Queensland Health

An initiative of the Queensland Sexual Health Strategy

Queensland Government

North Queensland Aboriginal and Torres Strait Islander sexually transmissible infections action plan 2016–2021

Published by the State of Queensland
(Queensland Health), 2016

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For more information contact:
Aboriginal and Torres Strait Islander Health Branch
GPO Box 48, Brisbane QLD 4001
Email ATSIHB_Corro@health.qld.gov.au
Phone 07 3006 2863

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QH723 04/16

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Acknowledgements

Queensland Health acknowledges and pays respect to Aboriginal and Torres Strait Islander people, on whose land we provide health services in Queensland, and the elders past and present.

This action plan has been developed in partnership between the Tropical Public Health Unit (Townsville HHS) and Tropical Public Health Services (Cairns and Hinterland HHS) and the Aboriginal and Torres Strait Islander Health Branch (Department of Health). Particular thanks to Elisha McGuiness (Tropical Public Health Unit) for drafting the plan, with clinical support from Dr Annie Preston-Thomas (Tropical Public Health Services).

Consultation was wide ranging and included HHS clinical and executive staff, the Aboriginal and Torres Strait Islander Community Controlled Health Sector, Primary Health Networks and relevant academic and content experts in the field of Aboriginal and Torres Strait Islander sexual health.

Specific acknowledgements to the following groups and individuals for their time and contributions:

- The Chairs and Boards of the five HHSs, including Mr John Bearne and Mr Col Meng, respectively the former Chairs of Townsville HHS Board and Mackay HHS Board. Particular thanks to Mr Paul Woodhouse, Chair of North West HHS Board, for highlighting the importance of this issue and the need for change.
- Members of the 'Chief Executive Steering Committee for Sexual Health in Aboriginal and Torres Strait Islander people in North Queensland', with special thanks to Dr Jill Newland, Chief Executive of Torres and Cape HHS, as Chair of this Committee.
- Members of the Expert Coordination Group for Indigenous Sexual Health in North Queensland, including representation from the Aboriginal and Torres Strait Islander Community Controlled Health Sector, HHS sexual health staff, the Statewide Maternity and Neonatal Clinical Network and the University of Queensland.
- Di Maurer, Greg Richards, Amanda Wingett and Tim Kershaw from the Department of Health's Aboriginal and Torres Strait Islander Health Branch for their ongoing support and editorial review.
- Staff from the Department of Health's Communicable Diseases Branch, Strategic Policy and Legislation Branch and Integrated Communications Branch.
- Associate Professor James Ward, Head, Infectious Diseases Research Aboriginal and Torres Strait Islander Health, South Australian Health and Medical Research Institute.

Goals

1. Eliminate congenital syphilis in Aboriginal and Torres Strait Islander babies in North Queensland by December 2017.
2. Control the syphilis outbreaks in the North Queensland Aboriginal and Torres Strait Islander population by December 2020.
3. Progressively reduce the prevalence of syphilis, chlamydia and gonorrhoea among Aboriginal and Torres Strait Islander people in North Queensland.

Introduction

For many years sexually transmissible infections (STIs) have been disproportionately affecting Aboriginal and Torres Strait Islander people, particularly those living in rural and remote areas. More recently, the re-emergence of infectious syphilis, with multiple outbreaks declared across four of the five North Queensland (NQ) Hospital and Health Services (HHS), and the occurrences of baby deaths from congenital syphilis, have demonstrated the need for an urgent and coordinated response.

Unlike many non-communicable diseases, the occurrence of STIs and their related health complications can be significantly reduced for Aboriginal and Torres Strait Islander people over a relatively short timeframe through targeted screening, treatment, contact tracing, health promotion and safe sexual practices.

Snapshot for five[i] HHSs in North Queensland (2010–2015)

- 79% (n=605) of notifications for infectious syphilis in NQ were for Aboriginal and Torres Strait Islander people.
- 74% of these notifications occurred in the 15–29 year old age group.
- Females account for 54% (n=325) of the notifications for Aboriginal and Torres Strait Islander people. Females only account for 9% (n=15) of notifications for non-Indigenous people.
- Six of the seven babies with congenital syphilis for this period were Aboriginal and/or Torres Strait Islander.
- Of the seven cases of congenital syphilis, three deaths occurred, all Aboriginal and/or Torres Strait Islander babies.[ii]

For the purpose of the *North Queensland Aboriginal and Torres Strait Islander sexually transmissible infections action plan 2016–2021*, STIs refer to all STIs with an emphasis on infectious and congenital syphilis, chlamydia and gonorrhoea. Although the action plan has no direct focus on human immunodeficiency virus (HIV), there is convincing evidence that controlling these STIs will also reduce the risk of HIV acquisition and transmission and a potential outbreak in this at risk population[1,2,3].

i Torres and Cape, Cairns and Hinterland, Townsville, North West and Mackay Hospital and Health Services.

ii Additional epidemiological information in Appendix 1—Epidemiological snapshot.

North Queensland Aboriginal and Torres Strait Islander STI action plan 2016–2021

The action plan is a direct response to the increasing prevalence of syphilis in North Queensland. While aligning with the *Queensland Sexual Health Strategy 2016–2021*, which addresses a broad range of sexual and reproductive issues, the action plan is specifically aimed at reducing the burden of STIs in Aboriginal and Torres Strait Islander people in NQ. The action plan outlines a regional coordination approach for STI services, increasing service capacity, embedding STI testing and management in primary healthcare, and increasing prevention, testing and treatment efforts through health promotion and professional development. A coordinated regional approach ensures the best use of limited resources and draws on the strengths of each HHS to provide high quality STI services that deliver tangible and sustained outcomes.

The specific activities within the action plan have been grouped into the following domains:

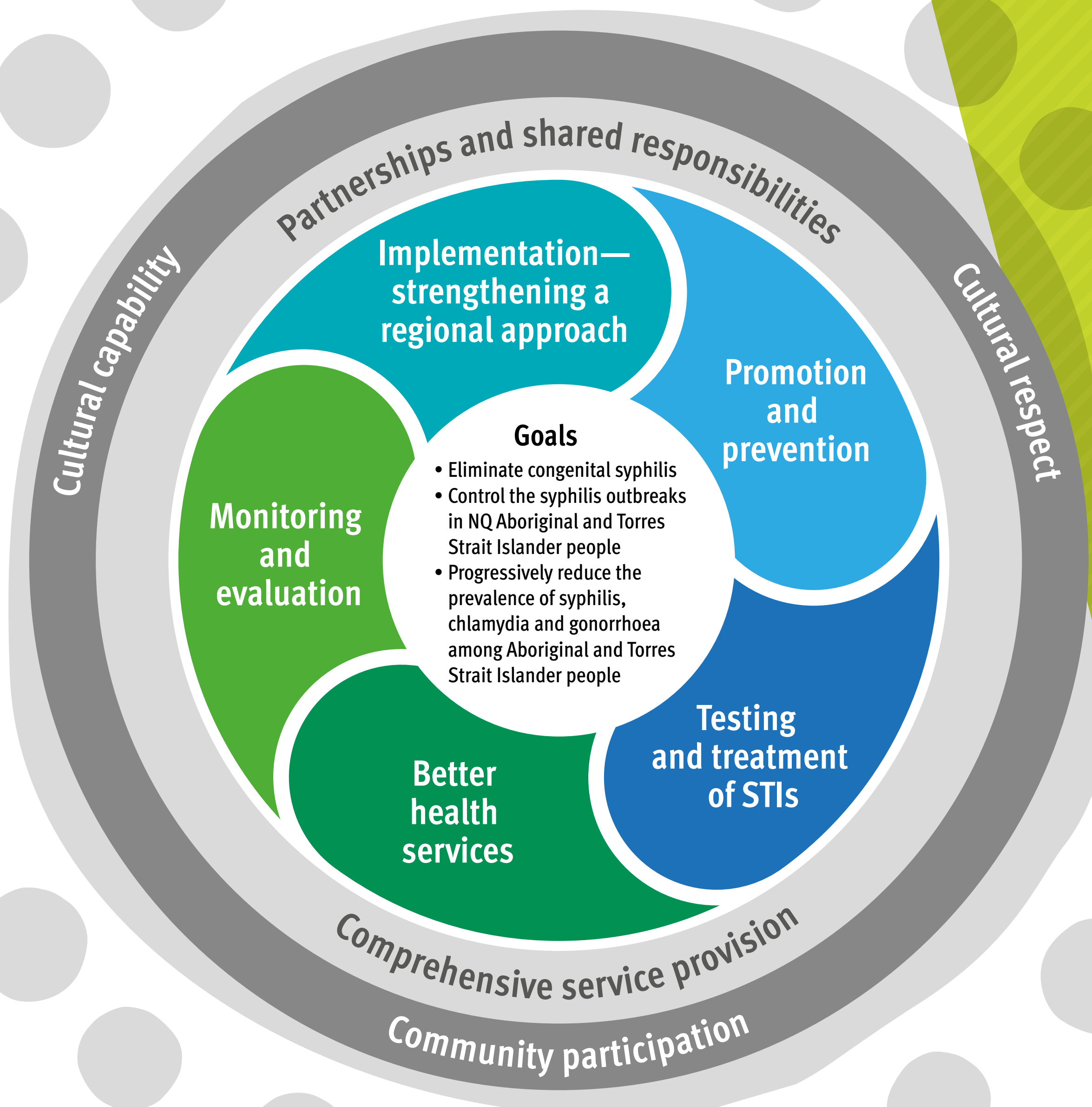
Implementation—strengthening a regional approach
Implement a coordinated and planned response to ensure the reduction of STIs among Aboriginal and Torres Strait Islander people in NQ.

Promotion and prevention
Improve the knowledge and awareness of STIs and protective behaviours among Aboriginal and Torres Strait Islander people in NQ, particularly those under 30 years of age, through the delivery of evidence based, culturally appropriate sexual health promotion.

Testing and treatment of STIs
Improve access to and delivery of culturally secure STI services, including best practice STI testing and management.

Better health services
Improve the knowledge and skills of the workforce to provide culturally secure services and appropriate models of care for delivery of STI services to Aboriginal and Torres Strait Islander people.

Monitoring and evaluation
Establish data collection and surveillance systems to enable the effective review of progress and improvement towards achieving the goals of the action plan.


Partnerships and shared responsibilities
Cultural capability
Cultural respect
Implementation—strengthening a regional approach
Promotion and prevention
Monitoring and evaluation
Goals
• Eliminate congenital syphilis
• Control the syphilis outbreaks in NQ Aboriginal and Torres Strait Islander people
• Progressively reduce the prevalence of syphilis, chlamydia and gonorrhoea among Aboriginal and Torres Strait Islander people
Better health services
Testing and treatment of STIs
Comprehensive service provision
Community participation

Implementation—strengthening a regional approach

To address STIs in a landscape of a highly mobile and young population, it is critical that the management of these infections takes a broader approach which goes beyond community, clinic service areas and HHS boundaries. Notwithstanding the need to build the capacity of existing services, a coordinated regional approach allows the identification and direction of resources to specific geographic or population groups to redress the current high rates of infectious syphilis and other STIs.

As such, a clear and coordinated regional framework for management of STIs across NQ HHS boundaries is required. Key actions in this area include having a clear mechanism for regional oversight, engagement across the five HHSs and other key partners, centralised public health support in NQ, and working with local communities and clinics.

It is also important that implementation is undertaken with consideration of the following key success factors:

- **Partnerships and shared responsibilities**—a coordinated approach to the reorientation of services, with clearly defined roles and responsibilities.
- **Cultural capability**—ensuring that people have the appropriate skills, knowledge and behaviours required to plan, support, improve and deliver culturally secure services to Aboriginal and Torres Strait Islander people.
- **Cultural respect**—acknowledging and respecting the diversity in Aboriginal and Torres Strait Islander peoples' cultures and their right to the provision of equitable, accessible, culturally secure and quality healthcare.
- **Community participation**—the involvement of communities is critical in the planning of programs that involve or impact them[4]. Aboriginal and Torres Strait Islander people at all levels must be active participants in the development of solutions to reduce the rates of STIs.
- **Comprehensive service provision**—ensuring an appropriate balance between health promotion, prevention, early intervention, treatment and education, based on local epidemiology, demography, scientific evidence and cultural and community input.

Priority 1: Implementation—strengthening a regional approach

Action/s	Timeline	Responsibility
Build leadership and coordination for the NQ Aboriginal and Torres Strait Islander STI response		
Coordinate the implementation of, and reporting against, the NQ STI action plan in the five HHSs through the Chief Executive Steering Committee, supported by a project officer.	August 2016	Torres and Cape HHS
Link Aboriginal and Torres Strait Islander STI services and programs in NQ to the actions in the action plan, as part of HHS service agreements and NGO contracts with the DoH.	July 2016	A&TSIHB with CE Steering Committee
Ensure executive and clinical accountability for STI related outcomes in primary healthcare, midwifery and antenatal care and sexual healthcare across NQ through performance agreements.	November 2016	CE Steering Committee
Regional guidelines for screening and management of syphilis		
Review and standardise antenatal (AN) screening recommendations/ guidelines in NQ, in both outbreak and non-outbreak contexts.	December 2016, then as required	AN clinical care service providers – HHS, PHC Services and TPHS
Review guidelines for management of syphilis in pregnancy and follow-up of neonates to inform recommendations for NQ clinicians.		
Disseminate, promote and ensure implementation of AN screening guidelines.	By December 2016	HHSs with PHNs
Develop guidelines to support the expansion of syphilis Point of Care (POC) testing where appropriate.	By October 2016	HHSs
Ensure that testing for syphilis and HIV occurs when clients return a positive test for other STIs.	January 2017	HHSs
Review the effectiveness of 'routine add-on' syphilis testing and make recommendations for regional implementation.	February 2017	Mount Isa SH
Develop guidelines to support STI testing, including syphilis, in young people under 15 years.	July 2016	ECG

Priority 1: Implementation—strengthening a regional approach (cont.)

Action/s	Timeline	Responsibility
Implement an evidence based and centralised public health response to manage STIs in NQ		
Support HHS Outbreak Response Teams to provide timely and optimal responses to outbreaks of syphilis.	August 2016	TPHS
Build capacity of the Cairns and Townsville public health units to provide regional public health guidance on STIs to the five HHSs in NQ, as identified in Appendix 2.	July 2016	Cairns and Hinterland HHS, Townsville HHS
Review evidence for public health strategies e.g. periodic presumptive treatment and expedited partner delivered treatment.	Ongoing	TPHS with MJSO, A&TSICCHS, ECG and HHS SH services
Maintain a focus on STIs and specifically syphilis, with key partners, relevant stakeholders and community leaders		
HHSs to engage with the Aboriginal and Torres Strait Islander Community Controlled Health Sector (A&TSICCHS), GPs, PHNs, youth organisations, relevant NGO and Community Based Organisations to develop strategic STI responses in their areas.	July 2016–ongoing	HHSs
Develop and maintain system wide partnerships and processes for the early identification and response to increasing HIV notifications among Aboriginal and Torres Strait Islander people in NQ.	July 2016 – ongoing	CDB and CE Steering Committee
Work with established networks to present information and consult with Aboriginal and Torres Strait Islander community leaders around the action required to address STIs among Aboriginal and Torres Strait Islander people, particularly young people (15–29 years).	Ongoing	PHC services and HHSs including Outreach Response Teams
Enable effective STI service delivery and capacity building of local staff in Primary Healthcare		
Outreach sexual health services work to develop capacity of local staff to deliver STI services, build system capacity within the local health service for STI care and provide specialist STI care as required.	August 2016 – ongoing	HHS Sexual Health Outreach Staff
Develop and implement training for clinical and primary healthcare staff in remote communities on STI testing and treatment and, where deemed relevant, for clinicians.	December 2016	HHSs and TPHUs

Promotion and prevention

Specialised community engagement, social marketing and evidence based sexual health education for children and young people, including curriculum based education, is essential to raise individual and community awareness of STIs, promote risk modification and safe sex practices to prevent STI transmission and to increase the number of young people seeking STI testing.

Health promotion programs will address gaps in young people's knowledge about their risk of acquiring STIs, promote skills such as negotiating condom use, building self-efficacy to seek healthcare services and making safer choices, including when under the influence of drugs and/or alcohol. It is essential that the cultural and social contexts of Aboriginal and Torres Strait Islander young people and the influence of geographic location are considered in program design. Community input into development, particularly young community members, is integral to program design, and effectiveness is reliant upon their continued involvement.

Historically, some health promotion activities may have been delivered without collaborating with existing health services or having key community ownership. The action plan provides a framework to ensure health promotion activities support existing health services and take into consideration the needs of communities.

Priority 2: Promotion and prevention

Action/s	Timeline	Responsibility
Engaging local Aboriginal and Torres Strait Islander communities in health promotion activities		
Work with local community representatives to ensure community consultation and engagement processes are established and maintained to provide guidance and local approval on all decision making and service planning in relation to STI services, both clinical and health promotion.	Ongoing 2016–2021	HHSs with TPHU support
Engage with the priority population of young Aboriginal and Torres Strait Islander people, aged 15–29, to identify appropriate and effective methods for the delivery of sexual health communication initiatives suitable for remote communities, that are designed to increase knowledge and awareness of STIs.	From July 2016 – ongoing	HHSs with TPHU support
Provide opportunities for community advocacy, mobilisation and action in relation to sex and relationship issues impacting communities and requiring community led solutions.	From January 2017–2021	HHSs with TPHU support
Build local health and community services' capacity to sustain meaningful action on sexual health promotion issues beyond the timeframe of the five year STI action plan.	From January 2017–2021	HHSs with TPHU support

Priority 2: Promotion and prevention (cont.)

Action/s	Timeline	Responsibility
Increase access to contraceptive services, including family planning and all-hours-access condoms		
Provide and expand access to contraceptive and family planning services to engage more young women in services and enable interactions to offer STI testing.	Commence January 2017	PHC services with HHSs
Implement a standardised NQ protocol and policy on condom provision for HHSs suited to the needs of Aboriginal and Torres Strait Islander young people.	By June 2017	HHS SH services with TPHS
Undertake an audit of condom infrastructure across NQ to establish baseline availability and identify communities with no, or very limited, all hours, discreet condom access.	By September 2016	TPHS
Ensure regular monitoring and high quality surveillance of condom infrastructure is undertaken as part of the condom availability survey.	Telephone audit 6 monthly from September 2016 Annual site visits when suitable for local services	TPHS
Establish partnerships across HHSs and with local government and community services to expand all hours, discreet condom access.	Ongoing	Local PHC services with support from TPHS
Develop condom promotion initiatives with identified communities to promote condom uptake and safe sex practices		
Implement locally applicable condom promotion initiatives to increase condom uptake.	From 2017–2021	TPHS with HHSs and PHC services
Work with local communities to develop locally appropriate condom branding utilising arts based engagement strategies.	January 2018	TPHS with HHSs and PHC services

Priority 2: Promotion and prevention (cont.)

Action/s	Timeline	Responsibility
Provide comprehensive sexuality and relationships education for Aboriginal and Torres Strait Islander youth with a focus on STI prevention and risk reduction in a variety of settings		
Implement and evaluate the pilot of the Strong, Proud, Healthy and Safe Sexuality and Relationships Education Curriculum (Years 5–10) developed in partnership with Far North Queensland region of Education Queensland (EQ).	May 2016–December 2016	TPHS in Partnership with EQ
Implement effective evidence based educational programs to increase STI knowledge and influence positive choices among young at risk Aboriginal and Torres Strait Islander people not engaged in formal education in settings most accessible to them, e.g. employment services, men's and women's groups, PCYC, sports, corrections.	July 2016–June 2018	HHS SH Services
Develop awareness raising social marketing campaigns targeting STIs, for young Aboriginal and Torres Strait Islander people in regional centres		
Collaborate with Queensland Aboriginal and Islander Health Council (QAIHC) on the development of an awareness raising campaign.	July 2016–June 2017	Integrated Communications Branch with CDB and A&TSIHB
Conduct market research with Aboriginal and Torres Strait Islander young people, relevant community agencies and A&TSICCHS to inform the development of culturally appropriate and locally relevant awareness campaigns suitable for use in major regional centres.	July 2016–onwards	Integrated Communications Branch with CDB, TPHS, A&TSIHB

Testing and treatment of STIs

The increasing incidence of syphilis in NQ requires that a series of immediate actions are undertaken to redress the risk of future cases of congenital syphilis and to slow, and eventually reverse, the rate of infectious syphilis among Aboriginal and Torres Strait Islander people. A number of specific activities will be implemented within the first 12 to 24 months of the action plan, and then embedded into ongoing primary healthcare services as required.

To respond to the increased notifications of infectious syphilis a number of targeted community screening activities will be undertaken in both remote and regional locations. These screening activities will be linked to appropriate treatment, health promotion and contact tracing activities.

The current high incidence of syphilis in NQ for Aboriginal and Torres Strait Islander people has followed a principally heterosexual mode of transmission, with females representing over 50 per cent of the current notifications. In addition, with the highest risk age group being 15–29 years, it is important to ensure increased screening for syphilis, and other STIs, is embedded in antenatal care to reduce the incidence of congenital syphilis and other complications during pregnancy and child birth.

Priority 3: Testing and treatment of STIs

Action/s	Timeline	Responsibility
Reducing the risk of congenital syphilis		
All pregnant women are tested for syphilis as per endorsed regional clinical guidelines.	March 2017–Ongoing	AN clinical care service providers – HHS & PHC Services
All pregnant women diagnosed with syphilis are managed in accordance with recommended guidelines.	By December 2016	Statewide Neonatal and Maternity Care Network in partnership with ECG and relevant local clinicians
All cases of congenital syphilis are investigated as a sentinel event using root cause analysis.	July 2016–ongoing	CDB to support HHSs
All babies born to mothers with untreated syphilis are managed in accordance with recommended guidelines, and cases are closely monitored and reviewed.	July 2016–ongoing	HHSs

Priority 3: Testing and treatment of STIs (cont.)

Action/s	Timeline	Responsibility
Implement an evidence based and immediate HHS response to the ongoing outbreaks of syphilis in NQ		
Share regional STI notification data to inform the outbreak response.	July 2016	CDB with HHSs and TPHS
Recruit to key local positions to increase culturally secure screening, treatment and contact tracing, as identified in Appendix 2.	Immediate	HHS
Undertake, across NQ, intensive large scale and culturally secure community based screening in at least one regional and two remote communities identified as a priority from the rapid STI data. Intensive screening to be undertaken every three months for the first year of the action plan.	July 2016–June 2017	HHS
Undertake active case finding strategies, including culturally secure community based, time specific, screening activities.	Ongoing for duration of outbreaks	HHS
Support the scale up of syphilis testing in settings where high risk individuals present for healthcare, with particular focus on antenatal care.	Ongoing	HHS
Undertake regular communication with clinicians to ensure syphilis diagnosis and management remains a priority on clinical agendas.	Ongoing	TPHS in partnership with HHS SH services
Incorporate locally appropriate sexual health promotion initiatives to support the outbreak response.	January 2017–ongoing	TPHS in partnership with HHS SH services
Enhance contact tracing		
Prioritisation of contact tracing measures for named contacts of people with infectious syphilis.	July 2016–June 2021	All clinical services
Disseminate guidelines and resources to support GPs, A&TSICCHS and PHC services to perform contact tracing for clients with a positive STI notification.	July 2016–June 2021	HHS SH Services with contact tracing support officers
Promote culturally appropriate patient education materials to support patient initiated partner notification.	July 2016–June 2021	HHS SH Services with contact tracing support officers
Review and further develop a systematic region-wide approach to contact tracing incorporating interagency collaboration.	By March 2017	TPHS

Better health services

Across NQ, STI services are provided in a variety of contexts. The action plan proposes a set of actions and models-of-care to increase the capacity of existing services, provide a coordinated public health response to control the outbreak of syphilis, develop working partnerships, and increase the capacity and quality of clinical service delivery in multiple settings. Consultation has occurred with HHSs in regards to funding and service models of sexual health services targeted to Aboriginal and Torres Strait Islander people, and a series of service and staffing models have been agreed to (Appendix 2).

While recognising the value of these targeted services it is critical that STI screening and care for Aboriginal and Torres Strait Islander people is broadened into other areas of the health system. This includes partnerships with the Aboriginal and Torres Strait Islander Community Controlled Health Services, which in some locations are major providers of primary and antenatal care. The action plan therefore provides a series of actions to embed STI screening and care across multiple services.

Priority 4: Better health services

Action/s	Timeline	Responsibility
Develop a culturally capable and qualified workforce to deliver appropriate STI care to Aboriginal and Torres Strait Islander people, including in regional and remote locations		
Disseminate and promote implementation of the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033.	Ongoing	A&TSIHB
Disseminate and promote use of the Aboriginal and Torres Strait Islander adolescent sexual health guideline.	Ongoing	A&TSIHB
Provide training to staff to enhance the cultural capacity of STI services provided for Aboriginal and Torres Strait Islander people.	Ongoing	HHSs
Review the current Indigenous Sexual Health Worker (ISHW) workforce model to ensure the most appropriate recognition of ISHW skills and opportunities for career advancement and development for these professionals.	Commence January 2018	Workforce Strategy Branch
Facilitate opportunities for the sexual health nurse workforce to attain endorsement via the Central Queensland University Endorsement Program and True Relationships Queensland.	Ongoing from July 2016–June 2021	HHSs

Priority 4: Better health services (cont.)

Action/s	Timeline	Responsibility
Develop a culturally capable and qualified workforce to deliver appropriate STI care to Aboriginal and Torres Strait Islander people, including in regional and remote locations (cont.)		
Collaborate with current training providers to increase sexual health content in primary healthcare certificate training including clinical skill competency development.	By September 2016	TPHS
Develop an Indigenous Sexual Health Worker Mentoring program in partnership with the sexual health and men's and women's health services in the five HHSs, and link with the ASHM and QAIHC training and professional development services.	By February 2017	Cairns SH Service lead—in partnership with other SH services and A&TSICCHS
Provide the STI snapshots professional development education series sessions to staff in HHSs, A&TSICCHS and other services working in Aboriginal and Torres Strait Islander sexual health.	Twice yearly each year	Torres and Cape HHS with TPHS
Promote and support access to ASHM delivered STI training initiatives, Deadly Sex Congress and networks.	July 2016–December 2017	HHS SH Services with PHC Services
Support the development of best practice in STI prevention and management		
Implement activities that enable partnership building and sharing of STI best practice and innovation including: • Establish a regional Aboriginal and Torres Strait Islander STI services network, in partnership with the QAIHC. • Develop web based information on STI services in the region. • Host an annual forum to showcase STI best practice and achievements in the region, in partnership with Deadly Sex Congress if relevant. • Consider and disseminate relevant research findings, for example the study in remote and regional communities undertaken by the Australian Centre for Research Excellence in Aboriginal Sexual Health and Blood Borne Viruses.	Ongoing 2016–2021	HHS SH services with SH outreach teams and TPHS
Disseminate and promote relevant STI testing and management guidelines, including during pregnancy.	Ongoing July 2016–June 2021	HHSs with TPHS
Adopt a PHC approach within health service delivery to remote communities to create an environment that enables STI care to be embedded in routine clinical practice, including antenatal care.	From August 2016–ongoing	HHSs
Use learnings from STRIVE research, including the experiences of NT and WA service providers that are using this framework and NQ services involved with STRIVE, to develop NQ specific tools and feedback mechanisms.	Ongoing	TPHS in partnership with HHS SH services

Priority 4: Better health services (cont.)

Action/s	Timeline	Responsibility
Establish and implement systems and processes that support and enable clinicians to undertake STI testing and management for all Aboriginal and Torres Strait Islander people aged 15–29 years in Queensland Health facilities		
Executives to support prioritisation of STI testing and management as a part of routine service delivery by all clinicians, ensure clinicians are aware of this responsibility and monitor adherence.	By July 2016	HHSs
HHSs to prioritise annual STI testing, with a focus on Aboriginal and Torres Strait Islander people aged 15–29 years.	July 2016–June 2021	HHSs with PHC providers
Develop standardised forms and resources along with implementation protocols to support STI testing for example, pre-printed pathology forms or point of pathology collection prompts.	November 2016	HHS SH services
Review evidence for frequency of STI testing for Aboriginal and Torres Strait Islander young people in areas of high prevalence to inform regional guidelines.	By December 2016	CDB
Develop and implement systems and processes to enable best practice management of clients with STIs and their contacts, including recall of clients requiring STI treatment and follow-up post infection.	December 2016 with ongoing review	HHSs with TPHS
Develop service models to improve rates of STI testing for males.	March 2017	TPHS with HHS SH services
Increase capacity of A&TSICCHS to provide culturally secure STI testing services in partnership with HHSs		
HHSs to collaborate with local A&TSICCHS to increase the availability of culturally secure STI screening for Aboriginal and Torres Strait Islander young people, particularly in priority communities.	From July 2016	HHSs
Partner with A&TSICCHS and GPs to pilot 'Express STI Services' for Aboriginal and Torres Strait Islander people to increase young people's access to culturally secure sexual health screening and other services.	September 2016–June 2018	HHSs with Local GP clinics and A&TSICCHS
Evaluate the 'Express STI Services' to assess potential for expansion.	October 2017–December 2017	TPHS

Priority 4: Better health services (cont.)

Action/s	Timeline	Responsibility
Develop innovative approaches to outreach, to access clients who may not attend standard clinic services		
In partnership with Education Queensland, develop and implement a consistent service model for sexual health screening programs in schools including a pilot of syphilis PoC testing in this setting.	By October 2016	Cairns SH service
Partner with the peak bodies Queensland Rugby League and AFL Queensland to develop standardised programs for pre-season and pre-carnival health checks.	By February 2017 to implement from March 2017	TPHS
Explore opportunities to collaborate with corrective services to review STI processes in correctional and youth justice facilities to ensure appropriate testing, treatment and follow-up.	By April 2017	Cairns SH services with Townsville SH services
Develop a Memorandum of Understanding for Queensland Health and Education Queensland to undertake and support sexual health screening and education of 15–18 year old students in identified schools in NQ.	By November 2017	TPHS and Education Queensland NQ representatives
Increase access to point of care (PoC) testing within identified priority locations		
Explore the feasibility of using GeneXpert testing, and chlamydia and gonorrhoea PoC testing, into routine clinical practice.	From January 2017	PHC with HHS SH services
Increase access to PoC testing in all appropriate locations.	July 2017 onwards	CE Steering Committee

Monitoring and evaluation

The broader implementation of the action plan will be monitored through a performance framework (Appendix 3) as well as the reporting of specific implementation activities against milestones. The reporting framework contains two tiers of indicators, with the first tier being outcome measures and the second tier performance and quality indicators. Where appropriate, the performance indicators have been linked to related actions and indicators within the *Queensland Sexual Health Strategy 2016–2021, the Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2014–2017*[5] and Queensland Health's reporting to the Communicable Disease Network of Australia's (CDNA) Multi-jurisdictional Syphilis Outbreak Group (MJSO).

A key element of the action plan is embedding surveillance system outputs to support effective implementation and monitoring. Services will be supported to collect data that informs their service planning and delivery, and to set local level key performance indicators to measure their own progress and contribution towards the action plan.

The specialist function of outbreak and disease monitoring and surveillance will be provided centrally by the TPHS. In addition to this role they will support HHSs to implement local level continuous quality improvement initiatives and data collection suitable to local patient information systems.

The CE Steering Committee will provide oversight of reporting on progress and outcomes to the Director-General and the five HHS Board Chairs.

Priority 5: Monitoring and evaluation

Action/s	Timeline	Responsibility
Establish processes that support improved completeness and accuracy of data sets on Aboriginal and Torres Strait Islander status		
Increase the identification of Aboriginal and Torres Strait Islander status within relevant data collection.	Ongoing July 2016–June 2021	HHSs
Negotiate with private laboratories to access STI testing denominator data and advocate for collection of Aboriginal and Torres Strait Islander status by the laboratories.	By December 2016	CDB

Priority 5: Monitoring and evaluation (cont.)

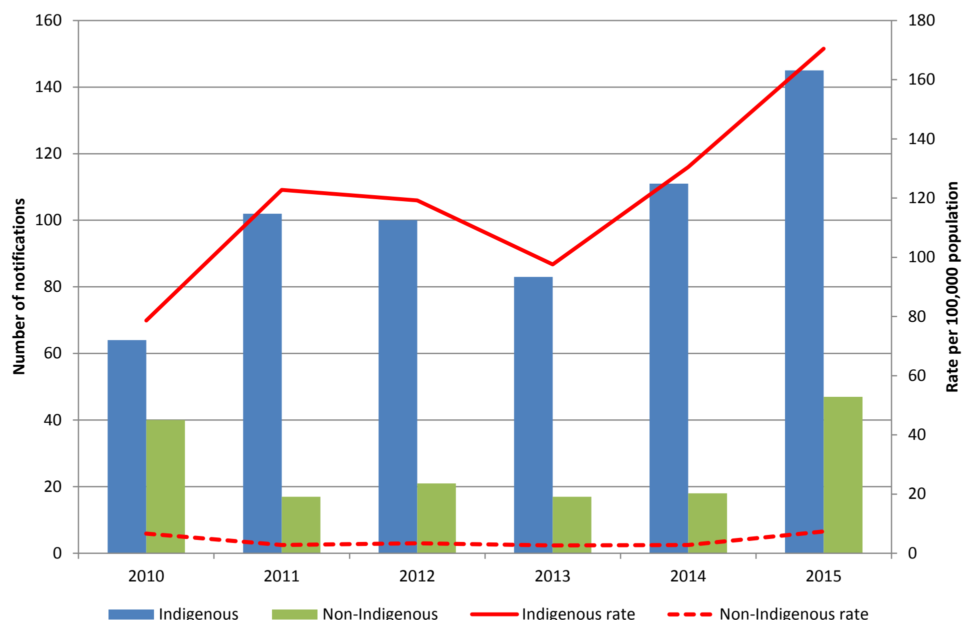
Action/s	Timeline	Responsibility
Develop the reporting frameworks and templates to ensure timely monitoring and evaluation of all actions in the action plan		
Develop STI data reporting templates for health services and clinicians.	January 2017–ongoing	HHSs with guidance from TPHS
Include STI indicators in HHS Service Agreements.	By July 2016	A&TSIHB
Incorporate STI action plan indicators and targets into performance schedules for relevant project schedules between the DoH and HHSs.	By July 2016	A&TSIHB
Prepare six monthly activity reports for presentation to the CE Steering Committee.	6 monthly December 2016 – June 2021	Project Officer to Chair of CE Steering Committee to coordinate with HHSs
Evaluate STI service delivery outcomes in line with key performance indicators identified in the action plan		
Develop evaluation and audit tools suitable for each type of clinical service to assess their progress towards key performance indicators and undertake evaluation periodically.	July 2016–June 2021	HHS SH services with PHC service, A&TSICCHS and TPHS services
Develop and implement an appropriate Continuous Quality Improvement framework to assist system level service delivery improvements that support achievement of the action plan goals.	July 2016–June 2021	HHS SH services with PHC service, A&TSICCHS and TPHS services
Undertake syphilis outbreak monitoring and surveillance and disseminate to relevant stakeholders		
Monitor the ongoing syphilis outbreak, and threats of possible emerging outbreaks, and report to HHSs as required.	July 2016 – ongoing for the duration of the outbreak	CDB with TPHS
Contribute to CDNA MJSO reporting and communicate relevant outcomes to stakeholders.	July 2016 – ongoing for the duration of the outbreak	CDB with TPHS
Undertake independent evaluations		
Evaluate the initial period of implementation of the action plan, including effectiveness of the rapid response screening approach and staffing structure, and revise the action plan accordingly.	June 2017–November 2018	TPHS with CE Steering Committee
Evaluate the effectiveness of the action plan in reducing STIs.	June 2020–January 2021	TPHS

Appendix 1 Epidemiological snapshot

The rate of infectious syphilis notifications is higher among Aboriginal and Torres Strait Islander peoples than among non-Indigenous Australians, both nationally and in Queensland. The number and rate of notifications of infectious syphilis in North Queensland are presented in Figure 1. In Australia, syphilis infections are primarily reported in two groups: heterosexual Aboriginal and Torres Strait Islander people, and men having male to male sex. In North Queensland, clusters and outbreaks of syphilis have been identified in the Aboriginal and Torres Strait Islander population. Notification counts for Aboriginal and Torres Strait Islander people in five HHS areas are presented in Figure 2.

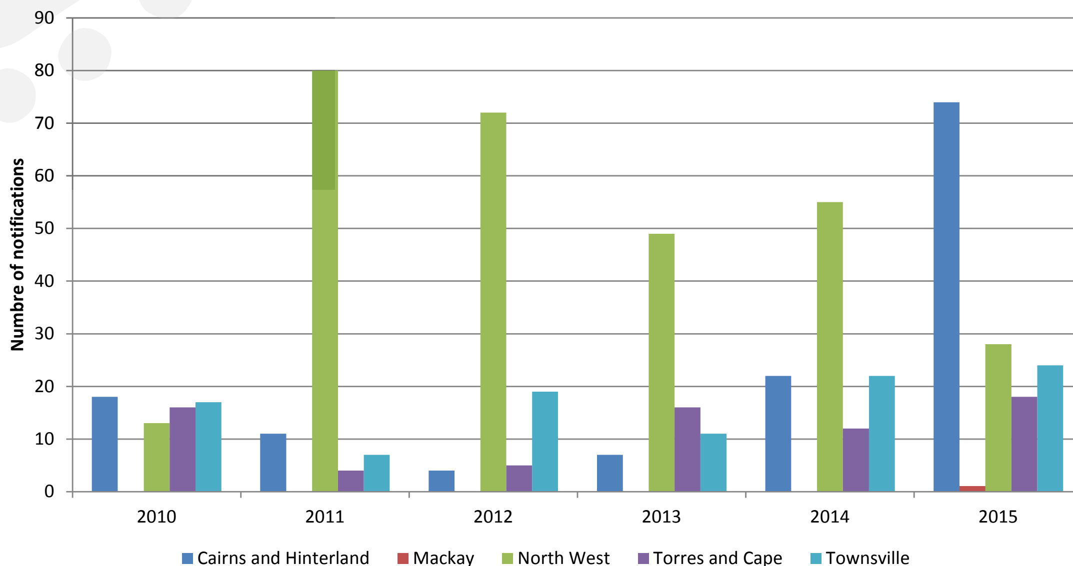
Infectious syphilis is sometimes asymptomatic (as with other STIs). Therefore the number of notified cases will be influenced by the amount of testing, and it is important that testing occurs in general practice and primary healthcare, not just in the sexual health clinic. In North Queensland, higher numbers of notifications among females and Aboriginal and Torres Strait Islander youth aged 15 to 29 years have resulted in an increased number of cases of syphilis during pregnancy (Figure 3). This in turn can lead to the serious consequences of congenital syphilis, which can result in disability and death of babies. This emphasises the need for higher coverage of testing, comprehensive follow-up and treatment in this population.

Figure 1: Number and rate per 100,000 population of infectious syphilis notifications in five North Queensland Hospital and Health Services by Aboriginal and Torres Strait Islander status, 1 January 2010 to 31 December 2015



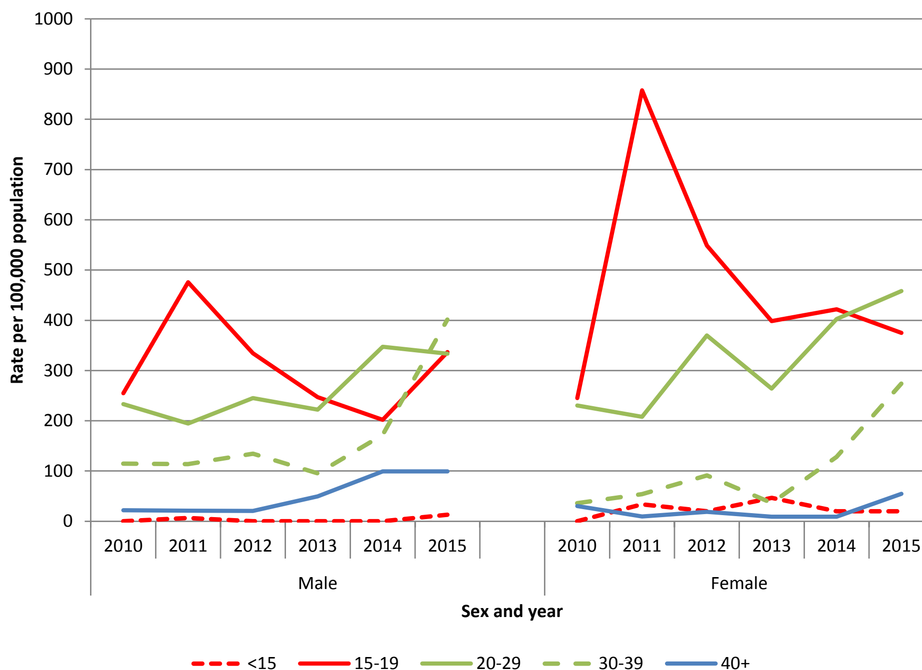
Note: Hospital and Health Services of Cairns and Hinterland, Mackay, North West, Torres and Cape, and Townsville. Data extracted from Notifiable Conditions System on 9 March 2016 by Onset Date.

Figure 2: Aboriginal and Torres Strait Islander notifications of infectious syphilis in five North Queensland Hospital and Health Services, 1 January 2010 to 31 December 2015



Note: Data extracted from Notifiable Conditions System on 9 March 2016 by Onset Date.

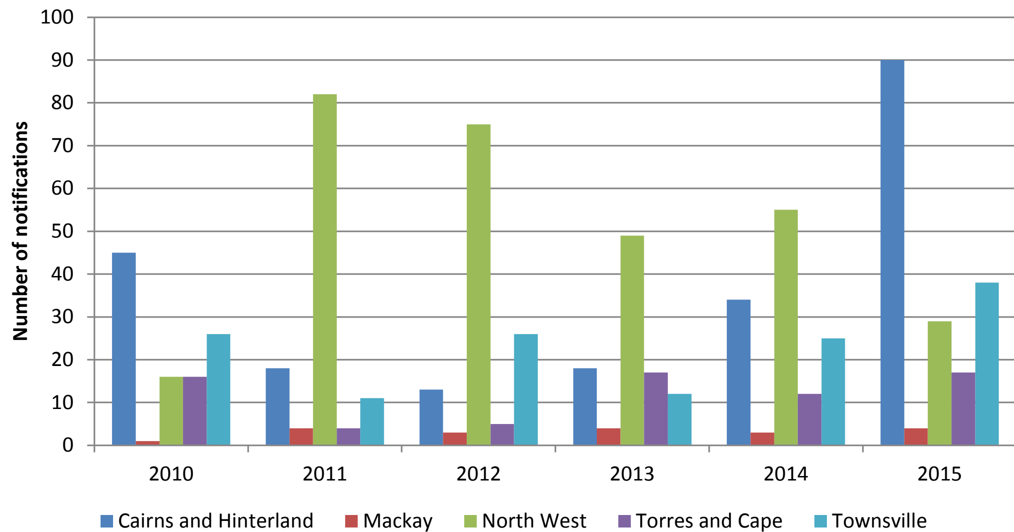
Figure 3: Rate per 100,000 population of infectious syphilis notifications in Aboriginal and Torres Strait Islander people in five North Queensland Hospital and Health Services by sex and age-group, 1 January 2010 to 31 December 2015



Note: Hospital and Health Services of Cairns and Hinterland, Mackay, North West, Torres and Cape, and Townsville.Data extracted from Notifiable Conditions System on 9 March 2016 by Onset Date.

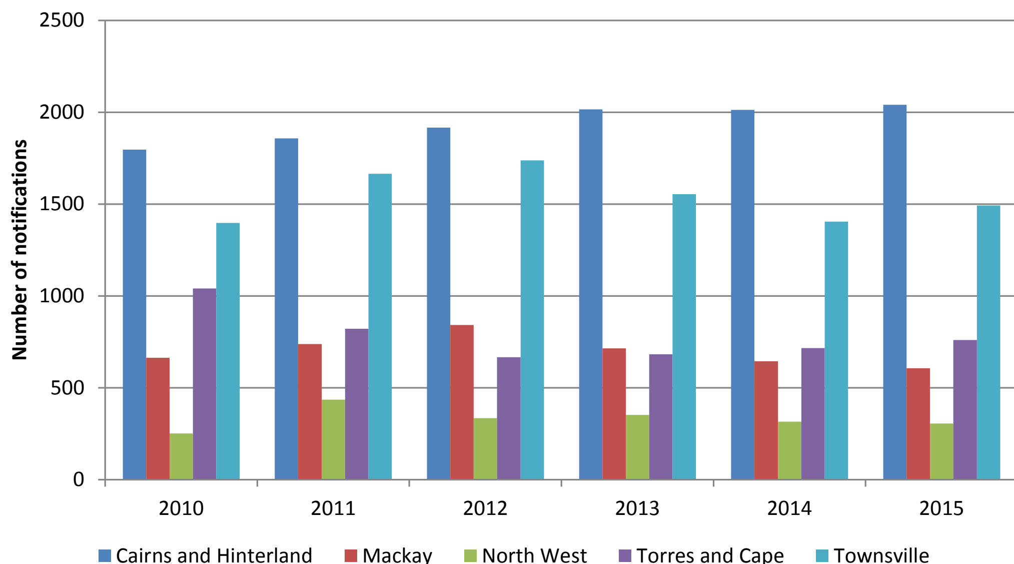
Notification rates of chlamydia and gonorrhoea are also higher among the Aboriginal and Torres Strait Islander population than the non-Indigenous population, both nationally and in Queensland. It should be noted that recording of Aboriginal and Torres Strait Islander status for chlamydia and gonorrhoea infection is significantly incomplete therefore HHS level reporting by Aboriginal and Torres Strait Islander status for these two infections is not possible. The total notifications for syphilis, chlamydia and gonorrhoea infections in North Queensland are presented below in Figures 4, 5 and 6.

Figure 4: Notifications of infectious syphilis in five North Queensland Hospital and Health Services, 1 January 2010 to 31 December 2015



Data extracted from Notifiable Conditions System on 9 March 2016 by Onset Date.

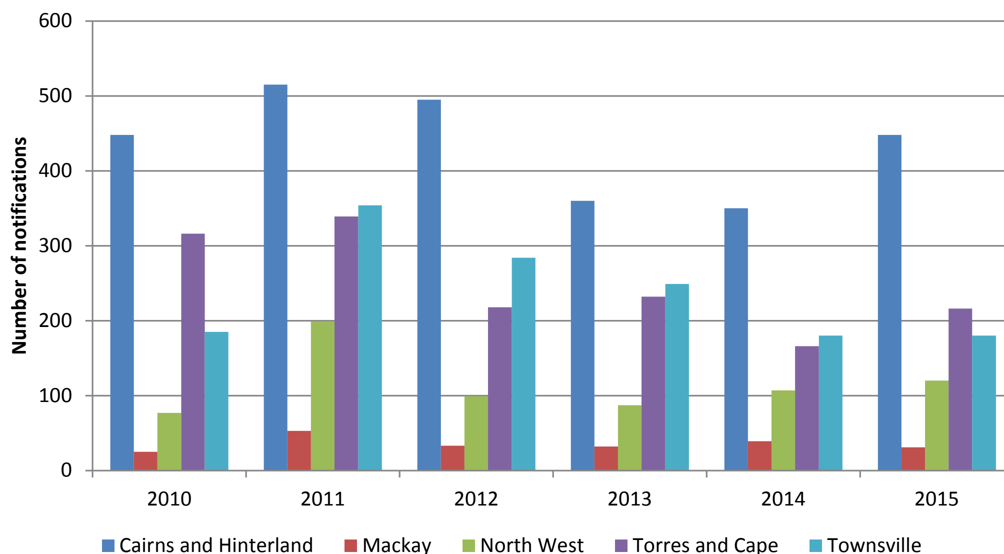
Figure 5: Notifications of chlamydia in five North Queensland Hospital and Health Services, 1 January 2010 to 31 December 2015



Data extracted from Notifiable Conditions System on 9 March 2016 by Onset Date.

Chlamydia is the most frequently reported sexually transmissible notifiable condition in Australia and Queensland. Nationally, the chlamydia notification rate for the Aboriginal and Torres Strait Islander population was three times that of the non-Indigenous population in 2014, with the rate seven times higher in remote areas. In Australia, the majority of chlamydia notifications in the Aboriginal and Torres Strait Islander population were among 15 to 29 year olds, a similar pattern to the non-Indigenous population.

Figure 6: Notifications of gonorrhoea in five North Queensland Hospital and Health Services, 1 January 2010 to 31 December 2015

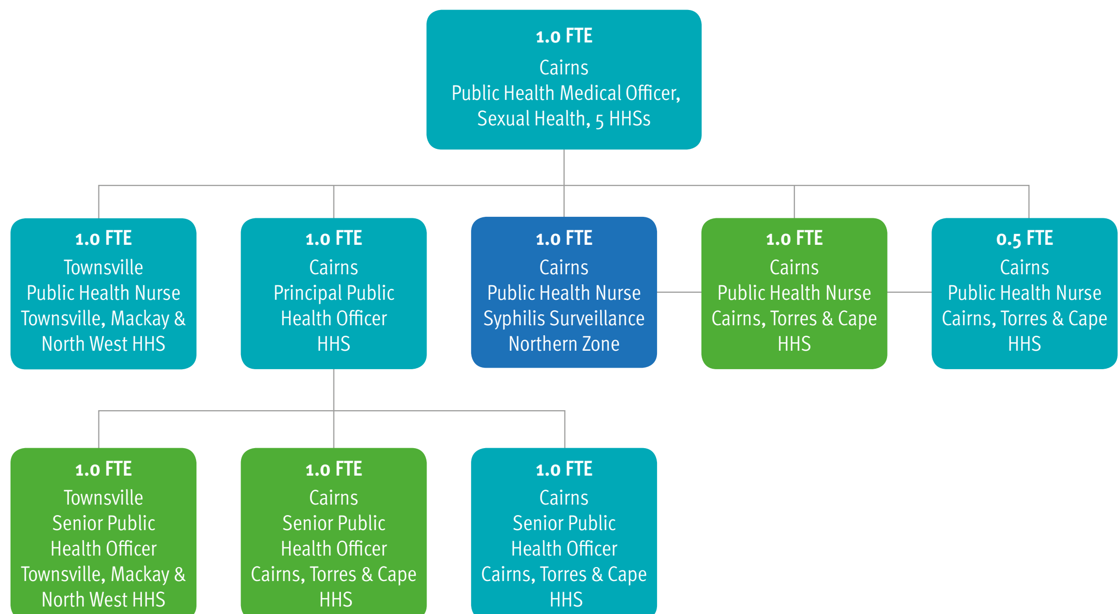


Data extracted from Notifiable Conditions System on 9 March 2016 by Onset Date.

Nationally, in 2014 the gonorrhoea notification rate for the Aboriginal and Torres Strait Islander population was 18 times that of the non-Indigenous population, with the rate 69 times higher in remote areas[6]. In Australia, the majority of gonorrhoea notifications in Aboriginal and Torres Strait Islander population were in 15 to 29 year olds.

Appendix 2
Staffing Models

Tropical Public Health Services
Regional Public Health STI Support



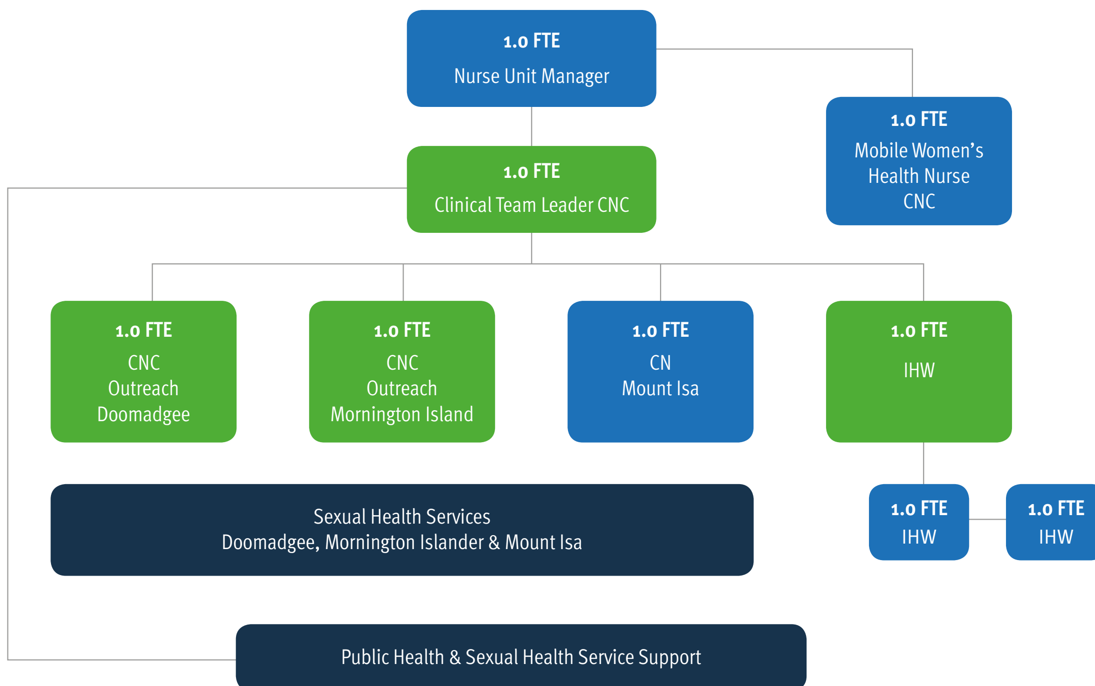
1.0 FTE
Cairns
Data Manager
5 HHSs
(will commence 2017/18)

Currently funded

Currently funded by Making Tracks Investment Strategy 2015–2018

Currently not funded

North West Hospital and Health Service Sexual Health

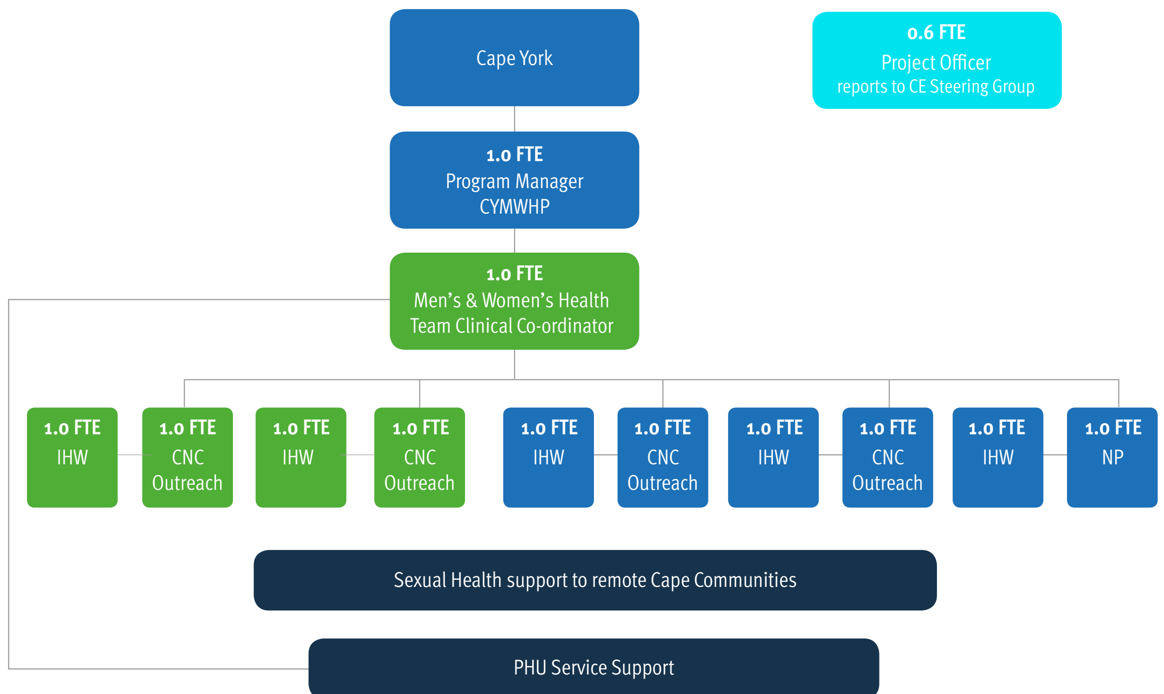


Currently funded

Currently funded by Making Tracks Investment Strategy 2015–2018

Currently not funded

Cape York Men's and Women's Health Program

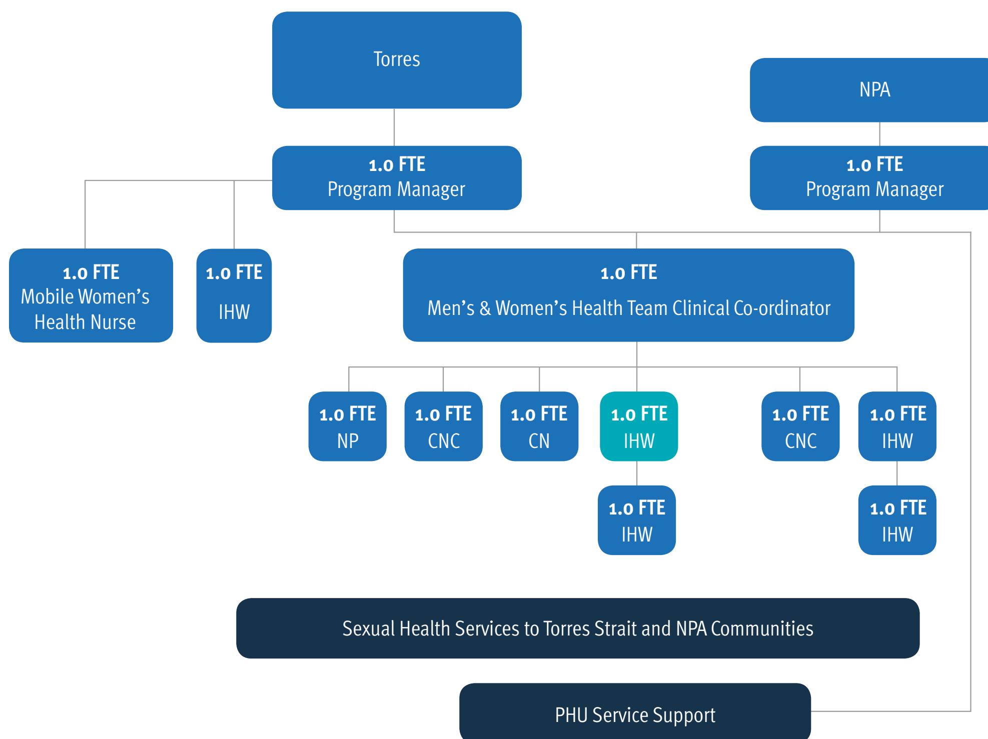


Currently funded

Currently funded by Making Tracks Investment Strategy 2015–2018

Currently not funded

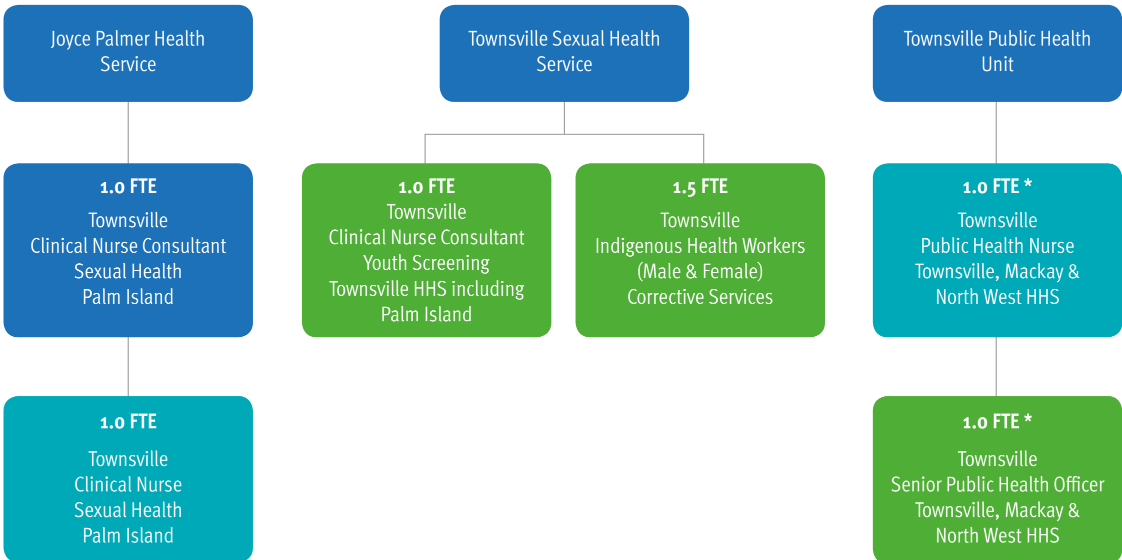
Torres Strait and Northern Peninsula Area (NPA) Men's and Women's Health Program



Currently funded

Currently not funded

Townsville Hospital and Health Service Aboriginal and Torres Strait Islander Sexual Health Services



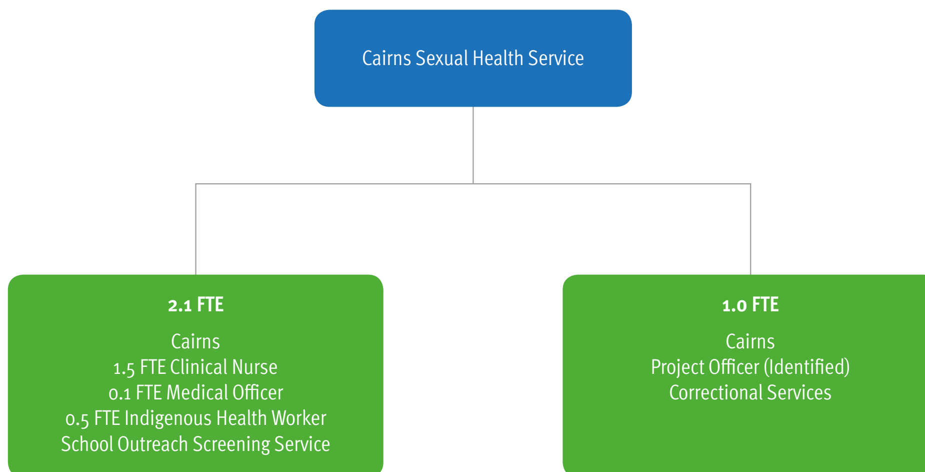
* Reports to Tropical Public Health Service (Cairns)

Currently funded

Currently funded by Making Tracks Investment Strategy 2015–2018

Currently not funded

Cairns and Hinterland Hospital and Health Service Aboriginal and Torres Strait Islander Sexual Health Services



Currently funded

Currently funded by Making Tracks Investment Strategy 2015–2018

Currently not funded

Appendix 3
Performance framework

Goal 1. Eliminate congenital syphilis in Aboriginal and Torres Strait Islander babies in North Queensland[iii] by December 2017

Tier 1: Outcome indicators	Target	Data source	Responsibility	Frequency
Number of notifications of congenital syphilis in Aboriginal and Torres Strait Islander babies	Zero	NOCS	CDB	Six monthly
Number of notifications of infectious syphilis during pregnancy, disaggregated by HHS, age and Indigenous status	Zero	NOCS	CDB	Six monthly
Number of infant deaths from congenital syphilis	Zero	NOCS	CDB	Six monthly
% of women[iv] tested for syphilis in accordance with agreed regional guidelines	100%	Antenatal audit (sampling across various sites)	HHS AN Units & TPHS	Baseline and annually
Tier 2: Performance and quality indicators	**Target**	**Data source**	**Responsibility**	**Frequency**
% of pregnant women[iv] diagnosed with syphilis treated within 1 week of diagnosis	100%	Syphilis surveillance system	TPHS	Annually
% of pregnant women[iv] diagnosed with syphilis who receive appropriate follow-up as per guidelines	100%	Syphilis surveillance system	TPHS	Annually
For all mothers diagnosed with syphilis during pregnancy, % of babies who are appropriately investigated and managed as per guidelines	100%	Syphilis surveillance system	TPHS	Annually

iii Includes Hospital and Health Services of Cairns and Hinterland, Mackay, North West, Torres and Cape, and Townsville.

iv Aboriginal and Torres Strait Islander status of the mother is not indicative of the Aboriginal or Torres Strait Islander status of the baby.

Goal 2. Control the syphilis outbreaks in the North Queensland Aboriginal and Torres Strait Islander population by December 2020

Tier 1: Outcome indicators	Target	Data source	Responsibility	Frequency
Number and rates of infectious syphilis notifications in NQ Aboriginal and Torres Strait Islander population disaggregated by HHS and reported by age and gender	1. Beyond 2018– decreasing rates of notification. 2. In 2021– halved the rate compared to the 2010-2015 period.	NOCS	CDB	Six monthly
% of Aboriginal and Torres Strait Islander 15-29 year olds tested for syphilis during community screens	≥70%	Auslab and local clinical data	Local services/ TPHS	As per screening schedule or per screen
Tier 2: Performance and quality indicators	**Target**	**Data source**	**Responsibility**	**Frequency**
% of Aboriginal and Torres Strait Islander people diagnosed with chlamydia and/or gonorrhoea who are tested for syphilis and HIV within four weeks of diagnosis	100%	Auslab Extraction	TPHS	Baseline and quarterly
% of cases of infectious syphilis which are investigated and treated within two weeks of diagnosis	80%	Syphilis surveillance system	TPHS	Quarterly
% of symptomatic syphilis cases diagnosed which are tested and treated for syphilis on first presentation	80%	Syphilis Surveillance System	TPHS	Quarterly
% of infectious syphilis cases which have repeat syphilis serology at 3-6 months post-treatment	80%	Syphilis Surveillance System	TPHS	Quarterly
% of named contacts of infectious syphilis cases who are tested and treated for syphilis on first presentation	80%	Syphilis Surveillance System	TPHS	Retrospectively Quarterly
% of infectious syphilis cases which have at least one named contact tested and treated within two weeks of case treatment	80%	Syphilis Surveillance System	TPHS	Quarterly
% of named contacts who are tested and treated for syphilis within four weeks of being named	80%	Syphilis Surveillance System	TPHS	Quarterly

Goal 3. Progressively reduce the prevalence of syphilis, chlamydia and gonorrhoea among Aboriginal and Torres Strait Islander people in North Queensland

Tier 1: Outcome indicators	Target	Data source	Responsibility	Frequency
Where Indigenous status is available, notification rates of chlamydia in NQ Aboriginal and Torres Strait Islander people by HHS reported by age and gender	Decreasing rates	NOCS	CDB	Six monthly
Where Indigenous status is available, notification rates of gonorrhoea in NQ Aboriginal and Torres Strait Islander people aggregated by HHS and analysed by age and gender	Decreasing rates	NOCS	CDB	Six monthly
% of resident Aboriginal and Torres Strait Islander population aged 15-29 years in remote communities tested for chlamydia, gonorrhoea and syphilis	70%	AUSLAB extraction or clinic level service performance audit	HHSs with TPHS	Annually
Tier 2: Performance and quality indicators	**Target**	**Data source**	**Responsibility**	**Frequency**
% of Aboriginal and Torres Strait Islander people diagnosed with STIs, treated within 7 days of positive pathology result	80%	Clinic level service performance audit	HHSs	Annually
% of Aboriginal and Torres Strait Islander people with chlamydia/ gonorrhoea infection retested 3 months post treatment	80%	Clinic level service performance audit	HHSs	Annually
% of named contacts of chlamydia/ gonorrhoea tested and treated within four weeks	80%	Clinic level service performance audit	HHSs	Annually
Number of all hours condom access points	One location in all remote Indigenous communities and three locations in each regional community	6 monthly condom audit	TPHS	Six monthly

Goal 3. Progressively reduce the prevalence of syphilis, chlamydia and gonorrhoea among Aboriginal and Torres Strait Islander people in North Queensland (cont.)

Tier 2: Performance and quality indicators	Target	Data source	Responsibility	Frequency
An increase in the uptake of condoms across all condom distribution points	Increased number of condoms distributed and stocked in dispensers	Quarterly condom stock inventories	TPHS	Quarterly
Number of schools implementing Strong, Proud, Healthy and Safe School based sexuality and relationships education curriculum pilot	Seven schools in NQ	Initial pilot program evaluation 2016	TPHS & Education Queensland	May–Dec 2016
Number of schools that the Strong, Proud, Healthy and Safe School based sexuality and relationships education curriculum expands to beyond the initial pilot phase	All NQ schools with a majority of Indigenous enrolments by 2021	Yearly Audit of School Curriculum implementation Workforce Audit	TPHS & Education Queensland	Annually in Term Two (approx. April)
Increased provision of sexual health clinical training for sexual health staff	The number of sexual health nurses who have completed endorsement training	Workforce audit & workplace mentoring program evaluation	HHSs	Annually
	The number of ISHW's undertaking specialist sexual health training and participating in workplace mentoring	Training audit by local sexual health support services	HHSs	Annually
Increased provision of clinical sexual health training to non-specialist sexual health staff	All new staff in remote communities complete mandatory introduction to STI testing and management training within 1 month of commencement. Refresher training undertaken by ongoing staff on a 12 monthly basis.	Training audit by local sexual health support services	HHSs	Annually

Appendix 4 Abbreviations

Acronym	Description
AN	Antenatal Care
ASHM	The Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine
A&TSICCHS	Aboriginal and Torres Strait Islander Community Controlled Health Sector
A&TSIHB	Aboriginal and Torres Strait Islander Health Branch
CDB	Communicable Diseases Branch
CDNA	Communicable Disease Network of Australia
CE Steering Committee	Chief Executive Steering Committee for Sexual Health in Aboriginal and Torres Strait Islander people in North Queensland
DoH	Department of Health (Queensland)
ECG	Expert Co-ordination Group
EQ	Education Queensland
GP	General Practitioner
HHS	Hospital and Health Service
ISHW	Indigenous Sexual Health Worker
MJSO	Multijurisdictional Syphilis Outbreak Group
NGO	Non-Government Organisation
NQ	North Queensland
NT	Northern Territory
PCYC	Police-Citizens Youth Club
PHC	Primary Healthcare
PHN	Primary Health Network
PoC	Point of Care
QAIHC	Queensland Aboriginal and Islander Health Council
SH	Sexual Health
STI	Sexually transmissible infections
STRIVE	STI in Remote communities: ImproVed & Enhanced primary health care
TAIHS	Townsville Aboriginal and Islander Health Service
TPHS	Tropical Public Health Services (Cairns)
TPHU	Tropical Public Health Unit (Townsville)
WA	Western Australia

Appendix 5
References

1. World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) 2008. Consultation on STI interventions for preventing HIV: appraisal of the evidence. Geneva: UNAIDS.
2. Korenromp EL, White RG, Orroth KK, Bakker R, Kamali A, Serwadda D et al. 2005. Determinants of the impact of sexually transmitted infection treatment on prevention of HIV infection: a synthesis of evidence from the Mwanza, Rakai, and Masaka intervention trials. J Infect Dis. 191: S168-78 doi: 10.1086/425274 pmid: 15627227.
3. Orroth KK, White RG, Korenromp EL, Bakker R, Changalucha J, Habbema JDF et al. 2006. Empirical observations underestimate the proportion of human immunodeficiency virus infections attributable to sexually transmitted diseases in the Mwanza and Rakai sexually transmitted disease treatment trials: simulation results. Sex Transm Dis. 33: 536-44 doi: 10.1097/01.olq.0000204667.11192.71 pmid: 16778738.
4. AH&MRC (Aboriginal Health and Medical Research Council) 2015. Aboriginal communities improving Aboriginal health: An evidence review on the contribution of Aboriginal Community Controlled Health Services to improving Aboriginal health. Sydney: AH&MRC.
5. Department of Health 2014. Fourth National Aboriginal and Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy 2014-2017. Canberra: Commonwealth of Australia. http://www.health.gov.au/internet/main/publishing.nsf/Content/4CBA8EFCE045DFA9CA257BF00020A9D0/$File/ATSI-BBV-STI-Strategy2014-v3.pdf
6. The Kirby Institute 2015. Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: Surveillance and Evaluation Report 2015. Sydney: The Kirby Institute.

Endorsements

Paul Woodhouse
Chair – North West Hospital and Health Board

Bob McCarthy
Chair – Torres and Cape Hospital and Health Board

Carolyn Eagle
Chair – Cairns and Hinterland Hospital and Health Board

Tony Mooney
Chair – Townsville Hospital and Health Board

Tim Mulherin
Chair – Mackay Hospital and Health Board

QH723 04/16