



'Aboriginal Health and wellbeing is close to my heart' – Ken Wyatt

Here, The Hon KEN WYATT, Assistant Minister for Health and Aged Care, introduces himself to our members and stakeholders and tells of his plans to build strong, resilient communities capable of closing the gap.

THE health and wellbeing of our First Australians is an issue very close to my heart. I believe it is everyone's business to ensure every Australian has the same opportunities for good health and long life. It is a fundamental human right, and a reasonable expectation, that any baby born in Australia, Indigenous and non-Indigenous, should have the best possible start to life, the prospect of good health and the same rates of life expectancy.

I grew up in the WA Wheatbelt town of Corrigin, where I was given the opportunity of a good education. It's something I grabbed with both hands, because I knew that it was important. I think that's what inspired me to become a teacher.

After 16 years of teaching in classrooms I entered the public service, helping to shape Indigenous education and health policies in WA and NSW.

Now as the Federal Minister responsible for Indigenous Health I hope to shape a better future for all Indigenous Australians.

A decade after the campaign to close the gap between Indigenous and non-Indigenous Australians began, we are starting to see positive change. But we still have a way to go before the health and life expectancy of all Australians is equal.

The 2016 Closing the Gap report reveals the target to halve the disparity in child mortality rates by 2018 is on track and immunisation rates are high.

There have also been improvements in the Indigenous mortality rate from chronic diseases, particularly circulatory disease.

But Indigenous cancer mortality rates are rising and the gap there is widening.

The report also shows that we are not yet on track to close the gap in life expectancy by 2031. There still remains a 10.6-year difference for males and 9.5-year difference for females compared with non-Indigenous Australians.

Our Indigenous communities are increasingly under threat from the scourge of illicit drugs such as ice, and we have some of the highest suicide and domestic violence rates in the country.

Aboriginal and Torres Strait



Assistant Minister Ken Wyatt officially opening Yurri- Burri- Ba Dunwich Clinic Redevelopment on North Stradbroke Island.



In October Federal Health Minister Sussan Ley was welcomed at the QAIHC offices by UIIH CEO Adrian Carson, NACCHO Chair and QAIHC CEO Matthew Cooke, the retiring Chair of QAIHC Lizzie Adams, UIIH Deputy Chair Stella Taylor-Johnson and QAIHC COO Sandy Gillies.

Islander men and women are more likely to be hospitalised for family-related assault than non-Indigenous Australians, 28 times more likely for men and 34 times more likely for women.

This needs to change and these are issues we as a Government are addressing urgently.

Our National Ice Action Strategy will see \$241 million spent over four years for local specialist drug

and alcohol treatment services through Primary Health Networks (PHN), with the close involvement of Aboriginal community controlled health services.

We are committed to tackling domestic violence rates in our Indigenous communities, with \$85 million allocated over three years to improve access to culturally sensitive, integrated mental health services. Under this initiative,

PHNs will plan, commission and implement services joining up closely related services for Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, alcohol and other drug treatment.

Primary Health Networks in each region will collaborate closely with relevant local Indigenous and mainstream primary health care

organisations, including Aboriginal community controlled health services and peak bodies.

Prime Minister Malcom Turnbull recently announced a \$100 million domestic violence action plan that will make a real difference in keeping women and children safe. The plan includes \$21 million to support Aboriginal and Torres Strait Islander people.

In October, I travelled to WA's Kimberley region with Health Minister Sussan Ley and Indigenous Affairs Minister Nigel Scullion to see first-hand a community plagued by suicide, drug and alcohol addiction and domestic violence.

We sat down with local leaders to listen to their stories and to hear their thoughts on what services they need, and how we as a government can support their efforts to tackle suicide, drugs and domestic violence. This is the first of many roundtable-style talks I plan to hold with local groups around the country, because I believe that it is by listening and working together that we will build strong, resilient communities capable of closing the gap.

I look forward to working with all stakeholders in the future. It is through the outstanding work of groups like the Institute of Urban Indigenous Health, the advocacy of organisations like NACCHO and partnering with local communities that we will one day see an Australia where all Australian's have exactly the same life expectancy, the same opportunities for good health – and the gap closed.



An update on STIs and BBVs: Things are Hepatitis B – improving access to vaccination, diagnosis and medical treatment

By A/Prof BENJAMIN COWIE, Director of the WHO Collaborating Centre for Viral Hepatitis, Doherty Institute

ABORIGINAL people were among the first groups in who hepatitis B was discovered in the 1960s – which is why for a while the virus was known as 'The Australia Antigen'.

The proportion of Aboriginal and Torres Strait Islander people living with chronic (long-term) hep B is around 10 times that of non-Indigenous people born in Australia. Of the 230,000 Australians estimated to be living with hep B, around 20,000 are thought to be Aboriginal or Torres Strait Islander people, and new infections with hep B are still occurring at four times the rate in Indigenous Australians.

Most people living with chronic hep B were infected as babies or young children, with infection being passed from mother to child or between young children. Someone infected as a baby has a 90% chance of going on to chronic hep B, while someone

infected as an adult only has a 5% chance of going on to long-term infection, but can still get very sick in the short term. In Australia, most infections in adults are caused through sexual contact with someone with hep B, or through unsafe injecting drug use.

Chronic hep B infection usually causes no symptoms and for most people will cause no long-term health problems – but for around one in four people living with hep B, the virus can cause severe liver scarring (cirrhosis) or liver cancer.

We know that liver diseases are one of the important causes of the life-expectancy gap experienced by Indigenous Australians – hep B is one of the conditions responsible for this.

Recent evidence from research in the Northern Territory suggests that Aboriginal people have a unique strain of the hep B virus passed on over many years that could explain why hep B in some Indigenous people might have a more severe course.

Unlike the other STIs and BBVs, hep B can be prevented by a safe, effective vaccine which has been provided for all infants in Australia since 2000 (and in the Northern Territory since 1990).

As a result, new hep B infections in children born since 2000 (and in those who received adolescent catch-up vaccination from 1998 onwards) have fallen substantially. However, funded hepatitis B vaccine for Indigenous adults is available in only some states and territories, which limits access for Aboriginal and Torres Strait Islander people who remain at much higher risk of hep B infection.

This inequality in access cannot continue.

For people who already have hep B infection, vaccination has no effect. We know many people living with hep B, including Indigenous people, have never been diagnosed.

However, being tested for hep B is easy – it's a simple blood test which can tell whether someone has hep B, is immune

through past infection or vaccination, or if a person needs vaccination.

National guidelines suggest all Aboriginal and Torres Strait Islander adults whose hep B status isn't known should be offered testing.

If someone is found to have hep B, they should receive counselling and household and sexual partners should be tested and vaccinated if not immune.

Highly effective treatments for hep B are available in Australia that greatly reduce the chance of developing liver scarring or cancer, and involve taking a tablet once a day. However, unlike for hep C, these are not cures – treatment needs to continue, often for many years.

We know that in many areas of Australia where most people living with hep B are Indigenous, treatment uptake is very low. This needs to be changed urgently. With better access to prevention, diagnosis and treatment, the burden of hep B on Indigenous health can be eliminated in coming years.

TABOO OR NOT TABOO

AHCSA's Sexual Health Program features young South Australian Aboriginal men and women in local STI and HIV preventative and community engagement campaigns.

- Annual STI and HIV education workshops for Aboriginal Health Workers
- Incentives for young people to participate in peer education and STI screening
- Improved participation in STI screening activities

Aboriginal Health Council of South Australia
our health, our choice, our way

Aboriginal Health Council of South Australia's sexual health program continues to promote awareness and supports South Australian Aboriginal Community Controlled Health Services to participate in STI Control programs. The program promotes STI prevention, screening and treatment of Chlamydia, Gonorrhoea and Trichomonas. The team also continues to raise awareness about HIV and Syphilis prevention, screening and treatment. For more information <http://ahcsa.org.au/health-programmes/sexual-health/> Contact: Sarah Betts (08) 8272 7200.

Hepatitis C – the bad news and the good

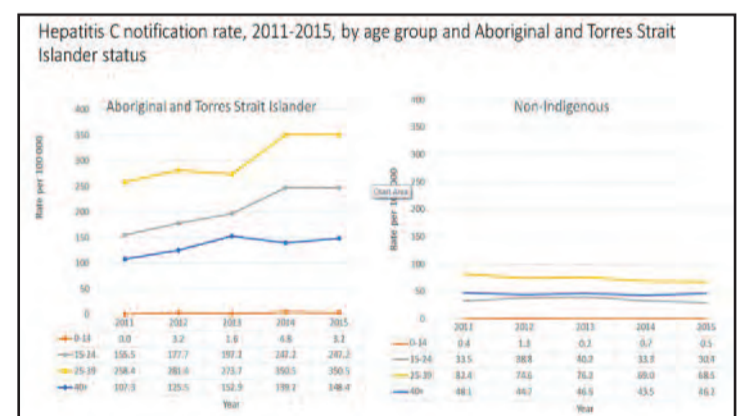
By A/Prof JAMES WARD, Head of Infectious Diseases Research, Aboriginal Health South Australian Health and Medical Research Institute

HEPATITIS C is a virus that affects the liver. It is thought that 95% of the hep C in Australia is acquired through sharing of injecting equipment or other equipment that transfers blood from one person to another, such as for tattooing.

Aboriginal and Torres Strait Islander people are overrepresented in hep C diagnoses in Australia, with an estimated 20,000-30,000 diagnoses in our population. Without treatment, hep C damages the liver, and can result in cancer and death.

The bad news is that over the past five years, rates of hep C diagnoses have increased by 43% in our community, yet the in the non-Indigenous community have been stable.

Particularly concerning are rates of diagnosis among people in the 15-24 age group, with rates eight times higher than non-Indigenous people in the same age group. This age group is concerning because it is most likely that these infections are new given the nature of hepatitis C being transmitted primarily through injection drug use.



Also of concern because of the high and rising Indigenous incarceration rates is the proportion of people in Australian prisons who are diagnosed with hep C, with an estimated 50-65% of all prisoners diagnosed with it.

The good news, however, is there is now a cure for hep C

Here are the facts.

- Daily tablets for 10-12 weeks are more than 90% effective of curing hep C

- The cost of these tablets is subsidised by the Government – a full script costs around \$40

- Hep C treatment can be organised by Aboriginal Community Controlled Health Services or any GP practice.

- There are very few side-effects from these new tablets that cure hep C.

In the first six months since

the Australian Government approved this new medication for treating hep C, almost 20,000 Australians have been cured. Of these we do not know how many Aboriginal and/or Torres Strait Islander people have been cured, but our suspicion is relatively low numbers.

Aboriginal and/or Torres Strait Islander people who have been diagnosed with Hep C have the right to get the advantage of this major breakthrough in hep C treatment.

Now is the time to encourage someone you know who is living with hep C to take treatment for this condition. The more people we can get cured of hep C the better the chances are of reducing new infections in the community.



bad, but there's some good news too...

HIV – are we at risk of losing the good news story in Aboriginal health?

Written by A/Prof James Ward South Australian Health and Medical Research Institute Adelaide; Dr David Johnson, Public Health Medical Officer, Aboriginal Health Council of SA; and Dr Salenna Elliott, Public Health Registrar, Aboriginal Health Council of SA

SINCE we started collecting HIV data among Aboriginal and Torres Strait Islander people in the early 1990s, rates of diagnosis have been similar or lower than for non-Indigenous people. It's been one of the good news stories of Aboriginal health for over two decades.

But is this all at risk?

Aboriginal people are at higher risk of HIV because of high rates of other STIs, because of increasing injecting drug use within communities including sharing of injection equipment between people, lower health literacy regarding HIV, and less access to primary health care and HIV specialist services.

Each year data are reported for all HIV diagnoses made in the previous year. These data are based on people reporting how they think they acquired HIV, e.g. via heterosexual sex, male-to-male sex, mother-to-child transmission, sharing injecting drug equipment etc. Data are also collected on Aboriginal and Torres Strait Islander status.

Over the past five years a worrying trend has emerged: HIV rates are stabilising in the non-Indigenous Australian-born population, while rates are increasing for our population.

The rate of HIV diagnosis among Aboriginal and Torres Strait Islander people is now for the first time more than double the non-Indigenous rate.

There are also important differences in how HIV is transmitted, with more cases among Aboriginal people attributed to heterosexual sex and injecting drug use.

In the past five years:

● 21% of cases in the Aboriginal population were attributed to heterosexual sex, compared to 14% amongst non-Indigenous people

● 16% of cases among Aboriginal people were attributed to injecting drug use compared to 3% of cases in the non-Indigenous population .

● 58% of new cases in the Aboriginal population were attributed to anal sex between men, compared to 80% among non-Indigenous people

These rising rates and different transmission patterns are of concern.

At the global level we have seen that HIV can escalate



THE Aboriginal and Torres Strait Islander HIV Awareness Logo above was developed for the national ATSIHAW Committee by Jasmine Sarin from JS Koori Designs who is an Aboriginal artist and graphic designer from Kamilaroi and Jerringa country of NSW.

quickly once it takes hold in marginalised populations such as Indigenous peoples, people who inject drugs, sex workers and prisoners. This has happened among Canada's First Nations peoples, and in Saskatchewan, clinicians and communities are calling for a state of emergency to be declared because of rapidly escalating HIV rates. Factors that place our communities at risk of an HIV epidemic include the high prevalence of other sexually transmissible infections (STIs) that increase risk of HIV transmission, limited access to sexual health services, education and prevention programs (particularly in regional and remote communities) and HIV-related stigma and shame.

For us to turn about the clear divergence in HIV rates we must act now.

While community education and awareness, condoms and safe sex are still the mainstay of HIV prevention – as are clean needles and syringes, detox services and drug rehabilitation for people who inject drugs – the use of HIV treatment medications is also now a major component of prevention strategies. We need to understand these new prevention tools and work out how to ensure their benefits reach our communities.

Treatment as prevention – the game-changer: Advances in HIV treatment medications mean that it's now possible for someone with HIV to live as long as the person next to them

who doesn't. Modern treatments also mean that the amount of HIV in the blood of a person with HIV can be reduced to an undetectable level. This is not a cure, but a person with an undetectable viral load is virtually non-infectious. At a community-wide level, the more people with HIV who reach an undetectable viral load the less chance there is for people to acquire HIV. This is called 'treatment as prevention'.

A drug to prevent HIV: There's also now a pill that can protect against HIV. Called Pre-Exposure Prophylaxis or PrEP for short, it involves HIV-negative people taking an HIV treatment antiretroviral drug before risk exposure, for example before having sex, to protect against contracting HIV. PrEP is only recommended for people most at risk of HIV, including men who have anal sex with men, and HIV-negative men or women with an HIV-positive partner.

Don't forget PEP: Post Exposure Prophylaxis is a tablet you take after a high risk exposure to HIV. PEP works by preventing HIV entering the lymph system, but only if it is given within 72 hours after the exposure. PEP is available at most hospital emergency departments and at sexual health services nationally.

For us to turn around rising HIV rates among Aboriginal people we need:

1. Enhanced community education and awareness about HIV and sexual health at both national and local level, such as Aboriginal and Torres Strait Islander HIV Awareness Week which has just completed its third year of activities.
2. Continued promotion of safe sex and safe injecting, with improved community access to condoms, testing and treatment for STIs, Needle and syringe programs.
3. Capacity for referrals to appropriate drug treatment services
4. Appropriate testing for HIV in Aboriginal primary care services for people at risk of HIV, including people who have a recent other STI diagnosis.
5. Enhanced early diagnosis and treatment rates, and education regarding the personal and community benefits of treatment as prevention.
6. Community education on HIV, including on 'treatment as prevention', PrEP and to address HIV-related stigma and shame.

The cure for HIV is still a long way off, so we all need to do our bit to ensure HIV doesn't take hold in our communities.

We acknowledge Ms Linda Forbes, of SAHMRI, who proof-read the articles here.

Hyper-vigilance is needed

By A/Prof James Ward, Head of Infectious Diseases, and Sarah Betts, STI Coordinator, Aboriginal Health Council of SA

RATES of common sexually transmissible infections (STIs) among our communities remain grossly disproportionate to rates among non-Indigenous Australians.

In the policy and programming context, it could be said that in the scheme of things, persisting high rates of STIs are alarming but not requiring more urgent attention than other areas of Aboriginal health, such as diabetes, cardiovascular and child and maternal health.

But should it be that way?

The failure to address high rates of STIs has immediate and long-term implications for our communities. Poor outcomes in pregnancy, shame and stigma, interpersonal violence as an outcome of STI transmission, infertility and a much higher chance that HIV will be transmitted are just some of these.

Those most affected are young

people, and the more remote a young Aboriginal person's community, the more likely they are to have not just one, but multiple STIs. Young people in our remote communities face many challenges – let's at least act to reduce the pervasive risk of STIs.

The main STIs

Let's take a look at some of the most common infections:

● **Chlamydia** is the most common STI in Australia, affecting both Aboriginal and non-Indigenous Australians, mainly in the age group 15-25 years. Rates among Aboriginal people are between three and five times that of the non-Indigenous population, whether in cities, regional and remote areas. Chlamydia rarely has symptoms. It is easily tested for and treated with a one-off dose of antibiotics. If not detected and treated, chlamydia can cause pelvic inflammatory disease and other serious complications in women, including poor outcomes in pregnancy.

● **Gonorrhoeae** and **syphilis** disproportionately affect young

Aboriginal people, particularly in remote and isolated communities. Rates of gonorrhoeae are 30 times higher for the Aboriginal population compared to the non-Indigenous population; and syphilis rates are five times higher.

An outbreak of syphilis that started in 2011 and has spread across northern and central Australian remote communities has us way out of reach of what once was thought to be possible; eliminating syphilis from our communities. Both STIs can cause major issues in pregnancy, including loss of the baby, and babies can be born with both infections. Both conditions are relatively easy tested for and treated with antibiotics.

● **Trichomonas** is another STI very prevalent among Aboriginal and Torres Strait Islander people. In remote communities we have found that around 25% of women found to have trichomonas.

Untreated Trichomonas can cause premature birth and low birth weight and of course facilitate HIV transmission.

Upping STI testing and treatment rates

So testing and treating STIs is straightforward if they're diagnosed early, but the consequences of failing to detect and treat infections are huge.

We need to understand what's stopping people getting tested. Shame and stigma obviously play a part, including for young people.

How can we get to the point that young people in our communities see sexual health checks as a normal part of living a healthy life? How can we ensure that babies aren't born with STIs?

The work happening at the individual health service and NACCHO affiliate level as well as in mainstream, is great. But we need to intensify our focus on:

1. Developing innovative community education and awareness to make sure young people are aware of these STIs and the need to test.
2. Equipping young people with skills and tools to prevent STIs.
3. Ensuring we are all aware

that STIs often don't have symptoms but are easily tested for and cured.

4. Ensuring our health services are offering regular testing as per clinical guidelines

5. Normalising STI testing, including by making sure that STI testing is offered as part of Adult Health Assessments, particularly for young people between 16 and 29 years.

6. At a broader systemic level I believe an additional two national KPIs would be beneficial for raising the profile of this issue, in addition to a special PIP for full STI and BBV testing and elevation of STI testing in the Adult health check.

We have been working hard in research, trying to make sense of why STIs are still so common and to develop strategies bring down these unacceptably high rates. But much more work is required.

The recent defunding of 20 or so Aboriginal sexual health worker positions in NSW should not ever have happened.

Hyper-vigilance is needed. Let's all get on to this together.