



North Queensland  
**HIV Roundtable**

# Introduction to the Roundtable

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Queensland is strongly committed to closing the gap in health outcomes for Aboriginal and Torres Strait Islander people.

The North Queensland HIV Roundtable (Roundtable) provided a platform for a range of key stakeholders to meet and discuss tried and tested, and new and innovative ways to promote the prevention and integrated management of HIV in Aboriginal and Torres Strait Islander people and communities. A strong focus of the Roundtable was on the timely availability of data, evidence and surveillance including the need to collect granular qualitative data.

In addition to key stakeholders being present, a consumer representative contributed to discussion about the unique benefits of peer support in responding to the increasing notifications of HIV in North Queensland, in addition to identifying some of the barriers to engaging in healthcare from an Aboriginal and Torres Strait Islander perspective.

The broad range of strategies voiced at the Roundtable in relation to community engagement, prevention, preparedness for an increased number of HIV cases and barriers to engagement in healthcare, will assist the Communicable Diseases Branch to inform the Series of National Guidelines (SoNG) development process – a recommendation of the 2015 National Summit on Rising Sexually Transmissible Infections (STI) and Viral Hepatitis in Aboriginal and Torres Strait Islander Communities.

The Sexual Health Ministerial Advisory Committee (Committee) and the Communicable Diseases Branch extends its gratitude to the delegates who gave so freely of their time and expertise in their particular field to contribute to the discussion and the success of the Roundtable.

## Background

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In December 2015, a national summit on rising HIV, STIs and viral hepatitis in Aboriginal and Torres Strait Islander communities was held in Brisbane. This summit was organised by the South Australian Health and Medical Research Institute (SAHMRI), the Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) and the HIV Foundation Queensland (HIVFQ) and aligned with the 2015 Indigenous AIDS Awareness Week.

One of the recommendations from the 2015 summit was that the Communicable Diseases Network of Australia (CDNA) and relevant working groups develop a 'National HIV Outbreak Response Guideline' specific to Aboriginal and Torres Strait Islander communities.

The *Queensland Sexual Health Strategy 2016–2021* (Strategy) provides an overarching framework for action in key areas of sexual and reproductive health, and provides a holistic and coordinated approach to many challenges including addressing health disparities in specific population groups.

The related action plans underpinning the Strategy include the *HIV Action Plan 2016–2021* and the *North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016–2021*. These action plans clearly articulate goals for working towards the virtual elimination of new HIV transmission, controlling syphilis outbreaks and progressively reducing the prevalence of STIs in all Queenslanders with a focus on the specific needs of Aboriginal and Torres Strait Islander people.

In June 2017, the Committee was established to provide advice to the Minister for Health and Minister for Ambulance Services on sexual and reproductive health matters in the context of the Strategy. During the proceedings of the inaugural Committee meeting, it was discussed that a Roundtable be convened to examine options to address the rising rate of HIV in Aboriginal and Torres Strait Islander people and communities in North Queensland.

## HIV in Queensland

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Nationwide, newly diagnosed HIV notification rates have been stable over the last five years. However, there has been an increase in HIV notification rates among Aboriginal and Torres Strait Islander people, with a rate in 2016 more than double the Australian born non-Indigenous rate.

A similar trend in newly diagnosed HIV notifications has been reported in Queensland data, and more specifically, the increase mainly occurred among Aboriginal and Torres Strait Islander males (from 12.5 cases/100,000/year in 2012 to 18.3 cases/100,000/year in 2016), while notification rates fluctuated or remained stable for Aboriginal and Torres Strait Islander females, non-Indigenous males, and non-Indigenous females.

In 2016, Queensland data shows Aboriginal and Torres Strait Islander males had the highest notification rate of new HIV diagnoses (18.3/100,000/year), followed by non-Indigenous males (6.8/100,000/year), Aboriginal and Torres Strait Islander females (1.0/100,000/year), and non-Indigenous females (0.9/100,000/year).

In 2016, there were 20 newly diagnosed HIV cases notified in Aboriginal and Torres Strait Islander people in Queensland, 11 (55%) of which were from Cairns and Hinterland Hospital and Health Service (HHS), four (20%) from Metro North HHS, three (15%) from West Moreton HHS, and one (5%) from each of Central West and Gold Coast HHSs.

Since 2012, there has been an increase in newly diagnosed HIV cases in Aboriginal and Torres Strait Islander people in Cairns and Hinterland HHS, with a total of 37 new cases from January 2012 to September 2017. There were 74 new diagnoses in non-Indigenous people during the same period.

## Purpose and approach

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The Roundtable was held in Cairns on 17 and 18 October 2017, and was convened in response to the rising rates of HIV in Aboriginal and Torres Strait Islander people in North Queensland.

The Roundtable was designed to gather information to assist in the development of a framework for the prevention and integrated management of HIV in Aboriginal and Torres Strait Islander people and communities to maximise the health response for individuals with HIV and minimise the risk of onward transmission of HIV. Over the course of the two-day event, group and concurrent sessions were hosted to allow for targeted and in-depth discussions with all participants.

The discussions were facilitated by Emeritus Professor Cindy Shannon, Chair of the Committee, with presentations delivered to support discussions that set the scene, and provided an outline of both national and regional HIV epidemiological data, and current HIV management responses.

Keynote speakers on the first day of the Roundtable included Associate Professor James Ward from the South Australian Health and Medical Research Institute, who provided an overview of considerations across the HIV care continuum specific to Aboriginal and Torres Strait Islander people. Additionally, Associate Professor Melissa Gilles from the Western Australia Centre for Rural Health, provided insight into lessons learnt from the Western Australia HIV outbreaks in 1998 and 2011.

Day two commenced with a breakfast program which included health workers speaking about their experiences working with Aboriginal and Torres Strait Islander people diagnosed with HIV. Dr Kingsley Pearson, Senior Medical Officer, Gurriny Yealamucka delivered a plenary session on Aboriginal and Torres Strait Islander community engagement.

Facilitated concurrent sessions were held to gather important information about community engagement, identification of cultural and other barriers to individuals engaging in prevention, testing and treatment for HIV and data collection.

The sessions were divided into different healthcare settings with discussion around specific topics including primary and secondary prevention activities, collection and use of data and information and management of complex cases.

A graphic recorder was contracted to capture the discussion during the Roundtable in a visual format. The illustrations could pin-point issues raised during the discussions and were displayed at the venue during the Roundtable which generated further conversations.

## Presentations summary

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### Setting the Scene

#### HIV epidemiology overview

*Presented by Dr Christine Selvey, Medical Epidemiologist, Communicable Diseases Branch, Health Protection NSW*

Dr Christine Selvey presented a national overview of the HIV data. In 2016, 91 per cent of new HIV diagnoses nationally were male and the main transmission risk was men having sex with men (MSM) accounting for 70 per cent of the diagnoses. Twenty-one per cent of cases were attributable to heterosexual sex, 5 per cent to MSM and injecting drug use and 1 per cent to injecting drug use only.

Fifty-one per cent of HIV notifications nationally in Aboriginal and Torres Islander people were attributable to MSM, 20 per cent to heterosexual sex, 14 per cent to MSM and injecting drug use and 14 per cent to injecting drug use only (risk exposure data, 2012–2016). Dr Selvey highlighted the continued and increasing concern about injecting drug use exposure among Aboriginal and Torres Strait Islander people, and presented data detailing that from 2007 to 2016, the proportion of people identifying as Aboriginal or Torres Strait Islander participating in the national Needle and Syringe Program survey increased from 10 per cent to 18 per cent.

Forty-six of the 1,013 new HIV notifications in 2016 were in Aboriginal and Torres Islander people. Whilst the number was small, Dr Selvey highlighted the increasing divergence in the annual HIV notification rates between Aboriginal and Torres Strait Islander people and non-Indigenous Australian-born people. In 2016 the age standardised rate for Aboriginal and Torres Strait Islander males was double the rate for non-

Indigenous males and three times higher for Aboriginal and Torres Strait Island females compared to non-Indigenous females.

### Epidemiology of current North Queensland group of cases

*Presented by Dr Stephen Lambert, Medical Director, Epidemiology and Research Unit, Communicable Diseases Branch, Department of Health*

Dr Stephen Lambert outlined the role of the Communicable Diseases Branch, Department of Health and Hospital and Health Services in the notification process, including the collection of demographic risk factors to assist with enhanced surveillance of HIV. In Queensland, HIV notifications are recorded on the Notifiable Conditions System (NoCS) administered by the Communicable Diseases Branch. Name codes are used for HIV notifications for anonymity.

Dr Lambert highlighted the different demographics in Queensland for Aboriginal and Torres Strait Islander people contracting HIV compared to non-Indigenous people. From 1 January 2007 to 30 September 2017, 53 per cent of new diagnoses of HIV among Aboriginal and Torres Strait Islander people were in those aged 29 and younger, compared with 28 per cent of notifications for non-Indigenous people. Forty-four per cent of the new diagnosis in non-Indigenous people were aged 40 years and over, compared with 24 per cent in this age group for Aboriginal and Torres Strait Islander people.

The key differences in risk exposure in Queensland 1 January 2007 to 30 September 2017 were:

- a higher proportion of injecting drug use as the main risk among Aboriginal and Torres Strait Islander people diagnosed with HIV (8%) compared to non-Indigenous people (2%), with a higher proportion also reporting injecting drug use among Aboriginal and Torres Strait Island men who have sex with men (MSM) at 13 per cent compared with five per cent among non-Indigenous MSM.
- a lower proportion of diagnosis among heterosexual Aboriginal and Torres Strait Islander people (13%) compared with non-Indigenous people (21%).

Dr Lambert presented data collated from available information at the Communicable Diseases Branch and Cairns Sexual Health Service demonstrating connections between HIV cases who named another notified case as a previous sexual contact. This data showed an epidemiological link with another HIV notification in 10 of the 37 cases in Aboriginal and Torres Strait Islander people, compared with eight epidemiological links between the 74 notifications in non-Indigenous people. There was no information obtainable from available sources to identify any connections for 25 Aboriginal and Torres Strait Islander people or 62 non-Indigenous people.

Dr Lambert emphasised that these links cannot be used to infer transmission. Instead, this analysis demonstrates the gaps in surveillance data in terms of contact tracing and treatment information for all HIV notifications.

### *Considerations across the HIV continuum specific to Aboriginal and Torres Strait Islander people and communities*

*Presented by Associate Professor James Ward, Head of Infectious Disease Research, Aboriginal Health, South Australian Health and Medical Research Institute*

Associate Professor Ward presented a range of data detailing the burden of STIs and HIV in Aboriginal and Torres Strait Islander people, noting that until recently HIV notifications in Aboriginal and Torres Strait Islander people in Australia were comparable to that in the general population. Recently, notifications have been increasing. A/Professor Ward drew parallels to the experiences of Saskatchewan's (Canada) First Nation's people where HIV rates have increased to 11 times that of the national rate.

A/Professor Ward presented a modelling tool developed by the European Centre for Prevention and Disease Control (ECDC) that uses evidence-based methods to calculate HIV incidence in a given population. With this tool, it is possible to estimate the number of people living with HIV including those not diagnosed, the annual number of new infections, the average time between infection and diagnosis and the number of people in need of treatment according to CD4 cell counts.

A multi-strategy response to the current increase in notifications to Aboriginal and Torres Strait Islander people in North Queensland was proposed which includes education and improved health literacy, community empowerment, adequate primary healthcare blood borne virus (BBV) testing, access to pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), early access to and retention in anti-retroviral therapy to maintain an undetectable viral load for those diagnosed with HIV, as well as improved access to needle and syringe programs and opioid substitution treatment in Aboriginal and Torres Strait Islander people populations.

### *Key inclusions for a Framework for Prevention and Integrated Management of HIV in Aboriginal and Torres Strait Islander people and communities*

*Presented by Dr Annie Preston-Thomas, Public Health Medical Officer, Cairns and Hinterland Hospital and Health Service*

Dr Preston-Thomas presented an overview of the proposed structure of the Framework for the Prevention and Integrated Management of HIV in Aboriginal and Torres Strait Islander people and communities and the considerations to account for during the development phase.

Dr Preston-Thomas spoke about the epidemiological analysis of cases to identify who is at risk, where and when they may be at risk and the possible modes of transmission in specific groups including men who have sex with men and injecting drug users. This is particularly relevant in targeting those cohorts most at risk when developing the Framework to respond to the increasing notifications of HIV occurring in North Queensland.

The assignment of priority, rigorous governance and a management team to provide expert advice as necessary were further identified as crucial steps to undertake when developing the Framework. Other steps that Dr Preston-Thomas spoke to included undertaking a baseline needs assessment and the identification of gaps, comprehensive stakeholder and community engagement and health promotion, best practice sexual health service delivery, prevention activities, the alignment of new and existing resources, and what are the data requirements to inform appropriate strategies and monitor progress.

## Current management response

### Management of people living with HIV who place others at risk of HIV

*Presented by Dr Sonya Bennett, Executive Director, Communicable Diseases Branch, Department of Health*

Dr Bennett provided an overview of the *Guideline for the Management of People Living with HIV (PLHIV) whose behaviours may place others at risk of HIV*. The guideline covers a very small number of PLHIV. Dr Bennett stressed that supportive public health management of PLHIV is the first response, and the primary aim is to engage people in HIV treatment and care, and promote lifelong behaviour change to minimise transmission risk.

The guideline provides direction to the Department of Health and Queensland clinicians on managing PLHIV whose behaviours are of concern and potentially placing others at risk. It includes a five-level framework for case management. Dr Bennett discussed the role of the multidisciplinary HIV Advisory Panel that she chairs, and the role of the HIV Public Health Team based in the Department of Health's Communicable Diseases Branch (CDB) in supporting PLHIV and clinicians.

### The public health role in complex case management

*Presented by Jacqueline Kennedy, HIV Public Health Nurse, Communicable Diseases Branch, Department of Health*

Ms Kennedy provided information about the role of the HIV Public Health Team based in the department's CDB. This specialist team manages the notification and enhanced surveillance of HIV in Queensland, and provides advice and assistance with referral pathways into HIV care and ongoing management. They also assist clinicians with confidential HIV contact tracing and provide advice to assist clinicians managing people with HIV who may place others at risk of HIV.

Ms Kennedy noted that some individuals may require extra support to minimise HIV transmission risks, and that case management is an intensive process to remove barriers and support the person to engage in HIV related care and treatment, reduce future risks and enable contact tracing and treatment of partners who are or may have been at risk.

Undertaking case management was noted to be challenging in Aboriginal and Torres Strait Islander communities and in areas that currently don't have easily identifiable referral pathways or discreet, accessible services or local access to specialist clinicians. Contact tracing in small communities can be difficult and requires persistence and ingenuity. Specialist contact tracers can also assist.

Some people diagnosed with HIV have multiple or complex health related needs, unable to be managed by the client alone, and a multidisciplinary team of health and social support care providers may need to be involved.

## Current management response and complex case management

*Presented by Dr Darren Russell, Director Sexual Health, Cairns and Hinterland Hospital and Health Service*

Dr Russell's presentation drew on the Canadian experience to illustrate the magnitude of HIV in Canada's First Nation's people and the similarities to the rising notifications of HIV in Aboriginal and Torres Strait Island people in North Queensland.

Dr Russell then spoke about the current profile of the individuals in need of case management in Cairns including young people who often are highly mobile, have poor housing situations, poor finances, may have alcohol and drug issues, and poor engagement with health services or compliance with treatment.

Dr Russell articulated the social issues along with family responsibilities and cultural barriers such as stigma and shame which can cause leaks from the treatment cascade. Consequently, it was presented that there is a critical need for a multi-disciplinary care team with resources to travel to communities, as well as for comprehensive contact tracing and community linkages which relies on establishing rapport and trust over time.

## Lessons to be learned from Western Australia

*Presented by Associate Professor Marisa Gilles, Western Australia Centre of Rural Health*

Associate Professor Gilles presented about a case of HIV identified in 1994 in a remote Aboriginal community that resulted in a cluster of 20 cases, with a further six cases identified in 2011 linked to another remote location. Most cases were in young heterosexual women under the age of 22 years.

A/Professor Gilles advised that managing this cluster required an intensive public health response including case management, community awareness and health promotion with an initial team of five additional people formed to provide holistic clinical care and support. A/Professor Gilles emphasised the crucial role of Aboriginal Health Workers in the response.

Isolation was identified as a major issue for the clients, who experienced shame and a fear of community rejection. Retreats organised to form a support network for the women were a key component of the response.

A/Professor Gilles highlighted the need to collect data to assess the adequacy of the response including data on mortality, type and number of occasions of service, HIV viral loads, CD4 counts and pregnancy outcomes. The challenges included dealing with the chronicity of HIV, addressing alcohol and drug issues and homelessness and mobility highlighting the need to provide a 'one-stop' approach to health was also presented.

Pregnancy outcomes were a success with only two babies being born HIV positive out of a total of 26 babies born to this cohort of women. Achieving these outcomes required daily observed therapy to eight months gestation, with two staff dedicating up to three hours a day to achieve this. Crisis accommodation was also provided.

## Community Engagement

How do we effectively engage with Aboriginal and Torres Strait Islander people and communities across the care continuum – from prevention to complex case management?

*Dr Kingsley Pearson, Senior Medical Officer, Gurriny Yealamucka Health Service*

Dr Pearson spoke about the success of engagement and community managed programs in Yarrabah through Gurriny Yealamucka health service because these programs are underpinned by community ownership and control over decision making. It was noted that culture is central to the program, partnerships between local Aboriginal and Torres Strait Islander staff and non-Indigenous staff, and that using a team approach and trusting relationships with partners are established through networking and flexibility in implementation of programs.

Dr Pearson highlighted that the keys to engaging clients in sexual health care includes regular screening in the clinic and outreach adult health checks, opportunistic screening, treatment and contact tracing, retesting, education and awareness about sexual health, partnering with other health services for contact tracing, providing transportation, being culturally appropriate for both men and women, printed resources, campaigns, peer education workshops, and annual health checks for young people and adults.

Dr Pearson spoke about a social and emotional wellbeing model of care that has been implemented in Yarrabah where a biomedical and sociological, cultural and spiritual worldview, theory, skills and values are linked to recognise both physical and social determinants of health. Dr Pearson suggested that this model of care could be implemented in other sexual health services to curb the current increase in notifications of HIV.

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# Concurrent sessions summary

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The concurrent sessions focused on healthcare settings with discussion around specific topics including primary and secondary prevention activities, collection and use of data and information and management of complex cases.

The facilitated group sessions were structured to gather information for the development of a Framework for the Prevention and Integrated Management of HIV in Aboriginal and Torres Strait Islander people and communities to maximise the health response for individuals with HIV, and minimise the risk of further cases of HIV, along with important information about cultural and other barriers to individuals engaging in testing and treatment for HIV.

During the registration process on day one of the Roundtable, participants indicated their preference for which concurrent session they wanted to attend. Most participants elected to attend the Aboriginal and Torres Strait Islander community setting (n=30) and the primary healthcare setting (n=30) sessions, with a smaller number of participants attending the secondary/tertiary setting (n=20) session. Discussion was guided by a facilitator at each session using pre-prepared worksheets with a structured set of questions.

It was agreed across all three settings, that data and information collection needs to be enriched by qualitative data and research to enable understanding of opinions, motivations and social factors to develop insight into barriers and assist to understand diversity in populations. To enable the capture of such information, a review of data definitions to allow for specific Indigenous identification of terms would be required.

All groups concurred with the benefits of timely availability of testing, notification, contact and treatment data including mapping of care cascades locally would support and enhance a timely regional management response of an increased number of cases of HIV.

Key themes articulated at the Roundtable will be incorporated into the development of a framework for the prevention and integrated management of HIV in Aboriginal and Torres Strait Islander people and communities in North Queensland.

Clearly defined and articulated governance structures will outline responsibilities, accountabilities and provide leadership at the highest level. Commitment to a shared vision to reduce the rates of HIV and STIs in North Queensland while improving the health and wellbeing of Aboriginal and Torres Strait Islander people is needed to progress the Roundtable recommendations.

The following is an analysis of each of the concurrent session discussions.

## **Aboriginal and Torres Strait Islander community setting**

Participants in the Aboriginal and Torres Strait Islander community setting group engaged in discussion about the value of the Indigenous Health Worker (IHW) in health promotion and education to improve health literacy and awareness in community members. There was acknowledgement amongst the group that the IHW role is critical to enhancing community engagement and culturally appropriate healthcare. In addition, this group advocated for a workforce strengthened by increased numbers of IHW's supported by specific education and training.

Management solutions suggested by this group include the development of partnerships across the sector to address the social supports clients require to enable engagement in healthcare.

The benefits of a peer support model were strongly praised, particularly for clients newly diagnosed with HIV to navigate the health system and build relationships for ongoing support.

The importance of contact tracing as a component of management was raised across all settings, as were the barriers related to contact tracing, including the increased human resource requirements associated with contact tracing in Aboriginal and Torres Strait Islander communities, confidentiality, shame and high mobility of clients.

### **Primary healthcare setting**

When considering a preventive approach in primary healthcare settings, the discussion focused on provision of education and training for healthcare providers relevant to HIV prevention strategies, including PEP and PrEP, condoms and needle and syringe programs (NSPs).

Further discussion focused on the important role of IHWs in supporting clients to adhere to treatment regimens. It was however noted that there are currently limitations for IHWs in administration of medication for HIV management; this restriction is unique to Queensland.

It was agreed by the group that primary healthcare providers may benefit from access to additional public health unit and allied health workforce, to support them in the management of complex cases of people living with HIV (PLHIV). A regional partnerships approach was suggested to increase capacity to manage complex cases locally and to respond to an increased number of cases.

### **Secondary and tertiary healthcare settings**

In the secondary and tertiary healthcare settings, hospital emergency departments have a key role to play in prevention through testing and education. Emergency department clinicians could further be supported in this role through the introduction of a sexual health liaison position, to foster partnerships across the tertiary setting, increase the opportunity for testing, client and clinician education and augment referral pathways to community-based services.

Participants of this group also recognised the importance of case management models, like the chronic disease management model, which takes a social support approach along with peer support to enhance the integrated management of HIV in Aboriginal and Torres Strait Islander people.

Contact tracing was again a focus of discussion with acknowledgement of the resource intensive long-term approach required to establish relationships and build trust with Aboriginal and Torres Strait Islander people and communities.

# Towards a Framework for Prevention and Integrated Management of HIV in Aboriginal and Torres Strait Islander people and communities

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Following the concurrent sessions, a panel was formed with the facilitator of each group, comprising Associate Professor John Willis, Associate Professor James Ward, and Dr Darren Russell to present and discuss the key themes that were raised by participants in the concurrent sessions. Questions and further discussion was facilitated from the broader audience by the Roundtable Chair Emeritus Professor Cindy Shannon.

The information below is representative of the key themes that were presented and discussed during the panel discussion. While additional contextual information has been added by the department, to provide an enhanced evidence base to develop the Framework for Prevention and Integrated Management of HIV in Aboriginal and Torres Strait Islander people and communities, the information documented may not be representative of the department's position.

## A preventative approach

- **Workforce:** increased number of IHW positions and IHW training, upskilling of generalist clinical staff, including allied health, general practitioners and community-controlled health services.

In remote communities, recruitment and retention is significantly impacted on by inadequate provision of incentives for IHWs, that are usually provided to other health care workers e.g. housing, professional development allowance (including leave), professional support and career development opportunities. To overcome these barriers to IHW recruitment and retention, the following are suggested areas for improvement:

- Suitable training for entry-level through to advanced-level IHW is provided, including greater support for students, more opportunities for practice-based mentorship, group learning, residential schools and funds to support completion of higher education.
- Career advancement opportunities are available for IHWs.
- Support for increased clinical roles and additional support mechanisms (e.g. mentoring, clinical guidance) established.
- Training pathways and organisational structures/opportunities to attract people to community development/engagement and health promotion roles and career pathways; or other health related roles.
- Reducing barriers to completion of formal training required for scope of practice.

- **Health literacy and health promotion:** activities in schools and communities, including health literacy for community members about HIV testing, treatment, medications and stigma and discrimination associated with HIV.

Sexual health promotion covers a broad range of activities that are best conceptualised using the Ottawa Charter for Health Promotion framework. This approach emphasises working with communities to improve the conditions that determine sexual risk for high-risk populations. It includes; reorienting health services, community engagement strategies, population-wide sexual health communications, school-based sexuality and relationships education, and improvements in access to PEP, PrEP, NSPs and condoms. Building this broad sexual health promotion capacity will be critical for sustainable and continuing improvements in sexual health outcomes.

In addition to addressing the conditions that determine sexual risk, specialised community engagement, social marketing and evidence based education for Indigenous people, including curriculum based education for young people, is essential to raise individual and community awareness of HIV testing, treatment, medications and stigma and discrimination associated with HIV.

Health promotion programs will improve health literacy and address gaps in knowledge about their risk of acquiring HIV, and build self-efficacy to seek healthcare services to access and learn about treatment as prevention.

Community leaders are necessary partners in this process to ensure cultural appropriateness.

- **Testing:** increase opportunist testing, normalise testing in healthcare, more frequent testing for those at risk, increased and targeted testing of young people, testing of women and routine inclusion of testing in antenatal care.

Testing of individuals is the primary tool for diagnosing people with HIV and the immediate priority should be implementing effective screening strategies. Recruitment strategies should also consider how a positive diagnosis is communicated as this is an event that shapes how people understand and deal with the implications of a positive diagnosis. Access to culturally appropriate testing and diagnostic services is crucial in meeting the target that 90% of people with HIV know their HIV status, and services need to reflect the geographic spread and cultural diversity of the Aboriginal and Torres Strait Islander population.

- **PrEP and PEP:** integrated approach to prevention including health promotion and condom provision and bio-medical prevention.

Prevention strategies include condoms and other safe sex practices, PrEP, PEP and safer injecting drug use.

PrEP and PEP are bio-medical interventions. PrEP involves high-risk individuals taking HIV medication daily to prevent HIV from becoming established in the body. PEP is a one-month course of HIV antiretroviral therapy (ART) taken within 72 hours of a high-risk exposure to prevent becoming infected.

Other prevention strategies include increased testing rates, reducing the time between infection and diagnosis and early and sustained treatment for people living with HIV to achieve undetectable viral load.

Raising awareness among Aboriginal and Torres Strait Island communities of these strategies will assist in ensuring an effective prevention program.

- **Needle and Syringe Programs:** scale up NSPs in communities in consultation with community boards.

The provision of sterile injecting equipment through a variety of NSP outlets is a proven measure for the prevention of HIV and other BBVs. While the bulk of needles and syringes are distributed in major urban and regional centres, there is a need to ensure access in more rural and remote parts of Queensland. Needle dispensing machines (NDMs) have been successfully deployed across South-West Queensland. NDMs can provide anonymous 24-hour access to sterile injecting equipment without the need for additional staff.

- **Co-payments for anti-retroviral treatment:** are considered a barrier to treatment.

The individual and public health benefits of early and ongoing HIV ART are now well established with evidence confirming reduced mortality and morbidity. HIV transmission risk is dramatically reduced to negligible levels when a person with HIV is engaged in HIV medical care, is taking ART and has sustained undetectable HIV viral load. For these reasons access to affordable HIV treatment in a timely manner is important.

From 1 January 2017, the co-payments are \$38.80 for most PBS medicines or \$6.30 for concession card holders. This may present a financial barrier for some people living with HIV who may have a range of complex social and financial needs and time-limited financial support is available through Queensland Positive People's HIV Emergency Treatment Fund and Complex Client Fund. HHSs are independent statutory authorities and make local decisions about if co-payments may be waived in particularly pressing circumstances.

- **Cross border considerations:** Papua New Guinea (PNG) and high rates of HIV.

Sexual Health Services in Queensland treat a small number of PNG patients with HIV. Most of the PNG patients are Medicare ineligible, but some services, including Cairns Sexual Health Service, can treat patients on compassionate ground with support from pharmaceutical companies. PNG has a national HIV program, which provides free treatment and there is regular intergovernmental liaison between Queensland and PNG through the Torres Strait Cross Border Health Issues Committee.

## Integrated management response and treatment

- **Preparedness for management of increased number of cases:** convene a high-level cross-agency summit meeting to discuss a regional response and the ability to mobilise a regional response.

It is not possible to provide a specific definition of an HIV outbreak that can be universally applied. A working definition is: a greater than expected number of HIV cases diagnosed over a short period within a defined region or sexual network. The cases may arise independent of each other or from a single contact tracing effort.

Participants suggested that a high-level cross-agency meeting should be convened to determine whether the increase demonstrates recent or linked infections, is a real increase in local incidence and whether there are increases in contiguous regions/jurisdictions. An increase in testing locally cannot explain the finding of a cluster of cases of HIV given that HIV has historically been low in rural/remote populations in Australia. Within remote communities, 1-2 new HIV diagnoses may be

considered an outbreak, and it is essential that the healthcare workforce is aware of this, and prepared to respond accordingly.

The response may require an urgent re-prioritising of routine work and the allocation of existing staff and resources to address treatment and contact tracing.

- **Partnerships:** between health and the social service sector, clinician networks across government and non-government agencies, for example, uptake opportunities to provide education and treatment in custodial settings for Aboriginal and Torres Strait Islander people in North Queensland.

Forging partnerships and developing strong working relationships across different elements of the health sector, including government and non-government bodies, is essential to improving treatment uptake and adherence for people living with HIV.

In addition, promoting opportunities for shared learnings and knowledge exchange through participation in professional development is crucial, as well as in planning, implementing and evaluating health promotion activities in consultation with community controlled health services (CCHS), key community groups and stakeholders.

The Deadly Sex Congress held annually in Queensland is an important professional development event for IHW working in the sexual health field. From 2017, the Congress is supported by regional networking updates across Queensland.

- **Social support:** establish partnerships across the social service sector which enables a broad and holistic approach to supporting Aboriginal and Torres Strait Islander people living with HIV (PLHIV).

It is important for organisations who offer services to Aboriginal and Torres Strait Islander PLHIV, to ensure that the services are culturally appropriate, affordable and accessible to those in rural and remote areas. Services also need to ensure they promote an environment free of stigma and discrimination, and address important issues such as 'self-banishment', to encourage people back to community.

- **Models of care:** provision of both 'outreach' and 'in-reach' sexual health liaison services, specialised teams including social worker support, increased peer navigation, better use of health pathways, service hub model offering a multidisciplinary, individualised, holistic and culturally appropriate management response.

A multi-disciplinary team is required including skilled HIV nursing and IHWs with a maximum case load of 10-15 clients. Other team members should include a dedicated senior medical officer, senior public health officer, a health promotion officer, social worker and pharmacist. The Sexual Health Service should be the hub in the model, and support prescribing within primary healthcare, particularly the AMSs, to enable access to ART across the geographical area, including remote areas. The team should draw on the skills and expertise of non-government case workers to assist in retaining people in care, address housing needs and assist clients in managing finances. Crisis accommodation may need to be provided for some clients. There is a need for on-going access to specialist drug and alcohol advice, and access to NSPs should be considered. Provision for directly observed therapy should be considered for some clients including some pregnant women.

Activities involved in complex case management are multifaceted and time consuming and may require accompanying clients to appointments and supervising treatment supply.

- **Indigenous specific and culturally appropriate:** models of care, for example, Deadly Choices.

Improving the cultural competency of health care services can increase Aboriginal and Torres Strait Islander peoples' access to health care, increase the effectiveness of care that is received, and improve the disparities in health outcomes.

- **Workforce:** specialty training to overcome the limited scope of practice for administering medication and treatment by non-medical practitioners.

ART is provided to most people living with HIV. ART is classified as a 'section 100 Highly Specialised Drug', restricting prescribing to tertiary consultants and general practitioners (GPs) who are accredited and maintain their continuing professional development in HIV. There are more than 50 HIV accredited section 100 prescribers in Queensland. HIV is now a manageable chronic disease, and changing HIV medication prescribing to section 85 would enable all GPs to prescribe. This would require a change to national legislation.

Considering legislative change in Queensland to enable nurse practitioner prescribing may be an alternative option to increasing access to HIV medication supply. Nurse practitioners are the most senior nurses involved in diagnosing and treating patients. In Queensland, the *Health (Drugs and Poisons) Regulation 1996* enables nurse practitioners under the provisions of the *Drug Therapy Protocol – Nurse Practitioners* to; prescribe, give a written or oral instruction to administer or supply; or administer or supply scheduled medicines. This requires a defined 'practice scope' within six areas of metaspecialties. HIV could fall within the meta-specialties of the care of people with long-term conditions and primary health care. Work would need to be undertaken to define the expected HIV clinical speciality standards and clinical education requirements for nurse practitioners. Training packages could be commissioned to support nurse practitioners to meet the defined scope of practice.

- **Contact tracing:** is resource intensive and requires a standardised process for follow-up.

When patients are diagnosed with HIV it is vital that testing and treatment of their sexual partners is discussed and supported in a timely manner. Detection of HIV in contacts has the potential to reduce further transmission and allows early initiation of treatment in contacts diagnosed with HIV. For exposures to HIV within the last 72 hours, contacts may benefit from PEP.

Contact tracing is a delicate task and should not involve blaming the person with HIV. It may be difficult to manage in small communities and local knowledge is important to ensure appropriate follow-up of contacts. Contact tracing can be resource intensive, and each case will differ and may require persistence and ingenuity. Most people want to assist in the process, so it should not undermine the therapeutic relationship with the client. Clients who are well-informed, motivated and self-confident, can self-manage the contact tracing process and specialist contact tracers are available to assist clinicians when required.

## Data, evidence and surveillance

- **Qualitative Data:** collected to enable a sound understanding of opinions, motivations, barriers and social factors, including monitoring of stigma and discrimination of specific population groups.

To collect any data, where it may be quantitative or qualitative, standardised rigorous methodologies are followed. For example, data collected by the NOCS, is by its very nature quantitative. Enhanced surveillance data is collected by the HIV Public Health Team which takes the form of a standardised questionnaire (defined by the National BBVSTI Surveillance Subcommittee) which is sent to the notifying doctor for completion.

Qualitative data is collected by conducting small focus groups of between two and eight people. The discussion is guided by a pre-determined set of questions. Focus groups are conducted until the identified themes recur. Transcripts of the recorded audio files are then produced, analysed, recommendations identified of each theme and subsequently reported. Before conducting any qualitative research, appropriate approval needs to be sought from a Human Research Ethics Committee (HREC).

The HIV Roundtable could be considered a qualitative data collection exercise, in that a discussion was held with pre-determined questions, a graphic transcription was produced, this report could be considered the analysis of the themes and there will be recommendations at the end of the report. Attendees also gave consent upon registering for the event.

The need for rich qualitative research was a recurring theme of the HIV Roundtable. Qualitative research seeks to examine the 'lived experiences' and world views of people, rather than focusing on population surveillance. Collaborations of the department, HHS and NGOs would be better placed to progress this recommendation.

- **Evaluation:** of the peer navigator model.

As for conducting any qualitative research, the evaluation of either the process of establishing a service, developing a product, policy or resource, or assessing an outcome evaluation (the short, medium and long-term outcomes), involves following rigorous methodological guidelines and principles and is a specialised field of expertise. The purpose of any evaluation needs to be defined, articulated and agreed by all stakeholders to guide the methodology, but generally includes systematic collection and analysis of data to subsequently make an evidence-based conclusion regarding the effectiveness or efficiency of the subject under evaluation.

The need for an evaluation of the "Peer Navigator Model" was raised several times during the HIV Roundtable. An advisory committee would define with stakeholders the guidelines and scope of the evaluation, and contract the services of an experienced evaluator to carry out the evaluation.

[https://www.aes.asn.au/images/stories/files/membership/AES\\_Guidelines\\_web\\_v2.pdf](https://www.aes.asn.au/images/stories/files/membership/AES_Guidelines_web_v2.pdf)

- **Testing data:** is difficult to acquire; additional data from medical services within prisons is available and should be incorporated into reporting.

There are several issues around testing data. Pathology testing is conducted in Queensland by either the Queensland Health laboratories, or by private commercial companies.

Generally, the Queensland Health Sexual Health Services send their specimens for pathology to the Queensland Health laboratories for testing and doctors in general practice use private

pathology companies. Any positive result from these tests is electronically transmitted from the laboratories to CDB NoCS.

The following should be noted:

- The private companies are under no obligation to collect information regarding Indigenous identification; however, Indigenous status is collected on the pathology request slip by Queensland Health.
- The custodian of the NoCS data is not the custodian of the Pathology Queensland data.
- CDB can access Pathology Queensland data to analyse for reporting purposes but does not have access to private laboratory data.
- CDB is currently negotiating with private companies regarding the provision of aggregated data for monitoring the state-wide trends in testing, however as previously mentioned this will not include disaggregation by Indigenous status.
- The issue of including Indigenous status on the request forms of private companies is currently under investigation by several national committees.

The suggestion of incorporating testing data from correctional centres in reporting will be investigated by CDB including the issue of custodianship of the data.

- **Protocols:** established to enable timely sharing of sensitive data to enhance the system response to increased notifications.

When the CDB HIV Public Health Team receive a positive HIV test from the reference laboratory, a fax with a form to collect the enhanced surveillance information is then sent to the doctor who initially requested the test. The enhanced surveillance data is a national requirement for reporting to the National HIV Registry, and monitoring and surveillance of the patterns of disease reporting and acquisition in Queensland.

The follow-up of new diagnoses of HIV by the CDB HIV Public Health Team to obtain this necessary data is an ongoing process and can take a few months to complete.

The number of new notifications of all notifiable conditions in Queensland is reported and updated weekly on the Queensland Health website <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/notifiable/weekly>

Annual totals are also available and new notifications of HIV are reported by Queensland Health or Hospital and Health Services.

Further discussions need to be held by relevant parties to determine what data is needed, by whom and expectations of timeliness. Consultation should also ascertain if the clinics have timelier data and be supported to extract, analyse and interpret this data.

- **Care cascades:** are mapped locally and engagement of care is mapped constantly.

The UNAIDS targets state that by 2020; 90 per cent of all people living with HIV will know their HIV status, 90 per cent of all people diagnosed with HIV infection will received sustained ART and 90 per cent of all people receiving ART will have sustained viral suppression.

The Kirby Institute employs the use of statistical modelling to produce the “Care Cascades”. CDB is developing a protocol for producing Queensland-specific cascades, and investigating potential

sources of data, as information regarding ART is not currently collected in Queensland. Collaboration between CDB and individual clinics may provide data for the Care Cascade.

- **Current data definitions:** related to gender identity and sexual orientations are not broad enough to reflect the needs of Aboriginal and Torres Strait Islander people.

There is a difference between, “sex”, “gender identity” and “sexual orientation” and these terms are often used interchangeably. CDB reports “sex” and “risk exposure” to the National HIV Registry. The major risk exposure categories reported are predominantly sexual contact information of “men who have sex with men (MSM)”, “heterosexual”, “sex with both men and women” as well as other likely routes of transmission.

The presentation of data disaggregated by risk exposure (e.g. MSM) is an artefact of national reporting requirements. CDB collects this information from the client via the notifying clinic. The issues and concerns raised at the HIV Roundtable included comments such as “labels don’t work”.

Initial discussions with IHW around these “labels” provided some cultural context and general agreement to keep this item on the table for further discussion. Additionally, this issue should also be included in the qualitative work discussed earlier in this section, to incorporate both the perspective of the IHWs and their clients.

# Recommendations

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Aboriginal and Torres Strait Islander people have a holistic view of health and wellbeing that is linked to their cultural, spiritual, emotional and physical connection with the land and sea. The Roundtable provided a platform for key stakeholders to discuss ideas and solutions for a holistic healthcare response to rising rates of HIV in the local North Queensland context.

It is essential to partner with Aboriginal and Torres Strait Islander people and communities to identify goals for prevention of HIV, and be innovative in creating a service system that is culturally aware and supports an immediate and integrated management response when required. The Roundtable discussion indicated willingness by stakeholders to partner, co-design, implement and evaluate several solutions to the increasing rates of HIV in North Queensland.

The Roundtable report recommends the development of a *North Queensland HIV Action Plan: for prevention and integrated management of HIV in Aboriginal and Torres Strait Islander people and communities* (North Queensland HIV Action Plan) by the Communicable Diseases Branch in collaboration with relevant stakeholders in the Cairns and Hinterland Hospital and Health Service (HHS).

In addition, The North Queensland HIV Action Plan will include a priority action for the development of a North Queensland HIV management guideline (Guideline) to articulate a culturally appropriate, standardised regional public health response to an increase in the number of cases of HIV in Aboriginal and Torres Strait Islander people and communities.

The following strategic directions align with the outcome areas of the Queensland HIV Action Plan and the North Queensland Aboriginal and Torres Strait Islander STI Action Plan, and are reflective of the discussion at the Roundtable, as well as the 2015 Summit.

The North Queensland HIV Action Plan will outline key actions under the following headings:

- **Strengthening a regional response**
  - Preparedness for an increased number of HIV cases
  - Guideline for North Queensland outbreak response
  - Models of care are indigenous specific and culturally appropriate
  - Workforce
- **A preventive approach**
  - Community engagement
  - Health literacy and health promotion
  - Increase and normalise testing for HIV
  - Needle and Syringe Programs
- **Integrated management response**
  - Partnerships and collaboration
  - Best practice sexual healthcare

- Contact tracing
- **Data, evidence and surveillance**
  - Data collection
  - Research and evaluation
  - Epidemiological surveillance

## Appendix 1 – Delegates

The Roundtable was attended by 80 delegates from Queensland and interstate with extensive knowledge and expertise in the management of HIV, including representatives from organisations able to share their knowledge about strategies for engagement with Aboriginal and Torres Strait Islander people and communities.

Attendance at the Roundtable was by invitation with approximately 90 invitations extended to selected stakeholders from Queensland and interstate. Representatives from the five North Queensland HHS's (Cape and Torres HHS, Cairns and Hinterland HHS, Townsville HHS, North West HHS, Mackay HHS) attended the Roundtable; along with representatives of North Queensland community-controlled health services, Aboriginal and Torres Strait Islander peak body and associated networks, primary healthcare providers, consumer representative and other government and non-government agencies working in the HIV and sexual health sectors.

Mr Wilo Muwadda attended the Roundtable as a consumer representative and contributed generously to the discussion.

<b>Sexual Health Ministerial Advisory Committee members:</b>	
Emeritus Professor Cindy Shannon	Chair, Sexual Health Ministerial Advisory Committee Chair, North Queensland HIV Roundtable
Dr Anthony Allworth	Medical Director, Infectious Diseases, Metro North HHS and Sexual Health Ministerial Advisory Committee member
Dr Graham Nielsen	Sexual Health Physician, Biala Sexual Health Service, Metro North HHS and Sexual Health Ministerial Advisory Committee member
Mr Phillip Carswell	Community member, Sexual Health Ministerial Advisory Committee
<b>Queensland Department of Health representatives:</b>	
Dr Sonya Bennett	Executive Director, Communicable Diseases Branch
Dr Alun Richards	Medical Director, BBV/STI Unit, Communicable Diseases Branch
Dr Stephen Lambert	Senior Medical Epidemiologist, ERU, Communicable Diseases Branch
Ms Carolyn Lang	Advanced Epidemiologist, ERU, Communicable Diseases Branch
Ms Toni Farrell	Manager, Office of the Executive Director, Communicable Diseases Branch
Ms Sharon McDonald	A/Manager, Sexual Health Strategy, Communicable Diseases Branch
Mr Kyle Fogarty	Principal Program Officer, Sexual Health Strategy, Communicable Diseases Branch

Ms Julie Harvey	Principal Public Health Officer, BBV/STI Unit, Communicable Diseases Branch
Ms Jacqueline Kennedy	HIV Public Health Nurse, HIV Public Health team, Communicable Diseases Branch
Ms Allison Mackie	Principal Public Health Officer, BBV/STI Unit, Communicable Diseases Branch
Mr Craig Carey	Director, Service Agreement Strategy and Management Unit
Ms Lyndsay Hardman	Manager, Service Agreement Strategy and Management Unit
Ms Di Maurer	Director, Aboriginal and Torres Strait Islander Health Branch
Mr Gregory Richards	Manager, Aboriginal and Torres Strait Islander Health Branch
Ms Vanda Simpson	Principal Policy Officer, Aboriginal and Torres Strait Islander Health Branch
<b>Hospital and Health Service (HHS) representatives:</b>	
Ms Clare Douglas	Chief Executive, Cairns and Hinterland HHS
Dr Darren Russell	Director, Sexual Health Service, Cairns and Hinterland HHS
Ms Colette Cashman	Clinical Nurse Consultant, Sexual Health Service, Cairns and Hinterland HHS
Dr Roscoe Taylor	A/Director, Tropical Public Health Unit, Cairns and Hinterland HHS
Dr Annie Preston-Thomas	Public Health Medical Officer, Tropical Public Health Unit, Cairns and Hinterland HHS
Ms Sally Rubenach	Manager Health Surveillance, Tropical Public Health Unit, Cairns and Hinterland HHS
Ms Carla Gorton	HIV Clinical Coordinator, Sexual Health Service, Cairns and Hinterland HHS
Ms Therese Howard	Public Health Nurse, Queensland Syphilis Surveillance Service, Cairns and Hinterland HHS
Ms Anissa Jaros	Nurse Unit Manager, Lotus Glen Health Service, Cairns and Hinterland HHS
Mr Jesse Pardon	Clinical Nurse Consultant, Lotus Glen Health Service, Cairns and Hinterland HHS
Ms Venessa Curnow	Director, Aboriginal and Torres Strait Islander Health, Cairns and Hinterland HHS

Ms Julie Brown	Coordinator, Community Mental Health, Cairns and Hinterland HHS
Mr Michael Tervit	Clinical Director, Mental Health, Cairns and Hinterland HHS
Mr Malcolm Lawrence	Project Officer, Community Health, Cairns and Hinterland HHS
Ms Sara Yeganeh	Pharmacist, Cairns and Hinterland HHS
Ms Simone Lukies	Pharmacy Assistant, Cairns and Hinterland HHS
Ms Sandra Soki	Health Worker, Cairns North Community Health, Cairns and Hinterland HHS
Mr John Mara	Health Worker, Cairns North Community Health, Cairns and Hinterland HHS
Mr Morgan Dempsey	Health Worker, Cairns North Community Health, Cairns and Hinterland HHS
Mr Simon Doyle-Adams	Clinical Nurse Consultant, Sexual Health Service, Cairns and Hinterland HHS
Ms Debbie Penney	Contact Tracing Support Officer and Aboriginal and Torres Strait Islander Youth Outreach Nurse, Sexual Health Service, Cairns and Hinterland HHS
Dr Julian Langton Lockton	Clinical Director & Staff Specialist, Biala Sexual Health Service, MNHHS
Dr Diane Rowling	Senior Medical Officer, Biala Sexual Health Service, MNHHS
Ms Lisa-Davies Jones	Chief Executive, North West HHS
A/Prof Alan Sandford	Executive Director Medical Services, North West HHS
Ms Joanna Shaw	Nursing Director, North West HHS
Ms Christine Mann	Director, Cultural Capability, North West HHS
Ms Jaylin Rose	Health Worker, North West HHS
Mr Terry Mehan	Interim Chief Executive, Torres and Cape HHS
Ms Yoko Nakata	Clinical Nurse Consultant, Men's and Women's Health, Torres and Cape HHS
Ms Ann Richards	Manager, Public Health South, Torres and Cape HHS
Ms Joanne Leamy	Men's and Women's Sexual Health Coordinator, Family Health Unit, Torres and Cape HHS
Ms Angela Cooper	HIV Clinical Coordinator, Townsville HHS
Ms Penny Kenchington	Nurse Practitioner, Sexual Health Service, Townsville HHS

<b>Government Agency representatives:</b>	
Ms Ann Nicholls	Facility Manager, Lotus Glen Correctional Centre
Ms Karen Shannon	A/Seargent, Cross Cultural Liaison Unit, Queensland Police Service
Ms Maj-Lis Dalton	Liaison Officer, Cross Cultural Liaison Unit, Queensland Police Service
<b>Non-Government Organisations and Academic Representatives:</b>	
Professor John Kaldor	Program Head, Kirby Institute, University of NSW
Professor Jon Willis	Poche Centre for Indigenous Health, University of Queensland
Professor Charles Gilks	HIV/STI Professorial Chair, University of Queensland
A/Professor James Ward	Head Infectious Disease Research Aboriginal Health, South Australian Health and Medical Research Institute
A/Professor Marisa Gilles	Consultant Public Health Medicine, Western Australian Centre for Rural Health
Dr Manoji Gunathilake	Sexual Health Physician, Northern Territory Department of Health
Dr Christine Selvey	Medical Epidemiologist, BBV/ STI Surveillance sub-committee and Communicable Diseases Network Australia (CDNA)
Dr Judith Dean	School of Public Health, University of Queensland
Dr Katelin Haynes	Queensland Program Manager, Australasian Society of HIV Viral hepatitis and Sexual Health Medicine (ASHM)
Mr Michael Scott	Executive Director, Queensland AIDS Council
Ms Nikki Hill	Health Promotion Officer, Queensland AIDS Council
Mr Geoff Manu	General Manager, Queensland Injectors Health Network (QuiHN)
Mr Simon O'Connor	Executive Officer, Queensland Positive People
Mr Chris Howard	Program Manager, Queensland Positive People
Mr Michael Brown	Peer Navigator, Queensland Positive People
Mr Wilo Muwadda	Consumer Representative
Mr Mark Saunders	STI Coordinator, Queensland Aboriginal and Islander Health Council

Ms Wendy Burke	Indigenous Health Project Officer, Northern Aboriginal and Torres Strait Islander Health Alliance
Dr Kingsley Pearson	Senior Medical Officer, Gurriny Yealamucka Health Service
Mr Milton Mossman	Health Worker, Gurriny Yealamucka Health Service
Ms Tamar Patterson	Health Worker, Gurriny Yealamucka Health Service
Dr Alana Young	Senior Medical Officer, Mamu Health Service Innisfail
Ms Kathy Anderson	Chief Executive Officer, Townsville Aboriginal and Islander Health Service
Dr Theunis Kotzee	Senior Medical Officer, Townsville Aboriginal and Islander Health Service
Ms Laurel McCarthy	Executive Officer, Wuchopperen Health Service Cairns

## Appendix 2 – Roundtable Agenda

Day 1- Tuesday 17 October 2017	
Time	Session
12.30pm	<b>Registration: Light lunch, tea and coffee</b>
1:10pm	<b>Traditional Welcome to Country</b> Ms Henrietta Marrie - Gimy Walubara Yidinji
1:20pm	<b>Welcome Address</b> Roundtable Chair Emeritus Professor Cindy Shannon
1:45pm	<b>Setting the Scene</b>
	<b>HIV epidemiology overview</b> Dr Christine Selvey, Medical Epidemiologist, Communicable Diseases Branch, Health Protection NSW
	<b>Epidemiology of current North Queensland group of cases</b> Dr Stephen Lambert -Senior Medical Epidemiologist, Communicable Diseases Branch, Prevention Division Department of Health.
	<b>Considerations across the HIV continuum specific to Aboriginal and Torres Strait Islander people and communities</b> Associate Professor James Ward – South Australian Health and Medical Research Institute.
	<b>Key inclusions for a Framework for Prevention and Integrated Management of HIV in Aboriginal and Torres Strait Islander people and communities</b> Dr Annie Preston-Thomas- Public Health Medical Officer, Cairns and Hinterland Hospital and Health Service.
3:00pm	<b>Afternoon Tea</b>
3:15pm	<b>Current Management response</b>
	<b>Management of People living with HIV (PLHIV) who place others at risk of HIV</b> Dr Sonya Bennett – Executive Director, Communicable Diseases Branch, Prevention Division Department of Health.
	<b>The public health role in complex case management</b> Ms Jacqueline Kennedy- HIV Public Health Nurse, Communicable Disease Branch, Prevention Division Department of Health.
	<b>Current management response and complex case management</b> Dr Darren Russell- Director Sexual Health, Cairns and Hinterland Hospital and Health Service.
	<b>Lessons to be learned from Western Australia</b> Associate Professor Marisa Gilles, Western Australia Centre of Rural Health.

	<b>SWOT discussion</b> Roundtable Chair Emeritus Professor Cindy Shannon
<b>5:15pm</b>	<b>Summation</b> Roundtable Chair Emeritus Professor Cindy Shannon
<b>7:00pm</b>	<b>Roundtable Dinner at Pullman Reef Hotel</b> ( <i>Urchins reception</i> )
Day 2- Wednesday 18 October 2017	
Time	Session
<b>8:00am</b>	<b>Roundtable Breakfast at Pullman Reef Hotel</b> ( <i>Michaelmas Cay Ballroom</i> ) Engagement in care – a perspective from frontline health workers
<b>9:00-9:30am</b>	<b>Community Engagement</b> <b>How do we effectively engage with Aboriginal and Torres Strait Islander people and communities across the care continuum- from prevention to complex case management?</b> Dr Kingsley Pearson – Senior Medical Officer and Ms Katrina Connelly- Gurriny Yealamucka Health Service
<b>9:30-10:30am</b>	<b>Concurrent Sessions</b>
	<b>1. Aboriginal and Torres Strait Islander community setting</b> ( <i>Michaelmas Cay</i> ) Group facilitator – Dr Kingsley Pearson <ul style="list-style-type: none"> <li>○ Prevention activities - What is working and what is not working so well in the community setting considering primary and secondary prevention activities?</li> <li>○ Effective management including contact tracing - What are the resources, cultural considerations or other specific needs of the community?</li> <li>○ Data and Information - What do we need to collect for an effective health response?</li> </ul>
	<b>2. Primary healthcare setting</b> ( <i>Urchins 2</i> ) Group facilitator – Emeritus Professor Cindy Shannon <ul style="list-style-type: none"> <li>○ Prevention activities - Consider primary prevention activities in a primary healthcare setting and the role of primary healthcare providers in secondary prevention activities including increased testing, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)</li> <li>○ Effective and timely case management, contact tracing and communication in a primary healthcare setting - What is working and what is not working so well?</li> <li>○ Data information – What data, at a local level, is collected and how can this be utilised?</li> </ul>
	<b>3. Secondary/tertiary healthcare setting</b> ( <i>Urchins 3</i> ) Group facilitator – Dr Darren Russell <ul style="list-style-type: none"> <li>○ Prevention activities – Consider the role of a tertiary service provider in primary or secondary prevention activities</li> <li>○ Comprehensive management of individuals diagnosed with HIV – consider the stakeholders required for effective and timely case management including contact tracing and best practice sexual healthcare</li> <li>○ Data and Information- What do we have and need for an effective health response? What are the data requirements to inform appropriate management strategies and monitor progress?</li> </ul>

<b>10:30am</b>	<b>Morning Tea</b>
<b>10:45am</b>	<b>Towards a Framework for Prevention and Integrated Management of HIV and sustainable systems in Aboriginal and Torres Strait Islander people and communities</b>
	<b>Feedback from the concurrent sessions – Group facilitators</b>
	<b>How can communities, the health sector (public and private) and the broader system work together to ensure an effective and sustainable response to HIV in Aboriginal and Torres Strait Islander people and communities?</b> Roundtable Chair Emeritus Professor Cindy Shannon.
	<b>Second SWOT discussion</b> Roundtable Chair Emeritus Professor Cindy Shannon.
<b>12:30-1:00pm</b>	<b>Summation and Close</b> Roundtable Chair Emeritus Professor Cindy Shannon

## Appendix 3 – Concurrent session participant contributions

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Participants of the Roundtable indicated when they registered on day one which concurrent session they would like to attend. Most participants elected to attend the Aboriginal and Torres Strait Islander community setting (n=30) and the primary healthcare setting (n=30) sessions with a smaller number of participants attending the secondary/tertiary setting (n=20) session. Discussion was guided by the facilitator of each session using pre-prepared worksheets with a structured set of questions.

**Note:** The following information reflects the discussion as recorded by departmental staff present in each of the concurrent sessions.

### Aboriginal and Torres Strait Islander community setting – Associate Professor John Willis

**Prevention activities** - What is working and what is not working so well in the community setting considering primary and secondary prevention activities?

- Prevention strategies available in a community setting include behavioural strategies, health promotion, harm reduction through NSP, treatment as prevention, PrEP, STI testing and HIV retesting.
- The health literacy related to HIV is low in many Aboriginal and Torres Strait Islander communities. Indigenous health workers (IHW) may also have low levels of knowledge about HIV and how to educate community members about HIV.
- IHW's would benefit from upskilling and ongoing support in relation to sexual health and HIV.
- Further education is needed across the sector about HIV and STIs particularly for mental health and alcohol, tobacco and other drugs (ATODS) clinicians.
- Increase testing outside of sexual health services.
- Increased focus on HIV as there has been for other STIs. This includes awareness raising campaigns targeted at young people.
- Normalise sexual health checks and reduce stigma by discussing sexual health and HIV in community settings. Community events where *Condoman* was used have been successful in engaging community members.
- Young person's health check is an ideal way to begin a conversation about sexual health including STI and HIV testing. The health check is localised and individualised and can be performed annually.
- National Aborigines and Islanders Day Observance Committee (NAIDOC) week is a community event that can be used to promote information about condom use and STI and HIV testing. Following on from this, access to information and condoms can be difficult so all services should promote the availability of sexual health information and condoms.
- Checklists and flowcharts for staff to follow when promoting and administering PEP.
- IHW's require sufficient education about intravenous drug use (IVDU) and harm reduction measures.

- Cross agency and community support for implementing NSPs.
- Lotus Glen prison has a high proportion of Aboriginal and Torres Strait Islander males with an average six-month length of stay; there is an opportunity for education programs to be delivered in the correctional facility.
- Solutions need to be community led and designed as each community will have unique needs. Language should be attractive to Aboriginal and Torres Strait Islander people. Evidence around community engagement is essential.
- Community specific information and resources including a focus on language and other cultural considerations.

**When considering effective case management and contact tracing** - What are the resources, cultural considerations or other specific needs of the community?

- Sufficient numbers of skilled IHW's are required.
- Partnership and collaboration between government agencies, for example Department of Housing, Queensland Police Service, Queensland Corrective Services and non-government organisations including Aboriginal community controlled health services.
- Contact tracing is an immediate priority and a management response. Using a 'flying squad concept' may enable the capacity to respond in areas where there is evidence of increased cases. Consider improved methods and successful models of contact tracing.
- Models of care underpinned by Aboriginal and Torres Strait Islander health workers are essential, and relationships are a vital component of engagement in care.
- A multidisciplinary health service hub including outreach services providing holistic care that is culturally appropriate where HIV or sexual health are part of the healthcare provided.
- Strong advocacy for peer support to assist clients newly diagnosed with HIV to navigate the health system and build relationships for ongoing support.
- Barriers to engagement in care may include family, shame, confidentiality, social issues and mobility.

**Data and Information** - What do we need to collect for an effective health response?

- Testing follow-up register and recalls for treatment, retesting and contacts.
- Information needs to be collected and shared about success in case management and build a case for investment in strategies that are proven successful.
- Qualitative data and research to enable understanding of opinions, motivations and social factors to develop insight into barriers and assist to understand diversity in populations.
- Lack of integrated data management systems, for example between prison health and broader health services.
- Timely surveillance reports.

## Primary healthcare setting – Associate Professor James Ward

**Prevention activities** - Consider primary prevention activities in a primary healthcare setting and the role of primary healthcare providers in secondary prevention activities including increased testing, PrEP and PEP.

- Orientation, upskilling and ongoing professional development are required for a range of healthcare providers and allied health staff across the region on STI and HIV. There needs to be a focus on agency, casual and locum staff.
- There is a need to have sufficient staffing levels particularly for large catchment areas, recognising the intensity of work often required when working with Aboriginal and Torres Strait Islander people diagnosed with HIV.
- There is a need to increase education and information to primary healthcare providers about HIV prevention strategies, including PEP and PrEP, condoms and NSPs.
- Sexual health checks should be undertaken in general practice in an ongoing effort to reduce STIs, this includes screening to be undertaken for all STIs, not just HIV. Consideration could be given to an STI component be mandated in the Medicare Benefits Scheme (MBS) item number 715 (Medicare Health Assessment for Aboriginal and Torres Strait Islander People).
- Access to NSPs is critical to prevention. Communities can be shunned due to stigma associated with NSPs and it is essential Elders and boards in communities are aware of the evidence of NSPs in averting both hepatitis and HIV infections. It is important to recognise that the 15–24 year age group has the highest incidence for hepatitis C and the median age of the Australian Needle and Syringe Program Survey (ANSPS) participants is currently close to 40 years of age; therefore, potentially high levels of equipment sharing in the younger age group may lead to increased BBV transmission.
- Adopt models of care that reach people who inject drugs (PWID), for example *Deadly Liver Mob* in NSW.
- Preparation for an increased number of cases is an important preventative measure. Protocols are required for all primary healthcare providers in the region in the event of an increased number of cases detected. It should be recognised that this response might be considered where one or two cases are detected in a service where there have never been any cases detected previously.
- Partnerships between sexual health services, public health units and Aboriginal Medical Services and other sectors will increase capacity and is critical to success in managing an increase in cases.
- Services need to demonstrate that they accept all cohorts of people and are willing to accept people for discrete treatment.

**Effective and timely case management, contact tracing and communication in a primary healthcare setting** - What is working and what is not working so well?

- Opportunistic testing works well, however IHW's cannot provide treatment creating a barrier in regional communities. Medication dispensing is restrictive for IHW's and differs to other states and territories. This barrier to treatment is currently being recognised at a Commonwealth level and through the newly amended Drugs and Poisons legislation.

- Develop a model that enables GPs and Nurse Practitioners to prescribe s100 drugs with assistance from current s100 prescribers.
- Social support is essential to the success of treatment adherence for many people diagnosed with HIV. Social workers as a discipline should be factored into staffing for sexual health services. In services that don't have social work or social wellbeing staff, partnership and collaboration with other local services is needed.
- Individualised care from IHW's supports clients to change their behaviour and adhere to treatment. There needs to be a long-term relationship built with the client.
- There is a need for a regional public health unit who can receive referrals from sexual health services, primary health care providers including Aboriginal CCHSs for management of complex cases of PLWHIV with a pool of resources to deliver social support when required.
- Increase support for GPs to assist with contact tracing and any social issues associated with complex cases of PLHIV.
- Establish from existing services, an expert group of clinicians to assist regional or remote services when an increased number of cases are detected.

**Data and information** – What data, at a local level, is collected and how can this be utilised?

- Cross agency data sharing would enrich available data to inform high-risk areas for transmission.
- Ensure introduction of new initiatives into services are not disruptive to existing prevention and clinical care efforts as per feedback arising from Queensland pre-exposure prophylaxis trial (QPrEPd) study sites.
- Consistent and regular reporting across the region including standardised reports for STI testing, retesting for HIV, screening, missed opportunities, NSP distribution, treatment as prevention (TasP) and number of participants in QPrEPd study.
- There are issues with the number of databases that are used, which makes pulling the data together very difficult and labour intensive.

### **Secondary/tertiary healthcare setting - Dr Darren Russell**

**Prevention activities** – Consider the role of a tertiary service provider in primary or secondary prevention activities.

- PrEP and PEP were noted as prevention activities. Currently there are 2,000 participants on the PrEP study, 130 of those participants are in Cairns with approximately three percent identifying as Indigenous.
- Health literacy around ART, treatment and medications needs to be improved for clinicians including IHW's.
- Co-payments for ART are considered a barrier to treatment in Queensland.
- Hospital emergency departments are seen as having a key role to play in prevention through testing and education. A barrier to the success of this approach is the lack of clinician education and necessary clinician rotations.

- Offer point of care testing in emergency departments. Mount Isa emergency department prioritises testing for high-risk individuals including Aboriginal and Torres Strait Islander people.
- Universal HIV testing may be required in some communities. Cape and Torres HHS have included HIV testing to health checks.
- Roving sexual health teams or sexual health clinical liaison positions within the hospital environment that could provide specialist advice to clients and act as a resource and provide guidance to clinical staff. The hospital liaison role could also assist with linking clients with community services to ensure follow-up after testing.
- PEP requires constant intensive training of emergency department clinicians.

**Comprehensive management of individuals diagnosed with HIV** – Consider the stakeholders required for effective and timely case management including contact tracing and best practice sexual healthcare.

- Consideration of a service hub for Aboriginal and Torres Strait Islander PLWHIV which takes a social approach, including housing and welfare support, and provides an integrated chronic disease management model with a consistent clinical team and includes peer support.
- It is important to connect people diagnosed with HIV to peer support as Aboriginal and Torres Strait Islander clients may become isolated from their community following diagnosis.
- To help establish a connection to peer support for people newly diagnosed with HIV there should be a direct referral from the GP or clinic to Queensland Positive People (QPP).
- Renal disease management model involves individualised and holistic care.
- Some IHW's are not comfortable with discussing sexual health or sexuality.
- Assistance and support for general practitioners to approach the topic of sexual health with clients.
- Inclusion of HIV in health pathways for GPs has already occurred in Townsville and should be considered for implementation more broadly.
- Contact tracing is not just a clinic based activity and will require outreach within the community.
- Use of social media to locate individuals as part of the contact tracing process would save a considerable amount of time and resources.
- Contact tracing takes time and the initial focus needs to be on building trust with Aboriginal and Torres Strait Islander clients.
- Funding is required to enable greater and more intensive long-term care.

**Data and Information-** What do we have and need for an effective health response? What are the data requirements to inform appropriate management strategies and monitor progress?

- An early response to changing epidemics requires access to real-time testing, notification, contact and treatment data.
- Early access to notifications and testing data to inform the care cascade including mapping of the care cascade locally with engagement and retention in care mapped constantly.
- Testing data available through Pathology Queensland only covers approximately 50 percent (%) of testing data in North Queensland. Private pathology clinics do not identify Indigenous status.

- Good ART data is obtained through the CHHHS Sexual Health Pharmacy Service.
- Data collection related to Aboriginal and Torres Strait Islander people requires review of data definitions to allow for specific Indigenous identification of terms and include more broadly qualitative data collection in addition to quantitative data.

## Appendix 4 – Feedback Survey Results

Following the Roundtable, Communicable Diseases Branch circulated a feedback survey to participants. The *Survey Monkey* link was emailed to participants who were asked to provide feedback through a short 2-minute survey.

Of the 80 participants, 20 people responded to the survey. Predominantly the responses to the survey questions and open-ended free text questions were positive.

### Question 1:

The Roundtable was of value in sharing knowledge on community engagement, prevention strategies, complex case management and data to maximise the health response for Aboriginal and Torres Strait Islander people with HIV in North Queensland?

	STRONGLY AGREE	AGREE	NEITHER AGREE OR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	30.00% 6	65.00% 13	5.00% 1	0.00% 0	0.00% 0	20	1.75

### Question 2:

Did the Roundtable program enable provide adequate opportunities for discussion?

	STRONGLY AGREE	AGREE	NEITHER AGREE OR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	15.00% 3	70.00% 14	10.00% 2	5.00% 1	0.00% 0	20	2.05

### Question 3:

Overall did the Roundtable presentations include the right level of detail?

	STRONGLY AGREE	AGREE	NEITHER AGREE OR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	15.00% 3	80.00% 16	5.00% 1	0.00% 0	0.00% 0	20	1.90

#### Question 4:

Was the information you provided during the concurrent sessions adequately reflected in the panel discussion and summation?

	STRONGLY AGREE	AGREE	NEITHER AGREE OR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	15.00% 3	75.00% 15	5.00% 1	5.00% 1	0.00% 0	20	2.00

Additional comments:

- The voice of an openly HIV positive Indigenous person should have been formally included. I also noticed the absence of a speaker from the *2 Sprints Program* which has been working in this area for 20 years. The fact that this program has recently been de-funded by the Commonwealth is a matter of some concern. In that regard, a speaker from the Commonwealth Health Department would also have been useful.
- I think there could have been further discussion on community engagement & health promotion.

#### Question 5:

Do you have any additional feedback?

- It would be beneficial to know what progress has been made in the response to HIV since this roundtable to evaluate if it was an effective strategy. Has there been any feedback from the HHS executive representatives about their role in response? This pressing issue needs action from health services.
- The proceedings were well chaired, given the wide range and depth of the opinions sought. The inclusion by Skype of the speaker from WA was just wonderful and the contributions from the team from Yarrabah were inspirational. I was a bit concerned on the focus on "difficult" clients as it tends to stereotype the whole target group and such clients have always been a very, very small minority of the HIV population anyway. Difficulties in their lives usually revolve around endemic poverty, A&D issues and mental health not their Aboriginality. Interested to see the final report and any concrete actions that arise.
- Good overview of the problem and potential means of addressing it.
- A lot of the topics seemed similar to previous years, with very little coordinated approach to address issues. Would like to see more approaches that utilise a range of stakeholders from various sectors to support HIV/sexual health awareness and infection rates. The HIV sector seems quite insular.
- I welcome the opportunity to discuss these issues - but there was also a sense of frustration that many of the issues raised (again) had already been raised previously - specifically within the High-Level Summit on rising HIV, sexually transmissible infections (STI) and viral hepatitis in Aboriginal and Torres Strait Islander communities (FINAL REPORT - APRIL 2016). There was no revisiting of the recommendations that came from the High-Level Summit, nor any assessment of how we

have been tracking in relation to implementing some/any of those previous recommendations, which was thought by several participants to be a missed opportunity. There is frustration with raising the same issues repeatedly, when they do not seem to be addressed from one meeting to the next. An assessment needs to be done of what has been recommended from previous meetings; what (if anything) has been achieved and what gaps remain; what might be able to be done to address the remaining gaps; and what are the new, emerging issues.

# Appendix 5 – Graphic recording

**NORTH QLD HIV ROUND TABLE 17<sup>TH</sup> OCT 2017**

**DR STEPHEN LAMBERT**

**DR CHRISTINE SELVEY**

**Welcome!**

**HIV**

**WE HAVE A LOW RATE OF HIV IN QLD.**

**WE HAVE A SET PROCESS OF HOW WE COLLECT NOTIFICATIONS WHICH ENDS UP IN NoCs...**

**THERE ARE MORE NOTIFICATIONS IN ABORIGINAL & TORRES STRAIT ISLANDER PEOPLE AGED 20-29**

**WE HAVE A LOW RATE OF HIV IN QLD.**

**WE WANT TO GET THE SCENE**

**THIS HAS TO BE COMPLEMENTARY TO THE EXISTING ACTION PLANS**

**WE HAD AN OVERWHELMING RESPONSE**

**ENSURING THE DISCUSSIONS ARE RELEVANT TO STAKEHOLDERS**

**WE WANT TO GET THE SCENE**

**COLLECTING MORE ROBUST CONTACT DATA...**

**LOOKING AT THE OUTSPOKERS**

**THE DATA DOESN'T SHOW NEGATIVE TESTING**

**HOW CAN THIS HELP US UNDERSTAND**

**WE HAD AN OVERWHELMING RESPONSE**

**ENSURING THE DISCUSSIONS ARE RELEVANT TO STAKEHOLDERS**

**MOST COMMON DRUG USED FOR INJECTION IS METHAMPHETAMINE**

**WHO & HOW ARE PEOPLE GETTING TESTED?**

**KNOWING WHO IS AT RISK...**

**THERE HAS BEEN AN INCREASE IN THE RATES IN ABORIGINAL & TORRES STRAIT ISLANDER PEOPLE**

**THERE HAS BEEN A DECREASE IN THE NUMBERS OF THOSE BORN IN SUB-SAHARAN AFRICA**

**IT CAN BE SOME TIME AFTER INFECTION AFTER WHAT WE RECEIVE NOTIFICATION**

**NOTIFICATIONS HAVE BEEN STABLE IN THE LAST 5 YEARS**

**OLD NOTIFICATIONS HAVE BEEN HIGHER THAN OTHER STATES**

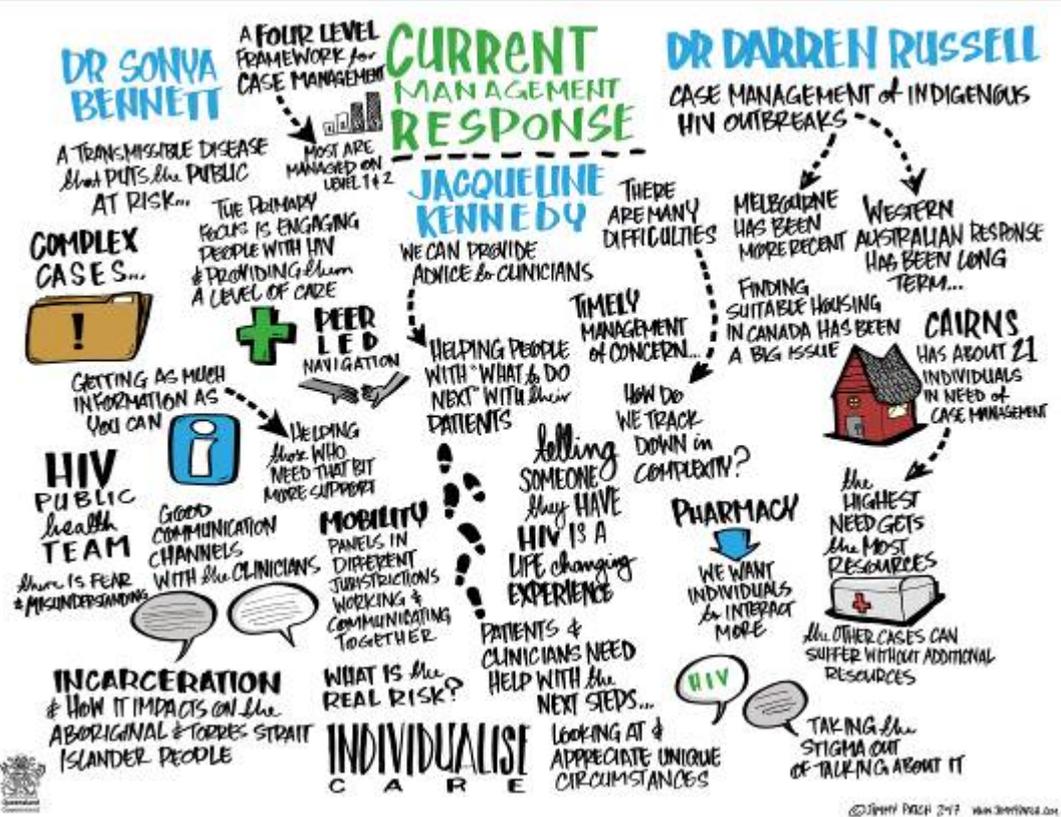
**Q1 STILL SHOWED SOME HIGH NOTIFICATIONS**

**CAIRNS & HINTERLAND MAKES UP 10% OF QLD NOTIFICATIONS OVER TEN YEARS**

**RATES OF TESTING FOR ABORIGINAL & TORRES STRAIT ISLANDER PEOPLE HAS BEEN LOW BUT IS SLOWLY INCREASING**

**THERE IS A LOT OF UNAVAILABLE DATA FOR UNDERSTANDING TRANSMISSIONS**

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# ASSOCIATE PROFESSOR MARISA GILLES



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