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Principles of good sexual health care relating to the high incidence of sexually transmissible infections (STIs) and blood borne viruses (BBVs) in Aboriginal and Torres Strait Islander Communities

Principles of good sexual health care relating to the high incidence of sexually transmissible infections (STIs) and blood borne viruses (BBVs) in Aboriginal and Torres Strait Islander Communities

These principles have been developed by the Royal Australasian College of Physician's Sexual Health in Aboriginal and Torres Strait Islander Communities Working Party. These principles are endorsed by the National Aboriginal and Torres Strait Islander Health Organisation (NACCHO).

The RACP supports policies and practices which facilitate appropriate, sensitive, targeted and effective health education and medical treatment concerning healthy sexual relations, including freedom from sexually transmitted infections, unplanned pregnancy, coercion and physical or psychological discomfort associated with sexuality¹.

Fundamental to any model of care is that it is relevant and responsive to the particular needs of the local community and people it serves. High rates of endemic STIs among Aboriginal and Torres Strait Islander populations are related to the impacts of colonisation. STIs are endemic in some regions disproportionately affecting Aboriginal and Torres Strait Islander communities. An unprecedented syphilis epidemic in Queensland began in 2011 and extended to the Northern Territory, Western Australia and South Australia.

It is therefore imperative that better systems, policies and strategies are developed *with* these communities and not imposed upon them. Effective sexual health care requires capacity in comprehensive primary health care that is the cornerstone of a sustainable health system for every population in Australia. Comprehensive primary health care controlled by Aboriginal and Torres Strait Islander communities ('Aboriginal community controlled health organisations - ACCHOs') should be available as a choice for local 'first-line' sexual health care.

“Engagement needs to occur through partnerships with Indigenous organisations within a framework of self-determination and Indigenous control”¹.

Aboriginal and Torres Strait Islander health experts should drive the development of how these principles should be applied in any models of care, initiatives or activities that are intended for Aboriginal and Torres Strait Islander communities. Community input, acceptability and engagement are essential.

These principles are recommended for mainstream primary health care as not all Aboriginal people will choose to access community-controlled organisations.

Patients require timely access to coordinated services including hospitals, dedicated sexual health clinics, education and specialist services when necessary – it's vital that these are culturally appropriate and safe.

Key elements involved

As for all health care provision, sexual health care needs to be culturally appropriate, provided by culturally competent and clinically expert staff according to their scope of practice and professional credentialing.

A comprehensive, long-term and sustainable approach, built on comprehensive primary health care, is fundamental – short-term activities are insufficient

Long-term investments in sexual health programs and services are needed to achieve low rates of STIs and good sexual health care for all Australians. Short-term, time limited activities do not achieve successful outcomes as trust and relationships within communities can take time to establish.

Long-term approaches allow the appropriate models of care and treatment to adapt to the changing needs of communities and contribute to the de-stigmatisation of sexual health services resulting in increased patient access and the ability to respond quickly to an epidemic.

Secure funding is needed to deliver sustainable and ongoing sexual health care and programs, and to support a well-trained and well-established workforce.

Recognising the central role of primary care health services

Access to high quality comprehensive, culturally appropriate Primary Health Care services (PHCs) is fundamental to the delivery of good sexual health care; this includes services provided by ACCHOs and by mainstream primary care, which currently perform 50% and 30% of STI tests in Aboriginal people respectively². The multidisciplinary teams within PHCs are well placed to deliver sexual health care, including education, prevention, treatment, management and referral to specialist services. PHCs are able to provide opportunistic and annual screening. The role of specialist sexual health services is to provide support and expertise to PHCs, along with providing services to priority populations³.

Community-engagement necessary to ensure widespread access and remove any stigma associated with accessing sexual health services

Community engagement and education are critical to ensuring community-wide sexual health education and health promoting behaviours including self-presentation for signs or symptoms of STIs. This approach ensures that access to health services for sexual health reasons is normalised and encouraged, removing the associated stigma. In particular, the de-stigmatisation of testing is an important factor to reduce endemic rates of STIs and promoting sexual and reproductive health.

Sexual health care must be easy to access, non-judgemental and available to all people regardless of age, ethnicity, culture, gender, sexuality and location⁴. Good sexual health care includes services free from homophobia, transphobia and any judgement relating to levels of sexual activity and sexual acts.

Optimise opportunistic screening for people accessing health services for other reasons, to increase participation rates

Capturing opportunities to undertake sexual health screening when people access health services for non-sexual health related matters increases the reach of screening programs ('opportunistic' screening). Embedding STI and HIV testing in established PHCs activity is an effective strategy as such an approach is both destigmatising and holistic. Consideration should be given to how sexual health screening, education and services can be incorporated into routine primary care; adult health checks should include sexual health screening as a mandatory item for young people.

STI and HIV point of care testing (POC) devices facilitate the rapid provision of test results and immediate treatment if an STI is diagnosed. The 'test-treat-go' model avoids reliance on patients returning after testing. As pathology results can be delayed due to distance in remote communities, the use of POC testing is particularly important in this context. Funding mechanisms and appropriate clinical guidelines are needed to ensure people who are diagnosed with HIV or an STI can receive correct treatment, counselling, contact tracing and connection to ongoing services they might require. Use of POC testing devices are not currently Medicare reimbursable.

STI testing in alternative venues may play a role in further normalising testing and reaching sub-populations who do not regularly access health services. Non-traditional initiatives may include targeting young people through drop-in centres, sports events, in schools and through peer counselling. Such screening is best conducted by local PHCs to ensure a holistic approach.

For remote and rural areas, strategies to prevent and detect STIs are best developed in community consultation ensuring strategies are acceptable and communities have a say in selecting strategies appropriate for their context. Yearly in-community screening are not always acceptable and effective in reducing STI rates in remote and rural communities. Factors enhancing the effectiveness of these strategies include delivery by usual primary health care rather than visiting teams unknown to the community.

Contact tracing and reduce re-infection rates

Contact tracing can help ensure the testing of sexual partners, reduce the length of infectivity and onwards transmission. Culturally sensitive contact tracing needs to involve local Aboriginal Health services and be led by Aboriginal health workers⁵. Sufficient resources are needed to deliver effective contact tracing for all STIs and it should be done in line with Australian guidelines. If resources are limited, contact tracing for cases of syphilis and HIV should be prioritised over other STIs. Where required, treatment and follow-up are recommended as a principle of good sexual health.

Reducing re-infection is a key follow up strategy to preventing ongoing transmission. Early detection of re-infection can be achieved through a focus on follow up screening post-treatment. Each state and territory needs formalised reduction of re-infection targets.

Prioritise those most in need, including young people and pregnant women in regions of high prevalence

Including: testing, timely diagnosis, contact tracing, management, treatment, education, and appropriate and sufficient follow-up. Where cases of congenital syphilis have occurred the testing and follow up testing of pregnant women needs to be prioritised. In some areas, HIV and STIs are not specifically concentrated among young people, meaning that it is important to test everyone.

Long-term, well-trained and well-supported workforce

Time limited sexual health programs and Fly In Fly Out (FIFO) workforce models have not been successful. Long term on the ground primary care staff are required to establish trust with individuals and develop knowledge of communities.

Maintaining a permanent professional workforce is integral to rural and remote sexual health care as smaller communities may not engage as readily with newer professionals. Staff retention in remote PHCs invites more consistent application of evidence-based strategies, as retention is associated with greater staff skill and capacity and continuity of care for patients⁶.

Good sexual health clinical care requires the long-term implementation of a primary care team-based program integrated into routine clinical business. The program must be supported by a multidisciplinary team, including general practitioners, nurses and midwives, Aboriginal health workers (AHWs) and practitioners (AHPs), sexual health physicians, infectious disease physicians, health promotion officers, public health, educators and youth workers – all of whom assist with delivering comprehensive health education, promotion and clinical care.

A significant barrier to STI and BBV testing and treatment in rural and remote areas is lack of access to Medical Officers currently required under the MBS to request pathology testing. Approved nurses, AHWs and AHPs should be able to use independent MBS provider numbers to order pathology for STIs and BBVs, and have the capacity to immediately initiate appropriate treatment, to maximise the benefit of their roles in communities and areas with a limited workforce.

Local staff must be able to independently access both individual pathology results and quality data regarding clinical indicators and clients with outstanding issues.

It is important that there is access to locally relevant and accessible ongoing training and support of this workforce to ensure information, knowledge and skills are kept up-to-date.

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- ¹ Engagement with Indigenous communities in key sectors – Resource sheet 23 Close the Gap Clearing House 2013
- ² James Ward et al, Sexual Health and relationships in young Aboriginal and Torres Strait Islander people: Results from the first national study assessing knowledge, risk practices and health service use in relation to sexually, 2014 transmitted infections and blood borne viruses
- ³ Ali et al Populations at Australian sexual health clinics, *Sexual Health*, 2013, 10, 456–459
- ⁴ World Health Organisation, Developing Sexual Health Programs – A Framework for Action, HO/RHR/HRP/10.22
- ⁵ Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine, Australasian Contact Tracing Guidelines 2016
- ⁶ Buykx P, Humphreys J, Wakerman J, Pashen D. Systematic review of effective retention incentives for health workers in rural and remote areas: towards evidence-based policy. *Aust J Rural Health* 2010;18(3):102-9