the sexual health of Aboriginal people living in WA, including reducing the transmission of STIs and HIV, and the number of unwanted pregnancies
- reduce the burden of disease of STIs and HIV on the WA Aboriginal population
- reduce the social stigma and shame associated with HIV and STIs within the Aboriginal community
- increase the involvement of Aboriginal people in the design and implementation of sexual health services.

The Strategy complements the *National Aboriginal and Torres Strait Islander Sexual Health and Blood-borne Virus Strategy 2005-2008*, the *5th National HIV/AIDS Strategy 2005-2008 and the National Sexually Transmitted Infections Strategy 2005-2008*. All three Strategies recognise the importance of partnerships between communities, health care providers and other agencies to address the complex issues related to sexual health.

In parallel with the development of the Strategy, a Regional STI Project has been implemented with the establishment of three Sexual Health teams located in the Pilbara, Kimberley and Goldfields Regions, respectively. These teams are working closely with Regional Population Health Units, ACCHSs, and other agencies and communities to coordinate and augment existing sexual health services for Aboriginal people.

The Strategy's principles of comprehensive sexual health service delivery and Aboriginal community ownership underpin the work of the Regional Sexual Health Teams, and the eight areas of activity in the Strategy will provide a framework for the Regional STI Project's performance indicators.

SECTION 1: INTRODUCTION

1.1. Why a Western Australian Aboriginal* Sexual Health Strategy?

Rates of sexually transmitted infections (STIs) in Aboriginal people in Western Australia (WA) have been unacceptably high for many years. STIs can have serious effects on the health of newborn infants and on reproduction, causing infertility in both men and women. High rates of infection place a significant burden of ill health on individuals, families and communities and increase the potential for a human immunodeficiency virus (HIV) epidemic in Aboriginal people.

The public health importance of STIs in the Western Australian Aboriginal community should not be underestimated. It is time for a coordinated, comprehensive response that is sustained over several years and has wide support. In 2003 the Western Australian Indigenous Sexual Health Advisory Committee (WAISHAC) initiated the development of a Western Australian Aboriginal Sexual Health Strategy. WAISHAC has representation from the State and Commonwealth Departments of Health, Aboriginal Community Controlled Health Services (ACCHSs) and other government and non-government organisations involved in sexual health policy development and service provision.

Prevention of new STI and HIV infections depends largely upon promotion of safe sexual behaviour, such as having fewer sexual partners, using condoms, not sharing injecting equipment, and effective, early treatment of STIs. [1] For Aboriginal people there are added issues, such as access to appropriate services. However, the skills and access to services that enable preventive behaviours are often difficult to achieve, especially for those who are young and faced with geographical, social or cultural barriers.

The traditional mainstream health approach has been to treat the disease rather than looking at causal pathways and other underlying issues. For example, STI incidence is usually higher in communities where there is ongoing social disadvantage, including unemployment and poverty. Poor access to sexual health services also leads to higher rates of STIs. While the impetus for this Strategy comes from the high rates and health impacts of STIs, it is important to focus on all the elements that contribute to poor sexual health, including social, economic, historical and structural elements.

Because of the multiple determinants of ill health, STIs and HIV have wide social implications and require ambitious and imaginative responses. The Strategy recognises the importance of broader sexual health issues, such as the contribution of harmful alcohol and drug use and sexual violence, but it is not within the scope of this Strategy to address these issues in isolation. It is hoped that linkages with other strategies will help to address these associated problems.

The Strategy is written for policy makers, leaders in the WA Aboriginal community, health care professionals and other related service providers. To be effective, the Strategy needs sustained and committed partnerships between the government and the non-government sector including ACCHS, Divisions of General Practice and other agencies.

The National Indigenous Australians' Sexual Health Strategy Implementation Plan (NIASHS) for 2001/02 to 2003/04 states:

> An effective response to Indigenous sexual health cannot be sustained by the health sector alone, much less by narrowly defined program areas within the sector. [2]

*This Strategy acknowledges that Aboriginal and Torres Strait Islander people are the original peoples of Australia. For the purposes of this Strategy, however, the term Aboriginal will be used in preference to "Aboriginal and Torres Strait Islander" in recognition that Aboriginal people are the original inhabitants of Western Australia.

The Strategy recognises the need to develop partnerships with agencies that do not have sexual health as their core business. Effective sexual health strategies will require working in partnership with, for example, the Departments of Justice, Education and Training, and Community Development and Youth Affairs. Partnerships will also need to be developed with non-government agencies involved in youth work, education and welfare.

Most importantly, the Strategy needs the support and involvement of the WA Aboriginal community to address the complex sexual health issues affecting its people.

The Strategy will be supported by an Implementation and Evaluation Plan to be developed in consultation with key stakeholders.

1.2. Sexual Health

The Strategy embraces the sexual health rights outlined in the *National Indigenous Australians' Health Strategy (NIASHS) 1996-97 to 2003-04* [3]:

- the right to enjoy and control sexual and reproductive behaviour in accordance with cultural values, kinship practices and individual ethics
- freedom from fear, shame, guilt and myths about choice of sexuality and sexual relationships
- freedom from diseases that are treatable or preventable, or both, and that may interfere with sexual life
- freedom from practices that interfere with the sexual health and emotional well-being of the individual

It is hoped that the Strategy will promote ongoing discussions about sexual health issues by Aboriginal people living in WA.

1.3. Aims

The main aims of the Strategy are to:

- improve the sexual health of Aboriginal people living in WA, including reducing the transmission of STIs and HIV and the number of unwanted pregnancies
- reduce the burden of disease of STIs and HIV on the WA Aboriginal population
- reduce the social stigma and shame associated with HIV and STIs within the Aboriginal community
- increase the involvement of Aboriginal people in the design and implementation of sexual health services.

1.4. Principles

There are three key principles underpinning the Strategy:

- partnerships and comprehensive programs
- proactive community responses
- primary health care approaches.

1.4.1. Partnerships and Comprehensive Programs

Since 1989, the Australian Government has released successive National HIV/AIDS Strategies, with partnerships being a key principle in each. Effective partnerships involve all levels of government, people living with or affected by HIV/AIDS, community organisations, and the medical and scientific communities working together to minimise the social and personal impacts of the disease. [4]

Effective sexual health programs are well planned and managed and involve community education, health promotion, data collection, clinical services, as well as training programs to support all of these activities. They also require strong links between the agencies, individuals and communities that provide and use these services, including public and community health services, ACCHS, primary health care medical services, hospital services, schools, youth organisations, the Departments of Justice and Education and Training, women's and men's organisations, and so on. Comprehensive sexual health programs therefore rely heavily on effective partnerships.

The Indigenous Australians' Sexual Health Committee reported in the *NIASHS Implementation Plan 2001/02 to 2003/04* that:

> Strong partnerships based on effective communication, mutual respect and shared commitment inevitably lead to improved outcomes. [2]

The NIASHS Implementation Plan lists a set of principles that underpin effective partnership processes with Indigenous people [2] and these are endorsed by the Strategy. They include:

1) Indigenous ownership of Indigenous health
Indigenous people being able to participate and have control over processes involving the decision-making and planning at all levels, and a shared understanding of the value of the Aboriginal community-controlled health sector.

2) Recognising and respecting the value of the differing perspectives, knowledge and experience of partners
The need to ensure that partnerships acknowledge and accept the unique qualities of all those involved, and to recognise and address any power imbalances that may eventuate.

3) Transparency of decision-making
The need to ensure that, at all levels, the process of decision-making is transparent, the process is meaningful to all concerned, and there is a structure in place that allows for members to seek redress if necessary.

1.4.2. Proactive Community Responses to Sexual Health

Community ownership of problems and solutions has been an important key to success in STI/HIV programs in Australia and overseas. In contexts as different as Anangu Pitjantjatjara lands in South Australia [5], Uganda in Africa [6] and San Francisco in the United States of America [7], the engagement of community leaders and affected individuals has played a key role in reducing the transmission of STIs/HIV.

The Strategy recognises that, when provided with accurate and appropriate information, Aboriginal communities have the capacity to develop responses that will work for them. Greater effort is needed to build Aboriginal community capacity to work effectively with these issues, through educating Aboriginal people about sexual health, and supporting individuals, families and communities to assume leadership roles.

1.4.3. Primary Health Care Approach

Primary health care (PHC) in an Aboriginal context refers to a community-based approach that allows communities to participate in the design and delivery of services [3]. The World Health Organization (WHO) *International Conference on Primary Health Care, Alma-Ata: Twenty-fifth Anniversary* [8] identified the need for equity in the delivery of health services, particularly to the level of communities' legitimate expectations. The Conference also recognised that shortcomings in the implementation of PHC are often attributed to poor leadership, lack of political commitment, inadequate resources and unrealistic expectations of what can be delivered by PHC. [9] PHC should include education for communities on prevention and control of major health issues, and recognition of the importance of links between the environment and disease.

Another definition of PHC incorporates personal care with health promotion, the prevention of illness and community development. [10] It follows that PHC includes the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It also encompasses an understanding of the social, economic, cultural and political determinants of health. [10]

A further definition of PHC, developed for conditions in Australia, seeks to extend the first level of the health system from diagnosis to treatment to the development of health. [11] It seeks to protect and promote the health of defined communities, and to address individual and population health problems at an early stage. It involves continuity of care, health promotion and education, integration of prevention with treatment, a concern for population as well as individual health, community involvement and the use of appropriate technology.

The Strategy recognises there are often complex issues involved in trying to introduce a sexual health program into an existing PHC service. When using a 'specialist' vertical program, there are concerns about sexual health workers being stigmatised because of negative perceptions associated with working in the area of STI/HIV prevention and control. When the business of sexual health is incorporated into broader responsibilities, so that sexual health activities are spread across a health service, the ongoing challenge is to maintain sexual health as a priority, and to recognise the importance of health promotion and asymptomatic case-finding.

Research has shown that access to services is a key issue for Aboriginal people, and this is especially so in the sensitive area of sexual health. Improving access to services includes both providing a service where previously there was none, and the refinement of existing services to make them more accessible for social, cultural and geographic reasons. Considerations of accessibility include perceived confidentiality, safety and cultural security. Depending on location, services may take the form of community nursing posts, hospital emergency departments, ACCHS or General Practitioner services or occasional visits to remote communities by health professionals,. While it is acknowledged that the ACCHS environment can provide cultural security and effective counselling and follow-up, it should be kept in mind that community members may opt to use community nursing posts or hospital emergency departments for STI services in order to preserve their anonymity. However, a situation where emergency departments are the only service for STI is far from ideal, and wherever possible, any geographical area should aim to provide a choice of services so that people can make decisions about the best environment for them. Partnerships and local solutions involving ACCHS, hospitals, community health and Population Health Units (PHUs) are essential for the provision of culturally safe sexual health to Aboriginal people in ways that are respectful and professional.

1.5. Organisation of the Strategy

The Strategy is divided into a number of sections:

- **The Policy context**, which provides information on the linkages and relevance of past and current state and national strategies to the *WA Aboriginal Sexual Health Strategy 2005-2008*
- **Epidemiology of STIs/HIV in WA**
- **Priority groups**
- **Comprehensive Sexual Health Programs in Aboriginal Communities**
- **Sexual Health Strategy Targets 2005-2008.**

SECTION 2: POLICY CONTEXT

2.1. NIASHS 1996-97 to 2003-2004 and Implementation Plan 2001-02 to 2003-04; National Aboriginal and Torres Strait Islander Sexual Health and Blood-borne Virus Strategy 2005-2008 (NATSISHBBVS)

The NIASHS [2] and the NATSISHBBVS [12] have enabled Aboriginal communities to engage in the process of identifying appropriate sexual health initiatives. The NATSISHBBVS is built around five key areas:

- Partnerships
- Prevention
- Diagnosis, Care and Support
- Workforce
- Research and Data.

Many of the priority actions in each of these five areas are reflected in the priorities of the WA Strategy.

2.2. National HIV/AIDS Strategies 1989 to 2005 and National Sexually Transmitted Infection Strategy 2005-2008

The Australian Government's response to HIV/AIDS has included five National HIV/AIDS Strategies [4], the first being released in 1989. Each of these Strategies has recognised the ongoing threat of HIV/AIDS in Aboriginal communities. This threat continues in the context of other risks experienced by Aboriginal communities, including high rates of incarceration, substance misuse and injecting drug use, and other social determinants of health including inadequate housing and ongoing economic disadvantage. [4]

The *National STI Strategy 2005-2008* [13] identifies three priorities, the first being STIs in Aboriginal and Torres Strait Islander Communities. It reinforces many approaches identified in the NATSISHBBVS, including workforce development, improved access to treatment and care in the primary care setting, and augmented behavioural and social research. In addition, the National STI Strategy recommends improved collection and use of surveillance data, and education and health promotion especially for young people, and gay and other homosexually active men.

2.3. Explicit Performance Standards (EPS) for a State-wide Plan to Improve the Quality of Health Outcomes for Sexually Transmissible Diseases

In response to the high rates of STIs in Aboriginal communities in WA, a review was conducted in 1995-96 to improve outcomes of care. This review, known as the EPS, identified the following three priorities [14]:

- system-wide organisation and performance
- preparation and maintenance of the workforce
- roles and responsibilities at the local level.

The Strategy will endeavour to identify and promote those aspects of EPS that remain relevant, and strengthen or implement them as appropriate.

2.4. Other Relevant National and State Documents

Other relevant National and WA Strategies include*:

- *HIV/AIDS and Sexually Transmitted Infections: Education and Prevention Plan for Western Australia (2002)*
- *HIV/AIDS Treatment and Care Plan for Western Australia (2001)*
- *National Strategic Framework for Aboriginal and Torres Strait Health: Framework for action by Governments (2003)*
- *The National Indigenous Gay and Transgender Project and Sexual Health Strategy (1998)*
- *The National Communicable Diseases Surveillance Strategy (1996)*
- *The National Hepatitis C Strategy (2005)*
- *The National Drug Strategic Framework 1998-99 to 2002-2003 Building Partnerships (1998)*
- *The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, 2003*
- *The National HIV Testing Policy (1998)*

2.5. The Primary Health Care Access Program (PHCAP)

The aims of PHCAP are to improve access and provision of appropriate PHC. [15] In the Kimberley and the Pilbara, ACCHS are involved in partnership with the Commonwealth and State Governments in implementing this initiative. The key objectives of PHCAP are to:

- reorient the existing health system so that it is more appropriate to Aboriginal people
- increase the accessibility of appropriate primary health services
- provide capacity for Aboriginal people and communities to take greater responsibility for their own health.

The Strategy will need to coordinate with PHCAP planning processes to ensure that there are shared aims in the provision of sexual health PHC services in WA.

2.6. Summit on Aboriginal STIs, 24 September, 2003

Following concerted efforts to inform agencies and the Aboriginal community of the health risks posed by high rates of STIs, a Summit was held in September 2003 to draw high-level attention to this issue. The Summit noted concern at the unacceptably high rates of STIs among Aboriginal people in WA, and the burden of ill health this places on individuals, families and communities**. Concern was also expressed about the potential for an Aboriginal HIV epidemic.

It was acknowledged that the Aboriginal community has a right to know about its health status, including access to quality information about STIs. Such information should be disseminated in an appropriate format so as to be understood and meaningful for civic leaders and community members.

* For a copy of the documents listed please contact the Sexual Health and Blood-borne Virus Program, Department of Health.

** For a copy of the Summit report, please contact the Sexual Health and Blood-borne Virus Program, Department of Health.

Poor access to services was identified as a major contributing factor to the rates of STIs, and the need for improvements to prevention and care were identified. The Summit noted that PHC approaches are critical for access to comprehensive and appropriate health care, health information and health promotion, and that prevention and sexual health promotion should become a core priority of all services providing PHC to Aboriginal people in WA. The need for training programs to provide skilled workers was also noted.

Most of the issues identified from the Summit have been incorporated into this Strategy. One of the main outcomes from the event was the high level of Aboriginal community participation and involvement. This engagement has continued through the consultations for this Strategy during 2005.

SECTION 3: EPIDEMIOLOGY OF STIs/HIV IN WA

This section provides information on STIs and HIV in Aboriginal and non-Aboriginal people living in WA.

3.1. Demography of Aboriginal People in WA

In the 2001 Census, the WA population was 1.9 million. The WA Aboriginal population was 66,000, representing 3.5 per cent of the total population, and 14 per cent of the total Aboriginal population of Australia. WA has the third highest Aboriginal population behind New South Wales (29 per cent) and Queensland (27 per cent) [16]. Around a third of the WA Aboriginal population live in the Perth metropolitan area and two-thirds live outside, many in remote areas. In the Kimberley region, 42 per cent of the total population is Aboriginal, compared with the Perth metropolitan area where Aboriginal people represent only 1.3 per cent of the population. [17] The WA Aboriginal population is younger than the non-Aboriginal population. In 2001, 57 per cent of Aboriginal people were aged less than 25 years compared to 35 per cent of the non-Aboriginal population [17].

3.2. Poverty, STIs and HIV

Aboriginal people experience disproportionate levels of disadvantage, which are often reflected in health related problems. [18] The life expectancy for Aboriginal people is also considerably lower than for non-Aboriginal people. For example, the life expectancy for Indigenous males born in 1999-2001 is 56.3 compared with 77.0 years for total males, and for Indigenous females it was 62.8 years compared with 82.4 years for total females. [18]

International studies show a link between poverty and the spread of HIV. Social inequalities in income and employment status are powerful predictors of HIV infection, with low income and high levels of unemployment linked to greater exposure to risky sexual experiences. [19] People living in poverty also have diminished access to health information, absent or delayed diagnosis and treatment, and less concern about health and the future because of, difficulties in the present. [19]

3.3. Notification Systems for HIV and STIs

The WA *Health Act 1911* requires notification to the Department of Health (DOH) of six STIs: chancroid, syphilis, chlamydia, gonorrhoea, HIV/AIDS and donovanosis. Data on notifiable STIs (except HIV/AIDS) are collected and maintained by PHU in rural and remote areas and by CDCD in the Perth metropolitan area. Notifications (metropolitan, rural and remote) are collated centrally in the Western Australian Notifiable Infectious Diseases Database (WANIDD). Medical practitioners are required to notify all six STIs, and laboratories are required to notify all except chlamydia and HIV/AIDS. In practice, however, most laboratories notify all diagnosed STIs to the DOH.

There are limitations on the completeness of information on Aboriginality in WANIDD principally due to the fact that laboratories do not have this information. Notifications provided by medical practitioners have more complete demographic information, including Indigenous status, but not all clinicians routinely notify cases to the DOH.

HIV notifications in WA are reported centrally and managed in a separate database by CDCD in the DOH.

3.4. STIs in WA

Aboriginal people have higher notification rates for all bacterial STIs compared to the non-Indigenous population, and there is a younger age distribution of STIs in Aboriginal people than in non-Aboriginal people. For Aboriginal people there is a higher proportion of STIs notified among women. [20]

There are serious health implications for women who have an STI, with long-term effects on female reproductive health including ectopic pregnancy, pelvic inflammatory disease (PID), and infertility. [1] Despite the endemic levels of chlamydia and gonorrhoea amongst Aboriginal people in WA, there has been little published research on infertility in Aboriginal women. A study conducted in a remote community in the Northern Territory on reproductive health and infertility explored the relationship between STIs and infertility. The study found that 32 per cent of women had experienced an illness consistent with PID at some stage in their life, and that 29.4 per cent had experienced fertility problems. [21]

Because STIs cause inflammation or ulcerate the genital tract, they increase the risk of transmission of HIV. Epidemiological studies have shown that individuals are two to five times more likely to become infected with HIV if a pre-existing STI is present. [1] Therefore good STI control is good HIV control.

Notification data underestimate the true burden of STIs in the community, given that a high proportion of infections are asymptomatic. There is an urgent need for population samples, particularly of young people, to establish reliable prevalence and incidence data in order to estimate the true burden of disease. [22]

3.5. Chlamydia

Chlamydia (caused by *Chlamydia trachomatis*) is common globally, and its incidence has been increasing steadily in Western countries over the past two decades. [23] Chlamydia can result in serious health effects for women, including infection of the fallopian tubes, PID, ectopic pregnancy and infertility [23]. Chlamydia is usually known as a "silent" disease, with 75% of infected women and about 50% of infected men having no symptoms. If symptoms do occur, they usually appear within one to three weeks after a person is infected. [24]

Genital chlamydia became a notifiable disease in 1993 and is now the most commonly notified STI in WA. At that time, identification of chlamydia required microbiological culture or antigen detection tests but within the next few years, more sensitive nucleic acid amplication (PCR)* testing was introduced. PCR testing can also be performed on urine specimens, increasing the acceptability of testing to the community. Between 1993 and 2002, the annual number of notifications for chlamydia in WA tripled from around 1000 to 3000.

In 2004, there were 4332 chlamydia notifications, of which 1490 cases (34 per cent) had unknown Aboriginal status. Aboriginal people accounted for 1063 chlamydia notifications (ie 37 per cent of those for which data on Aboriginality status was available), giving a minimum age-standardised rate of 1206 per 100,000 population. The Aboriginal:non-Aboriginal notification rate ratio for chlamydia was 13:1. Aboriginal people aged 15 to 29 years are most affected, with the highest rates occurring in the 15 to 19 years age group (age-specific rate in 2004 = 5439 per 100,000 population). [23, 26]

* Polymerase Chain Reaction is a diagnostic tool used in clinical laboratories for the identification of the DNA of an organism. [25]

3.6. Gonorrhoea

Genital gonorrhoea (caused by the bacterium Neisseria gonorrhoeae) can pose serious health consequences if not treated early. Many infections in women do not show symptoms until complications such as PID have developed. PID can, in turn, lead to tubal scarring, resulting in ectopic pregnancy and infertility. Men with gonorrhoea more often experience symptoms severe enough to seek early treatment. The most common symptoms are discharge from the penis or vagina, often accompanied by painful or difficult urination. [23, 27]

In 2004, there were 1420 gonorrhoea notifications in WA, of which 39 cases (3 per cent) had unknown Aboriginal status. Aboriginal people comprised 1069 cases (77 per cent of notifications where Aboriginal status was known), an age-standardised notification rate of 1225 per 100,000 population, compared, to 16 per 100,000 population for non-Aboriginal people. The Aboriginal:non-Aboriginal notification rate ratio for gonorrhoea was 75:1. As with chlamydia, most cases occur in the age range 15 to 29 years, with the highest rates in the 15 to 19 years age group (age-specific rate in 2004 = 5102 per 100,000 population). [26]

3.7. Donovanosis

Donovanosis is a genital ulcerative disease, which often becomes chronic if not treated. It is usually found in developing countries as it is associated with poverty and poor access to diagnosis and treatment. It can have serious social implications for those infected because the ulcers are usually quite extensive and are often accompanied by an odour, which can lead to infected persons being marginalised from their community. Because donovanosis is an ulcerative disease it is a known cofactor for HIV transmission. [28] In WA, donovanosis has predominately affected Aboriginal people. WA has participated in a National Donovanosis Elimination Program in recent years, which has contributed to a reduction in the number of notified cases to fewer than five per year.

3.8. Syphilis

Syphilis is a painless disease with four stages: primary, secondary, latent and tertiary. During the primary stage, a painless ulcer appears at the infection site about three weeks after exposure. [23] After several weeks, the secondary stage symptoms may appear including skin rash, fever and swollen glands. Latent syphilis has no clinical symptoms. Tertiary syphilis may manifest after many years, and is associated with a range of heart and eye problems, hearing abnormalities, ulcers and lesions, and effects on the nervous system. [23, 27] As with other genital ulcers, syphilis increases the risk of HIV infection. [23, 27]

From 1993 to 1995, there were more than 50 primary and secondary syphilis cases notified in WA per year, mainly from the Kimberley region. Following an active screening program implemented in the Kimberley in the late 1980s, as well as improvements in access to PHC, transport and telecommunications in the region, the number of infectious (primary and secondary) syphilis notifications decreased to fewer than 10 in 1998.

Unfortunately, from 2000 to 2002, the Kimberley experienced a steady increase in the number of infectious syphilis notifications, to 39 in 2002, and the first case of congenital syphilis since 1989 occurred in 2001. In 2002, the rate of syphilis in the Indigenous population was again very high with the Aboriginal:non-Aboriginal rate ratio being 283:1. In the same year, there were no notifications for primary or secondary syphilis in non-Aboriginal females, compared to 33 in Aboriginal females.

The rise in syphilis notifications from 2000 to 2002 was a phenomenon that was experienced elsewhere across northern Australia. [29] The combination of an active public health campaign and an increased focus on STI's by health practitioners in the region reduced the number of new infections to 14 in 2003, though notifications subsequently increased to 37 (92 per cent of which were secondary syphilis cases) in 2004. Preliminary data for the first six months of 2005 suggest that syphilis is again under control, with just four notifications reported from the Kimberley region. [26]

In 2004, there were 49 notifications for primary and secondary syphilis in WA with 86 per cent of cases in Aboriginal people. The age-standardised notification rate for infectious syphilis was 46 per 100,000 population for Aboriginal people, with an Aboriginal:non-Aboriginal notification rate ratio of 115:1. As with chlamydia and gonorrhoea, 15 to 29 year olds were most affected, and the highest notification rate was among 15 to 19 year old Aboriginal people (age-specific rate in 2004 = 234 per 100,000 population). [26]

3.9. Human Immunodeficiency Virus (HIV)

HIV is transmitted by sexual contact with a person with HIV, by blood-to-blood contact such as sharing injecting equipment, or vertically (antenatally, perinatally, or postnatally through breastfeeding) from a woman with HIV infection to her infant. [30]

People living with HIV/AIDS (PLWHA) experience a range of illnesses as the disease progresses to Acquired Immune Deficiency Syndrome (AIDS). AIDS occurs when HIV infection has adversely affected a person's immune system to the point that an opportunistic infection or malignancy (an "AIDS defining illness") occurs. [23, 27] The rate of progression of HIV to AIDS varies between individuals and is faster in those who have chronic illnesses or other issues that impact on their health.

A total of 70 Aboriginal people have been notified with HIV in WA from 1983 to 2004, comprising 34 men and 36 women. Even though the numbers are relatively small, Aboriginal people living in WA are now at a statistically greater risk of HIV transmission than non-Aboriginal people. Of those Aboriginal men diagnosed with HIV, 42 per cent reported acquiring the virus from male-to-male sex and/or injecting drug use. Thirty-nine per cent of Aboriginal men reported heterosexual sex as their risk factor compared to 11 per cent of non-Aboriginal men.

From 1983 to 2004, more than half of all Aboriginal HIV notifications were in women. Aboriginal females were 10 times more likely to be infected than non-Aboriginal females. The high rate ratio of HIV infection is an indication of the vulnerability of Aboriginal women for acquiring HIV. [31]

3.10. Hepatitis B

The hepatitis B virus (HBV) has had a major impact on Aboriginal communities in Australia. Although a blood-borne virus, HBV is also transmitted sexually through either heterosexual or homosexual contact. [32] It can also be transmitted by blood-to-blood exposure, such as through sharing injecting equipment and non-sterile tattooing or body piercing. [33] Vertical transmission from mothers to their infants occurs as a result of exposure to maternal blood during the perinatal period. [33]

Certain population groups in Australia have high prevalence of hepatitis B carriage. These are Aboriginal people, and migrants from high prevalence regions including South East Asia, South and Central America, the Middle East, the Pacific Islands and Africa. [34] The development of successful and inexpensive vaccines has been an effective intervention in reducing the burden of morbidity and mortality from HBV internationally. [35]

The current prevalence of hepatitis B carriage for the Australian Aboriginal population is not known, but a study conducted in WA in 1989 showed carrier rates of between three to nine percent across the State, with past infection rates varying from 35 to 75 percent. [36] As a consequence, in WA, Aboriginal infants and adolescents were among the first to receive routine hepatitis B vaccine. [37] From the 1st January 1987, hepatitis B vaccination of three doses was made available to all babies born to Aboriginal mothers. [38] There are, however, still gaps in the delivery of services to Aboriginal people, and health professionals need to remain vigilant in ensuring Aboriginal people continue to have access to hepatitis B vaccination. [39]

SECTION 4: PRIORITY GROUPS

This Strategy recognises that poor sexual health will impact more heavily on certain groups and individuals. The following groups have been identified in the Strategy as being particularly vulnerable.

4.1. Young People

In WA, young Aboriginal people aged 15 to 24 carry the highest disease burden for STIs. In 2004, Aboriginal youth aged 15 to 24 years were 13 times more likely to be notified with chlamydia and 118 times more likely to be notified with gonorrhoea than non-Aboriginal youth. [26]

Behaviours that may put young people at greater risk of STIs include high rates of partner change, lack of skills to negotiate safe sex, and substance use. [40] In many situations, young people do not have the necessary skills or resources to understand the wider implications of engaging in unprotected sexual activity, or how to protect themselves from STI and HIV infection. [22] Their concept of future events may be distorted by either a fatalistic view on life, or a totally opposite view, displaying a sense of omnipotence, enhancing their vulnerability to infection.

In addition, young people may be reluctant or face difficulties in accessing health services. [22] Adolescents are often too shy and embarrassed to go to health services. They fear insensitive staff, a lack of privacy about their issues and potential breaches of confidentiality. [41]

The multiplicity of social issues impacting on Aboriginal young people complicates considerably any attempt to prevent and control STIs. Issues of family violence and sexual abuse are compounded by other social determinants of ill health such as poor housing, inadequate education and lack of employment opportunities. The combination of all these factors reduces the capacity of health services alone to respond effectively to the sexual health issues that Aboriginal young people encounter.

4.1.1 Teenage Pregnancy

Good quality sexual health education includes consideration of the consequences and implications of teenage pregnancy, along with skills to negotiate safe sex and avoid early debut of sexual intercourse.

Aboriginal teenagers have poorer health outcomes for their new-born babies. Babies born to Aboriginal teenagers are more likely to be small for gestational age, premature, have a congenital abnormality, and to require special and intensive care. [42] In addition, there are frequently negative consequences for education and social outcomes both for teenage parents and their children. [42, 43]

4.1.2 The Gordon Inquiry

In November 2001, the WA Government held a *Special Inquiry into the Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities. [44]* The *Gordon Inquiry* (as it is now known) released its final report in July 2002. It found that violence in many Aboriginal communities is endemic, with child abuse and child sexual abuse being under-reported. The Inquiry has prompted discussion and action on sexual abuse in communities by both government and non-government agencies. Child sexual abuse has been directly linked to high-risk sexual and drug-taking behaviour, as manifested by early first use of intoxicants, early initiation into sexual activity and increased rates of partner change. [45] These associations highlight the complexity of issues involved in reducing rates of STIs in Aboriginal communities, and that a purely biomedical approach is unlikely to be successful.

All elements of the NIASHS definition of sexual health impact especially heavily on young people: the need for skills and knowledge, and freedom from shame, fear and guilt; the capacity to control sexual behaviour and to be free from diseases that are treatable or preventable; and the need to be able to choose positive expressions of their sexuality. Holistic approaches to sexual health education in the context of relationships, self-esteem, power and identity are highly relevant to young people.

An outcome from the Gordon Inquiry is the implementation of cross-agency reporting protocols for child sexual abuse [46]. As one element of this response, the DOH is now required to report all notified STIs in children under 14 years old to the Department for Community Development (DCD) and the Police, for investigation as appropriate. The Gordon Inquiry has enabled frank discussions to occur about sexual health issues for Aboriginal people living in WA, and it is hoped that this Strategy will help to further promote those discussions and appropriate responses.

4.2. Men who have Sex with Men

The greatest burden of HIV/AIDS in Australia is borne by homosexually active men, with more than 77 per cent of new infections occurring in this group. [47] In WA from 1983 to 2004, 21 per cent of Indigenous HIV diagnoses were attributed to homosexual transmission. [26]

Aboriginal gay and transgender people can experience shame, discrimination and racism, as well as the added burden of alienation and rejection from family. [48] In 1994, the first Aboriginal and Torres Strait Islander Gay Men and Transgender Sexual Health conference resulted in the *Anwernekenhe Report* [49], which led to a nationwide study into the needs of Aboriginal and Torres Strait Islander gay men and transgender people ('sistergirls'). The recommendations from this project formed the basis of the Australian Federation of AIDS Organisations (AFAO) *National Indigenous Gay and Transgender Sexual Health Strategy* [48], which encourages the need for greater collaboration between health providers and Aboriginal gay men and sistergirls, including the need for more culturally appropriate HIV prevention and health promotion programs. AFAO has recently released and launched *Sistergirl – Keep Yourself Covered*, a new health promotion resource for Aboriginal and Torres Strait Islander sistergirls. [49]

Australia's AIDS Councils provide prevention programs and peer education for gay and homosexually active men, and will need to continue to be proactive in providing culturally specific programs for Aboriginal gay men and sistergirls. [48] The Western Australian AIDS Council (WAAC) employs two Aboriginal staff and encourages Aboriginal people to access their services.

As in the non-Aboriginal community, Aboriginal men who have sex with men but do not identify as gay, are especially difficult to reach, since they may not access gay-identified agencies, events and resources.

4.3. People who Misuse Substances

People who misuse substances are at an increased risk of contracting HIV and STIs. [50] Homelessness and mental illness are also linked to HIV/STI vulnerability and substance misuse. A cross-sectional Australian study of 34 street youth at risk of STIs found that 53 per cent had a mental illness, were alcohol dependent and had other substance-related disorders. [50]

A WA study investigated the experiences of Aboriginal people who are HIV positive. Many study participants reported that alcohol was a contributing factor to their HIV infection. [51] A further study conducted with Aboriginal people in central Australia reported that 36 per cent of people diagnosed with gonorrhoea had also misused alcohol, and that there was a high incidence of STIs among petrol sniffers, with female petrol sniffers being particularly at risk of gonorrhoea. [52]

There is an urgent need for primary health providers to work closely in partnership with drug and alcohol workers, to ensure access to appropriate diagnosis and treatment for clients for whom substance misuse is identified to be an issue.

4.4. People who Inject Drugs

Injecting drug use (IDU) is a significant risk factor for the transmission of HIV internationally and the main risk for the transmission of hepatitis C virus. Australia has a low incidence and prevalence of HIV infection in the IDU population, with a prevalence for HIV of less than three per cent. [53] This is primarily attributed to the widespread introduction of harm reduction measures, including needle and syringe programs, implemented early in the epidemic. [54] The picture from the USA is vastly different, where half of all new HIV infections (41,000 each year) occur in people who inject drugs as a result of sharing injecting equipment. [55]

In WA, between 1983 and 2002, 8.3 per cent of HIV infections in Aboriginal people and 5 per cent in non-Aboriginal people were attributed to IDU. [31]

A study by Gray and colleagues of Aboriginal injecting drug users in WA provided a conservative estimate of the prevalence of IDU amongst Aboriginal people aged over 15, residing in urban and major urban areas, of between 4.5 and 6 per cent. Their study revealed that 43 per cent of the 74 participants had shared needles and syringes and that this group had less knowledge about Blood-borne viruses (BBVs) and the risks associated with IDU than reported from elsewhere in Australia among Aboriginal injecting drug users. [56]

The ongoing challenge in Australia is to maintain a low incidence and prevalence of HIV infection in the general population. Both the national HIV and Hepatitis C strategies have emphasised the need to continue to support harm reduction, and to expand the accessibility of needle and syringe programs, education and counselling, along with measures to reduce supply and demand. There is also a need for public health providers to adapt their interventions to the changing patterns of injecting drug use across urban and rural settings and different drug/polydrug use. There is a clear need for ongoing initiatives to improve the sexual health of Aboriginal people who inject drugs, through the development of specific and targeted health promotion initiatives [4], including community development approaches that promote and strengthen partnerships between IDUs, peer-based organisations, ACCHS and Public Health Providers.

4.5. People in Prisons

Aboriginal Australians are markedly over-represented in prisons and other custodial institutions. The study conducted by Gray and colleagues in WA found that 58 per cent of the Aboriginal injecting drug users they interviewed had been in prison, with 23 per cent indicating that they had injected drugs, and shared needles and syringes while in prison. [56]

A study by Larson and colleagues revealed that Aboriginal injecting drug users were not only likely to be in prison or detention centres but were also likely to have close friends or relatives who were injecting drug users and who had also been incarcerated. [57] These findings show that Aboriginal injecting drug users are at greater risk of BBVs because of the high likelihood of incarceration and the high incidence of risk-taking behaviour while in prison.

The *National HIV/AIDS Strategy 1999-2000 to 2003-2004* [4] identified that the high levels of needle sharing among inmates in Australian prisons, the continuing availability of drugs, and the high numbers and mixing of prison inmates increases the risk of an outbreak of HIV among people in correctional settings. The Strategy identified the need for the implementation of harm-minimisation programs, and for the expansion of HIV/AIDS prevention and education initiatives directed at both inmates and staff in prison settings. [4]

People in prison may engage in behaviours that increase their risk of STI or BBV transmission. While testing for STIs and BBVs can be accessed at any time whilst a person is in prison, there is a need to continue to ensure that there is equitable access to health promotion, and treatment and care services for those in prison settings. [4]

4.6. People Living with HIV/AIDS

Over the period of the epidemic there have been considerable changes to the patterns of HIV/AIDS illness. Many of these changes are reflected in the availability of new and effective treatments for HIV. For many PLWHA this has meant a dramatic improvement in their prognosis and quality of life. [4] However, PLWHA also experience similar problems to someone living with a chronic illness. In the long term, this can be very debilitating and may be the cause of mental health issues into the future.

In Aboriginal communities, fear and ignorance about HIV/AIDS may result in discrimination, marginalisation and, on occasions, vilification. This can add additional pressure on those who are infected, and may further distance them from social networks, treatment services and supportive communities, thus increasing the risk of further transmission. Hence, a key issue for Aboriginal people living with HIV/AIDS, and for their partners, carers, families, friends and children, is the need to maintain privacy and confidentiality around their HIV status. [3] Participants in the research project *The Experiences of Aboriginal people in Western Australia who are HIV positive* indicated a preference for services that were holistic and respected confidentiality. [51] Appropriate services for those Aboriginal people who live in rural areas and those who live marginalised or chaotic lifestyles need to be maintained and further developed.

At the same time, while HIV remains hidden, it is difficult to break down stereotypes and reduce stigma. Support for HIV positive Aboriginal people living in WA who feel ready to speak out about being HIV positive will be an important step in breaking down the barriers of stigma and discrimination.

SECTION 5: COMPREHENSIVE SEXUAL HEALTH PROGRAMS IN ABORIGINAL COMMUNITIES

There are examples of successful comprehensive Aboriginal sexual health programs that have been developed and modelled upon a primary health care approach. In WA, there was a significant decrease in gonorrhoea notifications for men and women in the Wyndham East Kimberley Shire between 1998 and 1999. This decline in notified cases has been attributed to the establishment of an Aboriginal controlled PHC provider, the relative stability of health staff in the region, and comprehensive inter-agency activities between local health, education and youth services. The decrease in gonorrhoea rates was thought to be a real indication of reduced infection, rather than a decrease in disease identification. [58] This decrease in the notification of gonorrhoea for both men and women in this area has been sustained. [26]

The introduction of the Eight Way Model administered through Nganampa Health Council has been credited with reducing high rates of STIs [5]. The Model has also been adopted in the Ngaanyatjarra Lands through Ngaanyatjarra Health.

Although it has been developed and implemented in a remote primary health care setting, the Eight Way Model identifies the components of a successful sexual health program [5] and is widely applicable, at service, Regional and State levels. The model emphasises the need for sustained activity in each of the eight defined areas of activity, in order to achieve effective improvements in services, changes in behaviour and reduction in disease. The eight components are:

1. Planning and management
2. Health promotion and community education
3. Data collection and monitoring
4. Health hardware
5. Clinical services
6. Training
7. Research
8. Evaluation.

Each component of the model contributes to an integrated and comprehensive sexual health program that is appropriate for Aboriginal people. The model acknowledges that effective strategies to address high STI rates require coordinated activity in several areas. While it may be evident that clinical services, health promotion and condom availability are essential, it may not be so clear that good planning and coordination, careful collection and analysis of data, research to identify high-risk groups, and training opportunities are also key components to success. Neglecting any one area will reduce the effectiveness of the whole program.

Annual community screening has also been successful in reducing STIs in some settings. It is important that any community screening activity follow ethical and community protocols to ensure community acceptance and support. Despite the success of the public health program to reduce syphilis in the Kimberley in the mid 1990s, there were criticisms that community and individual consent was not obtained for some aspects of the program. Since the mid 1990s there have been several examples of Aboriginal community screening programs that assured community consent and support, such as Nganampa Health Council on the Anangu Pitjantjatjara lands, located in the remote area of Central Australia. [5]

SECTION 6: SEXUAL HEALTH STRATEGY TARGETS 2005 TO 2008

The WA Strategy has adopted the Eight Way Model as the basis for implementation. For each of the eight components, this section will provide:

- an outline and rationale
- an overall aim
- priority areas for action.

The ***Priorities for Action*** have been identified through research and analysis of the current situation, as well as the recommendations of past reviews and input from stakeholders.

6.1. Planning and Management

Outline and Rationale: Planning and management activities necessary for the implementation of a successful Aboriginal sexual health program include the following:

- setting clear goals for the program
- Aboriginal ownership, with participation in the process at all levels
- policies and protocols that have local relevance and acceptance
- clear roles and responsibilities for staff
- fostering and support of intra and inter-sectoral collaboration
- sustained and adequate funding.

Aims: Ensure current and emerging sexual and reproductive health risks and problems are identified and prioritised; and interventions are appraised, agreed and planned.

Ensure Aboriginal and broad stakeholder interest and ownership are developed.

Priorities for Action

- In collaboration with Aboriginal communities, develop mechanisms for raising awareness about the strong links between STIs and infertility.
- Develop Regional Sexual Health Plans with clear goals, roles and responsibilities.
- All regions to implement cross-sectoral regional sexual health forums that contribute to STI/HIV prevention and planning.
- Develop and implement strategies that provide for Aboriginal ownership, participation and acceptance of sexual health programs.
- All regions to have agreed protocols for the management and social support of people living with HIV/AIDS infection who reside in a community setting.
- Develop partnerships between existing stakeholders across the regions.

6.2. Health Promotion and Community Education

Outline and Rationale: Health promotion is an essential component of a comprehensive STI control program. The WHO Ottawa Charter identified five key action areas for health promotion. These included building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services [59].

If health promotion is seen only as community education and focuses only on raising awareness about the high rates of STIs or the high risks of transmission of STIs in certain populations, it runs the risk of stigmatising and alienating those populations most at risk. [60] However, if a health promotion approach is taken, covering each of the key action areas will help to ensure that supportive environments and community action will work to reduce the shame and stigma associated with STIs and HIV; the reorientation of health services will enable better access by people at risk; and the provision of personal skills will help those at risk to adopt healthy behaviours.

Population-based sexual health promotion programs need to involve Government and community-controlled health services and other NGOs in joint planning for development, implementation and evaluation. These health promotion initiatives should occur at both regional and local levels.

The Nganampa sexual health program identified that effective health promotion should incorporate the following three approaches:

- primary prevention: promoting and encouraging behaviour change
- secondary prevention: promoting the uptake of existing sexual health services
- tertiary prevention: giving attention to people who have STIs, and those who are at risk of re-infection. [5]

The Nganampa program also identified that effective sexual health promotion should incorporate the following principles:

- Community-wide sexual health education that has local relevance and acceptance for both men and women, and adolescents and other sub-groups within a community.
- Targeted sexual health, safe sex and safe injecting education for people at risk of STI/HIV, people who misuse alcohol or other substances, and people who inject drugs.
- Sexual health education targeting leaders and other influential community members.
- Building supportive environments that provide for the creation of healthy public policy.
- Building capacity in appropriate organisations and reorienting health services to provide appropriate sexual health services to high-risk groups as well as the general community.

The role of community members and professionals working outside the health sector should not be underestimated. Workers in the education and training, drug and alcohol, youth and mental health sectors can all play a role in providing information to communities and clients, and in creating supportive environments that promote change. For example, young people may be hard-to-reach clients of health services but frequent clients of youth or drug and alcohol services.

Aim: Ensure communities are supported through knowledge and skill interventions to adopt safer sexual behaviours.

Priorities for Action

- Through engaging and/or training workers in relevant sectors, provide comprehensive skills and knowledge-based sexual health education for all priority groups, including: people who have been diagnosed with an STI, young people, MSM, people who engage in harmful use of alcohol and other substances, people who inject drugs, people in prisons and PLWHA.
- Through engaging and/or training workers in relevant sectors, provide sexual health education for all community groups, targeting elders, family groups (parents and grandparents), leaders and other influential community members.
- Develop an active program to de-stigmatise STIs and HIV/AIDS in the community, which incorporates the use of trained sexual health educators whose training has included an examination of their own attitudes and values around sexual health matters and who are sensitive to Aboriginal cultural issues.
- Establish a statewide Aboriginal HIV-positive persons speaker program.
- Provide education on principles of harm reduction to health services and other agencies to increase the availability and safe disposal of sterile injecting equipment.
- All regions to deliver the Growing and Developing Healthy Relationships Curriculum Support materials [61] (or other relevant sexual health education) in schools.

6.3. Data Collection

Outline and Rationale: Following the *National Indigenous Sexual Health Strategy*, the term "data collection" is used in this context rather than surveillance.* Of particular interest are data on the incidence of STIs, although data on other matters, such as rates of teenage pregnancy, are also relevant.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments* [11] has identified data collection as a key component in improving health for Aboriginal and Torres Strait Islander people. The Framework links data collection with evaluation of interventions and research. It also identifies the need to establish a process to ensure that collection of data is appropriate, and that the data are analysed and published to enable identification of needs and evaluation of programs.

Regular collection and analysis of data allows for monitoring and evaluating the extent of a problem, ensuring interventions are targeted at the right groups, and evaluating the success of activities. Data need to be collected at both regional and local levels, and it is important that data have local relevance to health services. [62] Good use of data has been shown to motivate staff and community members to work together in reducing STI rates. Experience in Central Australia and elsewhere has shown that when Aboriginal people and health service staff are consulted and informed about the use of the data, they are motivated and interested to work together to reduce STI rates. [5]

STI/HIV data collection and analysis should include the following:

- identifying the prevalence and incidence of each STI. In practice, this is most likely to reflect cases identified through testing symptomatic people, as well as opportunistic screening and testing of named contacts.
- assessing the reliability of the reporting system
- providing regular feedback to communities, health services and other relevant stakeholders in user-friendly formats

* It has been suggested that the word surveillance has negative connotations and is not always an appropriate phrase for use in Indigenous communities. [2]

- providing more formal mechanisms for sharing data between the CDCD, PHUs, ACCHS and community-based organisations such as WAAC, FPWA and the Western Australian Substance Users' Association.

Aims: Ensure effective data collection systems are in place, and staff are able to use them to measure and evaluate program activity.

Ensure data and information are available in user-friendly formats for communities and other stakeholders.

Priorities for Action

- Disseminate user-friendly epidemiological data and analysis to Aboriginal communities and health services.
- Conduct an audit to identify the strengths and limitations of available data collection systems in WA and establish the possibility for informative data linkage. The purpose is to inform the development of guidelines for best practice and evidence-based approaches in the planning and delivery of sexual health programs.
- Develop, promote and support the collection of standardised sexual health data to provide a minimum level of measurement of activity and progress as the basis for informing and evaluating the ongoing development, planning and delivery of sexual health programs. STI service activity should be monitored by collecting information on:
  - number of tests and positive diagnoses
  - time to treatment.
- Encourage PHC to use and maintain regular client registers in order to facilitate delivery of screening and preventive interventions. This will provide opportunities for more accurate monitoring and mapping of the size and scope of STIs in particular communities.
- Provide regular feedback to communities on activity and STI rates in user-friendly formats, by the local STI team or other persons as appropriate.
- Actively improve identification of Aboriginality in STI data, through encouraging clinicians to identify Aboriginality on notification forms and better collaboration between PHC providers and PHUs. A longer-term aim is to encourage pathology providers to include an Aboriginality field on pathology request forms.
- Continue to support the Tristate Project, which enables shared data and coordinated follow-up across jurisdictions in Central Australia.

6.4. Health Hardware

Outline and Rationale: Health hardware for STI/HIV control includes condoms, sterile needles and other injecting equipment, and single-use sharps equipment used in ceremonial practices. [5] The consistent and correct use of condoms has been shown to be 90 per cent effective in preventing HIV transmission, and condoms are a proven preventive strategy for those who engage in high-risk behaviours, people who inject drugs, sex workers and people with STIs. [63] In many remote Aboriginal communities, however, there is often limited condom availability, accessibility and acceptance, with infrequent and inconsistent use. [5]

Health hardware strategies should include:

- Unlimited, confidential condom availability, on a 24-hour basis
- sterile injecting equipment available in a confidential and non-judgmental context

- appropriate education about the risks of HIV transmission through ceremonial practices.

Aim: Ensure appropriate means are readily available to enable safe sex and minimise harm associated with practices that place people at risk of BBV transmission.

Priorities for Action

- Work to reduce the stigma surrounding harm reduction equipment provision and use. For example, set targets for health and other services to have condoms, water-based lubricants and dental dams, and needles and syringes widely available. Importantly, communities should be able to determine their own distribution points for health hardware. The following list provides some possible distribution points and/or methods of dispensing:
  - ACCHS
  - Health clinics/hospitals
  - Swimming pool venues
  - TAFE Colleges/universities
  - Vending machines
  - Clubs and hotels
  - Condom trees
  - Roadhouses
  - Community Stores
  - Night Patrol workers and workers at Drying Out Shelters
  - Prisons
  - Brothels and Escort Agencies
  - Youth and women's refuges.
- Work to increase understanding and community leadership around the availability of needles and syringes, as well as the safe disposal of used equipment as a harm reduction measure.
- Explore social marketing strategies for health hardware that increases access and acceptance within communities.

6.5. Clinical Services

Outline and Rationale: Good STI management involves treating the person who presents with symptoms immediately, or as soon as possible, to prevent further infections to others. A comprehensive STI treatment and management plan should also include immediate follow-up treatment and management of the patient's sexual partner/s, and opportunistic or even community screening to identify those without symptoms is also essential.

Effective sexual health clinical services include:

- making clinical services as accessible as possible, which may include opportunistic, targeted and innovative methods of engaging particular groups; and increasing trust in the reliability, confidentiality and cultural security of the services through staff orientation and training
- timely access to diagnostic tests, and training for staff in appropriate specimen collection, storage and transport

- reducing the period of infection by reducing the time to treatment
- use of standard protocols for treatment and follow-up
- appropriate clinic design, for example, by providing separate diagnostic areas for men and women
- appropriate staffing, for example, by ensuring that both male and female staff are available
- informed consent for testing and treatment
- ensuring privacy and confidentiality
- provision of pre-test and post-test counselling
- effective and sensitive partner notification and contact tracing.

Aim: Ensure guidelines, information management systems and induction processes are identified, developed and/or refined to support best practice.

Priorities for Action

- Use of standard clinical management forms and treatment protocols in all services, State-wide.
- Develop innovative extensions of clinical services to reach target groups, such as mobile/outreach sexual health services provided in safe and neutral settings (eg youth agencies, youth clubs, TAFE colleges and at community events, such as sporting carnivals).
- Ensure any review of Metropolitan Sexual Health Services is appropriate to the needs of Aboriginal people.
- In very high prevalence areas, encourage communities to support and initiate community-wide testing programs, remembering that, before implementation, there needs to be acceptance and agreement by Aboriginal community members.
- Make more investment in provision of specific sexual health services in primary health settings.

6.6. Training

Outline and Rationale: The sexual health workforce includes doctors and nurses, Aboriginal health workers (AHW), health promotion officers and community educators. Many other professionals and community resource people such as teachers and youth workers also provide formal and informal education to at-risk groups. The Gordon Inquiry [44] identified sexual health training as important for child protection workers and others.

Essential training in clinical skills includes diagnosis, specimen collection, treatment and management. In addition, accessible and non-judgmental sexual health clinical services require staff whose training includes consideration of their own attitudes and values to sex and sexuality. It should be recognised that, while sexual health impacts on all people, those most at risk are likely to be the more marginalised members of any community. Cultural, economic, social and geographic barriers contribute to high STI rates in Aboriginal communities. The additional barrier of youth further distances those at risk from services and social supports. It is extremely important that workers do not place moral judgments on clients, but rather that services are as welcoming and as inclusive as possible.

In recognition of the complexity of sexual health issues, sexual health program leaders should be able to access training which includes [2]:

- counselling and communication skills
- working with young people
- knowledge of health promotion
- clinical care skills
- community capacity building skills
- knowledge of child protection issues
- advocacy skills
- administration skills
- basic research/evaluation skills
- an understanding of cultural issues and sensitivities
- principles of harm reduction.

Training in some of these areas is currently provided by a number of agencies through different formats, such as annual updates and short courses. For example, WAAC provides training in pre-test discussion and post-test counselling for HIV and BBVs, while some regional health services provide regular updates in clinical management.

Clinic workers often carry out roles in health promotion and community education, and appropriate training should be available. In addition, non-clinical workers in the health sector and in other professions such as the justice, education and welfare sectors, can also play a vital role in sexual health education by promoting safe sex practices, and encouraging at-risk individuals/groups to seek testing. The Nuts and Bolts of Sexual Health Program, which is offered by FPWA, provides basic training suitable for these groups, while FPWA's Community Educators course provides specific training in providing sexual health education in community contexts.

The involvement of Aboriginal people in all aspects of sexual health programs is essential for increasing Aboriginal ownership and effective responses to problems in sexual health. The Strategy acknowledges the importance of the availability of trained Aboriginal people to increase awareness and understanding of the issues for at-risk groups and communities more broadly, and to seek Aboriginal responses to these issues. Health promotion and community education activities need to include both information and fostering of skills in preventing STI transmission, and capacity building to generate community-owned solutions to improve sexual health. Trained, skilled Aboriginal community educators are needed to do this work. Particularly successful models for training Aboriginal community educators and trainers in these areas are vocational, apprenticeship-type positions, such as have been established at FPWA.

Short term training programs include the Mooditj Program offered by FPWA, which enables comprehensive sexual health training for those working with young Aboriginal people aged 11 to 14 years, while the FPWA PASH Program works on a peer education model, and provides skills and training to those working with 14 to 19 year olds.

Aim: Ensure workforce knowledge and skills in sexual and reproductive health are enhanced, and workers receive support.

Priorities for Action

- Provide accessible, quality clinical training in sexual health for health care workers including AHW, nurses and doctors.
- Extend training opportunities for working effectively with young people to GPs and other health staff.
- Health Services in high prevalence areas to provide STI induction and orientation programs that include cultural sensitivity to all health staff in service delivery roles, preferably within two weeks of commencing in the Service.
- All regions to provide annual sexual health clinical updates and in-service training.
- Provide introductory sexual health training and harm reduction courses for non-health workers such as youth workers, drug and alcohol workers, mental health workers, and others who are in close contact with high-risk groups.
- Provide timely information and updates for GPs on STI/HIV rates, treatment and care.
- Ensure all STI workers are skilled in pre-test discussion and post-test counselling.
- Provide training and educational opportunities that develop skills in management, evaluation and research for workers in Aboriginal sexual health.
- Provide training in data collection and the interpretation of data for relevant workers in agencies and health services.

6.7. Research

Outline and Rationale: The Strategy endorses sexual health research that follows the National Health and Medical Research Council (NHMRC) guidelines on Aboriginal Health Research [64] as outlined in the *Roadmap for Aboriginal and Torres Strait Islander Health Research*. [65] Research into STI/HIV issues should be designed to increase knowledge on how to reduce the transmission of STIs and HIV and to reduce teenage pregnancies, and should include the following principles [2]:

- research should produce positive outcomes for the community and not cause harm
- research should be conducted in close collaboration with the primary heath sector
- results of research should be provided to the community
- research should have an action focus to link with service providers
- AHW should be actively involved in the research process
- research processes must involve community development principles
- processes should provide for the transfer of research skills to Aboriginal people involved in the research.

Research can involve relatively simple activities conducted at a local level, such as ascertaining the availability of condoms.

Aim: Ensure opportunities to enhance knowledge about sexual health and ways to improve services are identified by engaging in appropriate research.

Priorities for Action

- Ensure that any sexual health research conducted complies with the NHMRC guidelines.
- Endeavour to base sexual health programs on existing research findings and evidence.
- Endeavour to ensure that findings from research are analysed and provided to communities wherever possible.
- Actively seek out opportunities for relevant and acceptable sexual heath research projects.
- Relevant ethics committees should provide approval for appropriate research processes.
- Relevant peak groups should provide endorsement of research findings, and promote, disseminate and monitor implementation recommendations.

6.8. Evaluation and Monitoring

Outline and Rationale: Evaluation and monitoring of programs are important to ensure the overall effectiveness of sexual health services. Effective sexual service health evaluation should ensure ongoing review and refinement of the operations of STI programs. [5] Importantly, programs should set clear, measurable goals and objectives so that evaluation is possible.

Evaluation and monitoring of sexual health strategies should be able to:

- measure the performance of strategies at a local, state and national level
- provide an effective mechanism for accountability to all stakeholders
- provide a means to communicate findings to the wider community
- ensure that the stated objectives and priorities of the program are continually informed by solid social and epidemiological data
- assist managers and policy makers with access to timely and accurate information on program performance [2].

Aim: Ensure sexual and reproductive health programs are evaluated as part of local continuous quality enhancement.

Priorities for Action

- All regional and health service programs to set measurable goals and objectives to evaluate the success of sexual health programs according to health and community acceptability outcomes.
- Evaluate long-term impact of specific interventions such as PASH, and the Growing and Developing Health Relationships Curriculum Support materials. [61]
- Identify critical interventions that have made a difference.

SECTION 7: REFERENCES

1. Sangani P, Rutherford G, Wilkinson D. Population-based interventions for reducing sexually transmitted infections, including HIV infection (Cochrane Review). *The Cochrane Library* 2003: 1-14.
2. Commonwealth Department of Health and Aged Care. *National Indigenous Australians' Sexual Health Strategy; Implementation Plan 2001/02 to 2003/04*. 1997, Australian Government Publishing Service: Canberra.
3. Commonwealth Department of Health and Aged Care. *National Indigenous Australians' Sexual Health Strategy 1996-97 to 2003-04*. 1997, Australian Government Publishing Service: Canberra.
4. Commonwealth Department of Health and Aged Care. *National HIV/AIDS Strategy 1999-2000 to 2003-2004 Changes and Challenges*. 2000, Commonwealth Department of Health and Ageing: Canberra.
5. Commonwealth Department of Health and Aged Care. *STD control in remote Aboriginal communities: A manual for clinic workers*. 1999, Commonwealth Department of Health and Aged Care: Canberra.
6. Shelton J, Halperin D, Nantulya V, Potts M, Gayle H, Holmes K. Partner Reduction is crucial for balanced "ABC" approach to HIV prevention. British Medical Journal 2004; 328: 891-893.
7. Wilson D. Partner reduction and the prevention of HIV/AIDS: The most effective strategies come from within communities. *British Medical Journal* 2004; 328: 848-849.
8. World Health Organization. International Conference on Primary Health Care, Alma-Ata: twenty-fifth anniversary. *Fifty-Sixth World Health Assembly*. 2003.
9. Subramanian M. *Analysis and Communication of Statistics on Human Development: A Global Experience with Health Data*. 2000, World Health Organization: Geneva.
10. Keleher H. Why Primary Health Care Offers a more Comprehensive Approach to Tackling Health Inequalities than Primary Care. *Australian Journal of Primary Health* 2001; 7: 57-61.
11. National Aboriginal and Torres Strait Islander Health Council Secretariat. *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments*. 2003, Australian Government: Canberra.
12. Commonwealth Department of Health and Ageing. *National Aboriginal and Torres Strait Islander Sexual Health and Blood-borne Virus Strategy 2005-2008*. 2005, Australian Government: Canberra.
13. Commonwealth Department of Health and Ageing. *National Sexually Transmissible Infections Strategy*. 2005, Australian Government: Canberra.
14. Health Department of Western Australia. *Workforce and Educational Framework for STD Management*. 1997, Health Department of Western Australia.
15. Commonwealth Department of Health and Ageing. *Department of Health and Ageing Annual Report*. 2004, Australian Government: Canberra.
16. Australian Bureau of Statistics. *Population Distribution, Aboriginal and Torres Strait Islander Australians*. 2002, Australian Bureau of Statistics: Canberra.

17. Australian Bureau of Statistics. *2001 Census of Population and Housing Indigenous Profiles*. 2001, Australian Bureau Statistics: Canberra.

18. Council of Australian Governments. *Steering Committee for the Review of Government Service Provision Overcoming Indigenous Disadvantage:Key Indicators 2003*. 2003, Council of Australian Governments: Canberra.

19. Fassin D, Schneider H. The politics of AIDS in South Africa: beyond the controversies. *British Medical Journal* 2003; 326: 495-497.

20. Atthowe J, Thompson S, Giele C *The Epidemiology of Sexually Transmissible Infections and Blood-Borne Viruses in Western Australia 1990 to 2000*. 2003, Department of Health: Perth.

21. Kildea S, Bowden F. Reproductive health, infertility and sexually transmitted infections in Indigenous women in a remote community in the Northern Territory. *Australian & New Zealand Journal of Public Health* 2000; 24: 382-386.

22. Skinner R, Hickey M. Current priorities for adolescent sexual and reproductive health in Australia. *Medical Journal Australia* 2003; 179: 158-161.

23. Heymann D, ed. Control of Communicable Diseases Manual. 18th ed. 2004, American Public Health Association: Washington DC.

24. Centers for Disease Control and Prevention. *Chlamydia Fact Sheet*. 2004, Department of Health and Human Services: Atlanta.

25. Alcamo I, *Fundamentals of Microbiology*. Sixth ed. 2001, Sudbury, Massachusetts: Jones and Bartlett Publishers.

26. Communicable Disease Control Directorate, Department of Health, Western Australia *Unpublished Data*. 2005: Perth.

27. Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines. *Morbidity and Mortality Weekly Report* 2002; 51.

28. Miller P. *Donovanosis control or eradication? A situation review of donovanosis in Aboriginal and Torres Strait Islander populations in Australia*. 2001, Commonwealth Department of Health and Aged Care: Canberra.

29. Northern Territory Disease Control Bulletin available at *http://www.nt.gov.au/health/cdc/bulletin/index.shtml* [accessed on 27/09/05].

30. National Centre in HIV Epidemiology and Clinical Research. *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2004*. 2004, National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales: Sydney, NSW.

31. Wright M, Geile C, Dance P, Thompson S. Fulfilling prophecy? Sexually transmitted infections and HIV in Indigenous people in WA. *Medical Journal Australia* 2005; 183: 124-128.

32. Shapiro C. Epidemiology of hepatitis B. *Pediatric Infectious Disease Journal* 1993; 12: 433-437.

33. Mandell G, Bennett J, Dolin R, *Principles and Practice of Infectious Diseases*. Fifth ed. Vol. 1. 2000, Philadelphia: Churchill Livingstone.

34. National Health and Medical Research Council. The Australian Immunisation Handbook. 8th ed. 2003, Canberra: Australian Government Publishing Service.

35. Kao J, Chen D. Global control of hepatitis B virus infection. *The Lancet Infectious Diseases* 2002; 2: 395-403.

36. National Health and Medical Research Council. The Australian Immunisation Handbook. 7th ed. 2000, Canberra: Australian Government Publishing Service.

37. Hanna J, Faoagali J, Buda P, Sheridan J. Further observations on the immune response to recombinant hepatitis B vaccine after administration to Aboriginal and Torres Strait Island children. *Journal of Pediatric Child Health* 1997; 33: 67-70.

38. Health Department of Western Australia. *Hepatitis B Immunisation Programme*. 1986, Department of Health: Perth.

39. Malcolm R, Ludwick L, Brookes D, Hanna J. The investigation of a 'cluster' of hepatitis B in teenagers from an Indigenous community in North Queensland. *Australian New Zealand Journal of Public Health* 2000; 24: 353-355.

40. Peersman G, Flores S, Zee A, Eke A. Interventions for preventing HIV infection in young people in developing countries (Protocol for a Cochrane Review). *The Cochrane Library* 2003: 1-14.

41. Futterman D. Youth and HIV: The Epidemic Continues. *The Physicians Research Network Notebook* 2003; 8: 21-24.

42. Westenberg L, van der Klis K, Chan A, Dekker G, Keane R. Aboriginal teenage pregnancies compared with non-Aboriginal in South Australia 1995-1999. *Australian & New Zealand Journal of Obstetrics Gynaecology* 2002; 42: 187-192.

43. Coren E, Barlow J. Individual and Group-Based Parenting Programmes for Improving Psychosocial Outcomes for teenage Parents and their Children (Cochrane Review). *The Cochrane Library* 2004: 1-28.

44. Gordon S, Hallahan K, Henry D. *Putting the Picture Together, Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*. 2002, Department of Premier and Cabinet: Perth.

45. Jarvis T, Copeland J, Walton L. Exploring the nature of the relationship between child sexual abuse and substance use among women. *Addiction* 1998; 93: 865-875.

46. Department of Health, Government of Western Australia *Guidelines for Responding to Child Abuse, Neglect and the Impact of Family and Domestic Violence*. 2004, Department of Health.

47. National Centre in HIV Epidemiology and Clinical Research. *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report*. 2004, National Centre in HIV Epidemiology and Clinical Research, Australian Institute of Health and Welfare: Sydney.

48. Lee G. *The National Indigenous Gay and Transgender Project: Consultation Report and Sexual Health Strategy*. 1998, Australian Federation of AIDS Organisations: Sydney.

49. Australian Federation of AIDS Organisation. Anwernekenhe-The First Aboriginal and Torres Strait Islander Gay Men and Transgender Sexual Health Conference. *The First Aboriginal and Torres Strait Islander Gay Men and Transgender Sexual Health Conference*. 1994. Hamilton Downs Northern Territory.

50. Grossman D, Arbress G, Cavacuiti C, Urbshott G. Interventions for Preventing HIV Infection in Street Youth (Protocol for a Cochrane Review). *The Cochrane Library* 2004: 1-14.

51. Bonar M, Greville M, Thompson S. *Just Gettin' on with My Life without Thinkin' about It: the experiences of Aboriginal people in Western Australia who are HIV positive*. 2004, Department of Health: Perth, Western Australia.

52. Miller P, Law M, Torzillo P, Kaldor J. Incident sexually transmitted infections and their risk factors in an Aboriginal community in Australia: a population based cohort study. *Sexually Transmitted Information* 2001; 77: 21-25.

53. Crofts N, Aitken C, Kaldor J. The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not. *Medical Journal of Australia*. 1999; 170: 220-221.

54. Coutinho R. HIV and hepatitis C among injecting drug users. *British Medical Journal* 1998; 317: 424-425.

55. Rich J, Strong L, Meenakshi M, Macalino G. Strategies to Optimize the Impact of Needle Exchange Program. *The AIDS Reader* 2000; 10: 421-429.

56. Gray D, Saggers S, Atkinson D, Carter M, Loxley W, Hayward D. *The Harm Reduction Needs of Aboriginal People Who Inject Drugs*. 2001, National Drug Research Institute Curtin University of Technology: Perth. 1-102.

57. Larson A, Shannon C, Eldridge C. Indigenous Australians who inject drugs: results from a Brisbane study. *Drug and Alcohol Review* 1999; 18: 53-62.

58. Mak D, Marshall L. Gonorrhoea, chlamydia and syphilis in the Kimberley. *Communicable Disease Intelligence* 2003; 27: 370-372.

59. World Health Organization. *Ottawa Charter for Health Promotion*. 1986, World Health Organization: Ottawa.

60. Bowden F, Bastian I, Johnston F. A community-based approach to the control of sexually transmitted diseases in the Northern Territory. *Australian and New Zealand Journal of Public Health* 1997; 21: 519-523.

61. Department of Health, Department of Education. *Growing and Developing Healthy Relationships*. 2002, Government of Western Australia.

62. Murray R, Organising Prevention. *Aboriginal Primary Health Care: An Evidence-based Approach*, ed. Couzos S and Murray R. 2003, Melbourne: Oxford University Press. 149-159.

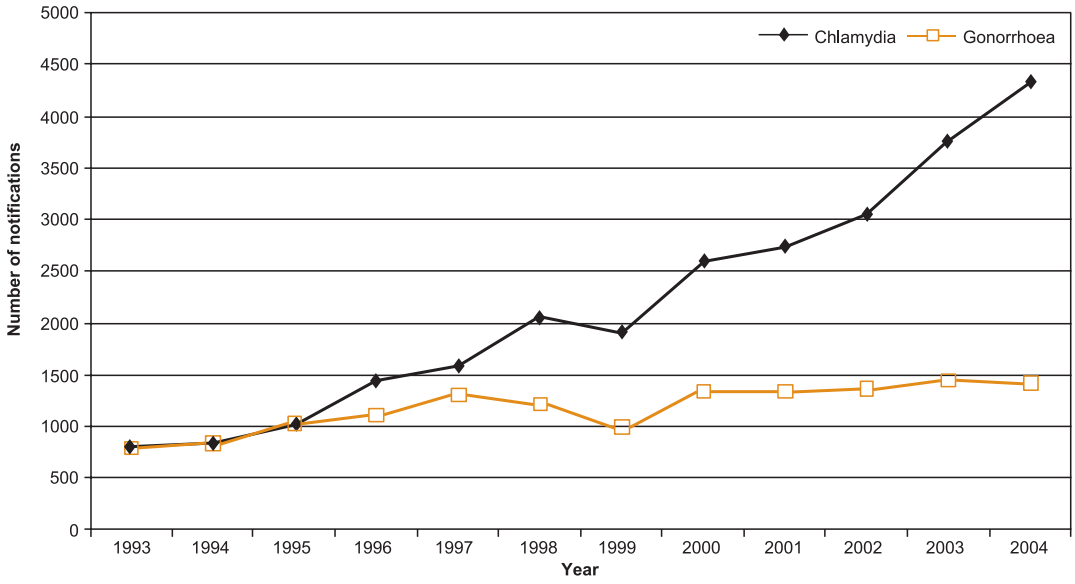
63. Hearst N. Condom Promotion for AIDS Prevention in the Developing World: Is it Working? *Study Family Planning* 2004; 35: 39-47.

64. National Health and Medical Research Council. *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. 2003, Australian Government: Canberra.

65. National Health and Medical Research Council. *The NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health Through Research*. 2002, Australian Government: Canberra.

APPENDIX 1: EPIDEMIOLOGICAL INFORMATION

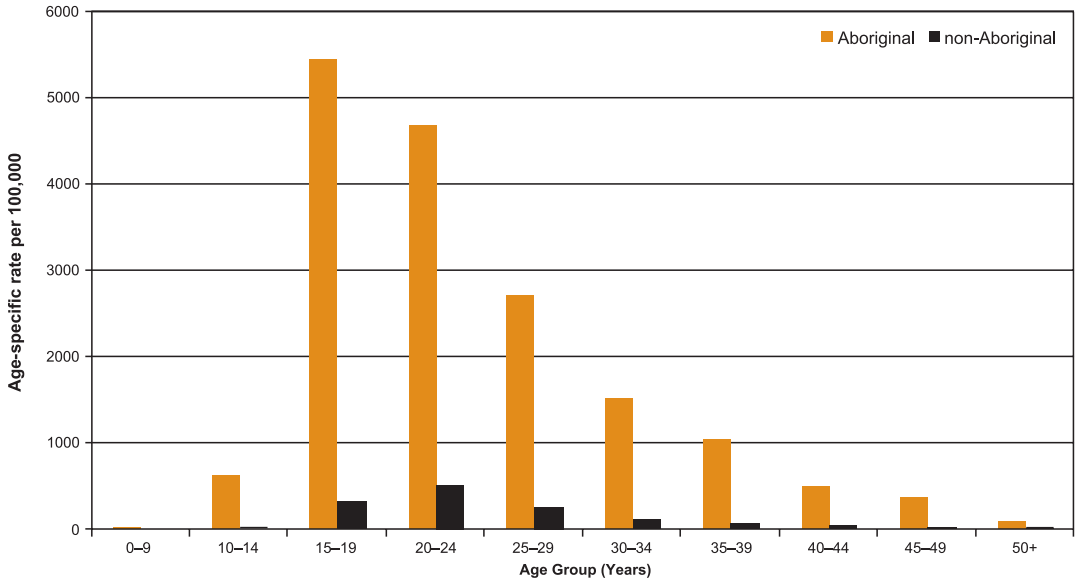
Figure 1: Chlamydia and Gonorrhoea Notifications in WA, 1993-2004



Source: Communicable Disease Control Directorate, WANIDD

Between 1993 and 2004, the number of notifications for chlamydia increased more than five-fold (Figure 1) from 808 to 4332. For gonorrhoea, the number of notifications has been relatively stable since 2000.

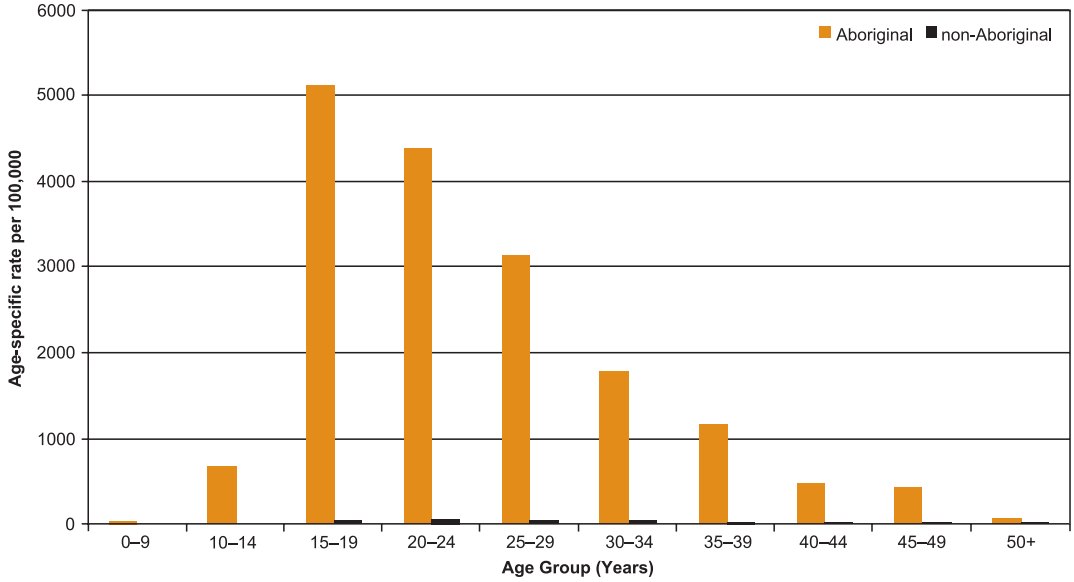
Figure 2: Age-specific Chlamydia Notification Rates by Aboriginality, WA, 2004



Source: Communicable Disease Control Directorate, WANIDD

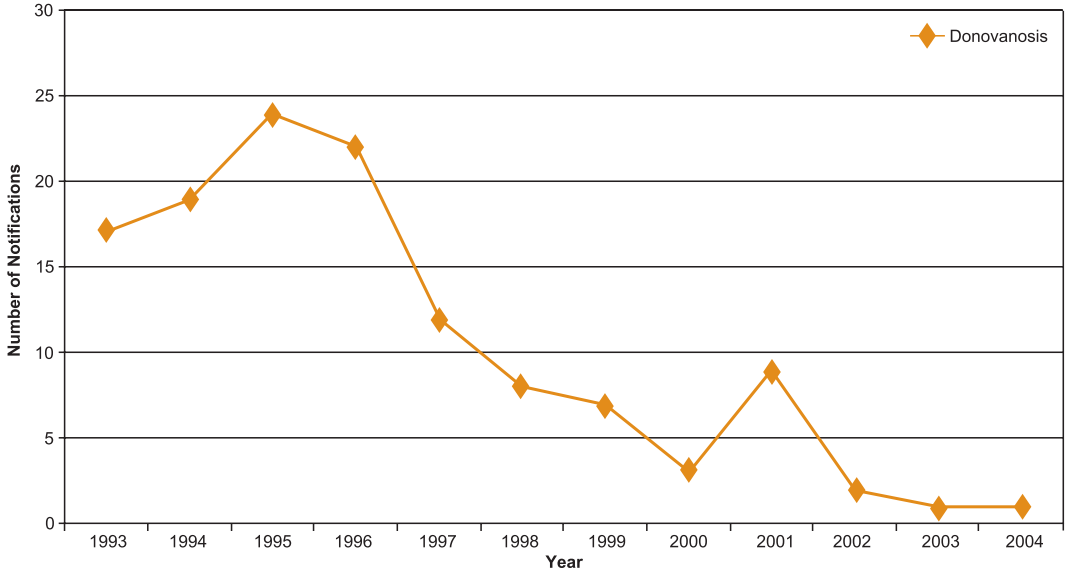
The 2004 age-specific notification rates of WA chlamydia cases that were identified by Aboriginality are shown in Figure 2. Notification rates were higher for Aboriginal people than for non-Aboriginal people in all age groups, but particularly among younger people. Aboriginal youth aged 15 to 19 yrs (age-specific notification rate in 2004 = 5439 per 100,000 population) were 17 times more likely to be notified with a chlamydia infection than non-Aboriginal youth (age-specific notification rate in 2004 = 317 per 100,000 population) of the same age.

Figure 3: Age-specific Gonorrhoea Notification Rates by Aboriginality, WA, 2004



The 2004 age-specific notification rates of WA gonorrhoea cases that were identified by Aboriginality are shown in Figure 3. As for chlamydia, notification rates were higher for Aboriginal people than for non-Aboriginal people in all age groups, but particularly among younger people. Gonorrhoea notifications were 182 times more likely to be reported among Aboriginal youth aged 15 to 19 yrs (age-specific notification rate in 2004 = 5102 per 100,000 population) than among non-Aboriginal youth (age-specific notification rate in 2004 = 28 per 100,000 population) of the same age.

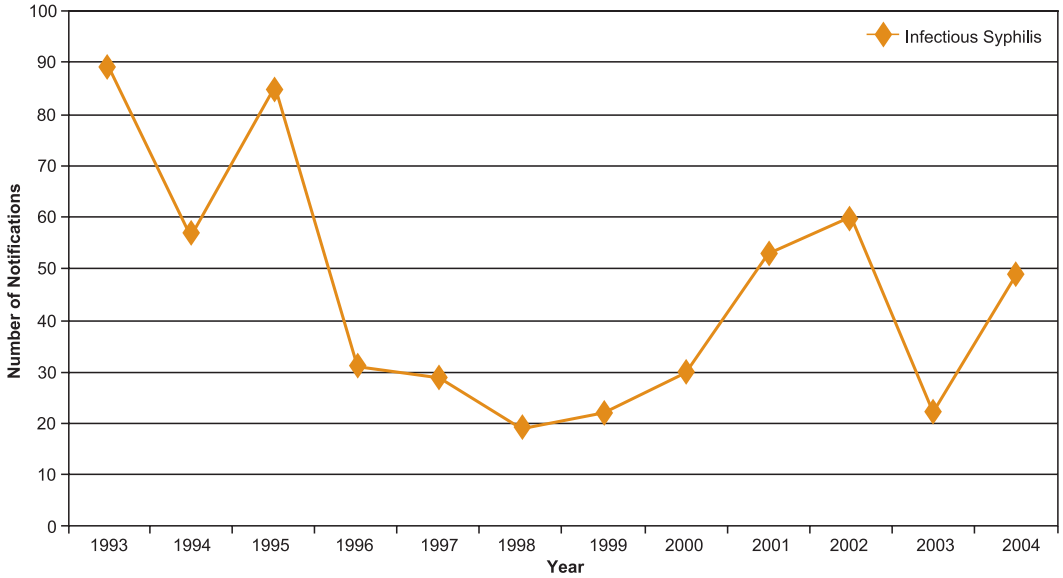
Figure 4: Donovanosis Notifications in WA, 1993-2004



Source: Communicable Disease Control Directorate, WANIDD

Since 1996, when there were 22 cases, the number of notifications of donovanosis has been steadily declining (Figure 4). There was just one case notified per year in 2003 and 2004. WA participation in a National Donovanosis Elimination Program may have contributed to the apparent terminal decline in this disease.

Figure 5: Infectious Syphilis (Primary and Secondary) Notifications in WA, 1993-2004



Source: Communicable Disease Control Directorate, WANIDD

From 1993 to 1995, the number of primary and secondary syphilis cases notified was more than 50 per year (Figure 5). There was a significant decrease in the number of primary and secondary syphilis notification to 17 cases in 2003. However, in 2004, it again increased to 49 notifications of primary and secondary syphilis, of which 86 per cent occurred in Aboriginal people and 14 per cent in non-Aboriginal people.

Table 1: Notified HIV Infection (number of cases) by Exposure Category and Aboriginal Status: WA, 1983-2004.

Exposure Category	Aboriginal						non-Aboriginal						WA (Total)	
	Male		Female		Total		Male		Female		Total			
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
MSM	8	23.5%	0	0.0%	8	11.4%	734	73.8%	0	0.0%	734	67.3%	742	63.9%
MSM/IDU	7	20.6%	0	0.0%	7	10.0%	61	6.1%	0	0.0%	61	5.6%	68	5.9%
IDU	4	11.8%	3	8.3%	7	10.0%	39	3.9%	14	14.4%	53	4.9%	60	5.2%
Heterosexual	13	38.2%	33	91.7%	46	65.7%	111	11.2%	74	76.3%	185	17.0%	231	19.9%
Vertical	1	2.9%	0	0.0%	1	1.4%	3	0.3%	1	1.0%	4	0.4%	5	0.4%
Unknown/Other	1	2.9%	0	0.0%	1	1.4%	17	1.7%	3	3.1%	20	1.8%	21	1.8%
Recipient of Blood Products	0	0.0%	0	0.0%	0	0.0%	29	2.9%	4	4.1%	33	3.0%	33	2.8%
Needlestick/splash	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	1.0%	1	0.1%	1	0.1%
Total	**34**	**100%**	**36**	**100%**	**70**	**100%**	**994**	**100%**	**97**	**100%**	**1091**	**100%**	**1161**	**100%**

MSM= men who have sex with men; IDU= injecting drug use

Source: Communicable Disease Control Directorate, HIV/AIDS Database

Likely route of HIV transmission is determined from the exposure history of the case using an hierarchical system of risk categories. Information on exposure category highlights differences in the epidemiology of HIV between Aboriginal and non-Aboriginal Western Australians (Table 1). Among non-Aboriginal people, men who have sex with men (MSM) accounted for 73 percent of infections (67 percent MSM plus 6 percent MSM+IDU), while heterosexual transmission accounted for 17 percent of notifications in the period 1983-2004. In contrast, 66 percent of notifications in Aboriginal people for this period were attributed to heterosexual exposure. IDU accounted for around 10 per cent of the infections in Aboriginal people and 5 per cent in non-Aboriginal people. Almost half the Aboriginal MSM also reported IDU, so that 20 per cent (14/70) of Aboriginal people notified with HIV reported IDU as a risk factor.

Table 2: HIV Notifications (numbers and age-standardised rates [ASR]) by Ethnicity and Sex, WA 1983-2004

HIV	Aboriginal	non-Aborignal	WA (Total)
Total % WA (Total) ASR	70 6% 5.9	1091 94% 3	1161 100%
Male % WA (Total) ASR	34 3% 5.7	989 97% 5.3	1023 100%
Female % WA (Total) ASR	36 27% 6	97 73% 0.6	133 100%
M:F Rate Ratio	1.0	8.8	
Transsexual % WA (Total)m	0 0%	5 100%	5 100%

Source: Communicable Disease Control Directorate, HIV/AIDS Database

For the period 1983 to 2004, 1161 HIV infections were notified among WA residents, 70 (6 per cent) in Aboriginal people and 1091 (94 per cent) in non-Aboriginal people (Table 2). Aboriginal males accounted for 3 per cent of the male notifications, whereas the 36 infections in Aboriginal females represented 27 per cent of all female notifications. Just over half of all Aboriginal HIV notifications are in Aboriginal women. The high rate ratio of HIV infection for Aboriginal women compared to non-Aboriginal women (10:1) suggests their greater vulnerability for acquiring HIV. This reflects the predominance of heterosexual transmission of HIV in Aboriginal people in WA.

APPENDIX 2: ORGANISATIONS THAT CONTRIBUTED TO THE STRATEGY CONSULTATIONS FEBRUARY – JUNE 2005

Consultation: Location or Type	Organisation	Location of Organisation
Kalgoorlie	Bega Garnbirringu	KALGOORLIE
Kalgoorlie	Coolgardie Health Care (AHW)	COOLGARDIE
Kalgoorlie	Curtin University Kalgoorlie (Indigenous Services Co-ordinator)	KALGOORLIE
Kalgoorlie	Department for Community Development (DCD)	KALGOORLIE
Kalgoorlie	Population Health	KALGOORLIE
Kalgoorlie	WA Country Health, Goldfields South Coastal Health Regions	KALGOORLIE
Derby	Community Health	DERBY
Derby	Department for Community Development (DCD)	FITZROY CROSSING
Derby	Department for Community Development (DCD)	DERBY
Derby	Derby Aboriginal Health Service	DERBY
Derby	Derby Police Station	DERBY
Derby	Jayida Burru Abuse & Violence Prevention Forum	DERBY
Derby	Marnin Bowa Dumbara – Family & Domestic Violence Support & Outreach Service	DERBY
Fitzroy Crossing	Fitzroy Crossing Police	FITZROY CROSSING
Fitzroy Crossing	Karrayili Adult Education Centre	FITZROY CROSSING
Fitzroy Crossing	Kimberley Aboriginal Law & Culture Centre	FITZROY CROSSING
Fitzroy Crossing	Fitzroy Valley Community Health	FITZROY CROSSING
Fitzroy Crossing	Nindilingarri Cultural Health Service	FITZROY CROSSING
Broome	Broome Youth Support Group	BROOME
Broome	Burdekin Youth In Action	BROOME
Broome	Catholic Education Office	BROOME
Broome	Community Health	BROOME
Broome	Department for Community Development (DCD)	BROOME
Broome	Kimberley Population Health Unit	BROOME
Kununurra	Centrelink	KUNUNURRA
Kununurra	Community Health	KUNUNURRA
Kununurra	Department for Community Development (DCD)	KUNUNURRA
Kununurra	Office for Children & Youth Affairs	KUNUNURRA
Kununurra	Department of Justice – Juvenile Justice	KUNUNURRA
Kununurra	Disability Services Commission	KUNUNURRA
Kununurra	East Kimberley Community Recovery Centre	KUNUNURRA
Kununurra	Gawooleng Crisis Centre	KUNUNURRA
Kununurra	Jardamu Safe House	KUNUNURRA
Kununurra	Kimberley Aboriginal Medical Services Council	KUNUNURRA
Kununurra	Kinway	KUNUNURRA
Kununurra	Kununurra Youth Services	KUNUNURRA
Kununurra	Ord Valley Aboriginal Health Services (OVAHS)	KUNUNURRA
Beechboro	Stand By Me Youth Service	BEECHBORO
Perth	Youth Health Services	BEECHBORO
Rockingham	Anglicare	ROCKINGHAM
Rockingham	Bridging the Gap	ROCKINGHAM
Rockingham	Centrelink	ROCKINGHAM
Rockingham	City of Rockingham	ROCKINGHAM
Rockingham	Department for Community Development (DCD)	ROCKINGHAM
Rockingham	Kadadjinymia-Challenger TAFE	ROCKINGHAM

Consultation: Location or Type	Organisation	Location of Organisation
Rockingham	Palmerston Assoc	ROCKINGHAM
Rockingham	Parent Adolescent Counselling Service (PAC) Anglicare WA	ROCKINGHAM
Rockingham	Anglicare WA	ROCKINGHAM
Rockingham	Smith Family Learning for Life Program	ROCKINGHAM
Rockingham	Town of Kwinana	ROCKINGHAM
Rockingham	Youth Focus	ROCKINGHAM
Rockingham	Youthlink	ROCKINGHAM
Midland	CentreLink	BEECHBORO
Midland	City of Swan	BEECHBORO
Midland	Jobs Pathway	BEECHBORO
Beechboro	Centrelink - Midland	MIDLAND
Beechboro	Jobs Pathway Midland	MIDLAND
Beechboro	Oake House North East Metropolitan Community Drug Service Team	MIDLAND
Beechboro	Parkerville Children's Home	MIDLAND
Beechboro	Youth Health Services	PERTH
Midland	Parkerville Children's Home	BEECHBORO
Midland	Youth Health Services	BEECHBORO
Port Hedland	Pilbara Public Health	SOUTH HEDLAND
Port Hedland	Youth Involvement Council	SOUTH HEDLAND
Port Hedland	Hedland Senior High	SOUTH HEDLAND
Port Hedland	Newman Community Health	SOUTH HEDLAND
Port Hedland	Dept Community Development	PORT HEDLAND
Port Hedland	Wirrraka Maya Health Service	SOUTH HEDLAND
Port Hedland	Pilbara Division of General Practice	KARRATHA
Port Hedland	Department for Community Development -Youth Junior Council	SOUTH HEDLAND
Roebourne	Roebourne Community Health	ROEBOURNE
Roebourne	Department of Justice	ROEBOURNE
Roebourne	Pilbara Gascoyne Health Service	ROEBOURNE
Roebourne	Disability Services Commission	ROEBOURNE
Roebourne	Karratha Community Health	KARRATHA
Roebourne	Karratha Youth Housing	KARRATHA
Roebourne	Roebourne Police/PCYC	ROEBOURNE
Roebourne	Department for Community Development (DCD)	ROEBOURNE
Roebourne	Safe House	ROEBOURNE
Roebourne	Roebourne Youth Centre	ROEBOURNE
Roebourne	Mawarnkarra Health Service	ROEBOURNE
Roebourne	North West Mental Health Service-Karratha	KARRATHA
Roebourne	Child Health Roebourne/Wickham	KARRATHA
Balgo	Balgo Community Health Service (RN)	BALGO
Balgo	Diocese of Broome	BALGO
Balgo	Health Worker, Balgo	BALGO
Balgo	Balgo – Kutjungka Catholic Parish	BALGO
Balgo	Mercy Clinic Balgo & Kutjungka	BALGO
Balgo	Mercy Health Care	BALGO
Balgo	Mulan Community Health Service (RN)	MULAN VIA HALLS CREEK
Balgo	Office for Aboriginal Health	PERTH
Balgo	Palyalatju Maparnpa Health	BALGO
Balgo	Youth Worker	BALGO
Halls Creek	Halls Creek Community Health	HALLS CREEK

Consultation: Location or Type	Organisation	Location of Organisation
Halls Creek	Halls Creek Hospital	HALLS CREEK
Halls Creek	Halls Creek Police	HALLS CREEK
Halls Creek	Yura Yungi Medical Service Council	HALLS CREEK
Halls Creek	Jungarni-Jutiya	HALLS CREEK
Halls Creek	TAFE Kimberley	HALLS CREEK
Written Submission	Department of Health - South Metro Area Health Service	FREMANTLE
Written Submission	Fremantle Hospital B2 Clinic	FREMANTLE
Written Submission	Fremantle Regional Division of General Practice Ltd (GP Network)	MYAREE
Written Submission	Department of Health - Communicable Disease Control	PERTH
Written Submission	Combined Universities Centre for Rural Health	GERALDTON
Written Submission	Department for Community Development (DCD)	PERTH
Written Submission	Department for Indigenous Affairs	PERTH
Written Submission	Department of Justice	PERTH
Written Submission	Kimberley Aboriginal Medical Services Council	BROOME
Written Submission	Broome Hype	BROOME
Written Submission	Wheatbelt Public Health Unit	NORTHAM
Written Submission	North Metro Area Health Service - Population Health	PERTH
Written Submission	Australian Medical Association, Dr Yes Program	PERTH
Written Submission	The Smith Family	KWINANA
Written Submission	Mirrabooka Primary School	DIANELLA

Delivering a **Healthy WA**

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