

Queensland Indigenous Sexual Health Strategy

2003 to 2006



Queensland Government
Queensland Health

Foreword

This first *Queensland Indigenous Sexual Health Strategy 2003 to 2006* provides government and non-government service providers with a blueprint for working together to jointly improve the sexual health of Queensland's Aboriginal and Torres Strait Islander population.

Already there is good work underway. Whilst this Strategy recognises the success of these programs, it attempts to add to them by building a more solid and sustainable framework for the future. It does this by identifying key outcomes for improved sexual health among Queensland's Indigenous population, and suggested strategies for achieving them. It encourages cooperation between government departments in a whole of government approach.

The Strategy seeks to promote the involvement of Indigenous communities, and in particular those most at risk of contracting sexually transmissible infections (STIs). Experience in the Australian HIV/AIDS epidemic has shown that a strong partnership between affected communities and health service providers represents the best approach to reducing the transmission and impact of STIs.

Genuine partnerships between local Aboriginal and Islander Community Controlled Health Services and Health Service District service providers are also strongly encouraged to foster better continuity of care for clients of these services. Many of the best examples of innovative services in Queensland have been achieved through collaboration between all key agencies in a local area.

Finally, this Strategy recognises the importance of Indigenous Sexual Health Workers and the key role they play in improving the sexual health of their local communities. It focuses on the positions of trust they often hold, and the vital link they provide to mainstream service providers at the primary health care level. The Strategy therefore promotes access to training and identification of career paths to encourage Indigenous Sexual Health Workers to undertake professional development and build careers in delivering services in this important area.

Whilst there are many programs that require concerted efforts to improve health outcomes for Queensland's Indigenous population, few have the potential to impact so directly on the outlook for future generations. It is with great pleasure we therefore commend to you the *Queensland Indigenous Sexual Health Strategy 2003 to 2006*.

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1 Introduction

The *Queensland Indigenous Sexual Health Strategy 2003 to 2006* provides a framework for developing collaborative approaches to improving the sexual health of Aboriginal and Torres Strait Islander people within Queensland.

The Strategy complements the broader *Queensland HIV, Hepatitis C and Sexual Health Strategy 2004 to 2007* which is currently under development. These Strategies together will inform the provision of HIV/AIDS, hepatitis C and sexual health services in Queensland.

2 Purpose of document

The Strategy aims to improve Queensland's response to Indigenous sexual health through the mobilisation of government and non-government agencies, service providers and Indigenous communities. It will do so by:

- informing service provision
- developing culturally responsive strategies for implementation
- establishing a planned and collaborative approach to these areas taking into account current and future needs
- targeting programs and available resources in the most effective and efficient manner
- specifying expected outcomes within a framework of key outcomes and priority action areas and strategies.

Operational from 2003 to 2006, it is proposed that a mid-term review be conducted by Queensland Health during 2004-05 to allow adjustments to reflect emerging trends and changing policy dynamics.

The Strategy identifies key outcomes to be achieved for Indigenous sexual health, guiding principles to apply to the development of responses, suggested strategies, and a range of corresponding indicators that can monitor progress towards achieving the outcomes. Government and non-government service providers are encouraged to incorporate these broad outcomes into their own planning under a whole of government approach, and develop appropriate strategies to assist in their achievement.

Already many successful examples of collaboration can be found across the state. These suggest the best results are achieved through a partnership between Queensland Health and other relevant government agencies, working together with local communities, Aboriginal and Islander Community Controlled Health Services and community councils in the planned delivery of services.

Separate agreements between Queensland Health and the Commonwealth Government also set out a range of aims, outcomes, and roles and responsibilities for the delivery of health services for Aboriginal people and Torres Strait Islanders. The *Queensland Indigenous Sexual Health Strategy 2003 to 2006* aims to reflect the principles set out in these documents.

3 Background

In 1993, the second *National HIV/AIDS Strategy* first reported the potential link between the spread of HIV/AIDS in Indigenous Australians and high rates of sexually transmitted diseases. It included Aboriginal and Torres Strait Islander people as a "priority target" for education and prevention efforts. The third *National HIV/AIDS Strategy* in 1996 went on to summarise the situation by saying that:

Sexually transmissible diseases (STDs) pose an important health problem in their own right. They are also markers of unsafe sexual practices that can result in HIV transmission, and the presence of some STDs facilitates HIV transmission. Given the high rates of STDs among Aboriginal and Islander people, and the potential for a large increase in HIV transmission in this group, control of STDs through sexual and reproductive health services is the first line of defence against HIV in this population.

In 1995 to address these concerns, the then Australian National Council on AIDS (ANCA) convened an Aboriginal and Torres Strait Islander forum on sexual health in Alice Springs. The forum also aimed to set down guidelines on how to address issues such as prevention, education, treatment and care, research and evaluation in relation to Indigenous sexual health. One of the most significant outcomes was the establishment of an ANCA

Working Party for Indigenous Australians' Sexual Health. Among four key tasks set for this new body was a requirement to develop a national Indigenous sexual health strategy to guide delivery of Indigenous sexual health programs.

The *National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99* (NIASHS) was subsequently launched by the Federal Minister for Health in March 1997. It has since become the benchmark by which all Indigenous sexual health programs are evaluated. In June 1999, the NIASHS was extended to 2003-04 to match the duration of the fourth *National HIV/AIDS Strategy*.

The *Queensland Indigenous Sexual Health Strategy 2003 to 2006* will assist in the continued implementation of the NIASHS in Queensland. It will also highlight gaps where additional work still needs to occur and has been developed with particular consideration of the rural and remote nature of many Indigenous communities across Queensland. Often these locations require sexual health services to be delivered in a primary health care setting.

The fundamental elements of the three successful national HIV/AIDS strategies to date have been:

- a harm minimisation approach
- non-partisan political support
- a partnership approach
- the involvement of affected communities
- promoting an enabling environment.

This Strategy supports the adoption of these same strategic approaches.

The *Queensland Indigenous Sexual Health Strategy 2003 to 2006* was developed through a consultation process involving:

- the development of a draft document based on the *Queensland Health HIV/AIDS Strategy 1999-2002*
- the establishment of a steering committee (see Appendix 1) to oversee the development of a first draft
- the distribution of a second draft incorporating the above comments to the Indigenous Health Coordinators and HIV/AIDS, Hepatitis C and Sexual Health Coordinators of Queensland Health; District Managers of all Queensland Health Health Service Districts; Queensland Health Corporate Office; Aboriginal and Islander Community Controlled Health Services; the Queensland Aboriginal and Islander Health Forum (QAIHF); the Apunipima Cape York Health Council; the Torres Strait Health Council; relevant government departments including the Commonwealth Office for Aboriginal and Torres Strait Islander Health; the Department of Aboriginal and Torres Strait Islander Policy; the Department of Premier and Cabinet; the Department of Families; Education Queensland; the Department of Primary Industries; the Department of Employment and Training; the Department of Corrective Services; relevant funded agencies; and the Sexual Health Society of Queensland
- the return of the final draft to the original steering committee for approval.

During the development of the Strategy, Queensland Health also actively participated in the mid term review of the NIASHS and the development of the fourth *National HIV/AIDS Strategy*, both of which influenced the content of this Strategy.

4 Policy context

The *Queensland Indigenous Sexual Health Strategy 2003 to 2006* operates within a range of international, national and state policy contexts. A short description of the most relevant is set out below.

4.1 International policy context

The Ottawa Charter and the Jakarta Declaration for Health Promotion

The Ottawa Charter provides a framework for the development of effective government and community responses to the transmission of all sexually transmissible infections and blood borne viruses, and the support of those infected. In the case of Indigenous sexual health, the Ottawa Charter's five key action areas have particular importance.

- Developing personal skills
 - Empowering individuals to take responsibility for their own health.

- Creating supportive environments
 - Establishing environments (eg. legislative, social and political environments) which help to guide community attitudes and values and that do not impede the effective delivery of programs and services.
- Building healthy public policy
 - Developing policies which are based on sound public health practice.
- Reorienting health services
 - Integrating the principles for management of HIV/AIDS, sexual health and hepatitis C (including health promotion strategies) into the practical service delivery level.
- Strengthening community action
 - Fostering ongoing community participation in the development of policies and programs, their delivery and evaluation.

The *Jakarta Declaration* for health promotion reinforces the benefits of health promotion interventions and consolidates the need to adopt health promotion principles and practices as core elements of prevention.

4.2 National policy context

National Indigenous Australians' Sexual Health Strategy 1996-97 to 2003-04

The NIASHS explores national roles and responsibilities, partnerships, prevention, support and treatment and care strategies, workforce issues, research and data collection, evaluation and monitoring. It also provides a number of prevention principles, guidelines and behaviour models for dealing with Indigenous research and data.

The NIASHS also contains sixty-seven recommendations for improving Indigenous sexual health. The Queensland Strategy attempts to address all recommendations relevant to Queensland.

The fourth National HIV/AIDS Strategy 1999-2000 to 2003-2004 Changes and Challenges

The current *National HIV/AIDS Strategy* is the fourth in a series of national strategies that have led Australia's response to the HIV/AIDS epidemic since 1989. The current strategy continues to recommend the importance of promoting a partnership approach between governments, the non-government sector and the community, particularly those groups most at risk and affected by HIV/AIDS including Indigenous Australians. It differs slightly from previous strategies in that it promotes greater integration between the HIV/AIDS Strategy and other government strategies and priorities, such as in the areas of Indigenous health and illicit drug use. The main aims continue to be to:

- eliminate the transmission of HIV
- minimise the personal and social impacts of HIV infection.

The evaluation of the second *National HIV/AIDS Strategy* by Professor Richard Feacham identified Indigenous Australians as a high risk group for infection with HIV due to the presence of high rates of STIs and a lack of access to primary health care. These findings have led to a significant strengthening of HIV/AIDS programs directed toward Indigenous people using mainstream HIV/AIDS funds. Some of these changes are also prescribed in the Public Health Outcome Funding Agreement, negotiated between each State and Territory and the Commonwealth.

Other key national strategies include:

- the *National Aboriginal and Torres Strait Islander Health Strategy 1989*
- the *National Drug Strategic Framework*
- the *National Hepatitis C Strategy 1999-2000 to 2003-2004*
- the *National Communicable Diseases Surveillance Strategy*
- *ANCAHRD/IGCAHRD HIV Testing Policy*
- the *National Indigenous Gay and Transgender Project Report*

4.3 Queensland policy context

As outlined earlier, this Strategy will complement the broader *Queensland HIV, Hepatitis C and Sexual Health Strategy 2004 to 2007*. It will therefore not attempt to reproduce all elements of that Strategy, but rather provide linkages to it relating to the particular needs of Indigenous people living with HIV/AIDS, Indigenous injecting drug users and those affected or at risk of being affected by STIs. This Strategy does however, provide an opportunity for closer examination of matters that require attention in an Indigenous context.

The Queensland Health HIV/AIDS Strategy framed in the context of sexual health 1999 to 2002

The *Queensland Health HIV/AIDS Strategy 1999 to 2002* was developed to guide Queensland Health's HIV/AIDS program, and to define links and partnerships with external government and non-government service providers critical to the success of the program. It also aims to refocus service delivery patterns to reflect the changing nature of the HIV epidemic in Queensland, with an increasing move toward outpatient and ambulatory care services for people living with HIV, and a greater focus on sexual health of at-risk groups.

Whilst primarily an internal document to assist in establishing these changes and redirecting resources, this Strategy also provides a framework for a larger state HIV, hepatitis C and sexual health strategy to be written during 2003-04.

The Aboriginal and Torres Strait Islander Health Policy 1994

In 1990 the Queensland Government became a signatory to the *National Aboriginal Health Strategy 1989*. The *Aboriginal and Torres Strait Islander Health Policy 1994* builds upon that national framework, setting direction for the implementation of health services for Indigenous people in Queensland. It sets out seven key areas for future action to improve the health of Indigenous people. This includes:

- community control of primary health care services
- participation
- culturally appropriate service provision
- needs-based criteria for service provision and resource allocation
- workforce planning and development
- information monitoring and evaluation
- across government approach.

The Queensland Health Indigenous Workforce Management Strategy 1999-2002

This policy sets out a pro-active strategy for increasing the number of Indigenous staff in the Queensland Health workforce. It promotes two key strategies.

- 1) Implementing a labour market development program to increase the level of health career choices and higher education support for Indigenous students.
- 2) Implementing an Indigenous workforce development program to increase recruitment, retention and career development of Indigenous people. It aims to increase the percentage of Indigenous staff employed by Queensland Health to 2% by the end of 2002, and 2% across all salary levels by 2010.

Aboriginal and Torres Strait Islander Framework Agreements

These two agreements signed by the Commonwealth and State Health Ministers, and key representatives of Aboriginal people (2002) and Torres Strait Islanders (1999), are statements of intent in relation to the improvement of the health status of Aboriginal and Torres Strait Islander people in Queensland. They confirm that Indigenous people have the worst health of any population group in Australia and are one of the most disadvantaged groups in the community. They establish a goal of achieving equitable health outcomes with the broader community through joint planning, improved access to mainstream services, better data collection and evaluation, and inter-sectoral collaboration.

The framework agreements also led to the establishment of a Queensland Aboriginal and Torres Strait Islander Health Partnership (Queensland Partnership) Forum and a Torres Strait Partnership Forum, to oversee progress on the agreement, and Commonwealth and State resource allocation. A Working Group of the Queensland Partnership Forum has been established to review the implementation of matters relating to sexual health. Members include representatives from the Commonwealth Office for Aboriginal and Torres Strait Islander Health, the Communicable Diseases Unit of Queensland Health, the Queensland Aboriginal and Islander Health Forum, and the Apunipima Cape York Health Council. This group reviews annual funding priorities, considers matters of policy in relation to Queensland, and represents a key forum for overseeing implementation of the Strategy. Decisions of the Working Group are reviewed and ratified by the Queensland Partnership Forum.

Queensland Health Corporate Plan 1999-2004

The *Queensland Health Corporate Plan* defines the goals and key values of Queensland Health. With the Mission Statement of “*Helping people to better health and well-being*”, it sets out a series of goals and key values which directly influence the direction and strategies adopted by Queensland Health.

Other key strategies that influence service delivery in this area include:

- *Reducing the Impact – the Queensland Health Hepatitis C Strategy 1997-2000*
- *The Queensland Government Youth Suicide Prevention Strategy*
- *The Queensland HIV, Hepatitis C and Sexual Health Strategy 2004 to 2007* (under development)

5 Epidemiology and management issues

With the exception of HIV/AIDS, data comparisons between states and territories on the status of Indigenous sexual health is difficult, primarily because they differ in the degree to which they collect Indigenous identifiers.

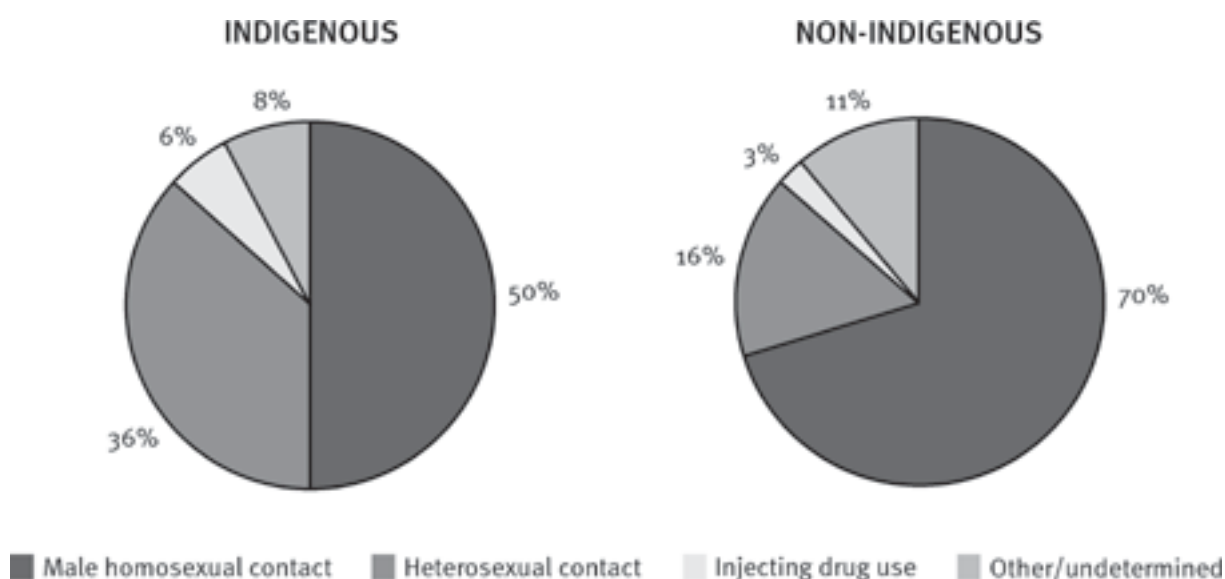
As a result, no attempt has been made to compare the data below with other states and territories. However, comparisons have been made regarding the sexual health of a selection of Indigenous communities within Queensland with that of the total Queensland population. With this as background, the following observations are made.

5.1 HIV/AIDS

National perspective

A 2001 report by the National Centre in HIV Epidemiology and Clinical Research suggests that overall rates of HIV and AIDS diagnoses *per capita* have varied little between Indigenous and non-Indigenous people. In both population groups, the most frequently reported mode of transmission was male homosexual contact. However, a higher proportion of heterosexually acquired cases of HIV infection has been reported among Indigenous people (36%) than for non-Indigenous people (16%) as shown in Figure 1.¹

Figure 1. HIV Diagnoses 1993–2000, by HIV exposure category and Indigenous status



¹National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report*, 2001, p. 17.

The gender distribution of infections differs between non-Indigenous and Indigenous cases, with 72.9% of Indigenous cases being male compared to 92.5% of non Indigenous cases. (Table 1).²

Table 1:

Characteristics of cases of newly diagnosed HIV infection in Indigenous people in Australia 1993-2000 by year

Number of cases, median age, and percent (number) of total cases for each year by sex, newly acquired infection and HIV exposure category.³

	1993	1994	1995	1996	1997	1998	1999	2000	Total
Total Cases	18	20	22	19	15	25	9	12	140
Males (%)	77.8	75.0	63.6	78.9	73.3	64.0	66.7	91.7	72.9
Median Age	29	29	26	29	36	31	28	37	30
Newly Acquired Infection %	16.7	5.0	31.8	10.5	26.4	20.0	33.3	8.3	18.6
HIV Exposure Cat									
Male homosexual contact	64.7	26.3	31.8	58.8	60.0	22.7	25.0	50.0	41.7
Male homosexual+IDU	0.0	26.3	18.2	5.9	6.7	13.6	12.5	8.3	12.1
Injecting Drug use	5.9	0.0	0.0	11.8	0.0	13.6	25.0	16.7	7.6
Heterosexual Contact	29.4	42.1	50.0	23.5	33.3	45.5	37.5	25.0	37.1
Haemophilia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Receipt of Blood Tiss	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mother at Risk	0.0	5.3	0.0	0.0	0.0	4.6	0.0	0.0	1.5
Other/Undetermined	5.6	5.0	0.0	10.5	0.0	12.0	11.1	0.0	5.7

Queensland

Similar patterns apply in Queensland to those being experienced nationally. Approximately two thirds of notifications of Indigenous people with HIV infection are among men who have sex with men including those who inject drugs. Female notifications account for 18% of the total 44 notifications cumulative to June 2000, (See Table 2) compared to non-Indigenous cases among which 7% are female.⁴

Table 2:

Aboriginal and Torres Strait Islander HIV notifications by transmission category, Queensland first diagnosis, 1997-2000

	1997	1998	1999	2000	Cumulative		
					1985 to December 2000	Males	Females
Men /sex with men	2	0	0	1	24	0	24
MSM + Inject. drug use	1	0	0	0	5	0	5
Injecting Drug Use	0	1	0	0	2	1	3
Heterosexual	0	0	1	1	5	6	11
Haemophilia	0	0	0	0	0	0	0
Blood transfusion	0	0	0	0	0	0	0
Maternal Transmission	0	0	0	0	0	0	0
Unknown	0	1	0	0	0	1	1
TOTAL	3	2	1	2	36	8	44

Source: Queensland Health - AIDS Medical Unit HIV/AIDS Report. Period to 31 December 2000 Unpublished.

² ibid., p. 34

³ ibid., p. 40

⁴ Queensland Health, *HIV/AIDS report 2000*, AIDS Medical Unit, Queensland Health, Brisbane, 2001, p 14.

5.2 Sexually transmissible infections

The NIASHS reported that compared with the non-Indigenous population, rates of notification for all bacterial STDs* such as gonorrhoea and syphilis are substantially higher among Indigenous Australians.⁵ Evidence from Queensland tends to support this assertion, however rates of infection with STIs amongst Indigenous Queenslanders vary dramatically depending on where they live.

For example, crude prevalence data on the presence of at least one STI in persons (over 15 years) from a range of communities, screened as part of Well Persons Health Checks conducted in Far North Queensland over the three years ended June 2001, revealed rates that varied between 6% and 30%.

Research by Dr Frank Bowden and Professor Kit Fairley in the Northern Territory also found high rates of STIs among Aboriginal and Torres Strait Islanders, but attributed them to poor access to treatment, not the number of sexual partners.⁶

The importance of access to primary health care in reducing rates of STIs is borne out by data from Western Australia reported in the NIASHS. It showed that rates of gonorrhoea infection among males was cut by two thirds between 1985 and 1995 in three Kimberley shires that had Aboriginal and Islander Community Controlled Health Services. There was no significant decline in shires without these services.⁷

Whilst prevention efforts to reduce STIs amongst Indigenous populations must be multi-faceted, these findings support an underlying principle of the *Queensland Indigenous Sexual Health Strategy 2003 to 2006* regarding the need for consistent access of Indigenous Queenslanders to a local primary health care service provider.

A Queensland Health project aimed at addressing the capacity of the health care system to collect accurate data will continue for the life of this Strategy. At present a lack of Indigenous identification on the Queensland Health notifiable diseases database means that it is not possible to accurately estimate the burden of disease due to STIs amongst Indigenous people. As chlamydia and gonorrhoea can be asymptomatic, cases can remain undetected without active screening. Therefore communities that lack an active screening program will appear to have lower infection rates than those with a screening program, even though their actual rates could be higher.

In an attempt therefore to present figures which highlight the higher rates of STIs experienced in Indigenous communities, data from a selection of Far North Queensland Statistical Local Areas (SLAs) (Figure 2) that have an Indigenous population greater than 50% has been compared to the whole population of Queensland.

The Five SLAs are: Carpentaria, Torres, Aurukun, Burke and Mornington Shires.

Figure 2: Indigenous State Legislative Areas (SLAs) in which the Indigenous population is greater than 50%

A summary is provided for the diseases listed below.

Chlamydia

Chlamydia is the most commonly notified of all STIs in Queensland, with over 4930 notifications for the 12 months ending December 2000. In the above areas where more than 50% of the population identify as Indigenous, rates of STIs are up to 20 times higher than rates for Queensland as a whole. For example during the same period in the five identified SLAs, notifications for chlamydia totalled 527, or approximately one tenth of Queensland's total. This equated to a rate in the 5 SLAs of 3261 notifications per 100,000 persons compared to a rate for the whole of Queensland of just 140 notifications per 100,000 persons.⁸



*The term STDs (sexually transmissible diseases) has since been replaced with STIs (sexually transmissible infections)

⁵ Department of Health and Aged Care, *National Indigenous Australians' Sexual Health Strategy 1996-97 to 2003-04*, Australian Government Publishing Service, Canberra, 1997, p. 25.

⁶ FJ Bowden & CK Fairley, 'Endemic STDs in the Northern Territory: estimations of effective rates of partner change', paper presented to the scientific meeting of the Royal Australian College of Physicians, Darwin, 24-25 June 1996.

⁷ Department of Health and Aged Care, op. cit., p. 56

⁸ Queensland Health, 'Notifiable conditions system – Queensland Health surveillance data', unpublished data, Brisbane, 2001.

These findings are supported by the results of the Well Persons Health Check (WPHC), conducted in communities with over 90% Indigenous population. During the year ended June 2001, the WPHC found a crude prevalence of chlamydia of 7% among persons over 15 years from the seven communities screened during that year. The adjusted prevalence among those aged between 15 and 25 years was higher at 16.3%.⁹ (NB: Comparisons between the SLA figures above and the WPHC cannot be made because the WPHC involves active screening of the population, whereas the SLA data includes all age groups and only those presenting for opportunistic testing and treatment).

Chlamydia presents a significant challenge for Indigenous health programs because in addition to reduced access to services in many parts of rural and remote Queensland, up to 70% of cases in women and 50% of cases in men are asymptomatic.¹⁰

These people may be unaware of their disease, yet able to unwittingly infect their sexual partners. In addition there is an increased risk of contracting HIV or becoming infertile, and in women chlamydia can lead to serious complications such as Pelvic Inflammatory Disease. Widespread screening programs to reach these asymptomatic cases remain the best option for dealing with this endemic problem.

To address this situation, in 1998 the Commonwealth Office for Aboriginal and Islander Health Services (OATSIH) introduced the Polymerase Chain Reaction (PCR) urine testing program for chlamydia and gonorrhoea. This new non-invasive technology combined with effective new one-dose treatment drugs, has significantly improved the opportunity for success of screening programs, and offers a real opportunity to reduce the overall disease burden of the two infections in Queensland Indigenous communities.

Already evidence exists of the success of this approach. One community in Far North Queensland took part in a WPHC in 1998, and then again in 2000. During the intervening period regular screening was encouraged by the local health service. The follow up screen found that chlamydia prevalence among 15–35 year olds had reduced from 24.4% in 1998 to 11.8% in 2000 ($p=0.059$).¹¹

A strong focus of the *Queensland Indigenous Sexual Health Strategy 2003 to 2006* therefore remains the continued expansion and use of PCR testing and opportunistic screening.

Gonorrhoea

Gonorrhoea is diagnosed much less frequently in Queensland with 1133 notifications during the 12 months ended December 2000. Like chlamydia, the prevalence of gonorrhoea varies widely across Indigenous communities, but is on average lower than for chlamydia. During 2000 in the five chosen SLAs, 208 cases of gonorrhoea were notified, or approximately 18% of the total for the State. This equated to a rate of 1287 cases per 100,000 compared to the rest of Queensland's rate of 32 cases per 100,000.¹²

In the year ended June 2001, the WPHC found a crude prevalence of gonorrhoea for persons 15 years and over of 0.7%. The adjusted prevalence of 15–25 year olds was higher at 2.2%.¹³

Gonorrhoea is also targeted by the PCR program and forms a major focus of the *Queensland Indigenous Sexual Health Strategy 2003 to 2006*.

Syphilis

Notifications of syphilis in Queensland fell between 1992 (687 notifications) and 1997 (309 notifications). However since that time, total notifications have risen significantly with a total of 895 notifications for the 12 months ending December 31, 2000.¹⁴

This rise can be attributed largely to both changes to the clinical definition of syphilis, and possible over-notification as a result of increased screening through the implementation of the WPHC in Far North Queensland. Once contracted, syphilis serology tests will continue to show positive throughout a person's life, despite the ability of treatments to provide an effective cure.

⁹ Queensland Health, *Implementation of the Well Persons Health Check in North Queensland July 2000 – June 2001 Summary of Activity*, report prepared for the Commonwealth Office for Aboriginal and Torres Strait Islander Health, Tropical Public Health Unit, Queensland Health, Cairns, 2001, p. 2.

¹⁰ S Hillis, C Black, J Newhall et al., 'New opportunities for chlamydia prevention: applications of science to public health practice', *Sexually Transmitted Diseases*, vol. 22, May-June, 1995, p. 197.

¹¹ Queensland Health, *Implementation of the Well Persons Health Check*, op. cit., p. 1.

¹² Queensland Health, 'Notifiable conditions system', loc. cit.

¹³ Queensland Health, *Implementation of the Well Persons Health Check*, op. cit., p. 2.

¹⁴ Queensland Health, 'Notifiable conditions system', loc. cit.

A State Syphilis Register commenced operation in July 2001 to register each episode of syphilis diagnosis and treatment. The Register will address the issue of successfully treated patients who may move between centres, being re-diagnosed, treated and notified several times over. Medical staff operating the register will also be available to assist with difficult diagnoses as required.

There have been no recorded cases of congenital syphilis since 1990, however the absence of such cases remains an important indicator of the success of early detection and management programs.

Trichomonas

Whilst not notifiable in Queensland, new evidence from studies around the world suggest a link between trichomonas and adverse pregnancy outcomes. A Vaginal Infections and Prematurity Study found that pregnant women with *T.vaginalis* had a 30% higher risk of delivering an infant with low birth weight or delivering before term, a 40 % higher risk of giving birth to an infant who was both pre-term and of low birth weight and nearly twice the risk of still birth or neonatal death as compared with women without *T.vaginalis* colonisation.¹⁵

A study in the Northern Territory found that in a sample population of 345 Indigenous women, 27% tested positive by PCR for trichomonas.¹⁶

Trichomonas was added to the WPHC in Far North Queensland in 1999. During the period ended June 2001 the WPHC found crude prevalence of trichomonas among those screened over 15 years of 9.6%. As with other sexually transmissible infections, prevalence was highest among 15–25 year olds at 11.4%.¹⁷

Whilst sequelae in men are not considered serious, due to the potential impact on pregnant women, Queensland Health will continue to seek an adjustment by OATSIH to the PCR testing program to allow for the inclusion of trichomonas testing in women during antenatal screening.

Genital herpes

As is the case with the general population, it is thought that a substantial proportion of the Indigenous population is infected with the herpes simplex virus (HSV), however no prevalence data exists to support this assertion.

Primary infection may be symptomatic, but most HSV infections are asymptomatic and hence go unrecognised. Genital herpes may be periodically reactivated, causing symptomatic lesions or asymptomatic viral shedding. This intermittent shedding may persist for years, and some cases may be lifelong. Risk of transmission appears to be highest during the prodrome and in the presence of lesions.

Genital herpes is the most common cause of genital ulceration in Australia and may be a factor increasing the risk of HIV transmission.¹⁸ For this reason genital herpes will be included in the creation of a genital ulcer disease test currently under development by Queensland Health. This will assist in identifying Indigenous patients with genital herpes who can then be targeted for education and prevention strategies.

Human papilloma virus (genital warts)

The human papilloma virus (HPV) is the cause of genital warts and a factor in cervical cancer. Most genital HPV infections are asymptomatic, subclinical or unrecognised, with only about 1% of HPV infection resulting in clinically apparent ano-genital warts.

Anal warts may regress spontaneously and most HPV infection is combated over time by an individual's immune system. The factors that influence this regression have not been defined, although it is seen more commonly in young people.

Conditions, which result in suppression of the immune system, such as pregnancy or smoking, may also lead to an increase in the occurrence of genital warts or a delay in combating HPV.

HPV is most commonly transmitted by sexual contact and transmission can occur regardless of the clinical manifestations. The incubation period is variable. The existence of infectivity and infection in the absence of symptoms make interruption of transmission extremely difficult. Transmission can also occur perinatally.

¹⁵M Cotch, J Pastorek, R Nugent et al., 'Trichomonas vaginalis associated with low birth weight and preterm delivery', *Sexually Transmitted Diseases*, vol. 24, no. 6, 1997, pp. 353-60.

¹⁶F Bowden, B Paterson, J Mein et al., 'Estimating the prevalence of trichomonas vaginalis, chlamydia trachomatis, neisseria gonorrhoeae, and human papillomavirus infection in indigenous women in northern Australia', *Sexually Transmitted Infections*, vol 75, 1999, pp. 431-434.

¹⁷Queensland Health, *Implementation of the Well Persons Health Check*, loc. cit.

¹⁸C Chen, R Ballard, C Beck-Sague et al., 'Human immunodeficiency virus infection and genital ulcer disease in South Africa: the herpetic connection', *Sexually Transmitted Diseases*, vol. 27, no. 1, 2000, pp. 21-29.

For HPV, like genital herpes, the extent of infection among the Queensland Indigenous populations is not known. Several treatment options are available, and it is essential that all women who have ever been sexually active should ensure regular and continuing cervical screening. This Strategy supports the strengthening of links between women's health programs and sexual health programs, to ensure appropriate treatment, support and referrals for those at risk.

Donovanosis

Nine cases of donovanosis were reported in Queensland during 2002¹⁹ and it is estimated that the prevalence of donovanosis is very low among Indigenous communities in the state. Donovanosis, by the nature of its disfiguring, unpleasant symptoms, remains a strong target of this Strategy.

In conjunction with the Apunipima Cape York Health Council, during 1999 Queensland Health commenced a Donovanosis Eradication Campaign. The goal of the campaign was to eradicate donovanosis from Queensland during the course of the *Queensland Indigenous Sexual Health Strategy 2003 to 2006*. The Commonwealth Department of Health and Ageing have also identified the eradication of donovanosis as a key policy objective and OATSIH have allocated additional funding for 2001/2003 for the employment of dedicated sexual health nursing positions in Far North Queensland, the Northern Territory and Western Australia to assist in achieving this goal.

A nucleic amplification (PCR) genital ulcer disease test has been developed to simplify the diagnosis of donovanosis and supplement current invasive testing methodologies. The new test will be included in a standardised primary health care protocol that will be developed during the life of this Strategy, to assist in diagnosis and treatment of genital ulcer diseases.

6 Key action areas

6.1 Key outcomes

The key outcomes of the *Queensland Indigenous Sexual Health Strategy 2003 to 2006* are to:

- reduce the transmission of sexually transmissible infections among the Queensland Indigenous population.
- minimise the impact of sexually transmissible infections on the Queensland Indigenous population.

6.2 Essential components

Strategies to achieve these key outcomes should be built around the following essential components.

6.2.1 Harm minimisation

Indigenous sexual health programs and services should adopt a harm minimisation approach. Harm minimisation is a philosophy that recognises that unsafe or illegal practices will continue to occur, but that governments have a responsibility to develop and implement population health measures designed to reduce the injury that such behaviours can cause, both to individuals and to the community.

In the context of Indigenous sexual health harm minimisation, these approaches would include encouraging the use of condoms during sexual encounters between casual partners, ensuring access to and use of safe injecting and ceremonial equipment, and encouraging regular sexual health checks for sexually active adults.

6.2.2 Peer education

This Strategy champions the role of peer based education initiatives which are described in the guiding principles for education and prevention in the *National HIV/AIDS Strategy 1996/7 to 1998/9* as:

Education and prevention programs for established emerging or potential epidemics in specific communities are best delivered by the communities involved, in partnership with governments, health professionals and researchers.

In practice this means that wherever possible, individuals from affected communities are best placed to influence the culture and practices within their specified community. For example, Indigenous people who inject drugs may be best placed to influence other Indigenous injecting drug users. This principle recognises

¹⁹Queensland Health, 'Notifiable conditions system – Queensland Health surveillance data', unpublished data, Brisbane, 2003.

the importance that peers have in effecting behaviour change and providing support. Peers may also include other individuals who provide support and assistance to community members, for example families, friends and Indigenous health workers. Wherever possible this Strategy encourages this approach for education and prevention strategies at the state and Health Service District level.

6.2.3 Population health approach

Population health approaches focus on the health and well being of populations, rather than specifically that of individuals and form the basis of most interventions adopted by Public Health Services, Queensland Health. Programs such as the WPHC, primary health care programs such as the Chronic Disease Strategy, and the statewide PCR screening program, are examples of this type of approach. The Strategy supports a strong population health focus to Indigenous sexual health and the expansion of programs similar to those mentioned above.

6.3 Strategic priorities

The following section sets out the strategic priorities on which government and non-government health providers and other relevant government departments must focus if the above outcomes are to be achieved.

Under each Priority are a series of suggested strategies which, if implemented, could help in achieving the outcomes described above. The list of strategies is not intended to be exhaustive or prescriptive. Rather it is intended to provide guidance to policy setters across the broad spectrum of government departments and agencies who are in a position to contribute, through their work, to the goal of improving the sexual health of Indigenous people in Queensland.

Potential performance indicators of success have also been included to assist in identifying ways by which the implementation of the Strategy can be measured. The list of performance indicators is also not intended to be exhaustive, and those that are included relate predominantly to health related outcomes. Other government departments and agencies are encouraged to consider their own performance indicators to assist in measuring their efforts to implement the Strategy.

Whilst suggesting performance targets or measures for the above indicators would be desirable, it is acknowledged that mechanisms for capture of the relevant data remain limited, and in many cases baseline data do not exist. It is hoped that implementation plans flowing from this Strategy will address both these mechanisms for capturing necessary data, and the setting of performance targets to measure success wherever possible.

6.3.1 Enabling environment

Objective

The creation of an environment that supports improved sexual health for the Queensland Indigenous population.

Guiding principles

The creation of an enabling environment must be built on principles that respect the contribution that Indigenous individuals and communities can make to improving their own health outcomes. Key elements of success include:

- providing individuals and communities with the knowledge and skills to take responsibility for their own health
- creating local and statewide political and social environments which assist local Indigenous communities to actively participate in the improvement and delivery of local programs
- an environment free of discrimination on the basis of sexual practice, gender or drug use behaviour
- removing barriers that inhibit active participation
- recognition of social determinants of health as contributing factors to a person's ability to negotiate sexual safety.

Target groups

- Government departments
- Indigenous community leaders

- Government and non-government health service providers
- General community

Strategies

Strategies that will assist in the creation of an enabling environment include the following.

- Encouraging regional planning initiatives that take a whole of government approach and recognise the impact of the full range of social determinants of health such as housing, education, social services and employment.
- Supporting the establishment of local Indigenous health councils that include representatives of all local agencies to promote collaboration, identify service gaps, and coordinate programs.
- Encouraging community wide public health strategies that promote participation of Indigenous communities in their own health care.
- Strengthening links within the Torres Strait Treaty Zone between relevant government departments of Papua New Guinea and Queensland.
- Strengthening links with AusAID funded programs operating within the Torres Strait Treaty Zone and partnerships between State and Commonwealth Government departments mandated to provide services in this region.
- Conducting education programs that reduce discrimination against Indigenous "at-risk" populations such as gay men, transgenders, people living with HIV/AIDS, sex workers and injecting drug users.
- Conduct education and training initiatives across a range of relevant health, education and work place settings, which incorporate Indigenous sexual health issues into community training programs.
- Cultural awareness training for non-Indigenous staff.

Key performance indicators

- Increased number of local health councils, forums, regional and cross border collaborative planning initiatives in operation in Indigenous communities.
- Increased number of community education programs planned and delivered locally with substantial community involvement.

6.3.2 Education and prevention

Objective

Implementation of best practice education and prevention strategies that will:

- increase awareness of sexually transmissible infections and how to prevent them
- decrease the incidence of sexually transmissible infections among the Queensland Indigenous population
- minimise the impact of, and prevent infertility associated with sexually transmissible infections
- be responsive to changes in epidemiology and risk behaviours over time.

Guiding principles

The NIASHS identifies a series of guidelines that should apply to the development of Indigenous sexual health strategies. It notes that certain elements are crucial for any prevention strategy and that these include:

- the provision of high quality, timely primary health care, particularly designed to reduce rates of STIs in Indigenous communities
- education programs that not only provide information on reducing risks but also support broader behaviour change within communities
- the provision of equipment that helps avoid risk – condoms, clean needles and single use equipment for ceremonial use
- an environment free of discrimination on the basis of sexual practice, race or drug use behaviour
- the development of high quality information systems that provide communities with timely information on the changing profile of HIV and its related risk factors, including STIs.²⁰

²⁰Department of Health and Aged Care, op. cit., pp. 5-6.

Target groups

Whilst this Strategy recognises the education and prevention needs of all Indigenous Queenslanders, it highlights the special needs of groups such as:

- Indigenous prisoners
- Indigenous gay men and sista-girls
- Indigenous people living with HIV/AIDS or hepatitis C
- Indigenous youth (aged 12 – 25 years)
- Indigenous homeless people
- Indigenous people who inject drugs
- Indigenous people who misuse alcohol and other substances
- Indigenous sex workers.

These groups closely reflect the at-risk populations identified by the NIASHS and also closely reflect the priorities of the *National HIV/AIDS Strategy*.

In addition, this Strategy recognises the special needs of:

- Indigenous people living in rural and remote areas or in regions identified in the Queensland Framework for Action in Aboriginal and Torres Strait Islander Health
- Indigenous women with undiagnosed chlamydia and gonorrhoea infections
- Indigenous school aged children
- and also the education and training needs of those working with Indigenous people across a range of health, education, welfare and custodial settings.

Strategies

Implement education and prevention strategies including the following.

- Development of school and peer based education programs that promote adoption of safe behaviours and regular sexual health checks for Indigenous populations, with a focus on identified special needs groups.
- Development of community education programs to promote harm minimisation strategies.
- Reorientation of Indigenous primary health care services and Correctional Centres to act as centres for behaviour change regarding safer sexual practices, and education to improve knowledge of sexual health matters.
- Coordination and implementation of Indigenous sexual health promotion activities within Queensland Health and where appropriate with other relevant government departments such as Corrective Services, Families and Education Queensland.
- Ensuring primary health care providers and community educators have access to all available data to inform the development, implementation and evaluation of programs and services.
- Development and implementation of strategies to minimise the potential risk of transmission of STIs between Indigenous populations and Papua New Guineans within the Torres Strait Treaty Zone.

Key performance indicator/s

- Reduction in the incidence and prevalence of sexually transmissible infections among the Queensland Indigenous population.
- Reduction in rates of Pelvic Inflammatory Disease among the Queensland Indigenous population.
- Number of education and prevention strategies implemented in the Torres Strait Treaty Zone.

6.3.3 Early detection and management

Objective

Implementation of evidence based early detection and management systems that will assist in service planning and delivery, and that focus on:

- enhancing the capacity of primary health care facilities to detect sexually transmissible infections and optimally manage disease sequelae

- implementation of recall and follow up systems
- assisting in the redesign of services to be culturally appropriate and accessible to all Indigenous communities.

Guiding principles

The NIASHS recommends how Indigenous primary health care could be strengthened, including:

- ensuring treatment is based on the best evidence-based practice, including the development and use of appropriate clinical care guidelines for diagnosis and management of STIs
- ensuring that clinical care guidelines are developed by those who use them and that they take account of the particular circumstances of local areas
- facilitating appropriate use of new non-invasive diagnostic techniques that encourage opportunistic and voluntary testing for STIs
- identifying and removing barriers that currently prevent the screening of asymptomatic people
- developing and maintaining mechanisms such as client recall systems for follow up
- developing and maintaining quality health information systems that provide communities with up to date information about changing disease profiles and related risk factors²¹.

Target groups

- All Indigenous people across Queensland should have access to appropriate primary health care including regular sexual health checks.

Strategies

Key strategies to improve early detection and management should include the following.

- Provision of active screening programs such as the Chronic Disease Strategy for the early detection, notification and treatment of sexually transmissible infections. Services should use non-invasive diagnostic technologies, simple treatment options and be a part of a continuum of care.
- Improved access to quality sexual health diagnostic, treatment and care services that form part of a continuum of care.
- Improvements in the coordination of services, referrals and contact tracing between government and community based service providers, and between related service providers (such as women's cancer screening services, correctional centres, sexual health clinics, refuges, hostels and domestic violence services) across Queensland.
- Enhance the capacity of services within the Torres Strait Treaty Zone to provide screening and treatment of sexually transmissible infections.
- Support the implementation of patient recall systems to ensure appropriate follow up and management.
- Ensure that services are culturally appropriate and staff remain sensitive to the needs of the local Indigenous population.
- Ensuring service providers have access to relevant up to date information to assist in the planning, development, implementation and evaluation of programs and services.

Key performance indicator/s

- Increased numbers of PCR tests conducted among Indigenous populations, and in particular in regions identified in the Queensland Framework for Action in Aboriginal and Torres Strait Islander Health.
- Evidence of increased collaboration and referrals between service providers supporting a continuum of care
- Eradication of Donovanosis in Queensland by 2004.

6.3.4 Skilled workforce

Objective

To develop and maintain a skilled workforce that can assist in reducing the transmission, and minimise the impact of sexually transmissible infections in the Queensland Indigenous population.

²¹Department of Health and Aged Care, op. cit., pp. 6-7.

Guiding principles

The NIASHS discusses a range of best practice principles applying to the Indigenous sexual health workforce. It notes that key elements of creating a successful workforce must include:

- recognition of the wide range of roles performed by health workers including traditional health, cultural brokerage, health promotion, environmental health and clinical care.
- accreditation of all training to allow workers to develop skills that can be applied in a range of settings.
- support for cultural awareness training for all health professionals
- standardisation of practice across primary health care settings and the establishment of best practice protocols and principles.

Target groups

- Health care professionals
- Workers in related services such as correctional facilities, youth workers, social workers and local government officers
- Community workers who deliver education and prevention programs.

Strategies

Strategies to improve the creation of a skilled workforce include the following.

- Supporting the development and enhancement of targeted clinical training programs to ensure provision of best practice Indigenous sexual health services.
- Providing training on safe sex, harm minimisation and related Indigenous cultural issues to workers across all government and non-government services working with identified Indigenous target populations. (See 6.3.2)
- Working with Health Service Districts and Aboriginal and Islander Community Controlled Health Services to ensure appropriate recognition of Indigenous Sexual Health Workers' competencies within the workforce and remuneration structures.
- Working with tertiary training providers to ensure career pathways for Indigenous Health Worker trainees and recognition of prior learning.
- Ensuring all non-Indigenous workers, providing sexual health services, undergo awareness training to improve their understanding of cultural factors affecting Indigenous health.
- Identifying training needs and collaborative training opportunities for health care workers in Queensland and adjacent parts of Papua New Guinea (PNG) in relation to HIV/AIDS and sexual health.

Key performance indicator/s

- Increased percentage of qualified Indigenous Health Workers providing health services consistent with their qualified competencies in Queensland.
- Number of qualified workers receiving remuneration and recognition consistent with their qualified competencies in Queensland.
- Increase in training opportunities identified and implemented between PNG and Queensland.

6.3.5 Research and data collection

Objectives

To:

- ensure government and non-government service providers are informed and have sound communication links
- support the introduction of clinical information systems to assist in local management and decision making
- ensure service planning and delivery is informed by quality research.

Guiding principles

The NIASHS discusses a range of best practice principles for conducting research connected with Aboriginal and Torres Strait Islander peoples.

They include:

- research must be developed in close collaboration with the primary health care sector
- research results must be disseminated at the community level
- research must be strategically focused and in particular illuminate matters of concern to service providers
- Indigenous health workers and health service managers must have sufficient skill and knowledge to be involved in the projects and research
- research must be part of the community development process
- researchers must adhere to ethical guidelines – whether those established by Indigenous people or the National Health and Medical Research Council's (NHMRC), "Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research"²².

Target groups

- Public health officials and epidemiologists
- Universities, tertiary sector training organisations
- State and national research establishments
- State government departments

Strategies

- Ensure all Indigenous sexual health data is handled sensitively and with respect in line with above-mentioned NHMRC Guidelines.
- Improve the quality and type of data available through relevant epidemiological data collection systems, including increased use of Indigenous identifiers.
- Improve program service delivery through collection and analysis of relevant information, reports and data.
- Ensure appropriate data and best practice information is available to providers of sexual health services to Indigenous people.
- Improve data collection in relation to PNG nationals' access to health services and STI diagnoses in the Torres Strait Treaty Zone.
- Participate in, or initiate research to establish data for the purposes of informing program planning and development.
- Ensure high quality monitoring and evaluation of education, prevention, treatment and care services.

Key performance indicator

Increase, over the life of this Strategy, in the number of Indigenous research projects conducted in Queensland that comply with the Guiding Principles described above.

6.3.6 Evaluation and monitoring

Objectives

To:

- ensure that progress in the implementation of this Strategy is subject to review.
- ensure programs are adapted as required, to improve delivery of the health outcomes identified.

Guiding principles

- All programs must reflect current best practice and be based on most current available data.
- Local area partnerships must be built on mutual trust and respect.
- Formal agreements should be entered into wherever possible to formalise working arrangements between local service providers.
- Community involvement should be incorporated into the design and delivery of evaluation and monitoring processes.
- Programs to be consistent with the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in May 2002.

²²Department of Health and Aged Care, op. cit., p. 13.

Target groups

All state government and non-government service providers involved in the development and delivery of Indigenous sexual health programs and services.

Strategies

- Conduct mid term reviews of this and other related government strategies.
- Provision by Health Service Districts of forums for the exchange of information and problem solving at the local level.
- Participation by Queensland Health in the Queensland Partnership Sexual Health Working Group.
- Government and non-government service providers review policies and procedures to consider ways to enhance the lead agency work of Queensland Health to improve the sexual health of Indigenous Queenslanders.

Key performance indicators

- Mid term review of this Strategy conducted by the end of 2004.
- Minimum of one local area forum held in each Zone per annum.
- Members and frequency of meetings of the Queensland Partnership Sexual Health Working Group.

7 Partnerships

Through this Strategy, Queensland aims to promote and support a partnership approach, described in the *National HIV/AIDS Strategy 1996-97 to 1998-99* as:

*...an effective cooperative effort between all levels of government, community organisations, the medical and scientific communities, people living with HIV/AIDS and other affected people, all working together to control the spread of HIV and to minimise the social and personal impacts of the disease. The partnership is based on a commitment to consultation and joint decision-making in all aspects of the response.*²³

Professor Richard Feacham in his evaluation of the second *National HIV/AIDS Strategy*, noted that:

*There are no shortcuts to comprehensive policy framework that involves the affected communities, brings out the best in all levels of government and ensures high quality professional participation. Maintaining the partnership involves constant hard work by all participants, but it is an achievement worth preserving.*²⁴

This Strategy recognises the value of collaboration in the delivery of Indigenous sexual health services across Queensland, and aims to promote close cooperation between the key target groups and stakeholders comprising the "partners" in Queensland's response to Indigenous sexual health. These key partners are set out below.

■ Queensland Health Corporate Office

Negotiation across the relevant business units within Queensland Health is required for developing the most effective and efficient responses to Indigenous sexual health issues. These units include Communicable Diseases Unit, Health Outcomes Unit, Health Funding and Systems Development Unit, Aboriginal and Torres Strait Islander Health Unit, Office of Rural Health, Zonal Management Units and Statewide Health and Non Government Services Unit.

■ Aboriginal and Islander Community Controlled Health Services and linked organisations

The first action area identified by the *Aboriginal and Torres Strait Islander Health Policy 1994* was community control of primary health care services. In line with this direction, decisions by the Queensland Partnership have seen gradual increases in the funding and staffing levels of Aboriginal and Islander Community Controlled Health Services. These services provide a range of basic primary care services across Queensland, providing an alternative to the mainstream facilities. In addition, there has been an increased focus on the role of Indigenous advocacy organisations such as the Queensland Aboriginal and Islander Health Forum, the Apunipima Cape York Health Council and the Torres Strait Regional Health Council. These peak organisations provide a range of vital services for their constituents including acting as advocates in negotiations with both state and federal governments. They are also critical to the provision of advice to inform policy, program development and evaluation. This Strategy aims to restate and strengthen these collaborative relationships.

²³Department of Health and Family Services, *Partnerships in practice: National HIV/AIDS Strategy 1996-97 to 1998-99*, Australian Government Publishing Service, Canberra, 1996, p. 23.

²⁴Department of Human Services and Health, *Valuing the past...investing in the future: evaluation of the National HIV/AIDS Strategy 1993-94 to 1995-96*, (Professor RGA Feachem, evaluator), Australian Government Publishing Service, Canberra, 1995, p. 9.

- **Health Service Districts and Zonal Management Units**

Health Service Districts (HSDs) are responsible for the provision of a range of primary care and Indigenous sexual health services appropriate to the geographical locations and populations they serve. The work and output of each HSD is managed by a Zonal Management Unit (ZMU) covering each of the Northern, Central and Southern Zones of Queensland Health.

Presently a range of specialist and generic Indigenous sexual health services exist, with varying capacities across HSD areas. HSDs also operate mainstream sexual health clinics, and HIV/AIDS and hepatitis C treatment programs. These must be culturally appropriate to Indigenous populations.

The Communicable Diseases Unit collaborates with the ZMUs, HSDs and the purchasing areas of Queensland Health in developing service contracts for the provision of Indigenous sexual health and hepatitis C programs and services across HSDs.

HIV/AIDS, Hepatitis C and Sexual Health Coordinators and Indigenous Health Coordinators located in each Zone are responsible for improving coordination and collaboration between government and non-government services both within and across HSDs.

- **Commonwealth Government**

The OATSIH within the Commonwealth Department of Health and Ageing has carriage for the implementation of the *National Indigenous Australians' Sexual Health Strategy 1996-97 to 2003-04*. Working in collaboration with States and Territories, and peak community organisations it directs funding to projects that support the implementation of the NIASHS. OATSIH also provides leadership on key strategic issues and sponsors the Indigenous Australians Sexual Health Committee (IASHC). This committee provides policy advice to OATSIH on matters relating to implementation.

- **Other State/Territory Governments**

Queensland Health works in collaboration with other States and Territories on the development and implementation of initiatives that have cross-border implications, including coordination of service provision and data collection.

- **Other State/Local Government departments**

Queensland Health works with other government departments in the development of Indigenous health related policy and in the delivery of prevention initiatives. Examples include collaborating with Education Queensland for delivery of education programs to schools; local government on the impact of specific services or programs on local resources; Department of Families on improving continuums of care between government services; particularly those for Indigenous young people; and Corrective Services for the delivery of education and prevention programs to Indigenous prisoners.

- **Research, medical, scientific and health care providers**

The continuing role of professionals in these fields is essential for the delivery of treatment and care services, and for the provision of quality training, research and policy advice. Queensland Health has established links with the Australasian College of Sexual Health Physicians, the Royal Australian College of General Practitioners, Divisions of General Practice and a range of universities and faculties. Other strategic partnerships are being fostered within the research and scientific communities (eg. National Centre for HIV Epidemiology and Clinical Research, and the Queensland Institute for Medical Research).

- **International partners**

Where practicable, Queensland Health seeks to work in collaboration with our international neighbours in identifying and implementing strategies that assist in the management of health concerns across jurisdictions, with a particular focus on Papua New Guinea.

8 Current issues affecting service delivery

A number of key challenges will be relevant during the life of the *Queensland Indigenous Sexual Health Strategy 2003 to 2006*.

- **Non-invasive diagnostic technology and single dose treatments**

The availability of non-invasive tests for sexually transmissible infections (eg. urine based PCR) has increased accessibility for large community screening of asymptomatic populations and the development of targeted outreach services delivered to identified at risk populations.

The use of simple specimen collection methodologies provides opportunities for genuine community collaboration and health promotion programs that more closely link education with clinical service delivery. Single dose therapies such as Azithromycin also provide the opportunity for quick, effective treatment of newly diagnosed cases. During the course of this Strategy, it will be necessary to widen the use of these new technologies through regular screening to promote earlier detection of asymptomatic infections.

- **Workforce planning**

It will be necessary through the life of this Strategy to identify opportunities that improve training and career paths for health professionals working in the area of Indigenous sexual health. This should include the continued review of the existing workforce composition to identify issues for workforce planning, obstacles to progress, and the continuation of professional development programs (such as those currently provided by the North Queensland Workforce Planning, Management and Development Unit and University of Queensland). This will require continued negotiation of funds to support remote learning opportunities, such as the distance learning packages currently offered to sexual health workers through the Rural Health Training Units.

- **Cross border issues**

Given the nature of the travel of many Indigenous Queenslanders across international, state and territory borders, it will be necessary to work with a range of governments to improve service delivery to Indigenous people living in these areas. This work should include efforts to better integrate services, improve access to early detection and treatment services, and improve data and monitoring systems. In particular, work needs to occur in the Torres Strait Treaty Zone and strengthening of Queensland's links to Papua New Guinea.

- **New therapies and implications for Indigenous people living with HIV/AIDS**

Advances in HIV medicine and diagnostic technologies have provided significant advances in the management and care of people living with HIV. It has also provided a basis for more ambulatory treatment programs and improved quality of life. These advances, whilst encouraging, present their own challenges for Indigenous people living with HIV in rural and remote communities, to ensure they have ease of access to quality medical care and drug therapies.

- **Improved Indigenous data collection**

To improve the epidemiological data on which Indigenous sexual health programs are based, it will be necessary to improve data collection mechanisms. This will include working with general practitioners and health service providers to ensure the capture of Indigenous identifiers. The establishment and operation of a syphilis register, installation of the SHIP and FERRET databases in dedicated Indigenous primary health care clinics, and moves towards the collection of a standardised data set amongst public sexual health clinics, will further improve data collection. The continued upgrading of relevant HIV/AIDS and sexual health databases, and conducting relevant research under the principles espoused by the NIASHS will also need to be continued through the life of this Strategy.

- **Cultural barriers to access**

The rich traditions associated with Indigenous culture also present several challenges to the provision of primary sexual health care. In many communities, traditional culture separates men's and women's business requiring primary health care facilities to employ separate men's and women's Indigenous sexual health workers. Available funding and a lack of sufficiently trained workers may not always make this possible. In addition these workers may have to work with a shame factor often associated with sex, and young workers may experience difficulties in being asked to provide services to their elders.

The inclusion of sexual health in the core training of all Indigenous Health Workers and improved focus on ensuring existing Indigenous Sexual Health Workers receive ongoing training and support to practice to the full extent of their competencies, will help to address this issue. In addition the inclusion of STI testing into broad based primary health care interventions, such as the Chronic Disease Strategy in Far North Queensland, will help to reduce stigma and move sexual health into the range of more mainstream health issues.

- **Partnerships**

During the life of this Strategy the quality of the partnership between Queensland Health, the Commonwealth OATSIH, Aboriginal and Islander Community Controlled Health Services and other

representative organisations needs to be strengthened. At the HSD level this could be achieved through the signing of memoranda of understanding (MOUs) between local Aboriginal and Islander Community Controlled Health Services. These MOUs should aim to increase trust and understanding, encourage the development and implementation of joint programs, and the sharing of resources. Programs that support continuity of care between the government and the community sector are also strongly encouraged including sharing of data where appropriate. Where a service is unable to offer Indigenous sexual health services to both sexes, joint programs and referral mechanisms between government and non-government service providers should aim to offer patient access to an Indigenous Sexual Health Worker of their own sex.

- **Improved links with women's health teams**

During the course of this Strategy, strong referral links need to be developed between women's sexual and reproductive health programs, sexual assault programs, women's cancer screening and Indigenous sexual health teams. The aim of these links should be to promote better continuity of care and to ensure that patient referral opportunities between the services are maximised.

- **Coordination across government**

Coordination across government departments ensures effective and comprehensive responses, particularly in areas such as education and law reform. Departments including Education, Corrective Services, Police, Justice and the Attorney General's, continue to perform an integral role in Queensland's response to Indigenous sexual health. These agencies also play an integral role in the implementation of the recommendations from the Intergovernmental Committee on AIDS Legal Working Party Report.

Coordination between levels of government is also required to further the success of particular initiatives. For example, local governments' role in safe disposal of infectious waste; strategies to address education of Indigenous people in correctional facilities, including youth detention centres; responsibility of local governments in relation to town planning particularly for positioning of needle availability programs etc.

- **Monitoring and evaluation**

As government funding becomes increasingly outcome focused, it is necessary to demonstrate the effectiveness of interventions and to monitor outcomes. To achieve this, it will be necessary to develop more effective strategies for evaluating the successes and outputs of programs and services. It will be necessary to consolidate those things that have been proven to work well.

However in doing this, innovative or speculative strategies will continue to be required including the need to advocate for support in their implementation. Ensuring that evaluation strategies are considered an integral part of program design will become a focus of service agreements, and also assist in attracting resources to areas of greatest demand.

- **Other health and environmental priorities**

It is unrealistic to expect that during the course of this Strategy, Indigenous sexual health will achieve the high priority status of other Indigenous health matters such as heart disease, diabetes etc. These factors contribute much more to Indigenous morbidity and mortality rates than does sexual ill-health. In addition, there are many other social determinants of health and environmental factors such as the misuse of alcohol, access to nutritious food, quality of housing, smoking and exercise that can also impact on the health of Indigenous Queenslanders. Accepting this reality, this Strategy concentrates on taking an holistic approach, promoting changes to primary health care practises that promote good sexual health and encouraging active population health programs. Where possible, programs developed under this Strategy should link with other Queensland strategies such as those addressing alcohol and drug programs, improved nutrition, physical activity, domestic violence and women's cancer. In particular, programs should link to the *Queensland HIV, Hepatitis C and Sexual Health Strategy 2004 to 2007*. This Strategy is currently under development and should be endorsed during the life of the *Queensland Indigenous Sexual Health Strategy 2003 to 2006*.

Appendix 1: Strategy Steering Committee Members

Mr Mark Counter (Chair)	Communicable Diseases Unit – Queensland Health
Ms Florence Williams	Queensland Aboriginal and Islander Health Forum
Ms Penny Marshall	Statewide Health and Non Government Services Unit – Queensland Health
Ms Toni Malamoo	Office for Aboriginal and Torres Strait Islander Health
Mr Marshall Saunders	Aboriginal and Torres Strait Islander Health Unit – Queensland Health
Ms Barbara Keys Tolhurst	Kambu Medical Centre
Ms Sue Archer	Apunipima Cape York Health Council
Ms Raelene Baker	Indigenous Health Coordinator – Queensland Health
Reverend Dalton Bon	Torres Strait Regional Health Authority

Glossary of Terms

Adjusted Prevalence	Total number of cases in a population at a given time after controlling for age/and or gender.
AHMAC	Australian Health Ministers' Advisory Council
AIDS	Acquired Immune Deficiency Syndrome
ANCA	Australian National Council on AIDS
ANCAHRD	Australian National Council on AIDS, Hepatitis C and Related Diseases
Crude Prevalence	Total number of cases in a population at a given time.
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSD	Health Service District
HSV	Herpes Simplex Virus
IASHC	Indigenous Australians Sexual Health Committee
IDU	Injecting Drug Use
IGCAHRD	Inter-governmental Committee on HIV/AIDS, Hepatitis C and Related Diseases
MoU	Memorandum of Understanding
MSM	Men who have sex with Men
NHMRC	National Health and Medical Research Council
NIASHS	National Indigenous Australians' Sexual Health Strategy 1996-97 to 2003-04
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PCR	Polymerase Chain Reaction
PNG	Papua New Guinea
QAIHF	Queensland Aboriginal and Islander Health Forum
SHIP	Sexual Health Information Program
SLA	State Legislative Area
STD	Sexually Transmitted Disease
STI	Sexually Transmissible Infection
WPHC	Well Persons Health Check
ZMU	Zonal Management Unit