This is the text of the annual Gollow Lecture at the Australasian Sexual Health Conference, delivered this year by James Ward, head, Aboriginal and Torres Strait Islander Health Program on Wednesday 28 September 2011.

Thank you…. Dreaming of health equality!….Addressing the unacceptable predicament! The use of evidence! Making a difference to address STI and BBV control for Australia's first peoples. Giving Voice to those who need their voice to be heard! This is what I would like to discuss today.

But first, let me begin by paying my respects from me and my family to the traditional owners of country- the Nyambri people, their elders both past and present, and acknowledge their continued custodianship of country, lore and culture here in Ngunnawal country, Canberra. Thank you Aunty Matilda for your sincere welcome for all us here; you have welcomed us generously, may you and your family live on through modern life in keeping this tradition of welcoming people to country as well as custodianship of country strong and deadly. May I also pay special respects to all my Aboriginal brothers and sisters in the room here today. I hope I do some justice to the issues we and many others in our communities confront each and every day. I know that there are many of you here from all different nations and that all of you make a unique contribution to this space.

Thanks also to Anne, Sarah, Frank and the Conference Organising Committee for inviting me to deliver this year's Gollow Lecture. It's a real honor for me and my brothers and sisters across the land to be given the privilege of delivering this year's Lecture. Dr Maurice Gollow, for those unaware, was the first President of the Australasian College of Venereologists and convened the very first of these meetings way back in 1978. From all accounts he was a visionary leader and a champion for the people. Sadly Dr Gollow passed away in April this year. I pay my respects to his family and friends and hope that I do capture his vision and commitment to this very important area of health.

In delivering this lecture today I do so with family origins dating back thousands of years to the centre of Australia; as a descendant of the Pitjantjarra and Nurrunga clans of the central and south Australia. I also at this time remember my father's family origins arising from County cork in Ireland. Some say it's the best of both worlds: Aboriginal and Irish; others say how blessed awful that is. I don't care! They are and were mum and dad!

In preparing for a lecture such as this, it's inevitable that some sort of self reflection takes place. I reflected on my own journey and how I came to be here in this place today. It should come as no surprise to any of you that I grew up in a period in Australia's history where for many Aboriginal people there existed separate conditions for schooling, housing and health care access, and enforceable restrictions determined where and when people could access town. This era set the parameters of my life. I and my family were expected to fail at school; we were denigrated with names like boong, coon and Abo in the public realms of our lives; and in our own safe havens. For us to be treated in this way was not the exception, it was the rule. These rules have affected me and my family through the generations. For my mother and her mother's generations, the rule was forced removal of children from mixed marriages. During this period they desperately fought to stop the Protectors of Aborigines, as they were called then, from taking away their own children. These historical policy norms and acceptable social rules I now embrace as part of my history and my family's history. I believe we should never forget the past in trying to understand what motivates us to do the things we do today. That is why I am here today, and it is against this background that I have partially contextualised this lecture- but this is not the only experience from which this lecture is drawn.

Despite everything that told me otherwise, I did excel in school, I did become a professional, I and others like me have made contributions to Australian society in ways that allow me to stand before you today. My professional experiences have also shaped who and how I am so I have drawn on my professional experiences in the development of this lecture. These have been varied; they have ranged from remote Australia to inner city Darlinghurst Sydney.

One mainstay in my professional life in roles that have encompassed community education, public health program and policy development and for the last four years leading the Aboriginal and Torres Strait Islander Health Research Program at the Kirby Institute has been my role as an advocate. As a black fulla, its part and parcel of who we are, advocates for us, our families, and the communities to whom we belong. It is this role I will never give up on. For me it is the combination of all these factors that is required to bring about change in our communities and it's these combined experiences which I will draw upon today.

As I said earlier I'd like to talk to five main points today.

1. Dreaming of health equality!
2. Addressing the unacceptable predicament!
3. The use of evidence!
4. Making a difference in STI and BBV control for Australia's first peoples.
5. And finally giving a voice to those who need their voices to be heard.

Let me turn to the first point: **Dreaming of health equality.**

You will note that I have deliberately entitled my presentation with the first word beginning with "Dreaming". It's a deliberate play on a significant concept for our communities. The word Dreaming is infinite, it links the past with the present to determine the future. It is fitting for this lecture as it encompasses the natural world, the land or country to which a person belongs, which provides the link between the people and The Dreaming. Dreaming of equality links the world in which we live to our culture's future. I and many other Aboriginal and Torres Strait Islander people are dreaming of equality. I hope you do too!

Great men the likes of Churchill, Ghandi and Truman have said that a society is judged by how it treats most disempowered. Unfortunately it is the most disempowered in the Australian community, Aboriginal and Torres Strait Islander people, who suffer the most from the failings of the current health system – one of the great hallmarks of Australian society. The challenges are real and significant and the health problems our mob face have been documented like clockwork for at least three decades.

Significantly reduced life expectancy, high maternal and infant rates of mortality and morbidity, low birth weight babies, developing country rates of infectious diseases including STIs, unacceptable levels of chronic disease, and generational problems of alcohol and drug abuse and violence: the list goes on. How can we judge ourselves as Australians who have traditionally favoured 'a fair go' when this is occurring? From this short listing alone I will leave you to ponder this question while I ponder what it is that we can dream in these circumstances.

So is it possible for us to dream that Australia's first peoples will achieve the same level of health status or dare I say even better than for non indigenous Australians in my lifetime or for the generations to come after us? Or is it possible that we can get our health care systems right that address the health needs of the most marginalised and achieve what we all strive for in Australia.

Is it possible to dream that one day I open the Saturday papers and read positive two page stories of young Aboriginal people rather than a two page spread of negative depiction of our communities and that our young people will not be tarnished with troublemakers, hopelessness and recklessness and that the only options for our mob will be help from the greatness of power in this country.

Is it possible to dream that rates of STI diagnoses we have seen for the last two decades particularly among our most vulnerable young people and our mob living in remote areas can be reduced significantly in our lifetime?

Is it possible to dream that for young Aboriginal people living that their first, second or third sexual experiences with their same aged peers won't be associated with acquiring an STI?

Or is it possible to dream that the luck or chance we have had so far in maintaining new HIV infections at the same rate for non Indigenous Australians or can we do better and reduce these to but a few annually in the future?

Or is it really possible to dream of a nation without the need for a specific national strategy addressing STIs and BBV for its First Nations peoples?

I believe it is essential to dream… it won't be easy, and it won't be achieved without hard work. Believing it is possible to turn these dreams into reality led me to establish a program of research at the Kirby Institute. This program of research has taken guts, determination and some help from some notable professors such as John Kaldor, Basil Donovan and David Cooper, along with nous, advocacy and an insiders view of Aboriginal culture in contemporary Australian society.

As you can see here shows the work we are involved in communities across Australia, it is broad and encompassing and is covering the fields of STI and BBV and has a philosophy of no research without translation to policy and or practice as well as capacity building. The situation is too dire not to do this. I plan to share some of this work in this Lecture and so will staff in the program through the rest of this conference. This Program is small in nature but big in dreaming. I hope we can make some difference in attaining equality for this generation and future generations of Aboriginal and Torres Strait Islander people.

I have to. It is the role and responsibility of people in my generation to be true to and build on the legacy given to us by fighters, leaders and warriors in our past, and it is what my contemporaries are working towards in other fields – the realisation of human rights and equality for all. We do this now because we HAVE to make it better for our future generations. We all dream the dream, and in our way, we try to make the dream real.

For me, the biggest barrier to achieving human rights and equality for all, and what my program of research in the Kirby Institute is trying to address and the second point of this talk, is the unacceptable predicament of STI and BBV rates and their outcomes within Aboriginal and Torres Strait Islander communities.

I am sure many of you gathered in this room need no introduction to the following figures, but just in case let me share just a few of the confronting figures impacting on our communities. How can it be that we have rates of chlamydia and gonorrhea reported in 2010 at close to five times and 27 times the rate reported among non Indigenous people?

And chlamydia diagnoses rates for people aged 15-19 at 4 times the rate and 56 times the rate for gonorrhoea compared to non Indigenous people in the same age groups?

These rates are exacerbated when we examine the data by place of residence with remote community members having the highest diagnosis rates.

While these figures are concerning, what is more confronting is the recently analysed data from our STRIVE study, and in particular our baseline prevalence study. STRIVE is a cluster randomised trial which is being rolled out in 67 remote communities in central and northern Australia.

Historically what we have tended to rely on in remote communities is notification data, which may or not be a true reflection of the burden of disease in these communities. As part of STRIVE we have completed a baseline prevalence assessment in each of the communities involved during 2010. In the baseline prevalence study we found chlamydia and gonorrhoea prevalence rates across the communities in the age group 16-34 of 9% and 7% for both men and women. While these rates don't appear that high they are at rate 10 and 15x that for non Indigenous studies in Australia with similar aged populations. Furthermore for the youngest age group 16-19 prevalence was significantly higher in both men and women.

These and other results of STRIVE will be presented in a symposium later this morning. I encourage you to attend this Symposium. STRIVE is the largest STI trial ever to be conducted in Australia, and certainly is one of the largest trials to be rolled out in all domains of Aboriginal health.

And while I have focused thus far on remote communities, let me tell you that this situation is not just limited to remote communities. Another study being rolled out by the Aboriginal Program at the Kirby Institute is a study called REACCH or Research Excellence in Aboriginal Community Controlled Health. This study is a partnership between my Program and NACCHO the National Aboriginal Community Controlled Health Organisation. This study is working with ACCHS in urban and regional centres.

It is unacceptable as we have recently discovered, that positivity rates for chlamydia among 16-19 year olds attending Aboriginal Community Controlled Health Services in major cities and regional areas is similar to positivity rates diagnosed in remote Aboriginal communities.

Why is this so that we have high rates of infection? There are many answers. Firstly we have a much younger demographic in our population, with almost 50% of our population aged less than 25, we also should consider mobility, ineffective primary care and not enough of a population health approach to STI control particularly in our remote settings as well as reckless behaviours of a minority within our communities- but that's not unique to our mob.

There are a few other things that I find unacceptable; first that young Aboriginal people are being hospitalised for disseminated gonococcal infection in 2011, second that until recently we have had very little systematic data on the burden of disease in urban and regional communities and finally its totally unacceptable that we have until recently very little behavioural information from young Aboriginal and Torres Strait Islander people, which is in stark contrast to other priority population groups in the community.

These issues I am sure you agree are just unacceptable for a nation such as Australia. It's unacceptable for four reasons (i) because A&TSI make up just 2.5 per cent of the total population (ii) because most of these figures have not just suddenly appeared but rather have been known for almost two decades (iii) because there is no other identifiable group in the Australian population facing such adversity and finally (iv) because we are midway through our third national strategy and it's like we have been sailing a ship without a captain. This situation is also a predicament because.. we don't seem to have a uniform and systematic approach nationally to address these issues which are both complex and diverse in nature.

And furthermore it's a predicament because these figures are the downstream result of something very wrong upstream, and this is where we have to be brave and step up to mark and make some big changes. But I will get to that later.

This situation is also an unacceptable predicament because what do we do about this, in a current environment of Aboriginal health resource allocation that doesn't prioritise STIs or BBVs; an environment where the impact of STI is not weighted equally to addressing disparate gaps between Aboriginal and non Indigenous people.

Many of you will be aware of the Current Close the Gap Campaign aiming to address the long standing disparity in health, education, social and living conditions for Indigenous Australians. Unfortunately the CTG indicators have thus far excluded STIs and BBVs. Rightly because they are largely weighted toward improving mortality rates, so that we effectively and rapidly address the gaps in life expectancy. But while I want so desperately for our people to stop dying early, I also want for our young people to have healthy sexual lives and for them not to have to endure STIs or the many negative outcomes associated with STI including poor outcomes in pregnancy. I also don't want our population to die earlier from conditions like HIV, because of policy exclusions such as this one. We should be encompassing and recognising the risks for our population now and into the future.

An important though underutilised tool to make the dream of human rights and equality for all a reality is evidence. This, the third point of my lecture is important because evidence underpins best practice and shows us where to put our effort. I think it's fair enough to say that addressing the unacceptably high rates of STIs and BBVs has been hampered by a severe lack of evidence based research. Without unpacking that agenda a great deal, this has arisen for two main reasons. First, the ways in which poor research methods in this area have resulted in the dissemination of information, which has been detrimental to those people and communities who participated in the research. Unfortunately, it is my view that poor research method and information sharing is still a feature of current research. Secondly, because we are not good as a sector in getting our results widely disseminated and more importantly *utilising* that information *effectively* to address gaps/ inform and direct programs.

We have gone some way to addressing the stigma associated with STIs and BBVs within our communities with the publishing of five Aboriginal and Torres Strait Islander Annual surveillance and evaluation reports. These reports are published annually by the Program at Kirby and appear in a format that is not only accessible and informative for communities- but shows the extent of the problem to our people in a comprehensive format.

But what I want to highlight is what we already know from the evidence but we somehow choose to ignore. To illustrate this, my third point of the talk, I go back to the long standing issue of very high STI rates within remote communities.

In Australia we have a very comprehensive network of primary health care services whose staff provide a range of services for Aboriginal people in communities across remote settings. Some do a fantastic job of providing STI care and for others I think it would be fair to say that there is room for improvement. I want to highlight just one of these services as an example but of course there are a couple of other notable documented cases where prevalence has significantly dropped.

Over the last decade and a half a comprehensive STI control program has been rolled out across the Anangu Pitjantajarra Yankantjurra Lands (APY) of north and western South Australia. Some of you may be familiar with the program and the 8 ways model developed by Nganampa Health Council. The 8 ways program is an holistic approach to STI programs and addresses all the necessary components to effectively address STI in remote communities.

This program has provided Australia with evidence that a programmed and systematic response to STI control can lead to demonstrable results in reducing STI prevalence rates. The essential components of this program have been multifaceted but consist mainly of (i)… a commitment from the community being a community controlled model and leadership within and commitment from the people who work in PHC facilities across the lands to address STIs (ii)…a programmed and coordinated effort and response rather an ad hoc approach to STI control, and finally but importantly a focus on good primary health care delivery and continuous quality improvement and documentation of all of this. I focus on the work of Nganampa Health Council because it has worked and it has worked successfully over a long period of time.

NHC have reduced community prevalence rates of chlamydia and gonorrhoea from around 20% to around 5%. And yet just across the border and in many other remote communities across the country I bet you there are prevalence rates of close to 10% as our STRIVE study has shown. Why have we not as a nation rolled out this model of care to other remote Aboriginal communities? Why have we chosen to ignore this model of appropriate PHC and instead look for other alternative options which haven't been tried and tested?

As I alluded to earlier --it is for this reason we have instigated the most ambitious of randomised trials, STRIVE in remote Australia. STRIVE is testing whether the systematic and coordinated delivery of STI control in communities over the next three years and the impact this may have on community prevalence rates of chlamydia, gonorrhea and trichomoniasis. We hope we can have some effect on unacceptable community prevalence rates over the next three years with an outcome of improving people's livelihoods.

The important thing about STRIVE is that it is embedded in current primary health acre service delivery;- we are not expecting people working in primary care to do anything outside of normal clinical guidelines and practice but at the same time we are making grand scale changes to the systems that people are working within to enable better STI control and practice. Things such as the implementation of a quality improvement program in STI control – a defined set of best practice indicators in STI control that we are hoping to reach during the trial – as well as major changes to existing PIMS. All of this within a trial environment where we can as accurately as possible determine the effects of the interventions implemented in STRIVE.

And if I can go back to Nganampa Health Council in SA and at the same time just across the border in the NT there is serious consideration for adopting a program aimed at STI control that hasn't been tried or tested within this setting.

On the cards AGAIN is a short-cut-sure-to-fail plan to roll out an STI population based treatment program or in other words a mass treatment program for STI control in remote Aboriginal communities. For those who are not clear, a mass treatment program involves the administration of antibiotic treatment without accompanying STI testing to all persons suspected or presumed to be at risk of STI. That is in communities with a high enough prevalence to warrant such a program. My innate advocate senses are on high alert for a number of reasons – and I flag these as a concern today because it is a highly sensitive area for us as Aboriginal people; and that is different strokes for different folks!

While I commend the commitment to have a discussion about this proposal, the issue is complex for a number of reasons. Firstly it is an intervention that isn't in line with current primary care practice and as such as has been proven time and time again when external interventions are placed upon our mob they do not work.

You only have to look at our communities in remote Australia now, to see not much has changed after four years of a top down imposed intervention and in fact we are considering a second wave of interventions for our mob. Secondly the logistics of rolling out such a program is hard to even imagine given that most remote communities in the NT would have high enough prevalence rates to warrant such a program and the logistics of this being rolled out across the NT would almost be impossible. Furthermore unless this approach seriously considers the inclusion of Aboriginal people who reside in the urban based centres particularly town camps in the NT such as Alice Springs, Tennant Creek, Katherine, Darwin and Nhulunbuy, then this program is likely to be very ineffective, because we all know that young people in remote communities come to town and have a good time while in town, and why not they are human beings too!

The third thing that concerns me with this approach is the way that both health service providers and community members view their respective roles in health service provision and seeking behaviour. For many PHC providers, this measure of STI control will negate the role that they play in STI control as they will wait for the next round of mass treatment to come around. And for community members who are already difficult to engage with health services in remote communities, how will they view the door knocker who drops a dosette box of pills off for all the adolescents and adults in the house. I can tell you when someone knocks on my door, which they often do, trying to sell me a new electricity or phone plan, I am not that happy. I would be even more unhappy if they were trying to deliver pills for me to take for STIs even though I hadn't placed myself at risk.

This type of intervention is not evidence based and born out of frustration, and does nothing to improve primary health care in the longer term. These interventions fly in the face of the evidence of what has been achieved just across the border in SA.

There is also international evidence that shows after mass treatment programs have been implemented, STI prevalence rates rise soon after a program has been completed and certainly many of the international studies have never achieved a plan with such logistics we have here in Australia. There is no reason to think that this wouldn't happen in the NT given the logistics of providing treatment to all young people around the same time across the NT including urban areas.

Is this a real option for our fellow Australians? We must resist the temptation of throwing resources at a select few people's policy position on how to solve the problem of the high rates of STIs. Surely a massive increase in getting existing primary care would be better. This is what is needed. Let's be brave in this area. It is far less contentious and it's what we are meant to be delivering.

Another piece of evidence I am concerned about is that over the last few years…. I have found it incredibly difficult to discover where the evidence came from to have a new found emphasis on funding private general practice (through the National Partnership Arrangements) to improve access for Aboriginal people. Under NPA a fair chunk of the money allocated to closing the gap in Aboriginal people's life expectancy has been allocated to private general practices. While I am not entirely philosophically opposed to this measure I do find it creates an unacceptable predicament when this comes at a cost to the Aboriginal Community Controlled Health Sector- for every close the gap dollar allocated to private general practice is a dollar less for Aboriginal community controlled health services.

I find it also unacceptable because it flies in the face of all evidence to date in this field. It is clear to me that the ACCHS sector is the primary provider of primary health care to Aboriginal people in Australia currently and probably will be for a long time to come unless they are choked to death with resource constraints placed upon them.

In 2008 there were more than 1.85 million episodes of care provided in ACCHS in Australia, these episodes of care were provided to 344,000 unique patients of which over 80% were Aboriginal and or TSI clients. It doesn't take much to work out that there is a huge proportion of the total Aboriginal and Torres Strait Islander population accessing these primary health care services already and what we should be doing is investing more in improving the outreach of this sector.

Shifting the point of access to private general practice is not going to translate to improved management and outcomes in STI and BBV because the gaps in service delivery often pertain to hard to reach populations– and also cut across secondary and tertiary services. ACCHS know their communities and have proven how to reach those who are most vulnerable and not accessing the health system. – It makes sense to build on existing systems and to build better connections across the health system.

I now come to the fourth point of my talk – making a difference in STI and BBV control for Australia's first peoples. All of the evidence says this, that when Aboriginal people or for that matter any people are in control of their lives they are healthier. This statement is germane to the program of research I head up at the Kirby Institute. We know that we hold the answers for our communities; we know we can and are making a difference to STI and BBV control for Australia's First Peoples. In my experience, this has been aided by my work with NACCHO as the peak body for ACCHS in Australia, a proven partner in our research. Our work has proven that with the right processes and protocols in place we can make a difference we have managed to bring research dollars and capabilities to this sector to improve outcomes. Our work is generating outcomes and knowledge – we now know that young people in the target age groups for STI and BBV are accessing these services, women more frequently than men but what needs to improve is solid primary health care delivery in STI control sufficient enough to address the burden of underlying disease in communities.

I want to highlight this effort here because we show definitively in three studies that ACCHS surpasses the role of GPs in delivering STI testing.

The ACCESS study examining chlamydia surveillance in Australia showed testing rates were three times higher than in private general practice and four times higher in our REACCH study a study in urban and regional centres.

Private general practice has a role to play in our business this is true, however, much of the work is successfully conducted through ACCHS. There are moral, logistical and ethical imperatives to strengthen the existing primary health care services that are managed and staffed and provide services to the population most at risk of poor health outcomes in Australia. It makes good sense to me and I am sure to you.

The fifth point that I wanted to touch on in this lecture is the importance of giving voice to those that need their voices to be heard. There is much suffering which accompanies having an STI/BBV or HIV either as an individual, a community, or indeed someone who works in this area – more often than not an isolated practitioner. Often we forget the vulnerability, the marginalisation, the personal and social costs of the epidemic when we are trying to understand what is going on in our communities. We do not have quality data from regional and urban environments both from a jurisdictional level but also from the community level. We have not had sufficient data to understand what is truly going on in many of our communities. How can we give voice to those with no voice, if we do not understand what is happening for them? Let me for a moment focus on the voicelessness of young Aboriginal women. We know that Aboriginal women have worse outcomes in pregnancy with regard to miscarriage, premature delivery and post partum infection – yet we have no data on what is causing these outcomes. These outcomes are possibly due to STIs, and highly likely due to STIs among young women residing in areas with very high rates of infection –because very few of those women get tested in tertiary care at the time of this traumatic experience – women might not be dying, but the costs to those women and relationships /families shouldn't be underestimated /ignored. We have to improve our service delivery and evidence to stop these terrible outcomes for families and communities.

Another group who struggle to get a voice in socio- political life both in Aboriginal communities and in broader Australian society are young people. I want you to think just for a second what we know about the behaviour of young Aboriginal people and where this arises from. What images arise in your imaginations? I hope it's not ones of helplessness, neglect and despair! These negative images are how the popular media often- and in some cases only ever portray young Aboriginal people. What about all the young Australian Aboriginal people who are excelling in many facets of Australian public life - health, sports, leadership, education and many other areas of public life. Unfortunately these attitudes can be internalised within our own sector; the number of times it has been said to me that young people in remote communities must be more promiscuous than their city based counterparts have been too many to recollect. I guarantee that most of your opinions have been shaped by popular media, who so often get it wrong. About two years ago I led a process with some of Australia's most prominent researchers to embark on a study to hear from young people themselves about their levels of knowledge risk behaviour and the level of access to health services they have. In the spirit of giving a voice to those whose voice needs to be heard, I want to present some of the preliminary findings here but not too many a paper will be presented on Thursday.

GOANNA as the study is called has so far collected surveys from over 800 young Aboriginal and Torres Strait Islander people from all S/T. A median age of 22, over 55% said they were single, close to 50% of participants said they had just one partner and 40% between 2 and 4 partners in the last twelve months. Moderate levels of knowledge to STI and BBV questions were reported and reasonably high levels of ever being tested for an STI were reported among this population. These results show a different picture to what I talked earlier of how popular media talk of young people and importantly gives a voice to them. The study also points us in the right direction for shaping policy and programs- for example the NT sample of close to 200 have so far shown us lower levels of knowledge of STI, more partners but higher rates of STI testing compared to other jurisdictions which confirms what we have suspected for some time.

Over the study period we will make some great advances in giving young people a voice in the crowded Indigenous health space. The really nice thing about this project is that young people are the drivers of data collection and some of those people are here today. It can be done!

In concluding this year's Gollow Lecture, I want to ask you with the challenges and constraints I have presented for your information, can we make an impact? Surely with all we have at our disposal today we can!

No one in this room wants to maintain the status quo of the unacceptable high rates of STIs and BBVs in Australia's most vulnerable population. Surely, at the point of being asked to include Aboriginal and Torres Strait Islander people in Australia's Constitution we can together show our maturity as a nation of nations, who can join together in unity and with purpose to bring this situation under control. It's time to turn those dreams I spoke of earlier into a reality. Dreams of human rights, of justice, of equality, of having the same opportunity in Australia without being made the same.

I want to sum up for you what I think the opportunities are, and what might be achievable.
We have to get right existing PHC infrastructure – we need to get PHCs not good but excellent at delivering STI and BBV control programs. We have to take some bold steps in matching service delivery investments with the problems that overwhelm our communities. We need to set realistic indicators in STI control at the local, jurisdictional and national level. The National Surveillance and Monitoring Plan goes some way to setting these goals. It is essential to work PHC services and communities, to set targets in STI control and assist them to reach these.

Our STRIVE study has set targets in the 67 communities we work with in STI including testing, coverage rates, retesting rates, understanding re-infection rates, contact tracing processes and interval times to treatment. People need goals set and milestones to show what it is they are achieving- not to be overwhelmed, but to steer the course for our effort.

The second area of investment should be in developing our workforce in public health and sexual health issues. Firstly we have to turn around the phenomena of disappearing Aboriginal Health Workers particularly those specialised in sexual health. We require commitment from Governments at all levels to instate health workers where there are too few, we require commitment from governments and this sector to enable health workers to have national standards that will enable them to conduct STI and BBV testing and routine clinical care for our own mob in communities across Australia. It's not that difficult. We must invest in this part of the workforce because it's this workforce who know their communities, will be there forever in their communities but it's also this workforce who are restrained by complex legalities in their current scope of practice particularly clinical.

On another level- workforce issues in this sector are fraught with problems and in my view are failing failed. Current training has resulted in a medical workforce ignorant –about comprehensive diagnosis, treatment and management at an individual and population base–of STIs and BBVs across a range of professions that should know better.

While on remote areas it is often said that the high turnover of staff is responsible for the poor control of STIs. I propose a more logical explanation: there is a serious gap in the knowledge about STI and the roles of practitioners in addressing the high rates of STIs. The few practitioners who do know how to work in this field have limited opportunities to impart their knowledge to others.

Clearly this an area where sexual health specialists could be doing a hell of a lot more - as well as a lot more to support capacity of PHCS to deliver appropriate services - so it is all of our responsibility - not just generalist nurses working in remote. If workforce issues were addressed, then what was found in a recent audit of files of close to 600 women in 5 communities with hyper endemic STI notifications where 20% of women who presented at the clinic with classic signs and symptoms of PID and yet very few were diagnosed, treated or managed – might never happen again**.** This is unacceptable.

Utilising new technology in innovative ways is another option to help address the unacceptably high rates of STI rates affecting young people and the resultant morbidity. POC testing for chlamydia, gonorrhea and trichomoniasis could be a priority given prevalence rates are above 10% in many communities and curative antibiotic treatment is available. We are about to embark on a randomised cross over trial in 10 or 12 remote communities to test the acceptability and feasibility of STI POC tests and their use in the Australian setting. This may be a new and emerging area of addressing STIs in the future.

Similarly the use of electronic media and social networking sites is an area of increasing research and programs we have rarely touched the surface of-- we should set this as a priority for future investigation.

The GOANNA Study has used PDAs or hand held computers as the main tool for data collection When asked of participants about the acceptability of PDAs >90% required no assistance in using the PDA, and greater than 85% felt it both easy to use and more private than a paper based survey.
Another area where we can make a difference is achieving the already set target of elimination of infectious syphilis from remote communities; we should be approaching this from a strengths-based rather than a deficit perspective and be driving this process already. What we require is systematic coordination across the jurisdictions to get this going. What is wrong with a good news story in Aboriginal health?

Last year there were just 130 diagnosis of infectious syphilis in Australia among Aboriginal and TSI people – elimination of syphilis is possible with the public health system we have in place in Australia.

We also need to maintain a hyper vigilance on rates of HIV in the Aboriginal community in Australia– maintaining a stable epidemic is what is required here. Focused attention on not only gay men, but also prioritising PWID, and people who sex work for favours, then we will succeed. We have started to address IDU issues but we are at the very tip of a very large iceberg and to date we have not addressed the sensitive area of sex worker issues.

We will have achieved what it is, that is needed and expected by Australian citizens – access to affordable, quality care and a future for our generations to carry on our culture and meet our obligations to country.

This is everyone’s business but all of these things need to go through the right processes and protocols of Aboriginal culture and lore.

Finally in closing this talk today I want you to know that over the last few years, I, like many other Aboriginal people have never felt more in a space where we have seen such a big commitment certainly in monetary terms to improving our people's health. I like many of our mob sincerely hope that this transpires to real improvements in all conditions for our people.

For our sector to be part of this we need to act now to implement the changes I have outlined here today. In summary we have to use our evidence intelligently, we have to strengthen existing models of PHC, we have to address workforce issues, we have to maintain our focus on remote communities as well as understand issues for our urban and regional populations and we have to give voice to the people whose voice needs to be heard. We need to make it everyone's business and you have to be part of this. We cannot do this on our own. It will require your commitment to advocacy your commitment in turning dreams into reality and your commitment in working with us as equal partners in making it all happen. But this has to be done respectfully sensitively and with dignity for our cultural protocols and Aboriginal ways of doing business.

Thank you for your time today. I look forward to continuing the journey with you and making a real difference to our people's lives. From the classic song penned by the legendary Paul Kelly and Kev Carmody: from little things big things grow.