Guideline

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HIV/AIDS, STI & Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009

Document Number GL2007_002

Publication date 01-Mar-2007

Functional Sub group Clinical/ Patient Services - Infectious diseases
Clinical/ Patient Services - Medical Treatment
Population Health - Communicable Diseases
Population Health - Health Promotion

Summary The NSW HIV/AIDS, Sexually Transmissible Infections and Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009 provides a tool for the implementation of the NSW HIV/AIDS Strategy 2006-2009 (PD2006_072), the NSW STI Strategy 2006-2009 (PD2006_071) and the NSW Hepatitis C Strategy 2006-2009; and the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Community Health Centres, Public Health Units

Audience Directors, Public Health Units, Drug & Alcohol, Mental Health, Aboriginal Health, Sexual Health

Distributed to Public Health System, Community Health Centres, Divisions of General Practice, NSW Department of Health, Public Health Units

Review date 01-Mar-2010

File No. 03/6447

Status Active

Director-General

NSW HIV/AIDS, Sexually Transmissible Infections and Hepatitis C Strategies:

Implementation Plan for Aboriginal People

2006–2009

Artwork by Wendy Bryan-Clothier

NSW HEALTH

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Artwork Description

Traditional representations of the male and female form are used. This is to highlight the physical form and the significance of sexually transmitted infections for the individual and in community health.

The upper portion of the picture depicts community members surrounded by different health service providers. Providers may not have communicated with each other in order to best address the needs of the community: the different directions the providers are facing, and their real or perceived proximity to the community members highlight these issues. The background is coloured as a desert with a rock fall to the left side, highlighting the instability of the situation for community. There are only small amounts of green along the river, indicating that in the past things have appeared to look good on paper.

The river delineates the barriers which health service providers have crossed as together they seek to help the community. The rocks from the rockslide have been used to create a path over the river to a new system. The footprints depict the community crossing from an unstable environment to a more supportive one. Now health service providers work together and focus on the needs of the community. On this side of the river the land is green and alive depicting the new, healthy environment.

Wendy Bryan-Clothier

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SHPN (AIDB) 060188
ISBN 1 7418 7029 1

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February 2007

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SECTION 1

Introduction

Background

The purpose of this Plan is to support health services to implement the following NSW Health Strategies:

- *NSW HIV/AIDS Strategy 2006–2009*
- *NSW Sexually Transmissible Infections Strategy 2006–2009*
- *NSW Hepatitis C Strategy 2006–2009*

Aboriginal people are identified as priority populations in each Strategy. This Implementation Plan provides a tool for coordinating responses to all three Strategies.

The Plan was written to be consistent with the *NSW Health Aboriginal Health Impact Statement* and Guidelines which should also be referred to in implementing this Plan.

A draft of this Plan was provided for comment to key stakeholders including Aboriginal Community Controlled Health Services and Area Health Services. In addition, consultation workshops to which all key stakeholders were invited were held in five centres across the state.

1.1 Aboriginal population of NSW

At the time of the most recent Census, conducted during 2001, there were 460,140 Aboriginal and Torres Strait Islander people living in Australia, comprising 2.4 per cent of the total Australian population.[1]

NSW has the largest Aboriginal and Torres Strait Islander population of any State or Territory with 29.4 per cent of all Aboriginal and Torres Strait Islander people, comprising 2.05 per cent of the total NSW population. The Aboriginal and Torres Strait Islander population in NSW increased from 70,019 in 1991 to 135,319 in 2001.

Within the Aboriginal and Torres Strait Islander population in NSW, 93.6 per cent of individuals indicated that they were Aboriginal, 3.5 per cent indicated that they were Torres Strait Islander, and 2.9 per cent indicated that they were Aboriginal and Torres Strait Islander.

Consistent with NSW Health policy, this Implementation Plan uses the term 'Aboriginal' in preference to 'Aboriginal and Torres Strait Islander' to recognise Aboriginal people as the original inhabitants of NSW.[2]

1.2 Social factors

Aboriginal people continue to face ongoing vulnerability as a consequence of their disadvantage in regard to all social determinants of health, in particular (at a population level) their experience of poverty, disempowerment, isolation and social disadvantage. Past government policies and practices have contributed to this, as recognised in the Productivity Commission report *Overcoming Indigenous Disadvantage: Key Indicators 2003*.
This vulnerability is compounded by inequality of access to health as well as other social services. Aboriginal people continue to experience significantly shorter life expectancy and high rates of chronic diseases such as diabetes and cardiovascular disease. Aboriginal people are over-represented within the Australian prison system.

NSW Health policies consistently identify poverty, isolation and inequality of access to services as having a major effect on the health of Aboriginal people in NSW. The NSW Aboriginal Affairs Plan 2003–2012 *Two Ways Together, Partnerships: A New Way of Doing Business with Aboriginal People* outlines the NSW Government's commitment and program for working with Aboriginal people to reduce social disadvantage.

1 Australian Bureau of Statistics (ABS) 2001. *Census of Populations and Housing*. ABS, Canberra.

2 NSW Department of Health 2005. *Preferred Terminology to be Used When Referring to Aboriginal and Torres Strait Islander Peoples*. NSW Health Policy Directive, PD2005_319.

Social factors relating to issues of sexuality, sexual identity, drug use, and gender are often regarded as sensitive and personal issues within society in general and can be difficult to discuss openly. This can be further compounded by specific cultural sensitivities within Aboriginal communities. Hence, in Aboriginal contexts, issues such as the impact of chlamydia on women's fertility and reproduction and the prevalence of male to male sexual practice, need to be considered within a wider context of attitudes, beliefs and practices around the issues identified above.

1.3 Epidemiological factors

The *NSW Public Health Act 1991* requires medical practitioners and laboratories to notify the NSW Department of Health of certain medical conditions. Sexually transmissible infections (STIs) including chlamydia and gonorrhoea and blood-borne infections (BBIs) including hepatitis B, hepatitis C and HIV are exclusively notifiable by laboratories. Syphilis is notifiable by doctors and laboratories.

Notification data may provide an underestimation of the prevalence of BBIs and STIs among Aboriginal people in NSW. The factors that influence this include the impact of reduced access to health services on testing rates and factors that may inhibit identification as Aboriginal in the context of BBI and STI testing.

1.3.1 HIV infection and AIDS

HIV is a viral infection for which there is currently no preventive vaccine. Prevention relies entirely on avoiding infection through, among other strategies, safe sexual practices and not sharing injecting equipment.

Information regarding Aboriginality is available on 80 to 90 per cent of notifications of HIV infection, and 90 to 95 per cent of AIDS notifications, for the years 2000 to 2005.

HIV

The number of notifications of HIV in people who identify as Aboriginal in the period 2000 to 2005 ranged between 1 and 8 per year, 28 in total for the six year period (compared to 1,944 notifications in non-Aboriginal people). The relatively small annual numbers of HIV notifications in people identifying as Aboriginal make analysis difficult and caution should be taken in interpreting the data.

In the period 2000 to 2005, 36 per cent of HIV notifications in Aboriginal people were in people aged 20 to 29 years and 36 per cent aged 30 to 39 years; compared to 25 per cent and 41 per cent, respectively, of notifications in non-Aboriginal people.

In the period 2000 to 2005, 79 per cent of notifications of HIV in Aboriginal people were male, compared to 89 per cent of notifications in non-Aboriginal people.

Similarly, in 14 per cent of notifications of HIV in Aboriginal people heterosexual sex was reported as the primary exposure, 32 per cent reported injecting drug use and 46 per cent reported male homosexual sex, compared to 17 per cent, 4 per cent and 70 per cent, respectively, of notifications in non-Aboriginal people.

AIDS

The number of notifications of AIDS in people who identify as Aboriginal in the period 2000 to 2005 ranged between 1 and 5 per year, 17 in total for the six year period (compared to 607 notifications in non-Aboriginal people). The relatively small annual numbers of AIDS notifications in people identifying as Aboriginal make analysis difficult and caution should be taken in interpreting the data.

AIDS diagnoses among Aboriginal people have remained stable since AIDS diagnoses were first collected for Aboriginal people. This is counter to the general trend of declining AIDS diagnoses and may reflect the convergence of a range of potential factors, including later HIV presentation, less uptake or adherence to treatment regimens, or the intersection of HIV/AIDS and poorer background health of Aboriginal people.

In the period 2000 to 2005, 82 per cent of AIDS notifications in Aboriginal people were in people aged 30 to 49 years; compared to 70 per cent of notifications in non-Aboriginal people.

In the period 2000 to 2005, 100 per cent of notifications of AIDS in Aboriginal people were male, compared to 91 per cent of notifications in non-Aboriginal people.

Similarly, in 12 per cent of notifications of AIDS in Aboriginal people heterosexual sex was reported as the primary exposure, 12 per cent reported injecting drug use and 71 per cent reported male homosexual sex, compared to 17 per cent, 5 per cent and 65 per cent, respectively, of notifications in non-Aboriginal people.

AIDS related deaths

The number of notifications of AIDS related deaths in people who identify as Aboriginal in the period 2000 to 2005 ranged between 1 and 3 per year, 11 in total for the six year period (compared to 288 notifications in non-Aboriginal people). The small number of notifications and uncertain data quality preclude further analysis.

1.3.2 Newly acquired hepatitis B virus infection

The hepatitis B virus (HBV) may be transmitted through using contaminated injecting equipment, close household and sexual contact, or from mother to child. Hepatitis B vaccine is recommended for, among other groups, all children and adolescents, household and sexual contacts of people infected with HBV, injecting drug users and people with hepatitis C. The vaccine is part of the Australian Standard Vaccination Schedule.

Newly acquired HBV is identified by the presence of blood markers of new infection, along with a negative test in the previous 24 months.

Information regarding Aboriginality is available on 50 to 70 per cent of notifications of newly acquired HBV for the years 2000 to 2005.

The number of notifications of newly acquired HBV in people who identify as Aboriginal decreased slightly from 7 cases in 2000 to 2 cases in 2005. The number of notifications in the non-Aboriginal community similarly decreased in this same period, from 47 cases in 2000 to 39 cases in 2005. The relatively small annual numbers of newly acquired HBV notifications in people identifying as Aboriginal make analysis difficult and caution should be taken in interpreting the data.

In the period 2000 to 2005, 33 per cent of newly acquired HBV notifications in Aboriginal people were in people aged 15 to 19 years, 33 per cent aged 20 to 29 years and 25 per cent aged 30 to 40 years; compared to 11 per cent, 38 per cent and 26 per cent of notifications in non-Aboriginal people, respectively.

In the period 2000 to 2005, 71 per cent of notifications of newly acquired HBV in Aboriginal people were male, compared to 71 per cent of notifications in non-Aboriginal people.

1.3.3 Newly acquired hepatitis C virus infection

The hepatitis C virus (HCV) is primarily transmitted through exposure to contaminated injecting equipment. There is currently no preventive vaccine for HCV.

Newly acquired HCV is identified through a positive blood test in a person who has had a negative test within the previous 24 months.

Information regarding Aboriginality is available on 50 to 80 per cent of notifications of newly acquired HCV for the years 2000 to 2005.

Characterising trends of diagnoses of newly acquired HCV in Aboriginal people is difficult because classification of a case as newly acquired and recording the person's Aboriginality is highly dependent on Public Health Unit case-follow-up practices.

In the period 2000 to 2005, 20 per cent of newly acquired HCV notifications in Aboriginal people were in people aged 15 to 19 years, 39 per cent aged 20 to 29 years and 25 per cent aged 30 to 40 years; compared to 11 per cent, 44 per cent and 30 per cent of notifications in non-Aboriginal people, respectively.

In the period 2000 to 2005, 56 per cent of notifications of newly acquired HCV in Aboriginal people were male, compared to 55 per cent of notifications in non-Aboriginal people.

1.3.4 Infectious syphilis

Syphilis is a bacterial infection transmitted through sexual contact with an infected person, or from mother to child.

Infectious syphilis is defined by the presence of signs and symptoms of early infection, blood markers of new infection, or laboratory evidence of infection in a person who has had a negative test in the previous 24 months.

Information regarding Aboriginality is available on 75 to 95 per cent of notifications of infectious syphilis for the years 2000 to 2005.

The number of notifications of infectious syphilis in people who identify as Aboriginal decreased from 29 cases in 2000 to 7 cases in 2005. That is, 36 per cent of all notifications of infectious syphilis to 3 per cent. The number of notifications in the non-Aboriginal community increased in this same period, from 32 cases in 2000 to 215 cases in 2005. The increase is principally seen in gay, non-Aboriginal men.

In the period 2000 to 2005, 21 per cent of infectious syphilis notifications in Aboriginal people were in people aged 15 to 19 years, 43 per cent aged 20 to 29 years and 23 per cent aged 30 to 30 years; compared to 2 per cent, 20 per cent and 43 per cent of notifications in non-Aboriginal people, respectively.

In the period 2000 to 2005, 38 per cent of notifications of infectious syphilis in Aboriginal people were male, compared to 93 per cent of notifications in non-Aboriginal people.

1.3.5 Accuracy and Completeness of Aboriginality in NSW STI and BBI Surveillance

There is a nationally accepted convention that epidemiological data is only presented by Aboriginality where the data completeness for the Aboriginality field exceeds 50 per cent. In NSW infectious diseases datasets only the diseases identified above meet this convention at this point of time.

In relation to the NSW case-reporting system for notifiable diseases, the completeness and accuracy of fields that record Aboriginality varies significantly across diseases. The quality of the information also varies based on the way in which the disease is notified (that is, whether it is notified by a doctor or by a laboratory) and whether or not public health follow-up is routine for the particular disease. Follow up is based on a number of factors including whether contact tracing is undertaken and by whom; treatment issues, including repeat visits to the medical practitioner for treatment; and the overall number of annual notifications and the resource implications of follow up (for example, in 2005 there were 242 notifications of infectious syphilis, compared with 11,282 notifications of chlamydia).

While NSW as well as national surveillance data on Aboriginal and Torres Strait Islander populations are incomplete, HIV, STIs and hepatitis B and C continue to be a significant source of morbidity among Aboriginal people in NSW. Surveillance and research are highlighted in this Implementation Plan as issues that will be addressed in consultation with Aboriginal people and their representative organisations to ensure they provide culturally appropriate and sensitive tools for service planning.

1.4 AH&MRC Blood-Borne Infections Project

During 2003, the Aboriginal Health and Medical Research Council of NSW (AH&MRC) was funded by the Australian Government Office for Aboriginal and Torres Strait Islander Health (OATSIH) to conduct a Blood Borne Infections (BBI) Project. The project explored ways to improve access to Aboriginal community controlled and mainstream health services for Aboriginal people at risk of or infected with a blood borne infection such as HIV or hepatitis B or C.

An extensive consultation process was undertaken by the AH&MRC for the project, which included visits to Aboriginal Community Controlled Health Services (ACCHSs) and Area Health Services (AHSs) across NSW. Key recommendations of the project report "*Increasing access to services in NSW for Aboriginal people at risk of contracting or who have blood borne infections*" (BBI Report) include:

- developing a holistic, whole-of-health and well-being approach to health service delivery
- strengthening the focus on the major areas of risk for HIV and hepatitis C
- building Aboriginal community awareness, understanding and ownership of BBI issues
- continuing to provide statewide leadership
- continuing initiatives to strengthen and support the Aboriginal sexual health worker projects
- providing resources to support prevention and health promotion activities
- addressing the needs of Aboriginal people in correctional facilities
- building an evidence base.

The directions established by this Implementation Plan are directly informed by and closely follow the findings of the BBI Report. In addition, the BBI Report incorporates literature reviews and detailed analyses of Aboriginal HIV/AIDS, STI and hepatitis C access issues, and can be read as a companion to this Implementation Plan.

1.5 NSW Aboriginal Sexual Health Program

The NSW Department of Health commenced funding for dedicated Aboriginal sexual health projects in 1989/1990. The Australian Government began contributing special funding towards this purpose at the commencement of the second *National HIV/AIDS Strategy 1993/1994 to 1995/1996*.

NSW has in place a large, well developed network of Aboriginal sexual health workers (ASHWs) across the state. This has been achieved through an effective partnership between the Department and the AH&MRC. Decisions regarding the establishment and location of Aboriginal sexual health projects were based on an

assessment of HIV and STI rates; population distribution; and geographical coverage. The Department has ensured an equal ratio of ACCHS to AHS projects, which has further strengthened and supported the *NSW Aboriginal Health Partnership Agreement 2001*.

The Department has implemented a range of ongoing strategies to strengthen and consolidate the network of ASHWs, including:

- maintaining the statewide support network for ASHWs (see Appendix C)
- organising network training and development activities
- providing funding for workforce development
- developing the *Core Competency Standards for Aboriginal and Torres Strait Islander Sexual Health Workers in NSW*
- funding the development and implementation of the distance learning package for a *Diploma of Community Services (Case Management) with a focus on Aboriginal Sexual Health* by the AH&MRC
- resourcing the NSW Aboriginal Sexual Health Advisory Committee (ASHAC)
- establishing two regional Aboriginal sexual health development positions (RASHP) to support local, regional and statewide infrastructures
- establishing additional statewide positions to address specific priority issues such as harm reduction and education resource development.

NSW AIDS Program funding disbursed to AHSs has supported the establishment of outreach sexual health clinics in some areas to provide a minimum level of sexual health services. This funding has enabled AHSs, in collaboration with ACCHSs, to introduce outreach clinical services to Aboriginal communities.

SECTION 2

Policy context

2.1 National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008

The *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008* (NATSISHBBVS) provides the overarching national strategic framework guiding HIV/AIDS, STI and hepatitis C service delivery to Aboriginal and Torres Strait Islander Australians. The NATSISHBBVS links with the National HIV/AIDS, STI and Hepatitis C Strategies.

Goal

The goal of the NATSISHBBVS is to reduce the transmission of and morbidity caused by HIV/AIDS, STIs and BBVs in the Aboriginal and Torres Strait Islander community and to minimise the social and personal impacts of these infections.

Objectives

The NATSISHBBVS seeks to:

- improve access to testing, diagnosis, treatment and care of HIV/AIDS, STIs and BBVs for Aboriginal and Torres Strait Islander people
- respond to Australia's role in the prevention of a HIV epidemic in the Torres Strait region
- improve surveillance and research activities in order to guide the development and implementation of prevention, treatment and care initiatives in the Aboriginal and Torres Strait Islander community
- improve awareness of HIV/AIDS, STIs and BBVs in the Aboriginal and Torres Strait Islander community
- develop and strengthen links with the related national mainstream strategies.

Priority areas

The four priority areas of the NATSISHBBVS are:

- sexually transmissible infections
- Aboriginal and Torres Strait Islander people living in the cross border region of Australia and Papua New Guinea
- access to needle and syringe programs (NSP)
- increased capacity in the health and community workforce to address all aspects of Aboriginal and Torres Strait Islander HIV/AIDS, STIs and BBVs.

2.2 NSW HIV/AIDS, STI and Hepatitis C Strategies

Overarching NSW Strategies for HIV/AIDS, STIs and hepatitis C build upon the corresponding national strategies by contextualising them to the NSW situation. The NSW HIV/AIDS, STI and Hepatitis C Strategies provide the framework and establish directions and priorities for the delivery of HIV/AIDS, STI and hepatitis C programs in NSW.

The three Strategies, which are informed by the BBI Report, identify Aboriginal communities as a priority for NSW HIV/AIDS, STIs and hepatitis C programs and seek to focus the efforts of these sectors in addressing this priority. The three Strategies are linked with this Implementation Plan to ensure that Aboriginal people are able to access HIV/AIDS, STI and hepatitis C services.

2.2.1 *NSW HIV/AIDS Strategy 2006–2009*

Goals

The goals of the Strategy are to:

- reduce new HIV infections in NSW
- improve the health of people living with HIV/AIDS
- reduce HIV-related discrimination and address systemic barriers to HIV health promotion.

Targets

The goals of the Strategy are quantified through the establishment of the following agreed targets:

- To reduce newly acquired HIV infection by 25 per cent by 2009
- To achieve annual reductions in the rates of gonorrhoea, infectious syphilis and chlamydia among priority populations

- To reduce the incidence and prevalence of physical and psychological disorders and associated disabilities in people living with HIV/AIDS
- To decrease the number of late diagnoses of HIV infection by 25 per cent by 2009
- To achieve successive annual reductions in AIDS related deaths by 2009
- To increase the number and distribution of s100 prescribers across NSW, and increase the number of general practitioners (GPs) involved in HIV care by 20 per cent by 2009.

Service Delivery Objectives

Additionally, the following service delivery objectives have been established:

- To improve the quality of HIV health promotion programs through community engagement, strengthened planning, and workforce development
- To improve access to, and the quality of, HIV/AIDS treatment, care and support services available to people living with HIV/AIDS in both specialist and mainstream settings through strengthened planning and workforce development
- To improve the alignment between service delivery, utilisation, resource allocation and strategic priorities in HIV prevention, treatment, care and support.

2.2.2 *NSW Sexually Transmissible Infections Strategy 2006–2009*

Goals

The goals of the Strategy are to:

- reduce the transmission of STIs; and
- reduce morbidity associated with STIs.

Strategies

The goals of the Strategy will be achieved through:

- increased community awareness and knowledge of STIs and capacity to reduce the risk of transmission
- increased use of condoms with casual sexual partners
- increased STI testing within priority population groups
- increased diagnosis, treatment and management of STIs.

Specific strategic objectives for Aboriginal people

The following objectives are established specifically in relation to Aboriginal communities:

- increase the use of condoms with casual and new sexual partners
- eliminate syphilis transmission within Aboriginal communities by 2009
- increase in early detection and treatment of bacterial and viral STIs
- increase in culturally appropriate and sensitive public sexual health service provision
- build the skills of the workforce
- improve the capacity of and collaboration with Aboriginal Community Controlled Health Services, and GPs who see Aboriginal people, to respond to STIs
- improve culturally appropriate STI surveillance and monitoring; and
- increase culturally appropriate STI related research within Aboriginal communities.

2.2.3 *NSW Hepatitis C Strategy 2006–2009*

The NSW Hepatitis C Strategy provides a framework and direction for the surveillance, control, prevention, treatment and management of hepatitis C.

Goals

The goals of the Strategy are to:

- minimise the transmission of hepatitis C
- improve the health status of people with hepatitis C
- minimise the negative personal, social and economic impact of hepatitis C.

Strategies

The goals of Strategy will be achieved by:

- implementing prevention and education strategies to reduce transmission of the hepatitis C virus
- providing equitable access to treatment, care and support services and increasing treatment uptake among people with hepatitis C
- reducing discrimination, stigmatisation and marginalisation experienced by people with hepatitis C
- improving the knowledge, skills and capacity of the workforce to meet the needs of people with or at risk of hepatitis C

- improving monitoring, surveillance and research to better inform the NSW response to hepatitis C.

The Strategy emphasises the importance of working with Aboriginal communities and organisations to address their hepatitis C prevention and education, and treatment, care and support needs.

2.3 NSW Aboriginal Health Strategies

The *NSW Aboriginal Health Strategic Plan 1999* is the key NSW Health policy underpinning health service delivery to Aboriginal people. The Plan is an initiative of the NSW Aboriginal Health Partnership and the *Agreement on the health of Aboriginal and Torres Strait Islander People*.[3]

The purpose of the Plan is to establish strategies to improve health outcomes for Aboriginal people in NSW.

The Plan is implemented in partnership with ACCHSs and has as its five key priorities:

- improving access to health services
- addressing identified health issues
- improving social and emotional well being
- increasing the effectiveness of health promotion
- creating an environment supportive of good health.

In addition to NSW Health policies on Aboriginal health, the NSW Government has made a whole-of-government commitment to working with Aboriginal people to reduce social disadvantage through the NSW Aboriginal Affairs Plan 2003–2012 *Two Ways Together, Partnerships: A New Way of Doing Business with Aboriginal People*.

The Two Ways Together Plan's overall objectives are to:

- develop committed partnerships between Aboriginal people and Government
- improve the social, economic, cultural and emotional wellbeing of Aboriginal people in NSW.

Achieving the objectives of the Plan will require:

- changing the way Government works with Aboriginal people
- enhancing the skills and capacity of Aboriginal communities and individuals
- achieving real and measurable improvements for Aboriginal people in seven priority areas for actions, with health being the highest priority
- supporting and affirming Aboriginal people's culture and heritage.

3 *Agreement on the health of Aboriginal and Torres Strait Islander People*. NSW Minister for Health, Aboriginal Health and Medical Research Council of NSW, Commonwealth Minister for Health and Ageing, and Chairperson of the Aboriginal and Torres Strait Islander Commission. Unpublished, 2002. [http://www.healthinfonet.ecu.edu.au/framework/nsw/docs/nsw_fa.pdf

SECTION 3

Purpose

3.1 Why this Implementation Plan?

The purpose of this Plan is to support health services in the implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies. The Plan was developed in partnership with the AH&MRC and informed by the BBI Report.

Despite the existence of a comprehensive health system, Aboriginal people in NSW continue to have poorer access to primary care and other health services.

While specialist Aboriginal sexual health projects in NSW have been effective, the delivery of sexual health services by non-Aboriginal agencies within the HIV/AIDS, STI and hepatitis C sectors (and the health system more broadly) continues to be variable.

The development of this Plan recognises a need to:

- build Aboriginal community ownership and participation in responding to HIV/AIDS, STIs and hepatitis C
- strengthen the delivery of HIV/AIDS, STI and hepatitis C programs to Aboriginal people
- strengthen the uniformity of service delivery tools across areas, including partnerships, service delivery models and local protocols/guidelines for service delivery.

As Aboriginal people are an identified priority population within the NSW HIV/AIDS, STI and Hepatitis C Strategies, all NSW AIDS Program funded agencies are responsible for ensuring the delivery of their services to Aboriginal communities. This requires that NSW AIDS Program funded agencies:

- give specific consideration to how all facets of the NSW HIV/AIDS, STI and Hepatitis C Strategies can best be implemented with Aboriginal people
- give specific consideration to how services can best be delivered to Aboriginal people
- implement strategies which will reduce barriers to access.

In addition, AHSs must work within the framework of the NSW Health Aboriginal Health Impact Statement and Guidelines, which require incorporating Aboriginal health needs and interests in all health policies and programs.

3.2 Aim

This Plan provides a tool for the implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies, and the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008*.

The aims of this Implementation Plan are to:

- reduce HIV, STI and hepatitis C infections among Aboriginal people in NSW
- reduce morbidity associated with HIV/AIDS, STIs and hepatitis C among Aboriginal people in NSW.

To achieve these aims, it will be necessary for ACCHSs and AHSs to:

- increase Aboriginal community participation and ownership of issues relating to HIV/AIDS, STIs and hepatitis C
- develop local planning tools, service delivery and education resources
- improve bridging and partnerships at various levels of health services in order to improve access to holistic health services for Aboriginal people and to improve links between related strategies and programs
- increase the focus on key issues and settings of risk
- improve workforce development in relation to health promotion, prevention, testing, care, treatment and surveillance
- improve culturally appropriate and sensitive surveillance of HIV/AIDS, STIs and hepatitis C in Aboriginal communities
- improve the collection and analysis of service utilisation data.

SECTION 4

Principles of the plan

The principles underpinning this Implementation Plan are consistent with those outlined in the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008* and NSW HIV/AIDS, STI and Hepatitis C Strategies.

These principles guide the planning and delivery of sexual health services to Aboriginal people.

4.1 Community ownership and participation

HIV/AIDS, STI and hepatitis C programs will be most effective when there is participation and ownership by local Aboriginal communities, and when there is recognition of the need for the programs by these communities.

Community ownership, a pivotal element of Aboriginal health policies, would be reflected by a recognition within Aboriginal communities of the significance of STIs, HIV/AIDS and hepatitis C to the health of community members, and by the active engagement of community members in responding to these issues. Central to this will be a focus on and inclusion of those vulnerable to and affected by HIV/AIDS, STIs and hepatitis C. At times this may involve working with communities and families to address feelings of rejection and discrimination.

4.2 Holistic approach to health

HIV/AIDS, STI and hepatitis C programs may be more acceptable to Aboriginal people, and therefore more accessible, when delivered within a holistic health framework that addresses the broader social, cultural, emotional, spiritual and other health experiences of Aboriginal people.

The literature review undertaken as part of the AH&MRC's BBI Report shows that sexual health is linked closely to general well-being within the Aboriginal community. The integration of HIV/AIDS, STI and hepatitis C issues within broader approaches may assist in lessening the stigma and shame associated with accessing health services. In addition, the development of holistic approaches to Aboriginal health is identified as a key strategy within state and national Aboriginal health policies. Delivering HIV/AIDS, STI and hepatitis C programs within a holistic health framework requires working in partnership with other health programs to develop and deliver integrated health services.

The health programs that this Implementation Plan addresses cover a spectrum ranging from health promotion, education and prevention, through to testing, treatment, care and support. These need to be developed in ways that ensure their suitability for Aboriginal people, and delivered within a holistic framework.

4.3 Collaboration and partnership

HIV/AIDS, STI and hepatitis C programs implemented with the participation and involvement of local communities will be more successful when they are supported by a partnership between key stakeholders and are conducted in collaboration with a range of health services.

At the state level, a partnership exists through the NSW Aboriginal Sexual Health Advisory Committee (ASHAC) between the NSW Department of Health and the AH&MRC; and representatives from ACCHSs, AHSs, community based organisations (CBOs) representing the statewide HIV/AIDS and hepatitis C sectors, and the Aboriginal sexual health workforce. ASHAC is linked to and supported by the NSW Aboriginal Health Partnership, the Ministerial Advisory Committee on HIV and Sexually Transmissible Infections (CAS) and the Ministerial Advisory Committee on Hepatitis (MACH).

Effective partnership and collaboration requires the respectful sharing of expertise, recognition of the unique contribution of each partner, and the undertaking of shared activity where appropriate. (**See Appendix B**).

4.4 Active outreach

An active outreach HIV/AIDS, STI and hepatitis C program will be most likely to reduce inequities in health status and improve Aboriginal access to health services where it is owned by an Aboriginal community, conducted in collaboration with other health services, and provides a holistic health program.

Mainstream health services are responsible for providing services to all people in NSW. Key NSW Health policies focus on reducing inequities in health status of marginalised populations, including Aboriginal people. An active outreach program to Aboriginal communities involves the delivery of health services directly within Aboriginal communities, particularly in circumstances where Aboriginal people are reluctant or unable to attend mainstream health services. (See Appendix B).

4.5 Evidence-based

The planning and implementation of Aboriginal HIV/AIDS, STI and hepatitis C services will be most effective when informed by good evidence, including research, program evaluation and service utilisation data.

The evidence base for Aboriginal HIV/AIDS, STI and hepatitis C programs is being strengthened at the state and local level through activities to improve the quality of Aboriginal notifiable diseases data. This data will better inform service planning.

4.6 Developing the workforce

A skilled, knowledgeable, respected and committed workforce is essential to the successful implementation of HIV/AIDS, STI and hepatitis C strategies for Aboriginal people.

It is important to recognise that Aboriginal health workers' capacity in their professional roles derives from and can be strengthened through experience and involvement with communities as well as from more formal training and skills development activities.

Workforce development activities which improve the knowledge and skills of Aboriginal sexual health workers and other health workers around cultural issues; sexual health; alcohol and other drugs; confidentiality; distinguishing personal from professional values and issues; teamwork; access issues; research; health promotion; and program design, implementation and evaluation are key strategies for ensuring the delivery of effective HIV/AIDS, STI and hepatitis C programs to Aboriginal communities. Supportive workplace practices such as supervision and mentoring have an important role in developing professional capacity to work with these often complex and sensitive areas.

SECTION 5

Priority focus areas

There are seven priority focus areas for this Implementation Plan. These arise from the Aims of the Plan. They have been grouped into three categories:

Good practice

1 Aboriginal community participation and involvement
2 Development of local policies, protocols and education resources
3 Bridging of services and strategies

Issues and settings

4 Focus on key issues of risk
5 Focus on key settings of risk

Infrastructure

6 Aboriginal sexual health workforce development
7 Research, surveillance and data

5.1 Good practice

5.1.1 Priority focus area 1: Aboriginal community participation and involvement

As reflected in Section 4: Principles, this Implementation Plan recognises that HIV/AIDS, STI and hepatitis C programs will be most effective when there is participation and ownership by local Aboriginal communities, and when there is recognition of the need and benefit for the programs by these communities. Community ownership would be reflected by recognition within Aboriginal communities of the significance of HIV/AIDS, STIs and hepatitis C to the health of community members, and by the active engagement of community members in responding to these issues.

The case study below outlines how an Area Health Service and an Aboriginal Community Controlled Health Service worked together to develop a sexual health strategy to meet the needs of local Aboriginal communities.

Case Study 1

Excerpt from the Foreword to the Aboriginal Sexual Health Strategy 2004–2006

Central Sydney Sexual Health Service (now part of Sydney South West Area Health Service) and Aboriginal Medical Service Cooperative Limited.

"This Aboriginal Sexual Health Strategy is endorsed by both the Chief Executive Officer of the Aboriginal Medical Service Coop Ltd Redfern (AMS) and the Chief Executive Officer of Central Sydney Area Health Service on behalf of the local Aboriginal Partnership.

A key component of the strategy is the establishment of both a Men's and a Women's Sexual Health Clinic supported by Aboriginal Health Workers from both CSAHS and the AMS Redfern. Aboriginal Health Workers play a key role in improving the sexual health and well-being of their local communities. These clinics have been tailored to respond to the community's need for diagnostic, treatment, counselling and education services which are provided in a confidential, culturally sensitive and appropriate manner.

The provision of these clinical services will be supported by information, education and health promotion programs which focus on increasing individual and community knowledge and choice, and professional training and skill development.

Another key component of the strategy is the formation of advisory structures to oversee the implementation of the strategy, which will also ensure that the services are responsive and accountable to local Aboriginal communities.

This strategy is a tribute to the commitment, expertise and enthusiasm of the staff and managers of the CSAHS Sexual Health Service and the AMS Redfern, and to the local community who have given freely of their time and knowledge in developing the strategy. It is also a tribute to the aspirations of all involved in improving the health and well being of the local communities."

Key outcome 1A

Increased Aboriginal community engagement with HIV/AIDS, STI and hepatitis C programs.

Strategy	Responsibility[A]	Measures of success	Time Frame
Establish local sexual health committee with representation from relevant mainstream and Aboriginal community controlled health services and Aboriginal community members.	**LEAD** AHSs **Partners** ACCHSs; Other AHS, and ASHWs	■ Establishment and maintenance of local committees and partnerships. ■ Membership of local committee is appropriate to local circumstances. ■ Provision of holistic, accessible services. ■ Number of Aboriginal people accessing services. ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies.	By Dec 2007
Work in partnership with relevant mainstream and Aboriginal community controlled health services to provide holistic health services, which include HIV/AIDS, STI and hepatitis C issues. Formalise local partnerships through the creation of Memoranda of Understanding.	**LEAD** AHSs and CBOs **Partners** ACCHSs; ASHWs and GPs		By Dec 2007 and then – Ongoing
Promotion of HIV/AIDS, STI and hepatitis C programs at events such as World AIDS Day/AIDS Awareness Week, and local cultural, community and sporting events such as NAIDOC and Family Days.	**LEAD** AHSs, CBOs and ASHWs **Partners** Other AHSs and ACCHSs		Ongoing
DOH, AH&MRC and CBOs to maintain and further develop partnerships/MOUs with each other and with Aboriginal communities in relation to HIV/AIDS, STIs and hepatitis C.	**LEAD** DOH, AH&MRC and CBOs		By Dec 2007 and then – Ongoing
Ensure that community elders and other key community members are engaged and their leadership sought.	**LEAD** AHSs and CBOs **Partners** ACCHS, ASHWs.		By Dec 2007 and then – Ongoing

A **AHSs** = sexual health and other AIDS Program funded services of AHSs; **Other AHSs** = other related non-AIDS Program funded services of AHSs; **ACCHS** = Aboriginal Community Controlled Health Services; **ASHW** = Aboriginal sexual health workers; **RASHP** = regional Aboriginal sexual health positions; **CBO** = AIDS Program funded community based organisations (NUAA, ACON, Hepatitis C Council); **AH&MRC** = Aboriginal Health and Medical Research Council; **DOH** = NSW Department of Health AIDS/infectious Diseases Branch; **Other DOH** = other related branches of DOH; **WDP** = NSW Health Workforce Development Program in Hepatitis, HIV and Sexual Health.

5.1.2 Priority focus area 2: development of local policies, protocols and education resources

The NSW Department of Health has issued a range of documents which guide the development of local policies and protocols for delivering services within the Aboriginal health, HIV/AIDS, STI, hepatitis C and other health sectors. The Aboriginal Health Impact Statement and Guidelines provide an overall operational tool to guide health service initiatives involving Aboriginal people. Additionally, this Implementation Plan provides a framework to specifically guide the development of local HIV/AIDS, STI and hepatitis C programs for Aboriginal people. The services provided should have the flexibility to meet the particular needs of individuals and the capacity to respond in a holistic manner.

This Implementation Plan also provides mechanisms to support ongoing development and access to Aboriginal specific HIV/AIDS, STI and hepatitis C education resources.

Below is a case study of a local service delivery model which highlights some basic strategies, including policies and protocols, used to successfully provide HIV/AIDS, STI and hepatitis C services to Aboriginal people. The case study highlights three key points: re-orientation, integration and implementation of active outreach.

Case Study 2

A multidisciplinary sexual health team providing comprehensive outreach programs to the Aboriginal Community (AH&MRC BBI Report)

The way services are structured, managed and delivered, and the way health professionals work together as a team, can be a huge influence on how clients feel about accessing the service, as well as the quality of care and service they receive from it.

Macquarie Area Health Service (now part of Greater Western Area Health Service) has a comprehensive sexual health team which provides services across a large geographical area. The team services the whole population and two ASHWs (male and female) allow a special focus on Aboriginal sexual health. Key features of the service are:

- Multidisciplinary approach, including medical, nursing, and Aboriginal sexual health workers.
- The team includes a visiting sexual health physician
- The HIV/AIDS and Related Programs Manager plays a crucial role in coordination, setting strategic directions and priorities for the service, and developing the skills of the ASHWs (including clinical and other skills required to work within a mainstream service).
- The team includes two ASHWs – one male and one female.
- Every member of staff is given the opportunity to be involved in decision making.
- Role modelling and mentoring is considered essential to staff development.
- Staff are encouraged to try things that they haven't done before, with appropriate support.
- There is a genuine commitment to building capacity in relation to skills acquisition and knowledge. Thus training is about giving knowledge to back up competencies rather than just teaching a skill (for example, workers know and understand what they are testing for and are not just taking a urine sample).
- ASHWs are trained to do comprehensive sexual health assessments of clients, including referral. They also do venipuncture, PCR screening, and pre and post test counselling. Ongoing training, including new skills, is provided based on periodic skills audits.
- A comprehensive set of operating procedures has been developed for ASHWs providing outreach services.
- ASHWs and other staff are respected for their life experiences as well as health experience.
- No new outreach service can commence until a comprehensive consultation process with the local community has been completed.

Other models of service delivery have also proven successful. It is appropriate that services explore different strategies in ensuring that an accessible culturally sensitive health service is provided to Aboriginal people. It is then important to develop local policies and protocols to implement these strategies. These should consider how to involve and work with local Aboriginal communities in order to re-orient the overall health service and how to ensure the availability of both male and female health staff. For example such a process of consideration is required when developing appropriate ways to conduct contact tracing within an Aboriginal context.

Another important issue is supporting service access through appropriate service location and design. A process for doing this is outlined in the checklist below.

Checklist for well located sexual health and related services (AH&MRC BBI Report)

- Close to reliable and regular transport.
- Discrete location, away from other high traffic/visibility gathering points and services.
- Without obvious proximity to security or law enforcement services.
- Minimal reception barriers to be crossed.
- Signposted in a way that de-stigmatises the main role of the service.
- Multiple access points – outreach (foot, van, car and other shopfront locations).
- Visible indications that the service is Koori friendly, for example, naming, posters, use of colours and symbols

While it is important that health services be provided in ways which are appropriate to the local needs, health services should meet statewide service planning standards.

Key outcome 2A

Development of culturally appropriate and sensitive HIV/AIDS, STI and hepatitis C programs which are accessible to local Aboriginal people and meet statewide service planning standards.

Strategy	**Responsibility**[A]	**Measures of success**	**Time Frame**
Develop, implement and monitor statewide policies and tools, such as this Implementation Plan, the Aboriginal Health Impact Statement and Guidelines, and the AH&MRC *Early Detection and Treatment Manual* to guide the development and delivery of HIV/AIDS, STI and hepatitis C services to local Aboriginal communities.	**LEAD** DOH **Partners** AH&MRC and ASHAC	■ Development and dissemination of statewide and local policies and tools. ■ Establishment, membership and maintenance of committees and partnerships. ■ Provision of holistic accessible services. ■ Number of Aboriginal people accessing services. ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies. ■ Referrals between sexual health services, antenatal, alcohol and drug and mental health services.	By June 2008
In consultation with ASHWs, develop local protocols and guidelines to support HIV/AIDS, STI and hepatitis C service delivery to Aboriginal people, including in relation to contact tracing, access to young people, NSPs and correctional settings.	**LEAD** AHSs **Partners** ACCHSs and ASHWs		By June 2008 and then – Ongoing
Regional Aboriginal Sexual Health Positions (RASHPs) to be available to health services to support the development and sharing of local protocols.	**LEAD** RASHPs		Ongoing
Re-orient health services to increase access to a range of health services, such as through the availability of male and female staff, outreach services, flexible service arrangements, and partnership agreements in line with statewide service planning standards.	**LEAD** AHSs **Partners** CBOs and ACCHSs		By June 2008 and then – Ongoing
Explore workforce development initiatives to further support the implementation of strategies listed to achieve this key outcome.	**LEAD** All services		By June 2008 and then – Ongoing
Establish and maintain the following statewide and local advisory bodies to support and oversee this outcome: ■ NSW Aboriginal Sexual Health Advisory Committee (ASHAC) ■ local advisory and planning committees (see KO 1A) ■ regular planing meetings between the regional and statewide Aboriginal sexual health positions, their managers and DOH	**LEAD** DOH and AHSs **Partners** AH&MRC, CBOs, ACCHSs and RASHPs		By Dec 2007 and then – Ongoing
Deliver cultural awareness training that specifically addresses issues relating to sexuality, sexual identity, and sexual health.	**LEAD** RASHPs, ASHWs		By June 2008

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Key outcome 2B

Mechanisms are in place to support ongoing development and access to Aboriginal culturally specific HIV/AIDS, STI and hepatitis C education resources.

Strategy	Responsibility[A]	Measures of success	Time Frame
AH&MRC and RASHPs to support the development and ensure availability of education resources across the state. (See also KO4A.)	**LEAD** AH&MRC and RASHPs	■ Development, dissemination and availability of appropriate education resources. ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies.	By June 2007 and then – Ongoing
ASHAC to monitor the appropriateness and availability of education resources.	**LEAD** ASHAC		Ongoing
All new education resources to be provided to the Department of Health in order for them to be approved in a timely manner before they are printed.	**LEAD** All services		Ongoing
All services and statewide CBOs involved in resource development and production to facilitate Aboriginal representation and engagement in materials development and distribution processes to ensure appropriateness of materials and effective reach to Aboriginal communities	**LEAD** AHSs **Partners** CBOs and ACCHSs		Ongoing

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5.1.3 Priority Focus Area 3: Bridging of Services and Strategies

HIV/AIDS, STI and hepatitis C services may be more effective for Aboriginal people when located within a broader, holistic approach rather than a disease-specific approach. This approach locates HIV/AIDS, STI and hepatitis C services and programs in a broad whole-of-health-and-wellbeing model. During consultations on this Implementation Plan the need for a diverse range of occupations and services to be involved was repeatedly stressed. Services mentioned included general practice; women's health, including ante-natal services; alcohol and drugs; sexual and domestic violence services; and mental health.

Improved partnerships at various levels of health services as well as links between related strategies and programs are important factors in improving HIV/AIDS, STI and hepatitis C service programming for Aboriginal people.

Below is a case study which outlines how various health services worked together to deliver holistic health services.

Case Study 3

Armidale – One Stop Shop Pilot Projects for Rural Health, Centre for Drug and Alcohol, NSW Health Department

This community-based Armidale pilot set out to co-ordinate and support selected community projects targeting 'at risk' young people. The aim was to strengthen and encourage the participation of young people in existing activities and to encourage and facilitate new activities.

The focus was on collaborative approaches to meet the needs of young people who were not accessing services. Local health and welfare service providers were assisted to approach young people in 'youth friendly' circumstances and then work jointly to provide effective integrated case management for those in the most 'at risk' groups.

The Aboriginal sexual health project in Armidale provided the following account of their involvement with the One Stop Shop Pilot:

"Aboriginal Sexual Health was invited to be part of the one stop shop through the project team and the youth themselves to provide sexual health educational programs for the at risk youth of Armidale. The aim of the project was to help young people make good choices for their health and well-being and to participate, and interact well with others, in their community.

The role of Aboriginal sexual health in this program was to take young people to the "One Stop Shop" where they can access information and a variety of services in a fun way all at the same time. Providing services in this way improved health outcomes, particularly in the areas of drug and alcohol use, sexual health, mental health and social health. Most importantly it was about listening to young people, finding out what they want and need, and involving them in the planning and running of programs.

- **Cinema events**:

Over 220 youth were invited to the cinema to view a movie that was chosen by a committee. The movie was divided with a 20 minute break in the middle. All services had the opportunity to display and provide information and education at the start, the middle and at the end of the movie.

- **Camp 180**:

28 young people were involved in this program. The program included three day camps and one overnight stay at Echidna Gully, which is situated 20km from Armidale on a property and caters for all youth activities. The days are set up with a good mix of fun and educational activities, for example archery, laser ball, bush walking, fishing, sports and swimming at the local pool. Each day was divided up into time slots of 40 minutes education and one hour fun throughout the day. This was based on a school hour day.

- **Tigers**:

The Tigers program ran one day a week for six weeks in conjunction with the Police-Citizens Youth Club. The program was also based on education and fun with the main focus being drugs and alcohol. All other services were also involved, including visits to the various services. Fun activities included rock wall climbing, basketball, pool table, table tennis and boxing.

Key outcome 3A

Increased capacity of a range of mainstream and specialist health services to contribute to HIV/AIDS, STI and hepatitis C services for Aboriginal people.

Strategy	Responsibility[A]	Measures of success	Time Frame
Offer training opportunities and support for main-stream (non-AIDS Program funded) health staff which provide the minimum skills required to recognise and deal with simple HIV/AIDS, STI and hepatitis C issues which may exist for their Aboriginal clients.	**LEAD** AHSs, WDP and CBOs	■ Number and mix of participants within partnerships, training workshops and events. ■ Provision of holistic accessible services. ■ Number of Aboriginal people accessing services. ■ The range of health and medical services and professionals able to meet the needs of Aboriginal clients. ■ The number of resources developed and distributed. ■ Capacity for service provision and support to follow clients movements across AHS areas. ■ Development of best practice standards for case management for Aboriginal people.	By June 2007 and then – ongoing
Make HIV/AIDS, STI and hepatitis C education resources available to a range of health services.	**LEAD** ASHWs, AHSs and CBOs		By June 2007 and then – Ongoing
Encourage all health services to support and participate in major HIV/AIDS, STI and hepatitis C events and campaigns, for example World AIDS Day; as well as specific Aboriginal events, such as NAIDOC Week	**LEAD** ASHWs, AHSs and CBOs		By June 2007 and then – Ongoing
Encourage HIV/AIDS, STI and hepatitis C staff (including managers) to regularly attend training programs and events which address Aboriginal health and cultural issues.	**LEAD** AHSs and CBOs		By June 2007 and then – Ongoing
Educate GPs (including HIV and hepatitis C S100 prescribers) and pharmacies on issues relating to Aboriginal clients and provide them with resources about local Aboriginal services and options for client referral.	**LEAD** AHSs and ASHWs **Partners** ACCHSs, CBOs and ASHM		By June 2008 and then – Ongoing
Educate alcohol and other drugs (AOD) services, on issues relating to Aboriginal clients and blood borne infections and identify pathways and partnerships to enhance service provision, including the potential for AOD services to provide HIV, STI and hepatitis C testing.	**LEAD** AHSs **Partners** AOD and CBOs		By June 2008 and then – Ongoing
All CBOs delivering HIV/AIDS, STI and hepatitis C education to health care workers and communities to include Aboriginal specific information in resources and programs.	**LEAD** CBOs **Partners** RASHPs, and ASHWs		By June 2007 and then – Ongoing
Explore strategies for linking services across Areas to support effective case management services for clients.	**LEAD** AHSs		By June 2008 and then – Ongoing
Clarify roles and responsibility for case management and coordination of services when a number of health services are involved in the provision of holistic services to Aboriginal clients.	**LEAD** AHSs **Partners** All other services		Ongoing
Include capacity for working effectively with Aboriginal clients in workforce recruitment selection criteria, as appropriate.	**LEAD** AHS		By Dec 2007 and then – Ongoing

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Key outcome 3B

Increased location of HIV/AIDS, STI and hepatitis C services and programs within a broader whole-of-health-and-wellbeing model.

Strategy	Responsibility[A]	Measures of success	Time Frame
Ensure representation and involvement of key stake-holder services on local planning committees (see KO 1A).	**LEAD** AHSs	■ Number and mix of participants within partnerships and committees. ■ Number of Aboriginal people accessing services. ■ Number of flexible service arrangements for Aboriginal people.	Ongoing
Review and provide feedback to non-AIDS Program funded mainstream health sectors at all levels, as opportunities arise, to promote the inclusion of Aboriginal HIV/AIDS, STI and hepatitis C issues.	**LEAD** DOH and AHSs **Partners** ASHAC, and AH&MRC		Ongoing
Sustain and continue locating ASHWs in both AHSs and ACCHSs to ensure ongoing partnerships between the two sectors and for the provision of HIV/AIDS, STI and hepatitis C issues within a holistic health model.	**LEAD** DOH		Ongoing
Reorient health services by using statewide tools such as the AH&MRC Early Detection and Treatment Manual.	**LEAD** AHSs, CBOs and ACCHSs		By June 2008 and then – Ongoing

Key outcome 3C

Roles of key stakeholders are defined, including how each stakeholder can contribute to HIV/AIDS, STI and hepatitis C service delivery within a holistic health model.

Strategy	Responsibility[A]	Measures of success	Time Frame
Explore with each stakeholder, through local and state planning and advisory committee structures, how their services can support the implementation of this Plan in line with Chapter 6 "Roles and responsibilities".	**LEAD** DOH and AHSs **Partners** AH&MRC, WDP and ASHAC	■ Provision of holistic accessible services. ■ Number of Aboriginal people accessing services. ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies. ■ Number of local plans developed and implemented	By Dec 2007 and then – Ongoing
Develop annual business plans for the delivery of programs and services to Aboriginal people in line with the NSW HIV/AIDS, STI and Hepatitis C Strategies and this Plan.	**LEAD** AHSs, CBOs, ACCHSs and ASHWs		Ongoing
Provide training to ASHWs on facilitation and interagency management skills.	**LEAD** RASHPs and WDP		By Dec 2007 and then – Ongoing
Statewide AIDS Program funded services to work in partnership with AH&MRC and other Aboriginal state-wide projects, in order to ensure Aboriginal people have access to services, programs and resources in line with the NSW HIV/AIDS, STI and Hepatitis C Strategies and this Plan.	**LEAD** CBOs, WDP, Family Planning NSW **Partners** AH&MRC and RASHP		By June 2007 and then – Ongoing

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5.2 Issues and Settings

Aboriginal people are a priority population for NSW HIV/AIDS, STI and hepatitis C services and programs. It is important that efforts be most directly targeted to the specific issues and settings of risk. This requires that there be a strong understanding of the impact of HIV/AIDS, STIs and hepatitis C within Aboriginal communities and specific sub-populations within the Aboriginal community, so that strategies can be appropriately targeted.

5.2.1 Priority focus area 4: key issues of risk

Data in this section outlining the key issues of risk for Aboriginal people are drawn from the AH&MRC BBI Report, the NSW HIV/AIDS, STI and Hepatitis C Strategies, and from national and NSW surveillance reports. Community consultations for this Plan requested that the effect of alcohol and other drugs and sexual violence on behaviour, and thus the transmission of BBIs, should be also included.

Issues of risk may vary between and within Areas and communities. AHSs and ACCHSs should examine and address the following key issues and develop appropriate local responses.

Injecting drug use

- Injecting drug use is a major source of infection with hepatitis C. Hepatitis C infection rates among Aboriginal injecting drug users vary from 40 per cent to 70 per cent and over.
- Data on HIV notifications among Aboriginal people indicates that there is a higher proportion of diagnoses attributed to injecting drug use.
- The National NSP Survey[4] found that between 8 per cent and 10 per cent of injecting drug users identified as Indigenous, compared with 2.1 per cent of people who identify as Indigenous in the general population. This figure could be even higher, since Indigenous injecting drug users could be less likely to attend NSPs or take part in surveys.

Safe sex

- Safe sex is a key strategy for preventing the transmission of HIV and STIs within communities. HIV/AIDS and STI services and programs for Aboriginal people should continue to maintain a key focus on educating individuals about how HIV and STIs are transmitted and how individual's can protect themselves and their partners.

Care and treatment

- Of those individuals diagnosed with hepatitis C where ethnicity was recorded in NSW, 10 per cent were Aboriginal. This compares with the Aboriginal population in NSW being approximately 2.05 per cent of the total population.
- The rate of HIV among Aboriginal people in NSW is the same as that of the population overall however, AIDS diagnoses among Aboriginal people have remained stable compared to the general trend of declining AIDS diagnoses.
- Nationally, the prevalence of STIs amongst Indigenous people is reported to be up to eight times higher than for the non-Indigenous population. This is due, in part, to poor access to services experienced by many Aboriginal people.

4 National Centre in HIV Epidemiology and Clinical Research (NCHECR) 2006. *Australian NSP Survey National Data Report 2001–2005*. NCHECR, The University of New South Wales, Sydney.

Key outcome 4A

Decreased stigma associated with injecting drug use, sexuality and related issues including harm reduction and safe sex.

Strategy	Responsibility[A]	Measures of success	Time Frame
AH&MRC, through its statewide harm reduction project (see KO 4B), to develop and implement Aboriginal specific education resources and programs focusing on harm reduction issues.	**LEAD** AH&MRC	■ Establishment and implementation of education resources and programs. ■ Number of Aboriginal people accessing services. ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies.	Ongoing
Continue the development and implementation of Aboriginal specific education resources and programs on safe sex issues across NSW, particularly among those most at risk of HIV and STIs including young people, gay men and sistergirls.	**LEAD** RASHPs, CBOs, ASHWs and AHSs		Ongoing
Ensure that NSW education campaigns addressing HIV/AIDS, STIs and hepatitis C are inclusive and appropriately tailored to Aboriginal communities.	**LEAD** DOH and AH&MRC		Ongoing
Provide appropriate training to ASHWs regarding health promotion and harm reduction principles.	**LEAD** RASHPs and WDP		Ongoing

Key outcome 4B

Increased access to HIV/AIDS, STI and hepatitis C services by Aboriginal people.

Strategy	Responsibility[A]	Measures of success	Time Frame
The statewide Aboriginal harm reduction project based at the AH&MRC to support the development of culturally sensitive harm reduction services for Aboriginal people within ACCHSs and other relevant settings as well as: ■ assist NSPs to increase access to Aboriginal people ■ develop education resources.	**LEAD** AH&MRC **Partners** AHSs, NUAA and WDP.	■ Development and distribution of safe sex and NSP education resources and programs within ACCHSs. ■ Number of Aboriginal people accessing services including specialist care and treatment services. ■ Number of Aboriginal health staff ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies. ■ Number of Aboriginal people accessing the range of NSP and harm reduction services.	2007 Ongoing
Raise awareness of the range of NSP outlets, including pharmacies.	**LEAD** AH&MRC Project **Partners** AHSs, ACCHSs, WDP and ASHWs		Ongoing
Continue the provision of safe sex resources from ACCHSs, AHSs and other services	**LEAD** All relevant services		Ongoing
Explore models of culturally sensitive HIV/AIDS, STI and hepatitis C care and treatment services which include partnerships between AHSs, ACCHSs, AOD and GPs, and address issues of responsibility for case management.	**LEAD** AHSs **Partners** Other AHS, AOD, local GPs, CBOs and ACCHSs		By June 2008 and then – Ongoing

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Key outcome 4B (continued)

Strategy	Responsibility[A]	Measures of success	Time Frame
Build on existing support services for specific Aboriginal sub-population groups, for example gay men, people living with HIV/AIDS and sistergirls.	**LEAD** CBOs **Partners** ASHWs and AHSs	■ Number of ACCHS operating NSP services. ■ Development of resources and programs integrating alcohol and drugs, and sexual violence, with HIV/AIDS, STI and hepatitis education and services.	Ongoing
Implement strategies to increase the number of Aboriginal staff in HIV/AIDS, STI and hepatitis C services as per KO 6C.	**LEAD** ASHs and CBOs		By June 2008 and then – Ongoing
Implement objectives relating to GPs and S100 Prescribers for HIV and hepatitis C as outlined in the NSW HIV/AIDS, STI and Hepatitis C Strategies.	**LEAD** All services		By June 2008 and then – Ongoing
Increase the number of Aboriginal health services authorised to operate NSP outlets.	**LEAD** AH&MRC **Partners** AHS, ASHWs, ACCHS and DOH		Ongoing
Develop referral pathways and service partnerships with AOD services in order to address links between alcohol and drugs and risks for HIV, STI and hepatis C transmission and ensure support for AOD service clients with HIV/AIDS, STI and hepatitis C diagnoses.	**LEAD** AHS **Partners** ASHWs, ACCHSs and AOD		Ongoing
Develop pathways with sexual assault services in order to address the impact of sexual violence on sexual health and vulnerability to HIV and STI transmission.	**LEAD** AHS **Partners** ASHWs, ACCHSs and sexual assault services		Ongoing

Key outcome 4C

Elimination of syphilis transmission within Aboriginal communities.

Strategy	Responsibility[A]	Measures of success	Time Frame
Review approaches used in other jurisdictions and internationally to eliminate syphilis.	**LEAD** DOH **Partner** AH&MRC	■ Establishment and implementation of programs. ■ Number of Aboriginal people accessing services. ■ Number of infections.	By June 2007
Convene stakeholder forum to coordinate responses and develop action plan.	**LEAD** DOH **Partner** AH&MRC		By June 2007
Implement appropriate cross-Area systems to improve diagnosis, care and treatment of Aboriginal people with syphilis.	**LEAD** DOH, AHSs **Partner** ACCHSs & RASHPs		By 2009

A **AHSs** = sexual health and other AIDS Program funded services of AHSs; **Other AHSs** = other related non-AIDS Program funded services of AHSs; **ACCHS** = Aboriginal Community Controlled Health Services; **ASHW** = Aboriginal sexual health workers; **RASHP** = regional Aboriginal sexual health positions; **CBO** = AIDS Program funded community based organisations (NUAA, ACON, Hepatitis C Council); **AH&MRC** = Aboriginal Health and Medical Research Council; **DOH** = NSW Department of Health AIDS/infectious Diseases Branch; **Other DOH** = other related branches of DOH; **WDP** = NSW Health Workforce Development Program in Hepatitis, HIV and Sexual Health.

5.2.2 Priority focus area 5: key settings of risk

Data in this section outlining the key settings of risk for Aboriginal people are drawn from the AH&MRC BBI Report, the NSW HIV/AIDS, STI and Hepatitis C Strategies, and from national and NSW surveillance reports.

Settings of risk may vary between and within Areas and communities. AHSs and ACCHSs should examine and address the following key settings and develop appropriate local responses.

Youth settings

Young Aboriginal people are considered a particular priority given that the Aboriginal population is generally younger in comparison to the non-Aboriginal population. 45 per cent of the Aboriginal population in NSW are aged between 15 and 44 compared to 32 per cent in the population as a whole.[5] In addition, the prevalence of hepatitis C among Aboriginal injecting drug users under 25 years of age is significantly higher than among non-Aboriginal injecting drug users.[6]

Settings which are primarily populated by young people, including places where young people 'hang out' or other settings such as Juvenile Justice Centres, school homework centres, youth centres, and other settings where activities such as sex work (including "sex for favours") may take place, are key settings for reaching young Aboriginal people at greatest risk.

Correctional settings

Aboriginal people are significantly over-represented within the Australian prison system, with 43 per cent of young people in NSW Juvenile Justice Centres being Aboriginal.[7] 59 per cent of all prisoner entrants report a history of injecting drug use,[8] with prison being an important point for transition to injecting drug use for Aboriginal prisoners.[9]

Aboriginal people in correctional settings require special attention in order to ensure that they have access to services within these settings and upon their release.

5 Australian Bureau of Statistics (ABS) 2001. *Census of Populations and Housing.* ABS, Canberra.

6 Correll, P., MacDonald, M., & Dore, G. 2000. *Hepatitis C Infection in Indigenous Communities in Australia*. Commonwealth Department of Health and Aged Care, Canberra.

7 NSW Department of Juvenile Justice (DJJ) 2005. *Annual Report 2004/2005*. DJJ, Sydney.

8 Butler T, Boonwaat L, Hailstone S. 2005. *National Prison Entrants' Blood Borne Virus Survey, 2004*. Centre for Health Research in Criminal Justice & National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, Sydney.

9 Lane, J. 1993. *Nu-Hit: A report on an Aboriginal Drug User Project.* AIDS Council of South Australia, Adelaide.

Key outcome 5A

Increased access by Aboriginal people to health services within key settings of risk.

Strategy	Responsibility[A]	Measures of success	Time Frame
Plan and provide regular culturally sensitive HIV/AIDS, STI and hepatitis C services to Aboriginal people within their settings, including through outreach and peer education. See strategies below.	**LEAD** AHSs **Partners** ASHWs, ACCHs, GPs and CBOs	■ Number of holistic accessible services. ■ Number of Aboriginal people accessing services. ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies. ■ Number of service agreements and MOUs between correctional facilities, NGOs, Justice Health and AHS's. ■ Services provided by Justice Health for HIV/STI/hepatitis C education, testing and treatment.	By Dec 2007 and then – Ongoing
Work with youth services and other health services which work with young people, to plan and provide HIV/AIDS, STI and hepatitis C testing, care and treatment services to Aboriginal young people within youth settings, for example, youth centres, entertain-ment/video games arcades, Juvenile Justice Centres, and other settings where activities such as sex work (including "sex for favours") may take place.	**LEAD** AHSs **Partners** ASHWs, ACCHs, GPs, CBOs, AOD, Justice Health, DJJ and Other AHS.		By Dec 2007 and then – Ongoing
Plan and provide regular HIV/AIDS, STI and hepatitis C testing, care and treatment services to adult and juvenile Aboriginal inmates.	**LEAD** Justice Health **Partners** DJJ and DCS		By Dec 2007 and then – Ongoing
Map and develop strategies to strengthen HIV/AIDS, STI and hepatitis C programs for Aboriginal people in correctional facilities.	**LEAD** DOH and statewide Aboriginal SH/BBV Prison Project		By Dec 2007 and then – Ongoing
Aboriginal Sexual Health Workers to be involved in Male and Female youth groups, 'Let's talk about sex' days, open days in schools.	**LEAD** ASHWs		Ongoing
Strengthen planning and service links between health and welfare services in correctional facilities and those in relevant external services to ensure effective service provision to clients in custody and custodial clients in the community, and to ensure continuity of service after discharge.	**LEAD** Justice Health **Partners** ACCHs, AHSs, ASHWs, GPs, DJJ and DCS		By Dec 2007 and then – Ongoing

A **AHSs** = sexual health and other AIDS Program funded services of AHSs; **Other AHSs** = other related non-AIDS Program funded services of AHSs; **ACCHS** = Aboriginal Community Controlled Health Services; **ASHW** = Aboriginal sexual health workers; **RASHP** = regional Aboriginal sexual health positions; **CBO** = AIDS Program funded community based organisations (NUAA, ACON, Hepatitis C Council); **AH&MRC** = Aboriginal Health and Medical Research Council; **DOH** = NSW Department of Health AIDS/infectious Diseases Branch; **Other DOH** = other related branches of DOH; **WDP** = NSW Health Workforce Development Program in Hepatitis, HIV and Sexual Health; **DJJ** = Department of Juvenile Justice; **DCS** = Department of Corrective Services.

5.3 Infrastructure

5.3.1 Priority focus area 6: Workforce Development

The AH&MRC BBI Report highlights the strong state-level support for the workforce development needs of ASHWs. At the state level, a number of workforce development initiatives have been implemented by the NSW Department of Health since the commencement of the Aboriginal sexual health program in NSW. These include:

- the annual three day ASHW Network training meeting
- the *Core Competency Standards for Aboriginal and Torres Strait Islander HIV/Sexual Health Workers in NSW*
- funding for the development and implementation of the *Diploma of Community Services (Case Management) with a focus on Aboriginal Sexual Health* based at the AH&MRC
- the establishment of Regional Aboriginal Sexual Health Positions
- funding for various projects to support and provide orientation and training programs.

The BBI Report highlights that, at the local level, ASHWs face specific challenges depending on the type of health service within which they are based. ASHWs in ACCHSs tended to be more isolated from the broader sexual health service infrastructure, while ASHWs within AHSs felt that they had less flexibility in the way they could access the Aboriginal community because of policy and workplace constraints.

Workforce development at the local level goes beyond increasing the skill and knowledge levels of Aboriginal sexual health workers. Local services need to play their part in supporting statewide initiatives by exploring how to expand and support the Aboriginal sexual health workforce and increase its capacity.

Another important aspect of workforce development is the increase of Aboriginal health staff within the mainstream health system, which will have a significant impact on improving health outcomes for Aboriginal people. The NSW Health *Aboriginal Workforce Development Strategic Plan*[10] has set a 2 per cent benchmark for the employment of Aboriginal people within the health system, which is equivalent to the percentage of the Aboriginal population of NSW. This provision is not restricted to designated Aboriginal positions.

However, as Aboriginal people are a priority population for the NSW HIV/AIDS, STI and Hepatitis C Strategies, AIDS Program funded health services should at a minimum meet the 2 per cent benchmark while striving for a higher percentage of Aboriginal people working within their services (other than those employed within identified Aboriginal sexual health positions). Increasing the number of Aboriginal people working within the overall HIV/AIDS, STI and hepatitis C workforce has the added benefit of addressing the issues of isolation often felt by Aboriginal staff, and the availability of both male and female Aboriginal health workers, therefore providing a more culturally sensitive service to Aboriginal communities.

10 NSW Department of Health (DOH) 2003. *Aboriginal Workforce Development Strategic Plan 2003–2007.* DOH, Sydney.

Key outcome 6A

Strengthened workforce development initiatives for ASHWs.

Strategy	Responsibility[A]	Measures of success	Time Frame
Maintain statewide/regional workforce development strategies.	**LEAD** DOH, AH&MRC, RASHPs and WDP	■ Number and mix of participants within workforce development initiatives. ■ Number of Aboriginal health staff. ■ Number of Aboriginal people accessing services. ■ Number and variety of training opportunities provided and undertaken by ASHWs. ■ ASHW staff turnover and retention rates.	Ongoing
Support ASHWs in accessing statewide/regional workforce development initiatives.	**LEAD** Managers of ASHWs **Partners** DOH, RASHPs and WDP		Ongoing
Increase the capacity of ASHWs as per KO 6B.	**LEAD** Managers of ASHWs **Partner** RASHP		Ongoing
Support local Aboriginal Employment Strategy as per KO 6C.	**LEAD** AHSs		Ongoing
RASHPs to be available to support the development of health services business plans, protocols and local Aboriginal Health Partnerships.	**LEAD** RASHPs **Partners** AHSs and ACCHSs		Ongoing
Support RASHPs with relevant training and accreditation required to support the implementation of this focus area.	**LEAD** Managers of RASHPs **Partners** DOH and AHMRC		By June 2007 and then – Ongoing
Provide ASHWs with workplace professional support, supervision and mentoring.	**LEAD** Managers of ASHWs		Ongoing
Develop workplace systems to provide continuous service when ASHWs are absent or on leave.	**LEAD** Managers of ASHWs		By Dec 2007
Provide ASHWs with training in health promotion and prevention of HIV, STI and hepatitis C transmission.	**LEAD** RASHPs and WDP		Ongoing

A **AHSs** = sexual health and other AIDS Program funded services of AHSs; **Other AHSs** = other related non-AIDS Program funded services of AHSs; **ACCHS** = Aboriginal Community Controlled Health Services; **ASHW** = Aboriginal sexual health workers; **RASHP** = regional Aboriginal sexual health positions; **CBO** = AIDS Program funded community based organisations (NUAA, ACON, Hepatitis C Council); **AH&MRC** = Aboriginal Health and Medical Research Council; **DOH** = NSW Department of Health AIDS/infectious Diseases Branch; **Other DOH** = other related branches of DOH; **WDP** = NSW Health Workforce Development Program in Hepatitis, HIV and Sexual Health.

Key outcome 6B

Increased capacity of the Aboriginal sexual health workforce.

Strategy	Responsibility[A]	Measures of success	Time Frame
Actively increase ASHWs involvement in all facets of HIV/AIDS, STI and hepatitis C service delivery to Aboriginal people.	**LEAD** AHSs **Partners** ASHWs	■ Number of holistic accessible services. ■ Number of Aboriginal people accessing services. ■ Number of partnerships.	By June 2007 and then – Ongoing
Consult ASHWs on Aboriginal HIV/AIDS, STI and hepatitis C issues.	**LEAD** AHSs and other relevant services		Ongoing
Define the role of ASHWs (as per ASHW core competency standards) and how they can contribute to HIV/AIDS, STI and hepatitis C service delivery under a holistic health model as per KO 3C.	**LEAD** Managers of ASHWs **Partner** RASHP		By June 2007 and then – Ongoing

Key outcome 6C

Increased number of Aboriginal health staff employed across the HIV/AIDS, STI and hepatitis C workforce.

Strategy	Responsibility[A]	Measures of success	Time Frame
Provide a career path for ASHWs by widely promoting any vacant RASHP, statewide projects and mainstream sexual health and related positions and provide support to ASHWs in establishing career pathways.	**LEAD** DOH and AHSs **Partners** Managers of ASHWs	■ Number of Aboriginal health staff. ■ Number of Aboriginal people accessing services.	Ongoing
Link with the local Aboriginal employment strategy to increase the number of Aboriginal health staff working within HIV/AIDS, STI and hepatitis C services.	**LEAD** AHSs		Ongoing
AIDS Program funding agreements with AHSs and ACCHSs to continue linking funds to ASHW positions.	**LEAD** DOH **Partners** AHSs and ACCHSs		Ongoing
Promote the availability of relevant trainee and scholarship programs.	**LEAD** DOH, AH&MRC, WDP, RASHPs and Managers		Ongoing

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5.3.2 Priority focus area 7: research and surveillance data

The NSW Department of Health has in place Aboriginal health information strategies that include the *NSW Aboriginal Health Information Guidelines*[11] and the *Better Practice Guidelines to Improve the Level of Aboriginal and Torres Strait Islander Identification in the New South Wales Public Health System*.[12]

Through ASHAC, the Department and the AH&MRC are undertaking further work to specifically improve recording Aboriginality in NSW STI and BBI Data Sets.

Social, behavioural and epidemiological research into risk factors and treatment issues specific to Aboriginal people will be undertaken during the life of this Plan. Research will be conducted with and involve Aboriginal communities and key Aboriginal stakeholders and will be undertaken in line with the *NSW Aboriginal Health Information Guidelines*.

Research, surveillance and data collection related to HIV/AIDS, STIs and hepatitis C among Aboriginal provides evidence for better planning and the development of services for Aboriginal people. Local utilisation of surveillance data and research findings is essential for successful service planning.

11 NSW Department of Health (DOH) 1998. N*SW Aboriginal Health Information Guidelines*. DOH, Sydney.

12 NSW Department of Health (DOH) 2000. *Better Practice Guidelines to Improve the Level of Aboriginal and Torres Strait Islander Identification in the NSW Public Health System*. DOH, Sydney.

Key outcome 7A

Improved accuracy and completeness of Aboriginality data in the NSW STI and BBI Surveillance System.

Strategy	Responsibility[A]	Measures of success	Time Frame
Examine and improve the current notification data on HIV/AIDS, STIs and hepatitis and reporting of Aboriginality to assess completeness.	**LEAD** DOH and AH&MRC	■ Establishment and implementation of data collection and reporting protocols ■ Completeness and accuracy of Aboriginality in surveillance system ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies.	2007
Identify issues which are affecting the collection of data on Aboriginality.	**LEAD** DOH, AH&MRC and ASHAC		2007
Develop and adapt existing data collections to augment surveillance data on HIV/AIDS, STIs and hepatitis C in Aboriginal people.	**LEAD** DOH, AH&MRC and ASHAC		By Dec 2007
Review progress with the implementation of the Aboriginal Health Information Strategies.	**LEAD** DOH, Aboriginal Health **Partners** AH&MRC		By Dec 2007 and then – Ongoing
Develop strategies to support Public Health Units (PHUs) and ACCHSs to improve accuracy and completeness of Aboriginality data.	**LEAD** DOH **Partners** AH&MRC		By Dec 2007

Key outcome 7B

HIV/AIDS, STI and hepatitis C surveillance informs planning for the delivery of health services to Aboriginal people in NSW.

Strategy	Responsibility[A]	Measures of success	Time Frame
Continue providing regular epidemiological data on HIV/AIDS, STIs and hepatitis C in a form that is accessible and meaningful to ACCHSs, AHSs and other relevant health services to support planning activity.	**LEAD** DOH	■ Availability and use of data for planning purposes. ■ Completeness and accuracy of Aboriginality in surveillance system. ■ Number of Aboriginal people accessing services. ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies	Ongoing
Form local AHS surveillance working groups, that involve key stakeholders including ASHWs, Public Health Units, HIV/AIDS, STI and hepatitis C services and General Practitioners, in order to facilitate the interpretation of local HIV/AIDS, STI and hepatitis C data.	**LEAD** AHSs		By Dec 2007 and then – Ongoing
Provide training on the interpretation and use of epidemiological and research data for planning services.	**LEAD** DOH **Partners** AHSs and research centres		By Dec 2007 and then – Ongoing
NSW Department of Health to monitor the number of Aboriginal people accessing HIV/AIDS, STI and hepatitis C programs through appropriate tools including periodic surveys and minimum data sets.	**LEAD** DOH		By June 2008 and then – Ongoing

A **AHSs** = sexual health and other AIDS Program funded services of AHSs; **Other AHSs** = other related non-AIDS Program funded services of AHSs; **ACCHS** = Aboriginal Community Controlled Health Services; **ASHW** = Aboriginal sexual health workers; **RASHP** = regional Aboriginal sexual health positions; **CBO** = AIDS Program funded community based organisations (NUAA, ACON, Hepatitis C Council); **AH&MRC** = Aboriginal Health and Medical Research Council; **DOH** = NSW Department of Health AIDS/infectious Diseases Branch; **Other DOH** = other related branches of DOH; **WDP** = NSW Health Workforce Development Program in Hepatitis, HIV and Sexual Health.

Key outcome 7C

Increase in social, behavioural and epidemiological research on HIV/AIDS, STI and hepatitis C issues for Aboriginal people.

Strategy	Responsibility[A]	Measures of success	Time Frame
Research centres operating in NSW to establish research priorities for Aboriginal people in partnership with key stakeholders.	**LEAD** Research centres and AH&MRC **Partner** DOH	■ Number of research projects with Aboriginal people. ■ Implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies	By Dec 2007 and then – Ongoing
Encourage research into risk factors and treatment issues specific to Aboriginal people.	**LEAD** Research centres and AH&MRC **Partner** DOH		By Dec 2007 and then – Ongoing
Ensure that findings of research contribute to priority setting, strategies and service/program planning.	**LEAD** DOH, Research centres and AH&MRC **Partners** AHSs and CBOs		Ongoing
Encourage, enable and assist Aboriginal organisations and ASHWs to be involved in and to undertake research projects.	**LEAD** Research centres and AH&MRC		Ongoing

A **AHSs** = sexual health and other AIDS Program funded services of AHSs; **Other AHSs** = other related non-AIDS Program funded services of AHSs; **ACCHS** = Aboriginal Community Controlled Health Services; **ASHW** = Aboriginal sexual health workers; **RASHP** = regional Aboriginal sexual health positions; **CBO** = AIDS Program funded community based organisations (NUAA, ACON, Hepatitis C Council); **AH&MRC** = Aboriginal Health and Medical Research Council; **DOH** = NSW Department of Health AIDS/infectious Diseases Branch; **Other DOH** = other related branches of DOH; **WDP** = NSW Health Workforce Development Program in Hepatitis, HIV and Sexual Health.

SECTION 6

Roles and responsibilities

Aboriginal sexual health workers (ASHWs) have been employed across NSW to provide capacity for the implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies within Aboriginal communities. The role of ASHWs includes:

- facilitating the collaborative planning and provision of HIV/AIDS, STI and hepatitis C services to local Aboriginal communities, in partnership with other health services
- playing an important role as cultural brokers by bridging the gap between Aboriginal and non-Aboriginal health services and local communities
- delivering direct education, prevention and clinical services, as appropriate, to priority individual clients, groups and communities.

Aboriginal sexual health workers have in some instances been seen as the sole providers of HIV/AIDS, STI and hepatitis C services to Aboriginal people. This perception has placed an increased expectation on the role and the workload of the ASHWs.

This Implementation Plan aims to identify key stakeholders at all levels of the health system with a role in providing or supporting HIV/AIDS, STI and hepatitis C programs for Aboriginal people in NSW.

6.1 Local level

6.1.1 Aboriginal community controlled health services

Aboriginal Community Controlled Health Services (ACCHSs) across NSW deliver primary health care to Aboriginal people, and facilitate the provision of culturally sensitive secondary and tertiary health services. ACCHSs are governed by a Board of Directors which is elected by the local Aboriginal community.

Board members and staff of ACCHSs play an important role in ensuring that members of their communities are aware of HIV/AIDS, STI and hepatitis C related issues and their impact on individuals and the community. They also play a key role in determining how HIV/AIDS, STI and hepatitis C services are delivered.

ACCHSs generally receive their primary funding from the Australian Government Department of Health and Ageing. Some ACCHSs also receive funding from the NSW Department of Health, including for Aboriginal sexual health projects.

The roles and responsibilities of ACCHSs in implementing this Plan include:

- exploring how HIV/AIDS, STI and hepatitis C issues can be supported and form part of the core business of the service, within a holistic health framework
- encouraging all Aboriginal health staff to attend HIV/AIDS, STI and hepatitis C training workshops in order to obtain basic HIV/AIDS, STI and hepatitis C knowledge and skills that can help them identify and manage HIV/AIDS, STI and hepatitis C issues that may arise during the course of their work
- identifying barriers to accessing the service for HIV/AIDS, STI and hepatitis C related issues and implementing strategies to address them
- supporting workforce development initiatives for Aboriginal sexual health workers; and
- supporting partnership initiatives which aim to provide holistic health services to communities.

6.1.2 Area health services

Area Health Services (AHSs) provide acute, ambulatory and community health services for local populations within their geographic catchment area.

HIV/AIDS, STI and Hepatitis C Services

Area Health Services receive NSW AIDS Program funding of approximately $60 million for the delivery of HIV/AIDS, STI and hepatitis C programs and services, including acute and ambulatory clinical services, health promotion, Needle Syringe Program, laboratory services, supported accommodation, and notifiable diseases surveillance.

AHSs undertake local planning for the delivery of HIV/AIDS, STI and hepatitis C services which contextualises relevant statewide strategies to local circumstances.

Aboriginal people are a priority population group for the NSW HIV/AIDS, STI and Hepatitis C Strategies. It is a requirement of these Strategies and of NSW AIDS Program funding that this be reflected within local plans for the delivery of related services.

The roles and responsibilities of Area Health Service-based HIV/AIDS, STI and hepatitis C services in implementing this Plan include:

- ensuring that Aboriginal people are an identified priority within Area-wide and service-specific planning documents
- ensuring that staff receive Aboriginal cultural awareness and respect training
- exploring the range of barriers which impede access to services by Aboriginal people and identifying and implementing strategies to improve Aboriginal access
- providing effective management and support to Area-based Aboriginal sexual health workers and ensuring that the role of these workers is appropriately delineated and does not extend to sole responsibility for the delivery of Aboriginal HIV/AIDS, STI and hepatitis C services by the Area
- expanding health service delivery to Aboriginal people, including by implementing active outreach models where appropriate.

Aboriginal health services

Area Health Service-based Aboriginal Health Units deliver programs and services which aim to improve the overall health status of Aboriginal people. Aboriginal Health Directors and staff are well placed to facilitate the delivery of holistic health services which include components addressing HIV/AIDS, STI and hepatitis C to their local Aboriginal communities.

Aboriginal health programs are well placed to support the implementation of this Plan, including through:

- identifying HIV/AIDS, STI and hepatitis C programs within the core business of the service and exploring opportunities for the incorporation of basic HIV/AIDS, STI and hepatitis C issues and services within more broadly-based Aboriginal health programs
- encouraging Aboriginal health workers to attend HIV/AIDS, STI and hepatitis C training workshops in order to obtain basic HIV/AIDS, STI and hepatitis C knowledge and skills that can help them identify and appropriately respond to HIV/AIDS, STI and hepatitis C related issues that may arise during the course of their work
- exploring opportunities for Aboriginal sexual health workers to be supported and increasing their participation in Aboriginal health worker network activities and workforce development opportunities
- supporting partnership initiatives which aim to provide holistic health services to Aboriginal communities.

Other health sectors

Strengthening and coordinating the delivery of Aboriginal health programs is a challenge experienced across the health system.

Area Health Services deliver a range of other health programs which provide opportunities for the inclusion of Aboriginal HIV/AIDS, STI and hepatitis C issues within a broader health framework. These programs include alcohol and other drugs, women's health, youth health, immunisation, cardiovascular health, health promotion, and mental health.

These health programs are able to support the implementation of this Plan through:

- supporting partnership initiatives undertaken by HIV/AIDS, STI and hepatitis C services in order to provide holistic health services to Aboriginal people
- supporting relevant staff to attend Aboriginal HIV/AIDS, STI and hepatitis C training initiatives.

6.2 Cross area/regional level

6.2.1 Regional Aboriginal sexual health projects

The NSW Department of Health has established regional Aboriginal sexual health projects to support the implementation of this Plan. The respective catchment areas for the positions are the northern half of NSW and the southern half of NSW.

The role of the positions is to support the work of the ASHWs within their catchment areas and to further support the partnerships between AHSs and ACCHSs.

In addition, each of the regional positions has a statewide role with a specific focus which includes the development of:

- statewide workforce development initiatives for ASHWs

- strategies to increase access to sexual health and harm reduction support services and education resources for Aboriginal people in correctional facilities across NSW.

These projects also play the pivotal role of bridging state and local level structures in order to support the implementation of this Plan by:

- ensuring the flow of information and communication particularly around strategies and initiatives of the Aboriginal and sexual health sectors, and other relevant statewide services
- providing support to Aboriginal sexual health workers in AHSs and ACCHSs within their region in the planning and local implementation of HIV/AIDS, STI and hepatitis C services to Aboriginal people
- strengthening partnerships between ACCHSs and AHSs as a strategy for improving the delivery of HIV/AIDS, STI and hepatitis C services to Aboriginal people
- providing feedback and advice to the Department and to statewide Aboriginal partnerships and advisory structures on Aboriginal HIV/AIDS, STI and hepatitis C related issues.

6.3 State Level

6.3.1 Aboriginal partnership and advisory structures

NSW Aboriginal health partnership agreement

The NSW Aboriginal Health Partnership was formed through an agreement between the AH&MRC, as the peak body for ACCHSs in NSW, and the NSW Government through its Health portfolio. The Partnership was originally formed in 1995, and a revised Partnership Agreement was signed in 1997. Following a review of the Agreement in 2000, a strengthened Partnership Agreement was signed in May 2001 by the NSW Minister for Health, the Chief Executive Officer of the AH&MRC, and the Deputy Chairperson of the AH&MRC.

The Partnership aims to:

- ensure that the expertise of Aboriginal communities is brought to the health care process through the development of agreed positions on health policy, strategic planning and broad resource allocation issues for Aboriginal health
- ensure that the philosophies and methods of operation of ACCHSs inform policy and planning initiatives which target Aboriginal people
- enhance opportunities for communities to actively address their health needs and to be involved in improving health and restoring physical, social, emotional and cultural well-being – the practical exercise of self-determination.

The NSW Aboriginal Health Partnership is complemented by the Australian Government/State Forum established by the NSW Agreement on Aboriginal and Torres Strait Islander Health. At Area Health Service level, local partnerships are established between Area Health Services and Aboriginal Community Controlled Health Services.

NSW Aboriginal sexual health advisory committee

The NSW Aboriginal Sexual Health Advisory Committee (ASHAC) was established under the NSW Aboriginal Health Partnership to:

- provide advice on the implementation of the national and NSW HIV/AIDS, STI and Hepatitis C Strategies for Aboriginal people in NSW
- ensure transparency of HIV/AIDS, STI and hepatitis C programs and resources provided for Aboriginal people in NSW
- ensure transparency of research and ethical practices provided for Aboriginal people in NSW
- provide advice on the development of statewide education resources
- advocate for the Aboriginal Sexual Health Workers Network in NSW
- provide feedback and advice to relevant NSW and Australian Government committees
- provide feedback and advice to the NSW Aboriginal Health Partnership
- ensure that HIV/AIDS, STI and hepatitis C issues are placed within the context of broader Aboriginal health concerns, through cross-government initiatives and by increasing the profile of HIV/AIDS, STI and hepatitis C as priority Aboriginal health issues.

6.3.2 Aboriginal Health and Medical Research Council of NSW (AH&MRC)

The Aboriginal Health and Medical Research Council of NSW (AH&MRC), formerly the Aboriginal Health Resource Co-op (AHRC), was established in 1985 as a recommendation of the *Brereton Report* by the NSW Aboriginal Task Force on Aboriginal Health in 1982/1983.[13] The *Report* recognised Aboriginal community control as crucial to laying the foundation for a better standard of health care for Aboriginal people.

The AH&MRC has a statewide representative role on behalf of its constituent members as well as responsibility for the planned expansion of its benevolent services that will be channelled directly into Aboriginal communities. Membership of the AH&MRC is open to ACCHSs. Associate membership is open to Aboriginal Community Controlled Health Committees which are in the process of establishing an ACCHS; and Aboriginal community controlled organisations that provide health-related services. Currently the AH&MRC represents more than 50 constituent members.

The AH&MRC plays an important role in supporting research and health promotion activities for Aboriginal people. Support for health promotion is provided through the NSW Collaborative Centre for Aboriginal Health Promotion, a joint initiative between the AH&MRC and NSW Health. The Centre is a major contributor to developing better practice health promotion approaches to improve Aboriginal health in NSW. The Centre ensures a strategic approach to Aboriginal health promotion as well as fostering leadership in health promotion at state level.

In relation to HIV/AIDS, STIs and hepatitis C, the AH&MRC plays an important role in developing and advising on statewide policies and resources and in ensuring policies and protocols are in place for the provision of culturally sensitive HIV/AIDS, STI and hepatitis C services to Aboriginal people. In mid 2004, the AH&MRC completed the BBI Project which explored ways to improve access to Aboriginal community controlled and mainstream health services for Aboriginal people at risk of, or infected with a blood-borne infection such as HIV or hepatitis B or C.

The AH&MRC administers three key statewide sexual health projects funded by the NSW Department of Health to support Aboriginal sexual health workers. These are:

- Diploma of Community Services (Case Management) with a focus on Aboriginal Sexual Health
- harm reduction project; and
- resource development project.

The roles and responsibilities of the AH&MRC in implementing this Plan include:

- informing and supporting the implementation of statewide directions and priorities for HIV/AIDS, STI and hepatitis C programs for Aboriginal people
- providing feedback and advice to the NSW Aboriginal Health Partnership on Aboriginal HIV/AIDS, STI and hepatitis C issues
- ensuring that HIV/AIDS, STI and hepatitis C issues are placed within the context of broader Aboriginal health, through cross-government initiatives and by increasing the profile of HIV/AIDS, STI and hepatitis C as priority Aboriginal health issues
- ensuring transparency of research and ethical practices around Aboriginal HIV/AIDS, STI and hepatitis C issues.

6.3.3 NSW Department of Health

The NSW Department of Health works for the people of NSW by leading system-wide health policy, planning and responses. The Department also allocates resources, monitors and manages performance and supports health-related whole-of-government initiatives.

AIDS/Infectious Diseases Branch (AIDB)

The Department's AIDS/Infectious Diseases Branch (AIDB) contributes to the achievement of the Department's vision by setting strategic directions to protect the health of people affected by and populations at risk of HIV/AIDS, STIs, hepatitis C, vaccine preventable diseases, and healthcare associated infections.

The AIDB is responsible for ensuring that NSW AIDS Program funded services prioritise the provision of HIV/AIDS, STI and hepatitis C services to Aboriginal people through implementation of this Plan.

The roles and responsibilities of the AIDB in implementing this Plan include:

- establishing statewide directions and priorities for HIV/AIDS, STI and hepatitis C programs to address the needs of Aboriginal people
- performance managing NSW AIDS Program funded services to ensure that they fulfil their roles and responsibilities as prescribed by the NSW HIV/AIDS, STI and Hepatitis C Strategies and this Implementation Plan
- providing feedback and advice to the NSW Aboriginal Health Partnership on Aboriginal HIV/AIDS, STI and hepatitis C issues
- ensuring the transparency of HIV/AIDS, STI and hepatitis C programs and resources provided for Aboriginal people in NSW.

13 Aboriginal Health and Medical Research Council of NSW (AH&MRC) Monograph Series Volume 1, Number 1,1999. *Primary, Secondary and Tertiary Health Care Services to Aboriginal Communities*. AH&MRC, Sydney.

Communicable Diseases Branch (CDB)

The Department's Communicable Diseases Branch (CDB) is tasked with the surveillance, prevention and control of communicable diseases in NSW. CDB works closely with public health units across NSW in outbreak investigation and control, follow up of cases of notifiable diseases, collation and analysis, and developing preventive strategies.

CDB works closely with AIDB and has an important role in co-ordinating surveillance activities and ensuring the quality of HIV/AIDS, STI and hepatitis C data, including in relation to Aboriginal people.

Centre for Aboriginal Health

The Department's Centre for Aboriginal Health has as its Directions Statement:

> *"Improved health of the Aboriginal (and Torres Strait Islander) people of NSW, including the restoration of social, emotional and cultural harmony and well being of individuals, families and communities through:*
>
> - a whole-of-life view of health
> - the practical exercise of the principles of self-determination
> - working in partnership
> - accessible, culturally appropriate and high quality services and programs
> - recognition of trauma and loss."

The Centre for Aboriginal Health, through its policy and strategy development role, is able to lead processes to foster the delivery of holistic health services for Aboriginal people which incorporate HIV/AIDS, STI and hepatitis C issues.

The Centre is well placed to support the implementation of this Plan through:

- exploring opportunities for the placement of Aboriginal HIV/AIDS, STI and hepatitis C issues within more broadly-based Aboriginal health programs including through cross-government initiatives
- fostering the development of a skilled health workforce through inclusion of sexual health competencies within the Aboriginal Workforce Development Qualifications Project
- raising the profile of Aboriginal HIV/AIDS, STI and hepatitis C issues within Area Health Service Aboriginal Health Units through the participation of Aboriginal sexual health representatives at the Aboriginal Health Worker Forum
- continuing to seek input from AIDB in order to provide advice to the NSW Aboriginal Health Partnership on Aboriginal HIV/AIDS, STI and hepatitis C issues.

Other NSW Department of Health Branches

Strengthening and coordinating the delivery of holistic Aboriginal health programs is a challenge experienced across the health system.

The Department is responsible for the strategic directions, funding and performance management of a range of mainstream health programs beyond the Aboriginal Health and HIV/AIDS, STI and hepatitis C programs, including programs addressing alcohol and other drugs, women's health, youth health, immunisation, cardiovascular health, health promotion, and mental health.

These programs are able to support the implementation of this Plan through:

- exploring opportunities for the incorporation of Aboriginal HIV/AIDS, STI and hepatitis C issues within a more broadly-based Aboriginal health context.

6.3.4 Statewide Community-Based Organisations (CBOs)

A number of statewide community-based organisations receive NSW AIDS Program funding to:

- provide communities affected by HIV/AIDS, STIs and/or hepatitis C with comprehensive health promotion and treatment, care and support services
- undertake systemic and individual advocacy
- represent affected communities.

These organisations include ACON (AIDS Council of NSW); People Living with HIV/AIDS NSW (PLWH/A NSW); the Hepatitis C Council of NSW (HCC NSW); and the NSW Users and AIDS Association (NUAA). Additionally, the Sex Workers Outreach Project (SWOP) operates as a program area of ACON.

These organisations provide services to populations including:

- gay and other homosexually active men
- injecting drug users
- sex workers
- people with HIV/AIDS
- people with hepatitis C.

Funding is also provided to a range of other community-based organisations to undertake service delivery at a local level.

The roles and responsibilities of statewide community-based organisations in implementing this Plan include:

- ensuring that their organisation's policies, resources and protocols meet the needs of Aboriginal members of the affected communities they represent
- working in partnership with relevant Aboriginal and HIV/AIDS, STI and hepatitis C services to provide culturally appropriate and sensitive services to Aboriginal members of affected communities.

6.3.5 Statewide programs delivered through Area Health Service

A number of Area Health Services in NSW manage statewide services funded through the NSW AIDS Program. Services such as the NSW Health Workforce Development Program in Hepatitis, HIV and Sexual Health (WDP), the AIDS Dementia & HIV Psychiatry Service (ADAHPS), the Paediatric HIV Service and the Heterosexual HIV/AIDS Service play a key role in supporting the implementation of HIV/AIDS, STI and hepatitis C services and programs to Aboriginal people.

Roles and responsibilities include:

- ensuring that policies, resources and protocols meet the needs of Aboriginal people
- ensuring that planning and consultation processes include the views of Aboriginal communities and services
- structuring advisory mechanisms and committees as an opportunity for ongoing participation by and partnership with Aboriginal people and service providers.

6.3.6 Non-Government Organisations (NGOs)

A range of non-government organisations receive NSW AIDS Program funding to provide programs and services that address the needs of specific populations. This includes funding provided to FPA Health (NSW) for HIV/AIDS health promotion with heterosexual women and men and people with an intellectual disability, the Leichhardt Women's Community Health Centre for the Women Partners of Bisexual Men's Project, and the Prisoners, Relationships and AIDS Project undertaken by CRC (Community Restorative Centre) Justice Support.

The specific program of activities and services undertaken by these non-government organisations varies depending on the needs of their target population. The organisations are responsible for consulting with their target populations and undertaking integrated health promotion programs that prevent HIV infection.

There are also a number of professional associations that play a key role in workforce development and advocacy. These include:

- the Australasian Society for HIV Medicine (ASHM), which has a specific and important role to play in delivering training on the medical aspects of HIV and hepatitis C management to Aboriginal workers and services
- academic and research bodies that contribute to knowledge and evidence that is critical for improving the health of Aboriginal people
- the Australasian Chapter of Sexual Health Medicine of the Royal Australian College of Physicians
- the Royal Australian College of General Practitioners
- the Australian New Zealand Association of Nurses in AIDS
- Social Workers in AIDS.

These various bodies and organisations are well placed to support the implementation of this Plan through:

- ensuring that their policies, resources and protocols meet the needs of Aboriginal people
- working in partnership with relevant Aboriginal and HIV/AIDS, STI and hepatitis C services to provide culturally appropriate and sensitive services to Aboriginal people.

6.4 National level

6.4.1 The Australian Government

The Australian Government is responsible for providing national leadership and facilitating the implementation of the *National HIV/AIDS, STI and Hepatitis C Strategies* and the N*ational Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy* across jurisdictions.

Through the Office for Aboriginal and Torres Strait Islander Health (OATSIH), the Australian Government has overall responsibility for coordinating the national response to improving sexual health and reducing blood borne viruses in Aboriginal and Torres Strait Islander people. The Australian Government is committed to providing strong national leadership in working across portfolios and jurisdictions to further the objectives of the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy*.

The role of the Australian Government in relation to improving sexual health and reducing blood borne viruses in Aboriginal and Torres Strait Islander people is to:

- facilitate national policy formation
- coordinate national initiatives
- commission research
- monitor and evaluate the National Strategy
- administer funding to State and Territory Governments and to ACCHSs.

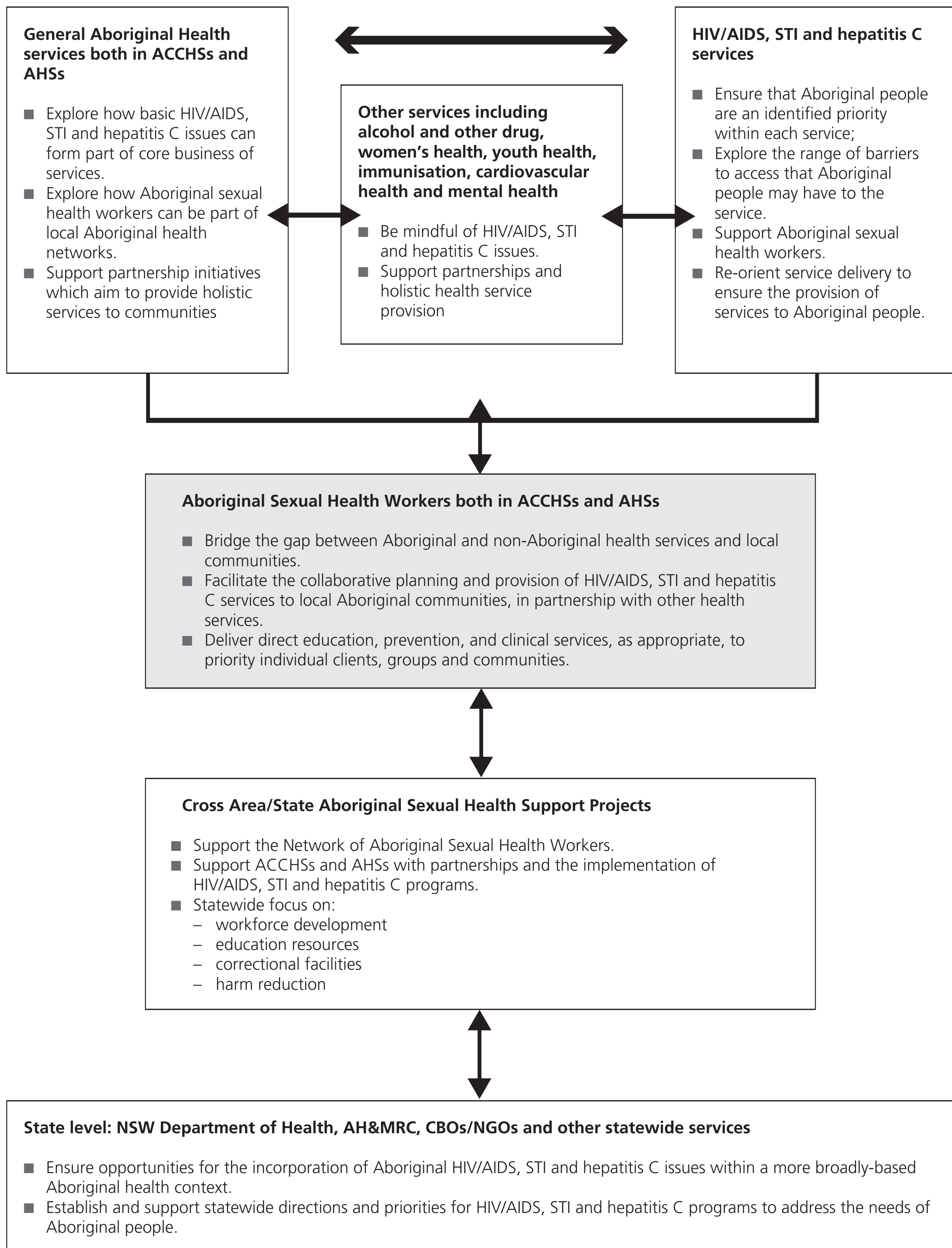
The Australian Government began contributing special funding towards the implementation of Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategies at the commencement of the second *National HIV/AIDS Strategy 1993/1994 to 1995/1996*.

6.4.2 National Advisory Committees

National advisory committees which contribute to HIV/AIDS, STI and hepatitis C outcomes for Aboriginal people include:

- the National Aboriginal and Torres Strait Islander Health Council, which provides advice to the Australian Government Minister for Health on strategies, priorities and policies to improve the health status of Aboriginal and Torres Strait Islander people
- the National Aboriginal Community Controlled Health Organisation (NACCHO), which is the peak body providing national representation for ACCHSs and providing advice on policy development for Aboriginal and Torres Strait Islander primary health care services and workforce issues
- the Ministerial Advisory Committee on HIV/AIDS, Sexual Health and Hepatitis (MACASHH), which provides advice to the Australian Government Minister for Health on all aspects of the national response to HIV/AIDS, STIs and hepatitis
- the Indigenous Australians' Sexual Health Committee (IASHC), a sub-committee of the MACASHH, which provides advice to the Australian Government Minister for Health on Aboriginal and Torres Strait Islander HIV/AIDS, STI and hepatitis issues, including the implementation of the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy*
- the Australian Population Health Development Principle Committee, Blood Borne Virus and Sexually Transmissible Infections Subcommittee, which is responsible for coordinating efforts under the *National HIV/AIDS, STI and Hepatitis C Strategies and the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy* across all state and territory jurisdictions and for developing nationally consistent reporting standards.

Roles and responsibilities in the delivery of HIV/AIDS, STI and hepatitis services to Aboriginal people in NSW.



State level: NSW Department of Health, AH&MRC, CBOs/NGOs and other statewide services

- Ensure opportunities for the incorporation of Aboriginal HIV/AIDS, STI and hepatitis C issues within a more broadly-based Aboriginal health context.
- Establish and support statewide directions and priorities for HIV/AIDS, STI and hepatitis C programs to address the needs of Aboriginal people.

SECTION 7

Implementation, monitoring and evaluation

The NSW Department of Health is committed to the successful implementation, monitoring and evaluation of this Plan as well as the NSW HIV/AIDS, STI and Hepatitis C Strategies. The implementation, monitoring and evaluation process is to determine the effectiveness and efficiency of NSW HIV/AIDS, STI and hepatitis C programs in achieving health outcomes for Aboriginal people and administering government funding.

Overall responsibility for monitoring the implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies rests with the Ministerial Advisory Committee on HIV and Sexually Transmissible Infections (CAS) and the Ministerial Advisory Committee on Hepatitis (MACH). In addition, the NSW Aboriginal Sexual Health Advisory Committee (ASHAC) will play a key role in the continued oversight of the implementation of the NSW HIV/AIDS, STI and Hepatitis C Strategies for Aboriginal people through this Implementation Plan.

Each funded service is responsible for translating statewide strategic priorities into local strategic and operational plans. Each service is required to regularly evaluate the effectiveness of their programs and services and to review the alignment between local priorities and statewide priorities.

Under the guidance of the CAS, MACH and ASHAC, the NSW Department of Health will use the following tools to monitor the implementation of the Strategies with Aboriginal communities:

- AHS Funding Plans
- AHS strategic plans
- CAS, MACH and ASHAC Minutes
- NGO Activity Reports
- behavioural data
- knowledge and attitude data
- prevalence data
- notification data
- ambulatory care data
- hospital admissions.

Reviews of the NSW HIV/AIDS, STI and Hepatitis C Strategies and this Implementation Plan will be undertaken during the life and at the end of the Strategies. The reviews will encompass process, impact and outcome evaluation, and will consider the extent to which strategies have been implemented, the quality of implementation initiatives, and the extent to which objectives have been met. The findings of the reviews and evaluations will be used to refine priorities for future strategies.

APPENDIX A

Acronyms

ACCHS	Aboriginal Community Controlled Health Service
ACON	AIDS Council of NSW
AH&MRC	Aboriginal Health and Medical Research Council of NSW
AHS	Area Health Service
AIDB	AIDS/Infectious Diseases Branch (NSW Department of Health)
AIDS	Acquired Immune Deficiency Syndrome
AOD	Alcohol and Other Drugs
ASHAC	NSW Aboriginal Sexual Health Advisory Committee
ASHW	Aboriginal Sexual Health Worker
BBI	Blood Borne Infection
CAH	Centre for Aboriginal Health (NSW Department of Health)
CAS	Ministerial Advisory Committee on HIV and Sexually Transmissible Infections
CBO	Community Based Organisation
CDB	Communicable Disease Branch (NSW Department of Health)
DCS	NSW Department of Corrective Services
DJJ	NSW Department of Juvenile Justice
DOH	NSW Department of Health
GP	General Practitioner
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCC NSW	Hepatitis C Council of NSW
HIV	Human Immunodeficiency Virus
IASHC	Indigenous Australian's Sexual Health Committee, a sub-committee of MACASHH (Australian Government)
JH	Justice Health
KO	Key Outcome
MACASHH	Ministerial Advisory Committee on HIV/AIDS, Sexual Health and Hepatitis (Australian Government)
MACH	Ministerial Advisory Committee on Hepatitis
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO	Non Government Organisation
NSP	Needle and Syringe Program
NSW	New South Wales
NUAA	NSW Users and AIDS Association
OATSIH	Office for Aboriginal and Torres Strait Islander Health (Australian Government Department of Health and Ageing)
PCYC	Police and Community Youth Clubs
PLWH/A NSW	People Living with HIV/AIDS NSW
PHU	Public Health Unit
RASHP	Regional Aboriginal Sexual Health Positions
S100	Section 100, National Health Act 1953
STI	Sexually Transmissible Infection
SWOP	Sex Workers Outreach Project, a program of ACON
WDP	NSW Health Workforce Development Program in Hepatitis, HIV and Sexual Health

APPENDIX B

Good practice models in Aboriginal sexual health

Partnerships

Partnerships can be defined in many ways and may take many forms. This Plan acknowledges that the process of establishing and maintaining partnerships can be a long-term process, time consuming and intensive. When done well, partnerships can also be highly effective – and indeed essential – in achieving good HIV/AIDS, STI and hepatitis C outcomes. The Plan also notes the existence of barriers at all levels to the formation of effective partnerships. It is therefore important for partnerships to have a clearly stated and agreed purpose for all services and individuals involved.

In the delivery of HIV/AIDS, STI and hepatitis C services to Aboriginal people in NSW, the strongest and most effective partnerships have often been those partnerships that were developed informally through shared priorities, mutual respect and the efforts of talented and motivated individuals.

Some important principles that have underpinned effective partnership processes are outlined by key state and national strategies. These principles include:

- Aboriginal ownership of Aboriginal health is recognised
- the partners retain their core values and identity while recognising and respecting the differing perspectives, knowledge and experience brought by other partners
- a balance of power and influence is maintained between the partners
- decision-making is transparent
- identification of priorities and development of partnerships is focused at the local level
- decision–making is based on evidence, where it is available
- agreed and meaningful evaluation is undertaken
- the partnership involves robust representation
- the partnership is based on mutual trust
- the partnership is of mutual benefit.

Active outreach

The aim of an active outreach program is to involve and work closely with Aboriginal communities in order to deliver culturally sensitive services directly to Aboriginal people in a place which is acceptable to Aboriginal people. This model of service delivery is different to the way health services generally operate. Active outreach is more challenging and requires time, effort and commitment by all involved for it to succeed.

The following are some of the key elements of a successful active outreach programs:

- Ensure the service has the technical systems in place for outreach clinics:
  - transportable clinical equipment, for instance, a fold-out examination bed and basic tools for diagnosis and treatment off-site
  - service protocols for outreach clinics, for instance, arrangements for storing and transporting sensitive records in a way that assures the community of confidentiality, and access to basic treatment by suitably trained nursing staff (such as via 'standing orders')
  - arrangements are in place to obtain professional support, second opinions, advanced counselling, specialised management and assistance when following-up contacts.
- Form a local area partnership committee which includes Aboriginal community members and all relevant local health services to inform and monitor the delivery of HIV/AIDS, STI and hepatitis C services across the local area.
- Form working groups under the above area committees to plan and deliver active outreach HIV/AIDS, STI and hepatitis C services to Aboriginal communities in the area. Members of these working group may differ as they should, where possible, include local staff for each outreach program. Members could include:
  - staff from the local ACCHS

- staff from local HIV/AIDS, STI and hepatitis C services
  - ASHWs
  - local Aboriginal health educators
  - staff from other relevant health services/sectors (where possible).
- Provide local Aboriginal cultural respect training to all members of the Area committee and all working group members involved in the active outreach program, including reception staff.
- Provide HIV/AIDS, STI and hepatitis C training to all members of the Area committee and all working group members involved in the active outreach program, including reception staff.
- Organise community education sessions as well as clinics as part of active outreach programs.
- Be consistent with the location, times and duration of outreach clinics and be prepared to not have any patients in the beginning – hence the importance of conducting community education sessions as part of the outreach programs.
- In cases where other relevant health services are not part of the original planning committee or working groups, continue to extend the invitation to other services to be part of a holistic outreach service.

NSW Aboriginal Sexual Health Workers Network training meetings

Approximately 40 Aboriginal sexual health projects operate in NSW within ACCHSs and AHSs, as well as ACON. These projects strengthen and support state partnership agreements at local levels.

The NSW Department of Health established an annual three-day Network Training Meeting in 1994/1995 to provide professional development and support to Aboriginal sexual health workers. The workers' involvement in this statewide network has been critical in the development and maintenance of links with relevant state and national frameworks and strategies.

The objectives and terms of reference for the Network Training Meeting were developed by participants at the 2003 meeting.

Objectives

The objectives of the Network Training Meetings are to:

- develop the Aboriginal sexual health Network by providing opportunities for showcasing projects, sharing resources as well as providing training opportunities which address the varying levels of skills, knowledge and interests
- provide ongoing peer support and networking opportunities for the Aboriginal sexual health Network in order to foster pride and empowerment and to provide an Aboriginal understanding and cultural perspective to sexual health; and
- provide representation and advocacy opportunities for the Aboriginal sexual health Network on future directions of policies and related issues.

Stakeholders

Stakeholders of the Network are:

- Aboriginal Sexual Health Workers in NSW
- AH&MRC
- NSW Department of Health – AIDS/Infectious Diseases Branch
- NSW Aboriginal Community Controlled Health Services (Managers)
- NSW Area Health Services (Managers)
- Statewide community based HIV/AIDS, STI and hepatitis C organisations
- Clients of Aboriginal Sexual Health Workers.

Terms of reference

Day one of Network Training Meeting:

- Focus on project updates and the sharing of resources, information, ideas and innovative projects.
- Provide a forum for the Network and relevant stakeholders to report on and discuss local and statewide issues.

Days two and three of Network Training Meeting:

- Focus on training issues based on training needs of the Network.
- Training provided over the two days to address the varying levels of skills, knowledge and interests of the workers.
- Concurrent training sessions to be organised if needed, which may also allow for further project presentations by the workers where relevant.

Overall:

- Provide an opportunity to identify gaps and recommend input into policy, workforce development and ongoing training opportunities for the Network.
- Provide a forum for network representation at relevant statewide committees.
- Ownership of the Network meeting is by the Network of Aboriginal sexual health workers. Invitation of any guests outside the Network including line managers is up to the discretion of the Network and their representatives coordinating the meeting.
- Attendance and involvement of workers at the Network meeting is essential in order to maintain and link with state/national frameworks and strategies.
- Accountability of workers to the Network and their place of employment is demonstrated by showing commitment in attendance and involvement over the period of the Network meeting and by ensuring best value for time, money and resources.
- A working group from the Network to coordinate the development of the agenda, training topics and location of the meeting. The working group to include representatives from state project officers, a mix of workers from different genders and workers from ACCHSs, AHSs and ACON.
- Network meetings to alternate between metropolitan and rural locations.
- State project officers to take responsibility for organising, facilitating and reporting on all aspects of the meeting in conjunction with the NSW Department of Health as relevant and appropriate.
- Outcomes of Network meetings to be reported to relevant stakeholders.
- Terms of reference can be altered by consensus at the state Network meetings.

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SHPN (AIDB) 060188