Challenges and solutions for moving forward to create a healthy life span

Consortium Workshop

June 2011
Acknowledgements

• Metro Local Aboriginal Land Council
• Consortium
• AHMRC
• ASHW Network
Overview

• Context
• Surveillance data - what do we know?
• Opportunities For the future what are we doing about this
'It is not credible to suggest that one of the wealthiest nations of the world cannot solve a health crisis affecting less than 3% of its citizens'

Tom Calma
Aboriginal and Torres Strait Islander Social Justice Commissioner
NSW Aboriginal Population
2006 Estimated Resident Population

Median age males 20 vs 36
Median age Females 22 vs 38

Non Indigenous
Aboriginal
Area of residence 2006 Aboriginal people vs. non-indigenous NSW
Australia’s Aboriginal and Torres Strait Islander population is projected to reach between 713,300 and 721,100 in 2021 from 517,000 in 2006, according to new figures from the Australian Bureau of Statistics (ABS).

Almost a 40% increase in population in 15 years

**Implications for service delivery in the near future particularly prevention messages**
### Snapshot of some of the social indicators for Aboriginal people in NSW

<table>
<thead>
<tr>
<th></th>
<th>Aboriginal</th>
<th>Non Aboriginal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population NSW</td>
<td>148,178</td>
<td>6,669,004</td>
</tr>
<tr>
<td>Median Age</td>
<td>20</td>
<td>37</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>17 years younger</td>
<td></td>
</tr>
<tr>
<td>Yr 12 attainment NSW</td>
<td>21%</td>
<td>47%</td>
</tr>
<tr>
<td>Individual Income</td>
<td>$296</td>
<td>$471</td>
</tr>
</tbody>
</table>
Figure 7.1.2 Self-assessed health status, by age, people aged 15 years and over, 2004-05

The current Aboriginal Health Arena

• Evidence or lack of environment
• Language in Aboriginal health agenda - whose problem is it; ours or everyone’s
• Deficit based model as opposed to a strength based approach
• Post apology + CTG environment
Close All the Gaps!

• November 2008, COAG released an announcement for an Indigenous Health package worth $1.6 billion over four years, with the Commonwealth contributing $806 million and the States $772 million.

• The funding is aimed at delivering more health professionals to Indigenous communities; expanding health services; and helping to tackle key risk factors, particularly chronic disease

• This presents some challenges for us working in STIs and BBVs as chronic disease does not generally include STIS and BBVs
NSW Aboriginal Health Partnership
2008-2013

• Two Levels STATE and Local levels:
• AT THE STATE LEVEL: The NSW AHP seeks to improve health outcomes for Aboriginal people through:
  • Developing agreed positions relating to Aboriginal health policy, strategic planning, services and equity in allocation of resources.
  • Ensuring that Aboriginal health retains a high priority in the health system overall; that it is integrated as a core element in all NSW Health policies and their implementation; and that effort is sustained.
  • Promoting a partnership approach at all levels within the health system.
• Keeping Aboriginal health stakeholders and community informed about the outcomes of the NSW AHP
NSW Aboriginal Sexual Health Program

- The NSW Department of Health commenced funding for dedicated Aboriginal sexual health projects in 1989/1990.

Aboriginal Sexual Health and HCV Workers

NSW has in place a large, well developed network of Aboriginal sexual health workers (ASHWs) across the state.

Two state-wide Coordinators

Pivotal to the response

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*
Achievements of NSW Response

• maintaining the statewide support network for ASHWs
• organising network training and development activities
• developing the Core Competency Standards for Aboriginal and Torres Strait Islander Sexual Health
• Workers in NSW
• funding the development and implementation of the Diploma of Aboriginal Sexual Health by the AH&MRC
• resourcing the NSW Aboriginal Sexual Health and Hepatitis Advisory Committee (ASHHAC)
• Establishing two regional Aboriginal sexual health development positions (RASHP) to support the network
• establishing additional statewide positions to address specific priority issues such as harm reduction and health promotion and HCV
• HIV remains low
• Syphilis remains very low
• STI BBI Manual
• BBI report
Surveillance

• What do we know?
• What don’t we know?
Reporting of Aboriginal and Torres Strait Islander identity at diagnosis of selected sexually transmitted infections, by State Territory, 2009

NCHECR 2010
The Sexual Health Disadvantage experienced by young Aboriginal and Torres Strait Islander people with regard to STIs
Comparison of population rates in age groups by Indigenous status 2009 - Chlamydia

Age Specific rate per 100000

Aboriginal

Non Indigenous

15-19 females

15-19 males
Comparison of Gonorrhoea age groups non Indigenous vs. Indigenous 2009

Age Specific rate per 100000

- 15-19 females: 3494
- 20-29 males: 98

Aboriginal vs. Non Indigenous
Comparison of Indigenous vs. non Indigenous Infectious Syphilis 2009

Age Specific rate per 100000

- Aboriginal: 110
- Non Indigenous: 24

- 15-19 females
- 30-39 males
HIV diagnoses in Australian born cases, 2005 – 2009, by Aboriginal & TSI status and HIV exposure category

Aboriginal and Torres Strait Islander

- Male homosexual contact: 45.7%
- Male homosexual contact and injecting drug use: 21.3%
- Injecting drug use: 7.4%
- Heterosexual contact: 20.3%
- Other/undetermined: 5.3%

Non-Indigenous

- Male homosexual contact: 70.6%
- Male homosexual contact and injecting drug use: 15.3%
- Injecting drug use: 3.5%
- Heterosexual contact: 8.1%

Excluding non-Indigenous cases who’s infection was acquired in a high prevalence country
HIV Notifications for NSW

• Small numbers annually ~5-10 p.a.
• Unknown quantity of STIs
• Vulnerable to rapid change
• Careful and close monitoring is required
• Generally different epidemiological profile re exposure category MSM; Hetero; IDU

- Estimated between 13,000~22,000 Aboriginal &/or TSI people have been exposed to HCV

- ~16,000 living with chronic HCV

- Equates to 8% of total Australian HCV population

- 3-4% of Australian Indigenous population cf. with 1% of Australian population

Limitations:
- Estimates are based on number of Aboriginal & TSI people participating in Annual NSP survey – accuracy?
- Does not take into consideration over representation of Aboriginal people in prison
Spatial clustering of STI cases
NSW 1993-2003

Chlamydia

Gonorrhoea

Syphilis

Schleihauf, Watkins, Plant  *Sex Transm Infect*  Aug 2008
Implications of Spatial distribution of STIs

• Postal areas are an important predictor of STI incidence in NSW

• NG and Infectious syphilis attributed to high incidence or “clustered outbreaks” in relatively small geographical areas e.g. 44% of NG in areas occupied by 3.6% of NSW population; 35% of syphilis in areas occupied by 23% of population

• NG and infectious syphilis endemic relative to diffuse distribution of CT across NSW
Table 7.2.5  Age standardised hospitalisation rates for infections with a predominantly sexual mode of transmission, per 1000 people, NSW, Victoria, Queensland, WA, SA, and public hospitals in the NT, 2006-07\textsuperscript{a, b, c}

<table>
<thead>
<tr>
<th></th>
<th>Indigenous</th>
<th>Non-Indigenous\textsuperscript{d}</th>
<th>Rate ratio</th>
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<tbody>
<tr>
<td>Syphilis</td>
<td>0.35</td>
<td>0.03</td>
<td>12.50</td>
</tr>
<tr>
<td>Gonococcal infection</td>
<td>0.33</td>
<td>0.01</td>
<td>41.95</td>
</tr>
<tr>
<td>Chlamydial infection</td>
<td>0.19</td>
<td>0.02</td>
<td>9.63</td>
</tr>
<tr>
<td>Other sexually transmitted diseases</td>
<td>0.48</td>
<td>0.20</td>
<td>2.35</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Hospitalisation rates are directly age standardised using the 2001 Australian population. \textsuperscript{b} Data are based on State or Territory of usual residence. \textsuperscript{c} Includes principal or additional diagnosis based on ICD-10-AM classification. \textsuperscript{d} Non-Indigenous includes hospitalisations of people identified as not Indigenous as well as those with a 'not stated' Indigenous status.

Source: AIHW National Hospital Morbidity Database (unpublished); table 7A.2.14.

For NSW, Victoria, Queensland, WA, SA and public hospitals in the NT:

- hospitalisation rates for sexually transmitted infections were greater for Indigenous people than non-Indigenous people in 2006-07 (table 7.2.5)
- hospitalisation rates for Indigenous people with gonococcal infection were 42.0 times as high, for syphilis 12.5 times as high and for chlamydial infections 9.6 times as high as the rates for non-Indigenous people (table 7.2.5)
- for Indigenous people, the hospitalisation rate for syphilis decreased from 2004-05 to 2006-07 (from 0.42 hospitalisations per 1000 people in 2004-05 to 0.35 hospitalisations per 1000 people in 2006-07. Hospitalisation rates for gonococcal infections, chlamydial infections and other sexually transmitted diseases all remained fairly constant over the period (table 7A.2.14).
Recent NSW Evidence

• NSP and Pharmacy Surveys
• Young persons survey
• Minimum Data Set Data
• ACCESS _ Chlamydia testing and positivity in NSW SHS and ACCHS
Future NSW Contributions to evidence base

- SHIMMER – CQI project in four ACCHS
- REACCH – Clinical Research in five ACCHS – HCV and HBV Evaluations, antenatal project, youth...
- Evaluations of NPA- IH HCV Program
- ACCEPt- Chlamydia trial in ACCHS and GP
- Data Linkage studies
- GOANNA – Young persons survey
- MDS Improvements
- Gonorrhoea changes in reporting?
Opportunities to enhance service delivery for Aboriginal people in NSW
8 WAYS SEXUAL HEALTH PROGRAMS

- Training
- Health Promotion Education
- Health hardware
- Policy Planning Management
- STI & BBV Control
- Clinical services
- Surveillance
- Monitoring & Evaluation
- Research

Developed by Nganampa Health Council Alice Springs
Health Promotion and Education

- School programs
- Embedded in community development principles
- Reach and impact
- Target audience involvement
- Locally produced
- Engaging technology
Health hardware

- Does the patient management system work effectively?
- Are condoms easily accessible?
- Are fit packs available?
Clinical services

- Is service youth friendly?
- Are clinicians competent in delving into SH and BBV issues with young people?
- Are clinicians testing the right people at the right time?
- Are clinical services easily accessible?
- Is there a need for clinical outreach for particular groups?
Monitoring & Evaluation

- Are the right people being tested?
- How often?
- Are there missed opportunities?
- Who is accessing your service?
- Are women higher attendees of the service?
- Is retesting done?
- What happens after a diagnosis for Viral hepatitis?
• Is there new technology available to test?
• Can you test a new mode of service delivery?
• How much impact did your school program have?
• What difference does your program have on clinical attendance?
Surveillance

- What does incidence and prevalence data look like locally, regionally, or state-wide?
- Do you have partnerships with your local PHU or lab?
- Can you seek information from them regarding testing and positivity?
- Has there been an increase in rates over time?
- What are trends for diseases?
Policy Planning & Management

• Does your service have a testing policy
• An outbreak policy
• Who do you engage for a HIV positive case?
• Are management supportive of change?
• Is the Board aware of your program?
• Can you influence CEO and Board of need for a NSP?
Training

• Are clinicians trained in sexual health and BBV?
• Are they competent in asking patients if they want a test or about risk behaviours?
• Is there a service wide approach to delivering holistic sexual health services?
8 ways +

• Staff
• Partnerships
• Key Performance Indicators (KPI)
• Continuous Quality Improvement (CQI)
• Patient Management Systems (PMS)
Key Performance Indicators

• Identifying and trialing KPIs for STI and BBV control in all funded services might be a good way to ensure this area of health is accorded same priority that the close the gap agenda currently does

CORE KPIS

Prevention
• Assessment of availability and cost of condoms in each community

Diagnosis and Treatment
• Number and proportion of residents aged 15 - 34 who were tested for STI
• Treatment interval for STI episodes

Workforce
• Assessment of workforce capacity to deliver clinical services in sexual health

Research and Surveillance
• Number & rate of STI diagnosed per 100,000 population

Developed by Menzies School of Health Research, Kirby Institute and NT Government
COMPREHENSIVE KPIS

**Partnerships**
- Assessment of sexual health services integration into primary health care
- Assessment of local interagency/interdepartmental forums and/or collaborations in SH

**Prevention**
- Development of sexual health promotion plan for health services
- Participation in community based events that include sexual health promotion

**Diagnosis and Treatment**
- Number and proportion of clinical presentations where appropriate tests were performed
- Number and proportion of appropriate treatment of STI
- Number and proportion of re-infections at 2-4 months following treatment for an STI
- Number of contacts treated per index case with a target of 1

**Workforce**
- Assessment of availability and access to sexual health education and training opportunities for staff

**Research and Surveillance**
- Test positivity rates
Continuous Quality Improvement
CQI

*Answers - How can we do things better?*

Involves-
• Governance
• Best practice standards
• Leadership and Management
• Data
• Tools
• Training
• Consumer input
• Health Team input
• Feedback
• Strategising
Patient Management Systems

• Most are individual patient centred and focused
• Not good at population health
• Either reconfigure by installing templates and report capabilities-$$$$
• Or installing software which can extract data from system and then cleaning and validating data
Summary- What have we got to be proud of in NSW

- Come from a relatively low priority to one of the best resourced programs in Australia
- ASHWs- pivotal to the response
- Very good policy response- but could be tighter in terms of evaluating that
- Partnership – excellent
- Research – emerging
- Commitment is here!
What don’t we have and what are the opportunities for enhancing current service delivery

• Knowledge and information to accurately identify issues
• Using an 8 ways + ( CQI+PMS+KPIs)
• Reflection and evaluating more strategically
Summary

• Lets start implementing what we know will work and make it work! And make a difference in NSW
• Continue developing partnerships
• Embrace the good will and intent in the community
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