1. Requirements for an effective sexual health and BBV program

Key points

- The requirements for effective sexual health and BBV programs include:
  - prevention and education
  - an enabling environment
  - workforce development
  - testing and diagnosis
  - disease management and clinical care
  - research, evaluation and surveillance.
- Appropriate and effective consultation enables communities themselves to help determine the processes, outcomes and sustainability of programs.
- Program activities are always enhanced by collaboration between various organisations that have contact with, or provide services to people and communities affected by STIs and BBVs.
- An enabling environment is one that is acceptable and improves access for people at risk of, or who are affected by, STIs and BBVs and it is also important for the effective delivery of clinical services.
- Workforce training should focus on current and emerging issues, address gaps in testing and management and meet the needs of staff working across a range of services.

Key goals of sexual health and BBV programs

The key goals and core components required for comprehensive programs are outlined in the *Fourth National Sexually Transmissible Infections Strategy 2018–2022* and *WA Sexual Health and Blood-borne Virus (BBV) Strategies (2015–2018)*.[1,2] The WA strategies (2019–2023) incorporate new developments, which are highlighted throughout this manual.

New and highly effective direct acting antivirals (DAA) for the treatment of hepatitis C became available on the Pharmaceutical Benefits Scheme (PBS) in 2016, making the elimination of hepatitis C an achievable goal. Other significant advancements that have occurred in recent years include new treatments for human immunodeficiency virus (HIV), and the rollout of the human papillomavirus (HPV) vaccine. While this manual will not specifically cover issues relating to HIV and HPV, it will focus on increasing access to testing and management of hepatitis B, hepatitis C and treatable STIs.

Despite those advancements, a syphilis outbreak that commenced in 2011 has extended beyond Queensland to the Northern Territory (NT), Western Australia (WA) and South Australia (SA), affecting mainly 15 to 30-year-old Aboriginal and Torres Strait Islander people living in remote and regional areas. The re-emergence of cases of congenital syphilis and neonatal deaths has necessitated an increased emphasis on responses and strategies to contain this outbreak and prevent adverse outcomes.

Increasing access to effective hepatitis C treatment and addressing the syphilis outbreak needs a multifaceted approach that highlights the key goals and requirements for effective sexual health and BBV programs. The *WA Aboriginal Sexual Health and Blood-Borne Virus Strategy 2015–2018*[3] emphasises the importance of partnerships between government, non-government organisations and the community in reducing the transmission and impact of STIs and BBVs.

Key goals are to:

- build awareness among priority populations
- improve testing rates
- increase access and awareness among priority populations and through the ongoing provision of coordinated and responsive training, resources and support programs for the workforce
- increase access to new HIV and hepatitis C treatments
- orient primary healthcare services to enhance STI and BBV testing among priority populations
- maximise community engagement with health programs by eliminating stigma and discrimination among priority populations
- conduct ongoing evaluation of health promotion and treatment programs and services to ensure they are meeting the needs of communities.[1]

Core components of a sexual health and BBV strategy

The core components of effective programs include:

- prevention and education
- an enabling environment
- workforce development
- testing and diagnosis
- disease management and clinical care
- research, evaluation and surveillance.[2]

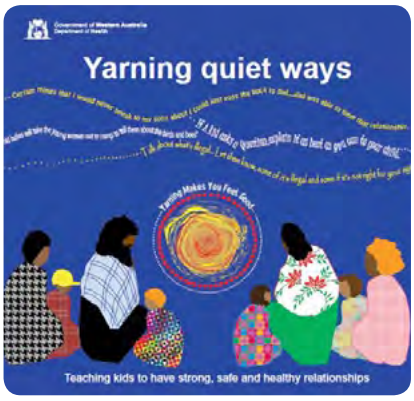
This section provides an overview of community consultation, partnerships, enabling environments and workforce development; other components will be discussed in the following chapters.

Community consultation and engagement

Appropriate and effective consultation enables communities to be engaged and involved in determining the processes, outcomes and sustainability of sexual health and BBV programs. It involves genuine listening and giving careful consideration to the views of community members, enabling them to be involved and collaborate to influence and shape programs. Effective communication also involves sharing information and providing feedback on the progress and outcomes of programs.

Good engagement and communication between services and communities develops trust and relationships that have many benefits for both. Elders and other key community members can provide unique knowledge, experience and insight. Their involvement can be empowering for the community and mutually valuable, as well as contributing to the success and sustainability of programs.[4, 5] Advice from local Aboriginal staff is essential to understanding cultural protocols when planning community engagement, community education programs or clinical services.

> "Community involvement and ownership help to build self-determination and community control. The more a community is involved, the more people will access sexual health services. Positive community involvement is also good for young people. Research shows that young Aboriginal and Torres Strait Islander people who feel connected to their families and have caring adults who are involved in their lives have a lower risk of poor sexual and reproductive health." — Djiyadi – can we talk? [4]



Yarning Quiet Ways Resource

Partnerships

The *WA Aboriginal Sexual Health and BBV Strategy 2015–2018* recognises the unacceptably high rates of STIs among Aboriginal people in WA and the importance of service providers and communities working together to improve sexual health outcomes.[3] Program activities are always enhanced by collaboration between various organisations that have contact with, or who provide services to, people and communities affected by STIs and BBVs. As every community differs with regard to what services are available, who accesses them and how they are accessed, an important first step in developing partnerships is to map out the main services and organisations in the community that engage with or provide services to priority populations.

Effective partnerships already exist in many regions; in others, if they do not need to be developed from scratch, they could be reinvigorated or strengthened. Where partnerships do exist, it is useful to revisit what programs are being delivered to ensure they support the key goals of current sexual health and BBV strategies.

Services and organisations that already collaborate or could be engaged in partnerships include:

- Health services (both primary care and hospital-based services and programs):
  - ACCHS
  - Sexual health clinics
  - Sexual Health Quarters (SHQ)
  - General practices
  - Antenatal outpatient clinics and outreach services
  - Mental health services
  - Headspace
  - Drug and alcohol services
  - NSPs
  - Corrective Services health clinics

Ngangganawili Aboriginal Health Service in Wiluna

- Community-based organisations:
  - Youth centres
  - Sporting clubs
  - High schools
  - Education and employment agencies such as TAFE colleges and Community Development Employment Projects (CDEP) programs
  - LGBTI (lesbian, gay, bisexual, transgender and intersex) organisations
  - Community council offices
- Networks and organisations that provide representation, education, counselling and advocacy:
  - Aboriginal Health Council of WA (AHCWA)
  - SHQ
  - Youth Affairs Council of Western Australia (YACWA)
  - Western Australian AIDS Council (WAAC)
  - Peer Based Harm Reduction WA
  - HepatitisWA.

Enabling environment

An enabling environment is one that is acceptable and improves access for people at risk or affected by STIs and BBVs, and is important for the effective delivery of clinical services. Ensuring clients are treated by all staff in a way that is respectful, non-judgemental and free of discrimination is essential for a service to be accessed by people who may be marginalised and who have limited access due to factors such as young age, culture, language, gender, sexuality, socioeconomic status and drug use. With regard to Aboriginal people, organisations and staff should have an understanding of cultural security and how to ensure it is provided through their services and programs.

Cultural security

It is essential that organisations and agencies understand the cultural context in which they are working, and ensure their programs and services are built upon elements that strengthen cultural identity, connection and leadership capacity among the Aboriginal people accessing them. The steps towards providing cultural security include:

Cultural awareness: sensitivity to the similarities and differences that exist between two different cultures and the use of this sensitivity in effective communication with members of another cultural group.

Cultural competency: becoming aware of the cultural differences that exist, appreciating and having an understanding of those differences and accepting them. It also means being prepared to guard against accepting your own behaviours, beliefs and actions as the norm.

Cultural safety: shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening. It is about creating an environment that is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need.[5]

Reference: Engaging with Aboriginal Children and Young People toolkit. Commissioner for Children and Young People WA, 2018.

Despite the presence of specialist sexual health services, most STI management is provided through primary healthcare services that provide a range of health care to the entire community. While it may not be possible to meet all the needs of priority populations or be feasible to change the location or infrastructure of existing services, changes can be made to reduce stigma and discrimination and remove barriers to access. Be mindful about who the priority population is and issues specific to them. Engage the community to determine changes that could be made to reduce barriers and improve access. Think about what your service does well and identify where there are barriers that could be addressed. These factors will be different, depending on the location and client group, but could include changing opening hours, providing transport to enable youth to attend after school, setting aside specific clinic days, providing separate entrances for men and women, providing waiting rooms that are welcoming, and having youth and culturally appropriate resources available.

Case study

SHQ: how we are making SHQ a more culturally safe space

Some activities and changes SHQ has implemented to become a more culturally safe and appropriate workplace include:

- receiving ongoing input from an external Aboriginal Advisory Committee
- involving Aboriginal educators in planning, delivery and evaluation of programs
- ensuring Aboriginal educators take a leadership role in promoting sexual health
- displaying culturally appropriate paintings in the waiting room of the clinic
- displaying a framed National Apology to the Stolen Generation
- displaying the National Apology translated into Chinese for the Magenta clinic so that Chinese sex workers are able to read and understand the National Apology and its significance
- implementing daily STI drop-in clinics
- implementing free appointments for people 18 years and under
- employing an Aboriginal educator to provide outreach services to street-based sex workers
- targeting marginalised groups (Aboriginal young people are commonly in the classes held by youth educators and promote SHQ services)
- encouraging visits by school groups, who either pretend or actually get tested for STIs.

The SHQ is upskilling our workforce to become more culturally aware and appropriate by:

- forming a Reconciliation Working Group to discuss issues as well as plan all-staff events for significant times such as Reconciliation Week, National Sorry Day and NAIDOC Week
- receiving ongoing input from an external Aboriginal Advisory Committee
- conducting cultural safety training for the SHQ workforce
- enhancing cultural awareness and understanding through social relationships and collaboration between Aboriginal and non-Aboriginal staff members
- developing a Reconciliation Action Plan that has been ratified by Reconciliation Australia.

Workforce development

Successful programs rely on having a skilled, knowledgeable, respected and committed workforce who can work as a team. Ensuring that our large, mobile health workforce is adequately trained as well as kept up-to-date with new and emerging issues presents many challenges.

Workforce development should aim to:

- build capacity and broaden the range of healthcare workers able to test for and manage STIs and BBVs
- enable practitioners to have the confidence, skills and knowledge to increase testing and provide appropriate and up-to-date management of STIs and BBVs
- work in partnership and use the skills of relevant health services and staff and existing programs to deliver training and support programs.

Most people with STIs are managed through primary healthcare services and, while training is often focused on staff working in primary care, people with STIs and BBVs are also frequently managed through hospitals. It is important when considering training programs to ensure that relevant hospital staff members are not overlooked, particularly those working in obstetrics, surgery and emergency departments.

Training the health workforce, particularly those working in regional and remote areas, presents unique challenges and issues such as:

- competing health priorities and training needs
- lack of adequate funds and staff to deliver training in some areas
- rapid staff turnover
- locum staff and visiting specialists who may have limited prior experience working in areas of high STI prevalence
- lack of knowledge about the epidemiology of STIs and clinical and public health guidelines specific to the region
- lack of experience and skills related to managing STIs and BBVs
- potential barriers due to gender, language and culture
- real or perceived lack of professional support available.

Identify the specific needs of the workforce and address gaps in management. Focus on key and emerging issues, gaps in management and the needs of staff in both primary care and hospital settings such as:

- local epidemiology of STIs and BBVs, the key age groups and priority populations affected
- clinical management guidelines specific to the region or priority population

- new and emerging issues, such as the responses to the syphilis outbreak, who is affected and updated testing and management protocols
- availability and access to new, better tolerated and more effective DAA treatment for hepatitis C
- addressing common gaps in testing and management such as:
  - increasing the low rates of testing among the highest risk age group (15 to 30) and in particular among 15 to 19-year-old women and young men
  - increasing the uptake of testing in a way that is easy and acceptable
  - integrating testing into routine healthcare delivery
  - improving the management of low abdominal pain and pelvic inflammatory disease (PID) among young women by increasing awareness of common presenting signs and symptoms, and addressing the common mismanagement of PID as urinary tract infections (UTIs) or appendicitis
- complying with public health responsibilities with regard to the notification of STIs and BBVs and mandatory reporting requirements.

Develop partnerships and use existing networks to assist with accessing and delivering training. Be familiar with what is available with regard to up-to-date STI and BBV clinical management guidelines, staff training and support. STI and BBV clinical management guidelines include:

- *Silver Book – A guide for managing sexually transmitted infections (Silver Book)*
- *Sexual Health Orientation Manual for Endemic Regions*
- Australian STI management guidelines
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) HIV and viral hepatitis resources and management guidelines
- *Communicable Diseases Network Australia (CDNA) National Guidelines for Public Health Units* – updated syphilis management guidelines
- Guidelines specific to a region or organisation such as the Kimberley Aboriginal Medical Services (KAMS) and Kimberley Population Health Unit (KPHU) clinical guidelines.

Organisations and services that provide or can assist with training:

- ASHM
- SHQ
- AHCWA
- Fremantle and Royal Perth Hospital Sexual Health Services
- Regional population/public health units (PHUs)

Case study

The Birds and the BBVs training: AHCWA

The Birds and the BBVs is a two-day training course that aims to build the capacity of Aboriginal health workers (AHWs) and others working with Aboriginal people to yarn about and normalise STI and BBV testing.

"Just following up with some good news in regards to the training you provided. A client presented who mentioned he was recently released from prison. I noticed he had a few tattoos so I asked a few questions about his time spent on the inside. He informed me he received two new tattoos. From there, I was able to identify the risk for hepatitis B, C and HIV. I informed him of the possible risk and he consented to blood tests. I was pleased that the training I received was able to be used in my practice so soon." — feedback from a health practitioner following the training.

Different models of health service delivery

While the main focus of this manual is on the delivery of sexual health and BBV programs through primary healthcare services, we acknowledge that people with or at risk of STIs and BBVs access a range of health services, and that their management is not confined to primary care. Hospitals have a significant role to play with regard to managing people with STIs and BBVs. In regional and remote areas, there are also different models of health service delivery that span both primary and hospital care. Hospitals may provide primary health care through outpatient clinics, and staff often provides both primary and tertiary care within those services, or they may work both in primary healthcare services and hospitals. Other services such as private general practices, the Royal Flying Doctor Service, Corrective Services health clinics and mental health services also provide primary and emergency care to people with STIs and BBVs.

Have plenty of condoms on hand

Nullagine Shop

Case study

Junior medical officer training: Kalgoorlie Hospital

The Goldfields PHU provides Goldfields-specific public health training to the junior medical officers who are on 12-week rural placement at Kalgoorlie Hospital. The unit, which has delivered this training since 2014, works through a structured program at the Kalgoorlie Health Campus. The Kalgoorlie Hospital runs a regular weekly education program for junior medical officers, which is also open to other medical officers, medical students and nurses. The unit nominates a session, preferably towards the start of the new term, to orient new staff, many of whom have never worked in the Goldfields before. Topics for discussion include the epidemiology of STIs and BBVs in the region, priority populations, management of common STIs and the role of the unit's sexual health team. Each session draws 12 to 15 participants and allows time for questions, discussion and networking. Delivering training on a regular basis not only provides information to new staff but has improved relationships and communication between staff at the hospital and the unit.

Hospital emergency departments, antenatal and maternity services and other outpatient services should be made aware of acute presentations such as:

- young women presenting with lower abdominal (pelvic) pain due to PID
- pregnant women presenting with adverse outcomes (possibly due to chlamydia, gonorrhoea and other STIs) such as early miscarriage, ectopic pregnancy, premature rupture of membranes, post-partum infection, and neonatal infections
- pregnant women presenting with adverse outcomes due to syphilis such as mid-term miscarriage, stillbirth and congenital syphilis
- men presenting with urethritis or epididymo-orchitis (inflammation) due to chlamydia or gonorrhoea, or both
- men and women presenting with complications of gonorrhoea such as septic arthritis or disseminated infections.

Orientation and training should also make staff aware of their responsibilities under WA health legislation regarding access for people who inject drugs (PWID) to clean needles and syringes, and appropriate information as required. For further information, see Chapter 9.

Staff and organisations who provide workforce training should be mindful and inclusive of relevant staff working outside of primary healthcare services to ensure that the broader workforce is able to provide appropriate services to people with or at risk of STIs and BBVs.