5. Outreach programs: planning, implementation and evaluation

Key points

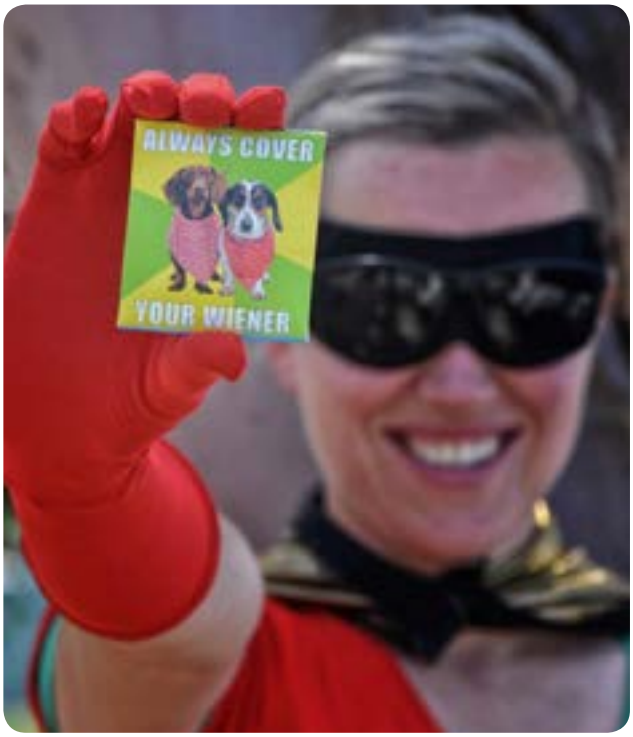
- Outreach programs can be an effective way to reach groups at risk of STIs and BBVs who have limited access to existing services.
- Outreach programs can consume a lot of time and resources so should be well targeted and properly evaluated to ensure the aims of the program have been met.
- Health service data should be used to identify whether the target group is already accessing the health service, whether STI and BBV management is appropriately integrated into routine visits and supported by health services systems, or whether services can be reorganised to become more accessible and acceptable for the target group.
- Effective outreach programs rely on good planning and effective partnerships between organisations.
- Evaluation of the process and outcomes is integral to the ongoing success of outreach programs.

What is an outreach program?

Outreach programs involve targeting health care to priority populations at risk of STIs and BBVs, particularly those who may be marginalised or who have limited access to existing services. Outreach programs can be delivered outside of established health services or they may use existing services in a way that is more suitable and acceptable to the target group.

STI and BBV outreach programs have many direct and indirect benefits including that they can:

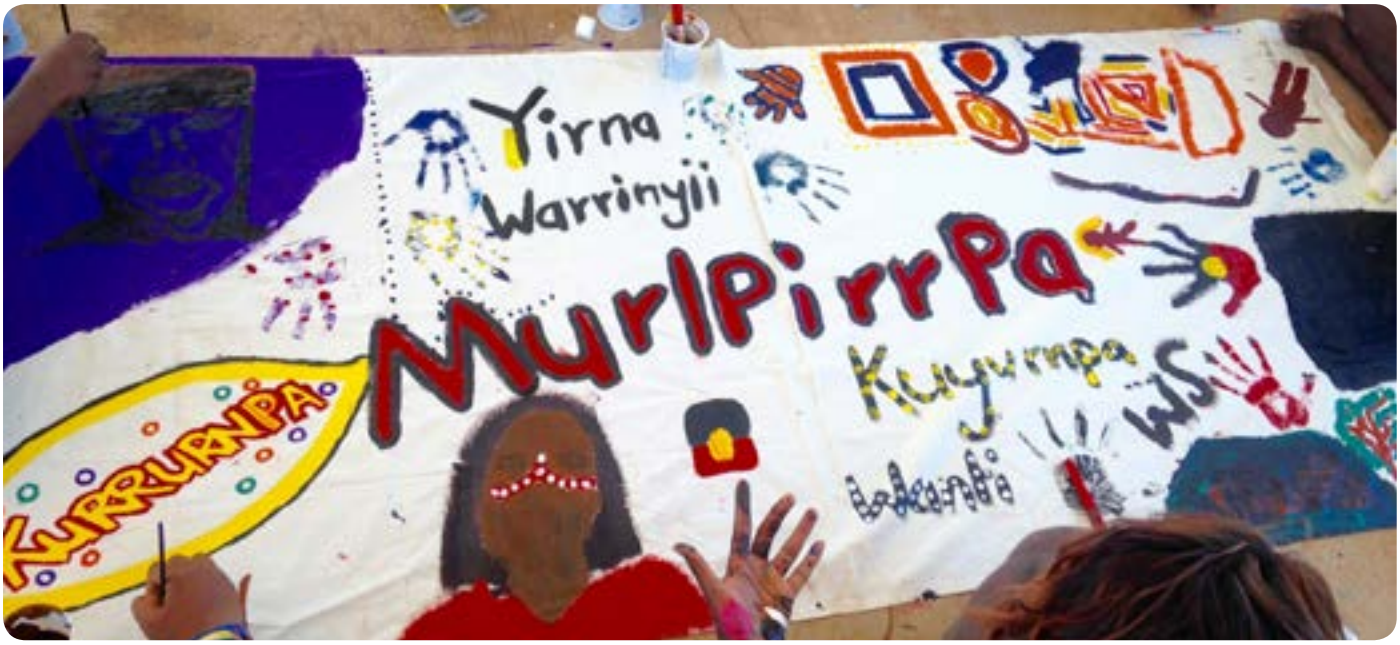
- enable engagement with priority populations who may be marginalised or who have limited access to services
- provide access for a lot of people to information, testing and treatment in a short time
- be tailored to meet the needs of the priority population
- provide a level of anonymity for people to access testing and treatment
- enable the development and strengthening of partnerships across a range of services.



Even superheros need protection

While outreach programs can be very effective, they can also consume a lot of time and resources and involve careful planning and implementation. When a program comes to an end, evaluation is important to ensure that priority populations were appropriately engaged and that the goals of the program were met in a cost-effective manner. Planners should bear in mind that outreach programs:

- are time and resource intensive and so should be targeted only to priority populations who have limited access to services
- should align with the broad aims of national and WA sexual health and BBV strategies
- should involve careful planning and engagement with key stakeholders, including priority populations, community, health and other organisations, to maximise success
- should be evaluated to ensure that the aims of the program were met or to enable parts of the program to be reviewed and fine-tuned to ensure the success of ongoing programs
- may be difficult to sustain in the longer term so should also aim to facilitate ongoing access for marginalised groups to existing services
- should not be delivered at the expense of ensuring that STI and BBV testing and management has been appropriately integrated into existing primary healthcare services already accessed by those at risk.



Engaging young Aboriginal people in Nullagine

Is an outreach program needed and is it targeting the priority group for STIs and BBVs?

The following two hypotheticals demonstrate some of the things that should be considered when planning and delivering outreach programs.

Well Women's Health Day

Due to the high rates of chlamydia among women in one community, health service staff decide to integrate STI and BBV testing into the Well Women's Health screening day, which is run every six months at a site away from the local clinic. Feedback and evaluation found that while the participants were interested in the information given, particularly as it gave them an opportunity to ask questions that they had felt embarrassed to ask at the clinic, no STIs or BBVs were detected. A review of the age of the participants identified that 80 per cent were over 40 and none were aged under 30 years. While there may have been value in providing information to this group, they are not the target age group for STI and BBV testing. Future involvement might include providing a staff member to give out information but in terms of testing and treatment, resources would be much better spent by focusing on the age group affected.

Outreach for young men

Staff at the clinic of a small community are concerned about the high rates of STIs among young people. They would like to conduct an outreach program for 15 to 24 year olds whom they believe do not access the clinic. The intended program would be similar to the program presented by another health service at a recent workshop. During the planning, however, the clinic manager extracted data on attendance and STI testing among 15 to 24 year olds over the past 12 months and found that 80 per cent of young women compared with only 50 per cent of young men attended the clinic. Among the young men who did attend, only 10 per cent had a PCR test taken compared to 65 per cent of young women. As a result, they identified that while attendance among men was lower than women, very few men had a PCR test when they did attend. Extracting this data before running the outreach program helped the staff to identify and address gaps within the existing service as well as identify the subgroup who truly were not accessing the service and who could benefit from a well-targeted outreach program.

Models of delivery of outreach programs

Outreach programs can be delivered in many different ways but should be tailored to meet the needs of the priority population and delivered in the most cost-effective way. STI and BBV outreach programs should focus on those at highest risk, such as 15 to 30 year olds or specific risk groups such as MSM, sex workers or injecting drug users. Be mindful that some priority populations within a community may not be easily identifiable or easily defined by young age alone. Consultations and partnerships with appropriate community members and organisations can assist to better identify priority populations and how best to improve access for them. While it may not always be possible to identify individuals at risk, it may be easier to identify and work with their broader social groups and networks to reach individuals within those groups who may be at risk of STIs or BBVs.

The box below outlines priority populations as defined in the WA and national STI and BBV strategies. Note that in the context of outreach programs, priority populations may be referred to as the 'target group'.

Priority population groups

Australia's response to STIs and BBVs is targeted towards specific priority populations who are identified based on epidemiological data. Past STI, hepatitis B, hepatitis C and HIV national strategies have specified the following priority populations:

- Gay men and other men who have sex with men
- People who inject drugs
- Young people
- Aboriginal and Torres Strait Islander People
- Sex workers
- People living with HIV and/or other BBVs
- People living within custodial settings
- Culturally and linguistically diverse populations
- Migrants and new refugees
- People from high HIV prevalence countries
- Travellers and mobile workers.

Outreach programs can have different goals and be delivered in a number of ways through:

- providing information, awareness raising, health promotion
- testing and treatment
- standalone STI and/or BBV programs
- integrated into, or delivered alongside, other outreach programs such as adult health checks or immunisation
- non-clinical settings in the community
- existing services reorganised to make them more accessible and acceptable, such as dedicated clinics, changing opening hours or providing transport.

It is always ideal to offer programs that are holistic and aim to deliver a number of outcomes, but this must be balanced by what is realistic and achievable, particularly in view of time and resource constraints. If integrating into or delivering alongside other outreach programs, ensure that the target group for the existing program aligns with the priority population for STI and BBV programs.

Where and how outreach programs are delivered will vary depending on many factors including what other services are available and accessible. Programs can be enhanced by developing and strengthening partnerships with other organisations that deliver services to the priority population. The services that people may already access within communities might include:

- youth or community centres
- sport and recreation centres
- educational facilities such as high schools and TAFE colleges
- employment programs
- drug and alcohol services
- mental health services
- corrective services.

There are many different examples and models that have been used across the country to deliver successful outreach programs to priority populations. Many have involved partnerships between health services and other organisations in a variety of settings to capitalise on the mix and skills of staff and maximise access to priority populations in an appropriate and acceptable way. Examples of outreach programs and models of STI and BBV testing include:

- annual community-wide STI screening conducted by health services such as the Nganampa Health Council, Ngaanyatjarra Health Service and Spinifex Health Service
- partnerships between ACCHS and other services such as schools, drug and alcohol services, and corrective services
- mobile buses
- programs coordinated by sexual health services and PHUs that use hospital emergency departments to conduct STI testing among 15 to 30 year olds[3]
- chlamydia and BBV testing using websites for young people to access pathology test request forms so they can drop off specimens via the mail or directly to a laboratory.[4]

Case study

Gonorrhoea and chlamydia WACHS Pilbara Emergency Department Project, Nickol Bay Hospital Karratha

The aims of this project were to:

- inform and raise the level of awareness among people attending the emergency department of the risks and possible outcomes of STIs
- increase awareness among staff of STIs and encourage them to increase asymptomatic screening among at risk groups
- increase STI screening rates among people at risk of STIs attending the emergency department
- reduce the time interval to treatment to reduce further transmission and complications of STIs
- implement the project in a manner that did not impede or increase the workload of staff in the emergency department.

Planning the project, developing the forms and processes (such as the inclusion and exclusion criteria) occurred in consultation and collaboration between the public health physician, the emergency department Medical Director, staff and the sexual health team. Posters and pamphlets were placed in the waiting area to raise awareness of the project. Participants signed a consent form and all pathology results were followed up by the sexual health team. The project started in February 2018, initially as a three-month trial, but the project remains ongoing. As the project progressed, staff identified some areas for improvement, modifying processes and consent forms.

Evaluation was conducted to determine the number of tests taken and the number of positive results by specific STI, as well as feedback from emergency department staff. To date, 37 people have been tested for chlamydia, gonorrhoea and trichomonas PCR through a urine sample. Eleven people were offered testing but declined and six were ineligible. Trichomonas was detected among three (8 per cent) of 37 people tested. Feedback from staff was that as a result of the project there was an increased awareness of STIs. In addition, the project resulted in improved communication and an increase in referrals from the emergency department to the sexual health team.

Factors that impacted the project included a planned move to a new health campus, new computer systems and a change of staff in the emergency department. The challenges highlighted the importance of having a nurse champion in the department to drive the project and encourage staff to participate, as well as the maintenance of good communication between the emergency department and the sexual health team through regular monthly meetings.

Planning and implementing outreach programs

Successful outreach programs rely on good planning, effective engagement with the target community and collaboration with other services. The Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN) has developed a toolkit to help plan and evaluate programs. The toolkit can be used and SiREN program staff can be contacted to help set up programs. The toolkit contains templates and checklists, and other resources include the *Aboriginal Health and Medical Research Council of NSW (AH&MRC) STI and BBV Manual*.[2] These and other comprehensive resources can be adapted and simplified to meet the needs of many outreach programs.

https://siren.org.au

http://www.ahmrc.org.au

When planning outreach programs, here are some things to consider:

- Identify the priority population for the program and think about the following:
  - Are members of the target group already accessing existing clinical services and, if so, are they offered appropriate information, testing and management for STIs and BBVs?
  - Is an outreach program warranted or do existing services, systems and staff need to be reorganised to make them more appropriate, acceptable and accessible?
  - What other services do they access?
  - Is there a target group such as a peer or social group that truly does not access services and that should be prioritised?
  - Are other outreach programs already delivered to them and, if so, can they be integrated?
- Identify the goals of the outreach program:
  - Is it to provide education, health promotion or to test and treat?
  - What other organisations should be involved to ensure an appropriate mix of skills is used to maximise the success of the program?
- Outline how the program will be delivered:
  - Do partnerships already exist between relevant services or do they need to be developed or strengthened?
  - Will it be delivered over one or several days?
  - What sites or organisations will be needed to implement the program and do they enable a safe environment for staff and participants?
  - Will follow-up be needed and where and when will that take place?
  - Have you clarified the roles and responsibilities of organisations and staff involved?
  - Have you mapped what resources will be needed with regards to time, equipment, workforce and mix of skills?
  - Have you estimated the number of participants and amount of equipment, medications and other supplies that may be needed?

- Can the program be run within existing resources or will additional funds be needed for certain parts of the program?
- Does transport need to be organised for participants?
- Do you need to use any activities, competitions or incentives to engage participants?
- How will consent be gained from participants?
- Does an information sheet or consent form need to be developed to assist with the consent process?

- Community ownership and engagement:
  - Does permission need to be gained from community representatives and leaders to run the program?
  - Have you liaised with the appropriate community representatives with regard to where and when to run the program and how to advertise it effectively?
  - Have you sought permission from community Elders prior to any program delivery? (Contact the local ACCHS for guidance on who to talk to within the community. In the absence of a local ACCHS, seek advice from other Aboriginal organisations such as the local land council.)
- Clarify the roles and responsibilities of staff and community members engaged to run the program with regard to:
  - engaging the target group
  - planning the fine detail
  - implementing the program
  - following up
  - entering data
  - evaluating the outcome
  - ensuring provision is made to keep staff and participants safe, such as the safe disposal of sharp implements and medical waste.
- Data management:
  - What information will be recorded? (e.g. the number of participants by age and gender, test results, treatment given)
  - How will information be recorded? (e.g. entered into an existing HIS or into a database or spreadsheet specifically for the program, or both)
  - Do you need to record unique identifiers to follow up abnormal test results?
  - How will confidentiality be maintained?
  - Regardless of the system used, data should be entered in a way that is easily extracted to enable evaluation.
  - Who will be responsible for data entry, extraction and analysis?
  - How will information about the program be fed back to staff and participants or community representatives?

Testing and treatment

If the aim of the outreach program is to provide testing for STIs or BBVs, planning needs to include both follow-up and management of abnormal test results. Outreach programs may aim to provide both testing and treatment at the same time, or may provide information only and links to clinical services that can provide testing and treatment.

For example, while information on STIs and BBVs is often provided to adolescents at schools, it may not always be appropriate or acceptable to staff and parents for adolescents to access testing and treatment at school. However, it may be acceptable to provide information regarding the clinical services that can be accessed for testing and treatment. If outreach programs aim to strengthen access for youth to existing services, it is important to ensure that part of that program is to work with health services and staff to ensure that the services are accessible and acceptable for adolescents and that they are offered appropriate testing and treatment for STI and BBVs when they do access the service. This may involve reorganising clinic hours, having specific clinics or staff on designated days or providing transport to improve access and ensure appropriate management.

When planning to test for STIs and BBVs through outreach programs:

- Clarify what STIs and BBVs will be tested for and what specimens will be required such as:
  - first void urine or self-obtained lower vaginal swab (SOLVS) for PCR +/- blood for BBVs
  - follow-up blood tests for BBVs for those with an STI detected (if not done initially).
- Determine how consent to testing will be obtained – on the day of testing or beforehand? Verbally or by signing a simple information and consent form?
- Ensure confidentiality and access to toilets and rooms for privacy.
- Clarify how participants will be informed of abnormal results, clarify the method for giving these results and ensure contact details are up-to-date.
- Determine how many staff members will be needed for the different stages of the program to ensure effective use of time and flow of participants (e.g. providing information, gaining consent, checking contact details and conducting testing).
- Determine whether the laboratory needs to be notified and prepared for additional specimens to process
- Know where and when follow-up and treatment will be given (e.g. will staff return to the site of testing to treat the following week or will participants be advised to access a particular health service for treatment?).
- If treatment is to be given on the day of testing:
  - will testing be conducted on the basis of an STI detected (if point of care testing is to be conducted)?
  - will presumptive treatment (before the receipt of test results) be given to all participants on the basis of high positivity rates and to avoid loss to follow-up?

- Will other tests be taken at follow-up?
- How will contact tracing be conducted?

Regardless of whether testing occurs within an established clinic or off-site, the same principles apply such as consent to testing, follow-up and management of abnormal results, contact tracing, appropriate handling, storage and transport of specimens to the laboratory, and occupational health and safety.

Case study

Pilbara PHU, Karratha.

In response to several syphilis notifications in the region, the aim was to provide education and STI testing for 14 to 25 year old Aboriginal people. Consultations were held with community Elders and other key stakeholders, including youth groups and staff from education, police and health services to discuss how best to access young men who may be marginalised from services. The Aboriginal Sexual Health Promotion Officer contacted four local football clubs to discuss providing education and STI testing for players. All clubs were keen to participate as they had a number of young Aboriginal men who attended training but who possibly weren't engaged with other organisations. Permission was given from the managers of the four clubs for the Aboriginal health worker to attend training after hours and to provide education on STIs with two 20-minute talks given over two nights. On completion of training, the players were given the opportunity to have STI screening conducted on-site and in private by two nurses.

Education was given to 45 players, with 18 STI and BBV screens conducted over two nights. One client who was identified as a contact of syphilis, also returned a positive test for gonorrhoea and was treated within seven days. Another 10 young men were identified as being at high risk of STIs.

Informal evaluation showed that while there was good attendance and encouragement to participate from both the players and coaches, participation could have been enhanced by more promotion. The consultation with community members proved valuable in reaching marginalised young men and highlights the need to be flexible in service provision.

Evaluation

Evaluating outreach programs is important to ensure that the aims were met and that the outcomes were worth the time and resources used. A CQI approach can also be used to review the measurable outcomes of outreach programs. CQI and program evaluation is discussed in more detail in Chapter 6 and resources such as the SiREN SHBBVP planning toolkit can be used as a guide. https://siren.org.au

In addition to evaluating the impact and outcomes of outreach programs, evaluating the process should involve discussions with staff from the organisations involved as well as with participants or representatives from the community. Discussions should be focused on what went well, what didn't go well or what were the gaps and how could they be improved upon for next time. Questions could include:

- Did the program run smoothly on the day?
- Was planning effective and were adequate resources allocated to run the program?
- Were staff members clear about their roles and responsibilities?
- Were participants properly informed? If not, how could community engagement be improved?
- Were participants and the community happy with the way the program was advertised and delivered?

Outreach through art: competition in Leonora