THE NATIONAL INDIGENOUS AUSTRALIANS’ SEXUAL HEALTH STRATEGY

IMPLEMENTATION PLAN FOR 2001/02 TO 2003/04

Prepared by: ANCAHRD’s Indigenous committee, the Indigenous Australians’ Sexual Health Committee (IASHC)
THE NATIONAL INDIGENOUS AUSTRALIANS’ SEXUAL HEALTH STRATEGY (NIASHS)

IMPLEMENTATION PLAN

FOR 2001/02 TO 2003/04
Sexual health means having:

- a level of personal knowledge and skills to make healthy life choices
- an ability to enjoy and control sexual behaviour based on personal and social values
- freedom from fear, shame, guilt and violation which affects self esteem and harms individuals, communities and relationships
- freedom from diseases, unplanned and unwanted pregnancy
- the freedom and right to choose positive expressions of sexuality

- with thanks to Ros Pearce and SHine SA -
FOREWORD

ANCAHRD’s Indigenous Committee has existed in its current incarnation, the Indigenous Australians’ Sexual Health Committee (IASHC), since December 1999. At the time a review was underway into the implementation of the National Indigenous Australians’ Sexual Health Strategy (NIASHS) which had been launched in March 1997.

The NIASHS is a unique document, forming an integral part of the mainstream HIV/AIDS and Hepatitis C Strategies while reflecting and remaining true to the core principles of autonomy, community control and the holistic notion of health expressed in the National Aboriginal Health Strategy. The NIASHS was developed by IASHC’s predecessor, the Indigenous Australians’ Sexual Health Working Party (IASHWP), which was established under ANCAHRD for that specific purpose. So while IASHWP’s primary role was to advise on the development of this national strategy, IASHC is responsible for advising the Minister and Department on its implementation and its evaluation. IASHC must ensure that Australia’s response to Indigenous sexual health issues under the NIASHS continues to be effective, evidence-based and sustainable.

This is the important work that IASHC has progressed under the leadership of 3 different Chairs. Initially Ms Kerry Arabena, the energetic and highly experienced inaugural IASHC Chair (12/1999 to 5/2001) who initiated IASHC’s workplan and presided over several of the Committee’s major outcomes. Mr Chris Lawrence, deputy Chair under Kerry, then bravely and most ably picked up the IASHC reigns upon Kerry’s departure. It was Chris who, as acting Chair, progressed the IASHC workplan and ensured a virtually seamless transition between Chairs. IASHC’s achievements to date; including last years highly successful workshops on STI Screening and Mapping Indigenous Risk, are a testament to Kerry and Chris’ commitment and drive. This entire exercise has been concluded under the guidance of Associate Professor Cindy Shannon who assumed the position of Chair on 1 September 2001.

This Implementation Plan is IASHC’s most recent achievement – setting out future directions for the implementation of the NIASHS. It attempts to steer planners around the obstacles and barriers to effective implementation which were identified by the Review and it looks at emerging issues such as the transmission of blood borne viruses via injecting drug use and the urgent need for appropriate health service delivery in prisons and juvenile detention centres. Readers will note the use of case-studies throughout the Implementation Plan. These are short descriptions of innovative and successful new approaches to problems, some of which are long-standing, as told by the workers on the ground who developed them. Our hope is that other workers will find the case-studies useful in their own work.

These case-studies also serve to highlight the incredible diversity that exists within and between Indigenous communities. We have learned that just because a particular approach or intervention works in one location, that is no guarantee that it will work somewhere else where priorities, attitudes and perspectives will inevitably differ. Rather than attempting to impose uniform approaches across diverse communities, we have adopted a two-pronged strategy to developing and disseminating models of good practice. In the first place, we seek to build the evidence base for sexual health interventions by identifying effective and flexible approaches that currently exist and examining the potential to
transplant such interventions to other areas. At the same time we are committed to building the capacity of communities to develop their own interventions that are appropriate to the specific circumstances of the community. These interventions might be based on those pre-existing and proven initiatives or on transferable elements of such interventions or they might be something newly developed. We believe, as do our colleagues on ANCAHRD and its committees, that the most effective response a community can make to any health issue, is a response developed and driven from within that community, and one which is based on that community’s shared understanding of the scope and nature of the issue.

It is partly because of this belief that IASHC was reluctant to make specific references within the Implementation Plan to Torres Strait Islander peoples. While we genuinely hope they find some value in the Plan, the precise nature of the Torres Strait Islands response to sexual health issues will be most effectively determined by the Torres Strait Islander peoples themselves. To this end, in 2000 the Torres Strait Sexual Health Strategy was released. We are nevertheless aware of the need for mainland agencies to work closely with Torres Strait Islanders on sexual health issues, particularly around cross border movement.

Another issue some people might find conspicuous by its absence in this Plan is any reference to the significant issue of sexual violence. Sexual violence is a complex and sensitive issue with significant and far reaching implications and consequences. While it is important that we address this issue quickly, it is equally important that we address it comprehensively, ensuring its numerous complexities are investigated and the full implications of its manifestations and consequences are explored and fully understood. We felt, quite simply, that we could not do justice to this issue in the more limited context of this Implementation Plan. On behalf of ANCAHRD and IASHC we would like to take this opportunity to acknowledge the responsibility we have to participate in community discussions around sexual violence, facilitate a better and broader understanding of the issue and make a worthwhile contribution to its solution.

To this end, and to the broader Indigenous sexual health effort, IASHC offers the most valuable resources it has at its disposal – the knowledge, experience and commitment of its members.

Finally, we would like to record our appreciation to the many people and organisations who have contributed to our work over many years and whose continuing efforts, we know, will make a difference.

Cindy Shannon
Chair, IASHC

Chris Puplick
Chair, ANCAHRD
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INTRODUCTION

(i) about this implementation plan

This Implementation Plan is designed to support people involved in the planning and implementation of health programs at all levels to effectively implement the National Indigenous Australians’ Sexual Health Strategy 1996/97 - 1998/99 (NIASHS).

The NIASHS was launched in March 1997 to promote and enhance the sexual health of all Indigenous Australians. In 1999, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) commissioned an independent review of its implementation in all jurisdictions across Australia.

The Review was conducted over approximately 12 months with the final report released in October 2000. The report makes 15 recommendations (reproduced in full in Appendix 1) regarding the future implementation of the NIASHS.

The findings of the Review were presented to the then Health Minister, Dr Wooldridge. The Minister noted that the NIASHS continued to represent the most appropriate response to Indigenous sexual health and agreed to extend the NIASHS to 2003/04, bringing it into line with the national mainstream strategies for HIV/AIDS and Hepatitis C.

As the primary advisory body to the Minister and Department of Health on HIV/AIDS, Hepatitis and related diseases, the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) is responding to the Review’s findings through its Indigenous committee, the Indigenous Australians’ Sexual Health Committee (IASHC).

IASHC believe it is appropriate to address the major issues identified by the Review by developing an Implementation Plan for the next phase of the NIASHS. The Implementation Plan attempts to guide health planners over some of the barriers and obstacles identified by the Review and lead ultimately to effective action on the ground.

IASHC see this Implementation Plan as the key to presenting future directions for the implementation of the NIASHS. It recommends processes for strengthening strategic planning under partnership arrangements at all levels, clarifies roles and responsibilities and investigates the need to broaden the evidence base for Indigenous sexual health.

It is also intended that this be a dynamic document, evolving over time to incorporate new knowledge and evidence, address emerging issues and respond to the changing needs of Indigenous Australians. In order to facilitate this process of evolution, IASHC welcome and encourage all suggestions and feedback.

IASHC emphasise that this implementation plan and its recommendations are intended to support and complement the State and Territory Partnership Forums that exist under the National Aboriginal and Torres Strait Islander Health Framework Agreements.
how to read this implementation plan

The following pages contain four chapters based on major themes identified by the Mid-Term Review and a series of Appendices.

Chapter 1 "Roles and Responsibilities" lists the various government and non-government agencies with a part to play in the implementation of the NIASHS and attempts to clarify their roles and responsibilities in respect to the NIASHS and each other.

Chapter 2 "Partnerships in Implementation" identifies key principles that underpin effective collaboration and proposes a simple set of recommendations to support shared planning processes under the partnership arrangements.

Chapter 3 "Building the Evidence Base of Good Practice" examines the need to support planning processes by building the evidence-base. It looks at clinical and social and behavioural research, monitoring and evaluation and explores related issues such as data collection and the dissemination of research findings.

Chapter 4 "Capacity Building" identifies key areas in which action is needed and explores ways to build the capacity of services and organisations to initiate action in those areas. Key areas include specialist training for the sexual health workforce and the provision of services to inmates of correctional facilities and other specific populations.

The Appendices set out related information, including the full set of recommendations of the final report of the Review of the NIASHS, IASHC’s National Priorities for the NIASHS 2001/02 to 2003/04, a restatement of the goal and objectives of the NIASHS, a glossary of terms and acronyms used in the text, a brief history of the NIASHS and several information sheets on relevant policies and structures.

To gain the most from this Plan, it should be read in conjunction with the NIASHS and with reference to the mainstream National Strategies for HIV/AIDS and Hepatitis C.

The recommendations contained in this Plan are not costed and many do not identify specific agencies or sectors to be responsible for their implementation. IASHC argues that effective responses to Indigenous sexual health and similarly complex issues requires comprehensive, community-wide action. Such action will necessarily be undertaken by a workforce from, and funded through programs of, a range of sectors, agencies and governments.

It should also be noted that many recommendations within this Plan reflect “gold standards” or “best practice”. IASHC believe it is important to identify these ideals as ultimate objectives but recognise that in many cases the capacity to achieve them is limited by lack of resources and other constraints.

The authors have attempted to identify links with related information, documents and organisations and where possible, have provided contact details and/or instructions for accessing them.
CHAPTER 1

ROLES AND RESPONSIBILITIES

The notion of "Partnership" is central to the implementation of the NIASHS, as it has been to the mainstream HIV/AIDS strategies since their inception. The partnership approach is an effective, cooperative effort between all levels of government, community organisations, medical and scientific communities and people living with or otherwise affected by sexually transmissible infections (STI), blood borne viruses (BBV) and other impediments to sexual health. The aim is to strengthen the overall effort by enhancing the capacity of each individual partner to fulfil their specific role. All partners working together to prevent the transmission and control the spread of STIs, BBVs and related diseases and to minimise their social and personal impacts.

The following chapter identifies some of the major stakeholders in Indigenous sexual health and briefly describes their role. Certain activities are core responsibilities of all stakeholders and form an important part of their role, regardless of the level and sector in which they operate. An important part of every stakeholder's role, for example, is looking for opportunities to form new partnerships and to support the activities of current partners. Other key activities include:

- facilitating recognition of sexual health as a priority;
- actively seeking opportunities to participate in Indigenous sexual health activities; and
- encouraging and supporting the participation of others in Indigenous sexual health activities.

An effective response to Indigenous sexual health cannot be sustained by the health sector alone, much less by narrowly defined program areas within the sector. The Indigenous Australians' Sexual Health Program, administered from within OATSIH, provides approximately $12 million per annum to support Indigenous sexual health services and projects across Australia. This Program alone cannot, and was never intended to, fund the effective implementation of the NIASHS across Australia.

All stakeholders therefore, and particularly funding bodies located in State and Territory and Commonwealth Government Departments, have a responsibility to examine the way they do business and identify opportunities to strengthen their contribution to the Indigenous sexual health effort. See Recommendation 4.3(e)
1.1 The Local Community Level

A wide range of local level organisations and individuals, within and outside the health sector, have an important role in the implementation of the NIASHS. These include:

Aboriginal medical services, state-funded local area health services, community members and particularly elders, Aboriginal health workers, health centre support staff, volunteers, health service managers and administrators, schools, refuges, Aboriginal hostels, community centres, relevant special interest groups and organisations that represent affected communities.

The roles and responsibilities of these organisations include:

- advocating for the interests of affected communities in decision making and policy formulation;
- developing, delivering and evaluating policies, programs and services;
- providing counselling, care and support for affected people;
- delivering sexual health primary health care services to Aboriginal and Torres Strait Islander people.

1.2 State and Territory Level

State and Territory Governments

State and Territory Governments provide leadership in the response to Indigenous sexual health at the level of their jurisdiction. State and Territory health authorities have responsibility for, and flexibility in, program delivery. Among their particular responsibilities are the following:

- making available financial, workforce and other resources to ensure an appropriate level of response to Indigenous sexual health issues in their jurisdiction;
- ensuring an appropriate level of coordination and cooperation between different areas of state government to ensure the seamless delivery of services to Indigenous clients;
- in conjunction with partners, implementing the NIASHS at the jurisdictional level;
- in conjunction with partners, establishing an Indigenous sexual health sub-committee under the State and Territory Partnership Forums;
- in conjunction with partners, developing and implementing a jurisdictional Indigenous sexual health strategy consistent with the aims and objectives of the NIASHS;
- establishing public policy and legislative frameworks consistent with the aims and objectives of the NIASHS;
investigating, analysing and monitoring the epidemiology of STI, BBV and related conditions within their jurisdiction;

providing workforce infrastructure and relevant professional development and training for workers;

ensuring effective intersectoral collaboration between State and Territory and local government agencies to ensure seamless delivery of services;

measuring and reporting on the implementation of the NIASHS within their jurisdiction.

State and Territory level Advisory Bodies and NGOs

The State and Territory Partnership Forums were formed in each jurisdiction under the Aboriginal Health Framework Agreements, and comprise:

- State governments, usually represented by their health department;
- the State NACCHO Affiliate;
- State ATSIC representation; and
- the Commonwealth, usually represented by the appropriate OATSIH State Office.

The Partnership Forums have 3 main responsibilities:

- to guide the development of regional plans;
- to inform policies and decision making in relation to mainstream and Indigenous-specific primary health care services;
- to evaluate the implementation of the Aboriginal Health Framework Agreements in their jurisdiction.

Non-government organisations such as the State AIDS and Hepatitis Councils employ workers and volunteers, often directly from affected communities, with specific and relevant skills and knowledge and make a valuable contribution to planning processes. The particular roles and responsibilities of these organisations may vary significantly, but each of them has an advocacy role on behalf of their constituency and each brings valuable resources, knowledge and experience to the planning table.

The NACCHO Affiliate in each state and territory represent the Aboriginal community controlled health services and their workforce at jurisdictional level.

The Inter-Governmental Committee on AIDS, Hepatitis C and Related Diseases (IGCAHRD) provides advice on implementation strategies for State/Territory offices, assists in the coordination of policies and processes between state jurisdictions, disseminates models of good practice and promotes relevant issues and priorities within State and Territory health departments. IGCAHRD also supports the work of Aboriginal Medical Services and grant in aid communities and provides public health advice to assist regional planning.
1.3 The National Level

The Commonwealth Government

The Commonwealth has a leadership role in Indigenous health, and the Department of Health and Ageing continues to be the principal Commonwealth agency responsible for coordinating the national response to Indigenous sexual health. The Office for Aboriginal and Torres Strait Islander Health (OATSIH) within the Department of Health and Ageing has primary carriage of the NIASHS. The Department has specific responsibility for:

- enabling, developing and coordinating national policy;
- administering funding for the Aboriginal community controlled health sector;
- in conjunction with IASHC and other partners, monitoring the implementation of the NIASHS and evaluating its effectiveness;
- commissioning research, health promotion and policy initiatives on a national basis;
- commissioning innovative pilot projects that have national relevance;
- addressing international cross-border issues;
- providing secretariat and policy support for national advisory committees.

A number of areas within the Department have a role in the Indigenous sexual health effort in accordance with the NIASHS. These include the Population Health Division (PHD) with carriage of the national mainstream HIV/AIDS and Hepatitis C Strategies; the Health Access and Financing Division responsible for administering the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Scheme (MBS) and the NHMRC to commission appropriate research and develop relevant guidelines.

There are also a range of Commonwealth departments and statutory bodies outside the health sector with an important role in Indigenous sexual health. Included are the Department of Family and Children’s Services, the Attorney Generals Office, the Department of Education, Science and Training and the Aboriginal and Torres Strait Islander Commission (ATSIC).

National level Non-Government Organisations and Advisory Bodies

The National Aboriginal and Torres Strait Islander Health Council provides advice to the Minister 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) is the peak body providing national representation for the Aboriginal community-controlled health sector. Its primary responsibilities include:
• representing the Aboriginal community-controlled health sector at the national level;
• policy development for Indigenous primary health care services;
• workforce issues;
• national level planning and negotiation.

The Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) was originally established to provide independent and expert advice to the Minister and the Department on the development and implementation of the first National HIV/AIDS Strategy. That role has now been expanded to include the provision of advice on related communicable diseases such as HCV and STI. ANCAHRD’s role includes:

• identifying needs, objectives and priorities for research, education and service provision for HIV/AIDS and related communicable diseases;
• increasing community understanding and knowledge of HIV/AIDS and related communicable diseases;
• developing and maintaining an optimal mix of specific and integrated services;
• maintaining the integrity of Australia’s approach to HIV/AIDS and related communicable diseases in the face of competing demands for resources.

The Indigenous Australians’ Sexual Health Committee (IASHC) was established as the Indigenous committee of ANCAHRD to provide advice to the Minister and the Department on Indigenous sexual health issues. Its primary role was initially to oversee the development of the NIASHS. IASHC’s role has evolved to include:

• the implementation of the NIASHS;
• monitoring and evaluation of the NIASHS;
• the identification of Indigenous needs, objectives and priorities for research, education and service provision for sexual health; and
• reporting to ANCAHRD on the above.
The following diagram charts the broad framework of stakeholders in Indigenous sexual health. It is not intended to be a complete picture, but rather provides a general understanding of relationships.

**Relationship Tree diagram**
The following diagram provides a basic framework of how funding for sexual health related activity travels from source to service. Again this may not be the case in each jurisdiction.

**Funding Tree diagram**

"...effective responses to Indigenous sexual health cannot be sustained through the health sector alone, much less by a narrowly defined Program area within that sector. All stakeholders have a responsibility to...identify opportunities to strengthen their contribution to the Indigenous sexual health effort."

**IASHC 2001**
CHAPTER 1 RECOMMENDATIONS

1.1 Local-level organisations

(a) That local organisations continue to explore ways and means for strengthening and increasing lines of communication with their clients. In developing such lines of communication, organisations should recognise that some clients of sexual health services, for example gay, lesbian, transgender and sistergirl clients, may have experienced dislocation and felt disempowered in their previous interaction with health services. The aims of these lines of communication should include:

- ensuring clients have access to planners and planning processes and can feed priorities and ideas onto the organisational agenda; and

- ensuring clients have access to all relevant information so they can understand the processes and policies behind organisations decisions and actions.

(b) That local organisations continue to explore opportunities to develop partnerships with key agencies and institutions in their vicinity. For example, organisations located near correctional institutions could form partnerships with those institutions, enabling the provision of cultural sensitivity and cross-cultural awareness training for prison officers and prison health workers and culturally appropriate health care services to prisoners.

Northern Indigenous Sexual Health Workers Reference Group (NISHWRG)

NISHWRG sits at the centre of North Queensland’s implementation of the NIASHS.

Since 1997, through recognition of the pivotal role that health workers play in the improvement of Indigenous sexual health, through their ability to inform the development of regional initiatives designed to increase the capacity of health workers in remote communities, this group progressed from feeling marginalised, undervalued and underutilised, to feeling valued, essential and empowered.

They are now central to the process of developing policy and resources in Indigenous sexual health in the state.

Through coming together as a group to accomplish defined tasks, change has occurred on the following levels:

- **Structural**: the reference group has created an interface between top-down policy and planning on the one hand, and bottom-up comprehensive program development on the other.

- **Workplace**: a shift in workplace culture has seen health workers recognised as experts in their field who can be looked to for advice. A stronger emphasis on clinical aspects of their role in emerging.

- **Personal**: health workers perceive themselves and their role as professionals very differently now. Once isolated individuals now identify strongly with a recognised and acknowledged group that has a voice.

www.apunipima.org.au
1.2 State and Territory level organisations

(a) That each state and territory jurisdiction establish sexual health committees as described in Chapter 2.2

(b) That state and territory health departments develop mechanisms to facilitate better intra-departmental communication and collaboration between areas responsible for Indigenous health and areas responsible for sexual health.

(c) That the State and Territory Partnership Forums or sexual health sub-committees identify a small number of simple process indicators to accumulate information around the implementation of the NIASHS in each jurisdiction. This information should take the form of a simple qualitative description of the implementation process and then reported to IASHC yearly for inclusion in IASHC’s annual report to ANCAHRD.

IASHC expect such information would allow them to report to ANCAHRD on:

- which organisations participated in planning, decision-making and funds allocation processes in each jurisdiction;
- the presence and effectiveness of collaboration between each level of activity;
- the number and quality of partnerships formed;
- the level of funding and the source of those funds allocated to implement the NIASHS; and
- the reasoning and rationale behind resource allocations and other decisions.

(d) That the State and Territory Partnership Forums and sexual health sub-committees ensure resource allocations at jurisdictional level are:

- Evidence-based;
- Based on needs identified and agreed;
- Consistent with the NIASHS.

(e) That the State and Territory Partnership Forums develop mechanisms that enable members of their sexual health sub-committees to communicate with their counterparts on the sub-committees established in other jurisdictions.
Queensland Indigenous Sexual Health Strategy:  
Queensland Health, in conjunction with the Queensland Aboriginal and Islander Health Forum, have developed a Queensland Indigenous Sexual Health Strategy incorporating blood borne viruses for 2002 to 2005.

The Queensland strategy aims to implement the National Indigenous Australians’ Sexual Health Strategy in a Queensland context through:

- Reduction in the incidence and prevalence of sexually transmissible infections and blood borne viruses in the Queensland Indigenous population.
- Reduction in the incidence and prevalence of sexually transmissible infection related morbidity and mortality and risk factors for disease progression in the Queensland Indigenous population.


1.3 National level organisations

(a) That the Commonwealth explore existing reporting requirements for Indigenous health to identify opportunities to strengthen and expand the body of performance information around the implementation of the NIASHS.

(b) That the Commonwealth Department of Health and Ageing develop mechanisms to facilitate improved communication and collaboration between its Central and State and Territory Offices and between different areas within Central Office.

(c) That IASHC use its ex-officio membership to directly and appropriately engage key national stakeholders – NACCHO, ATSIC and relevant NGOs such as National Research Centres – in the national response to Indigenous sexual health. Such engagement would include, but is not limited to, the following actions:

- raising awareness within their constituency of Indigenous sexual health as a priority;
- defining their role within the context of the national response to Indigenous sexual health;
- identifying mechanisms to strengthen and expand their role; and
- actively seeking opportunities to form new partnerships, participate in different aspects and address new issues with regard to Indigenous sexual health.
CHAPTER 2

PARTNERSHIPS IN IMPLEMENTATION

Chapter 1 noted the central role that partnerships play at all levels in the implementation of the NIASHS. The Review confirmed that the NIASHS is implemented most effectively where good partnership relationships exist and where they are actively fostered.

IASHC note that this remains true at all levels of activity, from national policy development to the State and Territory Partnership forums and the regional planning processes and to community-driven activities at the grass-roots level. Strong partnerships based on effective communication, mutual respect and shared commitment inevitably lead to improved outcomes.

IASHC recognises that the strongest and most effective partnerships are often those partnerships that develop informally through shared priorities, mutual respect and the efforts of talented and motivated individuals. IASHC also notes the existence of barriers at all levels to the formation of effective partnerships. These barriers often stem from communication problems which may lead, for example, to a failure to agree on the definition of a partnership or on the principles and processes upon which a partnership should be based or on the roles and responsibilities of each partner.

IASHC believes that embedding core principles within formally constituted mechanisms such as the State and Territory Partnership Forums or sexual health sub-committees will strengthen the potential of those partnerships. Achieving agreement on the principles and processes that underpin partnerships will facilitate open communication and reduce the capacity for misunderstandings to occur. Ultimately it establishes a framework for partnerships that can maintain effective collaboration through difficult times of organisational restructures and key staff turnover.

In section 2.1 IASHC has used the findings of the Review and the results of its own consultations to identify a set of general principles that it believes support effective collaborative partnerships. A shared commitment to these principles amongst planning partners is the starting point for creating the preconditions required for the successful collaborative implementation of the NIASHS.

In section 2.2 IASHC suggests a process for establishing a sexual health sub-committee under the Partnership Forums. IASHC believes that the critical planning processes taking place at this level can be supported by such formally constituted mechanisms.
2.1 Principles that underpin effective partnership processes

(a) Indigenous ownership of Indigenous health
- ensure responses to Indigenous sexual health are responses in which Indigenous people participate and over which Indigenous people are able to exert control;
- ensure Aboriginal community-controlled health sector participation in the identification of priorities, planning and decision-making at all levels; and
- ensure partnerships are characterised by a shared recognition, acceptance and understanding of the Aboriginal community controlled health sector.

(b) recognising and respecting the value of the differing perspectives, knowledge and experience of partners
- ensure partnerships are characterised by a shared understanding and appreciation of the value of the unique knowledge, experience, skills and expertise that each partner brings to the table; and
- ensure that the existence and impact of power dynamics within partnerships are recognised in the development stages and that processes designed to guide the functioning of partnerships can redress imbalances that may arise from unequal distribution of power.

(c) transparency of decision-making
- ensure all planning decisions and the evidence, the reasoning and the processes that lead to them are recorded and disseminated;
- ensure transparent funding arrangements so all parties can make meaningful plans knowing what program funds are available;
- ensure an agreed planning process is in place prior to engagement and ensure that process is easily understood and widely disseminated; and
- promote mechanisms that allow members of the partnership to register their concern with the planning process or outcomes.

(d) localised identification of priorities and development of partnerships
- identify individuals, groups and organisations with which to form partnerships – for example gay and transgender groups, domestic violence and rape crisis services, drug and alcohol services, IDU representative organisations, Corrections Institutions, prison health areas in State/Territory Governments, local schools as well as parent and teacher associations and other community groups.
(e) evidence-based decision making

- ensure the use of interventions and initiatives that have the best chance of success;
- acknowledge the experience of affected community members and their valuable role as a repository of evidence to support and guide planning; and
- ensure that resource allocation and other planning decisions are explicit and, to the extent that evidence allows, based on need. Agreed parameters could include the burden of disease, level of risk for disease, demographics and resource distribution.

(f) agreed and meaningful evaluation

- ensure partners define evaluation broadly to include its role in accumulating information to build the evidence base and guide planning decisions;
- ensure evaluation requirements are not out of proportion to the benefits of the information provided by the evaluation;
- ensure evaluation leads to the accumulation of ‘meaningful’ information; and
- ensure the development of performance indicators and monitoring mechanisms that are consistent with the principles expressed above.

(g) robust representation

- ensure sub-committees are representative;
- consider a quorum to ensure a minimum 50% Indigenous membership and attendance might be considered along with other mechanisms to facilitate representative decision-making in Indigenous sexual health; and
- ensure partnerships and the individuals involved in them are sufficiently robust to maintain rational and effective approaches in the face of highly sensitive issues and controversial people and ideas.
CASE STUDY:

WORKING IN PARTNERSHIP TO IMPROVE ACCESS TO SEXUAL HEALTH SERVICES

In 1994 a successful partnership was formed on the South Coast of NSW, between Aboriginal & non-Aboriginal health workers from government & community controlled organisations, and from sexual health & generalist backgrounds.

Workers and managers from Katungul AMS in Narooma; Aboriginal Health Education officers and Health Managers from local Community Health Centres; and the Area Sexual Health Team, then based in Goulburn, held a planning day to pool their knowledge and look at how best to provide sexual health services to the Aboriginal communities on the South Coast of NSW.

At the planning meeting it was agreed that training was needed for all involved, before any clinical or educational work was done within the communities. A six-week program was conducted where the skills and knowledge of the workers involved were shared amongst participants. The non-Aboriginal health workers received training on local Aboriginal cultural issues, and the Aboriginal health workers received training on sexual health.

At the end of the Program, they formed a steering committee that met at regular intervals to develop training resources and strategies to implement sexual health services. The Steering Committee would identify and discuss ideas which would be taken back to the local communities by the Aboriginal Health Workers for further discussion with community members. Now shaped to fit the particular circumstances of the local community, the ideas return once again to the Committee for fine-tuning and ultimately implementation.

Over the past 7 years this successful partnership has provided community education and screening services and developed education and training resources that have been disseminated and successfully used right across NSW.

The following have been the main ingredients for a successful partnership from our experiences on the South Coast:

- Involving a number of individuals and organisations from varied backgrounds. This broadens the available expertise, knowledge and resources to share.
- Respect for each other, and acknowledging that each member of the group has expertise, and something to offer.
- Constantly meeting and planning to ensure all aspects of a planned program have been thought through and agreed upon before providing a service.
- Constantly evaluating all services and seeking to improve them.
- Working together with a shared purpose - providing better access to health for the community.
- Sharing an understanding that it takes time for programs to earn the respect and trust of the community.
- And of course, having fun together, and developing strong bonds and working as a team.
2.2 IASHC suggestions for establishing a sexual health sub-committee under State and Territory Partnership Forums

1. form an Indigenous sexual health sub-committee
   - ensure representation reflects the diversity of communities, individuals, issues, and geography that constitute the sub-committee's area of responsibility;
   - ensure the sub-committee is auspiced by the appropriate State Partnership Forum and reflects that Forum's membership, including individuals with experience and/or expertise in Indigenous sexual health, service delivery, public health program planning and research etc;
   - agree on terms of reference to define the scope of the sub-committee's role and responsibilities;
   - agree to a strategic long-term approach while acting to address immediate priorities;
   - develop, sign and disseminate a document that clearly describes the principles, processes and mechanisms that will guide the operations of the sub-committee; and
   - consider the use of a 'deed of confidentiality' to establish and agree to rules governing the use of information provided at the planning table.

2. identify the scope of the issues
   - use available information to provide a 'snapshot' of the current status of Indigenous sexual health in the appropriate area;
   - identify unfulfilled data/information needs as well as a means of meeting those needs in the future to update the 'snapshot'; and
   - develop mechanisms to ensure appropriate policy makers and service providers have access to this 'snapshot' and the data/information it is based upon.

3. identify and reach agreement on the sources and level of resources available
   - ensure that detailed information about the level of resources available from all sources, and any conditions that may be attached to these resources, are available to the sub-committee to guide their planning and funding decisions.
4. identify priorities
   - the sub-committee should identify its Indigenous sexual health priorities on the basis of available data and evidence as well as the level and type of resources that are available.

5. identify effective programs and projects to address priority areas
   - planners should attempt to locate proven, evidence-based programs and projects that have previously achieved successful outcomes under comparable conditions.

6. develop a reporting framework
   - use the ‘snapshot’ referred to in recommendation 2 of this section as a baseline;
   - identify specific objectives that reflect the desired outcomes;
   - develop indicators to measure progress towards desired outcomes from the baseline; and
   - develop reporting mechanisms to ensure performance information is fed back to planners.

7. facilitate and support capacity building to enable collaborative partnership approaches at regional and grass-roots levels
   - seeding grants are a very useful mechanism for supporting demonstration and pilot programs with jurisdictional or national significance; and
   - special project grants can support and guide attempts to engage partners and reach priority populations, such as IDUs, and inmates of prisons and remand centres.
CASE STUDY:

NORTHERN TERRITORY INDIGENOUS SEXUAL HEALTH ADVISORY COMMITTEE

In the Northern Territory an Indigenous Sexual Health Advisory Committee was established as a subcommittee of the Northern Territory Partnership Forum. The Committee is administered by OATSIIH’s NT Office and comprises 4 full members: the Commonwealth Department of Health and Aged Care (OATSIIH); NT Department of Health and Community Services (AIDS/STI Program); the local NACCHO Affiliate (AMSANT); and ATSIC. There are also 2 ex-officio members: the NT AIDS Council and the Aboriginal Research and development Corporation. The Committee’s role is guided by 6 terms of reference:

1. Develop a comprehensive strategic plan aimed at preventing the spread of sexually transmitted infections, HIV/AIDS and Hepatitis C in Indigenous people of the Northern Territory; ensure equitable access to systems of care and support that will promote health and maintain quality of life for Indigenous people of the Northern Territory living with HIV/AIDS; and ensure provision of and support for appropriately trained health workers and educators in the sexual health field.

2. On the basis of the agreed Northern Territory strategic plan, develop joint funding proposals with a strong regional focus that address the critical aspects of access to prevention, diagnosis and treatment.

3. Provide an advisory role in relation to applications for funding under the NIASHS, including, identifying selection criteria and providing expertise in relation to medical, public health and primary health care.

4. Identify priority areas, and advise strategic approaches for the Northern Territory in:
   4.1 Prevention
      - Quality primary health care
      - Education strategies for reducing risk and changing behaviour
      - Harm reduction
   4.2 Treatment, Care and Support
   4.3 Workforce Issues
      - core competencies in sexual health for Aboriginal Health Workers
   4.4 Partnerships
      - building strong partnerships across sectors

5. Oversee the implementation of the Northern Territory strategic plan, including its evaluation and review.

6. Represent and advocate for organisations providing services under the NIASHS.
CHAPTER 3.

BUILDING AN EVIDENCE BASE FOR GOOD PRACTICE

The Review highlighted that the evidence base to support planners at all levels to implement effective sexual health activities is incomplete. IASHC agrees with this finding and identifies several fields and issues in this chapter it considers priorities. IASHC also notes the existence of valuable information that is not adequately recognised as part of the evidence base. IASHC believes it is appropriate to expand the conventional definition of ‘evidence’ to legitimise and incorporate the knowledge and experience of individuals and organisations working at the grass roots. Such evidence includes the results of in-house monitoring and evaluations and well documented observations over a period of time. In many cases, this evidence collected at the community level can identify immediate priorities and provide a basis for action. IASHC also emphasises the continuing need for evidence accumulated through conventional, scientifically rigorous research, such as randomised control trials.

The following chapter explores three streams of activity that together contribute to the evidence base that informs decision-making in Indigenous sexual health: monitoring, research and evaluation. IASHC emphasise the importance of ensuring such activity is consistent with principles of community control and Indigenous self-determination. Wherever possible and appropriate, the Aboriginal community controlled health sector and other Indigenous agencies should be supported to carry out their own evaluations and initiate their own research.

3.1 Monitoring

Monitoring is the tracking of programs and epidemiological evidence to enable better and more responsive planning and service delivery. Planners will have access to a variety of information sources including epidemiological data, internal service statistics, results of population-based screening programs and, particularly in the case of community level planners, the evidence accumulated through the long-term experience, knowledge and observations of its members.

3.2 Research

The IASHC work-plan articulates a research framework and identifies priority areas for research. The framework aims to build the evidence base in both the clinical and the social and behavioural areas, and is underpinned by appropriate data collection systems. In accepting the broader definition of the evidence base, IASHC also aims to foster qualitative research including ethnographic grounded theory and related social research fields.
IASHC recognises that developing ‘research partnerships’ with Indigenous Australians and their representative organisations is fundamental to research in this area. Such research partnerships require the direct participation of Indigenous Australians in all aspects of the research process. This includes identifying the need for research, planning, carrying out and evaluating research, addressing the ethical aspects of research and disseminating the results of research.

IASHC endorses a variety of approaches to identify research needs and use research activity to improve the evidence base. These approaches include forums, workshops and commissioned research. For example:

- the Regional Approaches to STI Management workshop held at the Australasian College of Sexual Health Physicians Annual Conference May 2001;
- the Mapping Indigenous Risk - How research can assist strategies on the ground workshop held in Sydney in 2001;
- the La Trobe Review of social and behavioural interventions in Indigenous sexual health and related fields;
- the Donovanosis Review "Donovanosis: control or eradication? A situation review of donovanosis in Aboriginal and Torres Islander populations in Australia";
- clearing houses such as Edith Cowan University’s Health info Net www.healthinfonet.ecu.edu.au; and
- professional journals and forums such as the Aboriginal Health Worker Journal and Aboriginal health worker conferences.

3.3 Reporting and Evaluation

The Review notes that developing a strategic approach to a monitoring and evaluation framework for the NIASHS is a particularly complex task. It cites the following reasons for this complexity:

- the diversity of the NIASHS, in terms of the activities it supports and the levels and settings in which they are carried out;
- the dearth of reliable epidemiological data;
- the reluctance of services to use valuable time and resources for data collection and reporting; and
- the shared responsibility between the Commonwealth, the state and territory governments and NGOs for implementing the NIASHS.

IASHC acknowledge these findings of the Review and propose a three pronged approach to evaluating the NIASHS. This approach includes ongoing reporting requirements at the individual project and service level, composite reporting requirements at the national level and periodic reviews of discrete components of the NIASHS as they are required.
IASHC suggests that stakeholders may need to reframe their understanding of evaluation, to more heavily emphasise its value as a planning tool and a means to build up the evidence base for Indigenous sexual health.

IASHC members have compiled a list of principles they believe form the basis for a more realistic and effective approach to evaluation.

**Evaluation:**

- should be a planning tool;
- should be as simple and non-intrusive as possible;
- should focus on measurements – processes, outcomes, outputs etc. – that are directly meaningful to the activity being evaluated;
- should contribute to the broader evidence base; and
- should facilitate Indigenous ownership.
CHAPTER 3: RECOMMENDATIONS

3.1 Monitoring

(a) That IASHC work with all stakeholders to:

- agree to a set of guiding principles to guide the collection, storage and dissemination of information;
- identify information needs to support effective planning processes for Indigenous sexual health; and
- clarify related issues such as Indigenous identification, privacy, confidentiality and ownership of information.

(b) That Communicable Disease Control Centres and, in jurisdictions without CDCCs, the appropriate government areas at State and Territory level, report regularly to State Partnership Forums or sexual health sub-committees on notifiable disease data pertaining to sexual health and the regional public health response to endemic/hyperendemic disease transmission.

(c) That primary health care services develop and regularly review health information management systems for client follow-up and the delivery of preventive health care services.

(d) That State and Territory Partnership Forums or sexual health sub-committees hold regular forums with direct care workers to discuss issues and share ideas around monitoring and data collection.

(e) That IASHC investigate the value of information-sharing mechanisms for primary health care services to facilitate contact tracing and follow-up services. IASHC’s investigation should closely examine associated issues such as privacy, confidentiality and ownership.
case study - Monitoring

PATIENT INFORMATION AND RECALL SYSTEMS IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY CONTROLLED HEALTH SERVICES

- Patient Information and Recall Systems (PIRS) use both demographic and clinical information from all clients who come in contact with a health service to determine individual life-long health care plans. These care plans have an emphasis upon regular screening, surveillance and other illness prevention activities and can prompt health workers when such interventions may be due.

- As well as assisting the organisation of health care delivery at an individual level, information systems maintain a database of each health service’s client population. This allows each health service to better monitor discrete population health programs as well as the overall performance of the service.

- Since January 1999, 73 health services in metropolitan, regional and remote areas have implemented a system. This represents over 60% of all community controlled health services considered likely to benefit from these systems.

- The Kimberley Aboriginal Medical Services Council, operating in the remote north-west of Western Australia, have over ten years of experience with using computerised recall systems. They have found that the systems relieve some of the organisational burden of coordinating illness prevention activities and have allowed Aboriginal health workers to play a more central role in managing these programs.

- Evidence is also emerging that the systems can considerably improve preventative health care coverage across communities. For example, East Kimberley AMS has been able to sustain cervical cancer screening rates of 65-80% amongst Aboriginal women in the Kununurra region for over a decade. This is equivalent to, or better than, national rates achieved by mainstream health services.
3.2 Research

(a) That IASHC work with NACCHO and other stakeholders to support Indigenous sexual health research that:
   • is consistent with principles of Indigenous ownership and self-determination; and
   • is consistent with guiding principles referred to in recommendation 3.1 (a).

(b) That IASHC develop an action plan based on the Report of the Mapping Indigenous Risk workshop held in July 2001. See case study below

(c) That IASHC explore opportunities for increasing the number of, and strengthening the training and support of, Indigenous researchers in diverse disciplines.

(d) That IASHC lobby the NHMRC and other research institutions and funding bodies to encourage more and better targeted research in the area of Indigenous sexual health.

(e) That IASHC work with the NHMRC and other research institutions to identify and develop a mechanism that, when required, will facilitate timely and appropriate research into emerging Indigenous sexual health issues.

(f) That IASHC work with NACCHO, OATSIH, health information clearing houses and research institutions to identify and develop a mechanism to collate, assess and broadly disseminate research findings.

The Mapping Indigenous Risk Workshop

The Mapping Indigenous Risk Workshop was held in response to three of the priorities established in the current Indigenous Australians’ Sexual Health Committee (IASHC) Research Work plan.

The committee established three goals for the workshop:

1. To summarise what is already known about Indigenous sexual and injecting risk;
2. To identify and define appropriate strategic research priorities in social and behavioural research related to reducing the impact of STI (including HIV and other blood borne viruses) in Indigenous Australians; and
3. To identify existing processes or propose new processes that foster broad-based collaboration between the three sectors involved in this research – the community, research and enabling (policy and funding decisions) sectors.

These goals are realised through three outcomes from the workshop:

1. A pre-workshop report which assesses what we know and what we are currently investigating to inform the discussion;
2. A workshop summary report which identifies gaps in what we know and priorities our research needs; and

3. A set of recommendations which outline strategies for moving forward cooperatively.

If there is an answer to the question “How can research support strategies on the ground?” the work done by participants at this historic workshop goes some way towards answering it. Their contributions, particularly in relation to the processes that research partnerships should use, and approaches that researchers and communities can make to develop up research proposals, were extraordinarily rich and deeply creative.

In the simplest terms, the workshop’s answer was that researchers should work in partnership with AMSs and other Indigenous groups to identify the information needed to design services and programs that will get funded, and meet needs. Researchers need to re-focus their work around proposals that will get results for people living in, and delivering services to, communities. One of the most productive things about the workshop was the possibility for new friendships that can grow into working relationships. These relationships will form the basis of research partnerships with community groups that can work towards resolving some of the issues raised at the workshop.

The list of research concepts and approaches developed in the final session of the workshop represent a fertile agenda for ongoing discussions with Indigenous communities, at National and local level, to explore questions of sexual and injecting risk. However the participants stressed many times that it was not possible to develop a set of uniform National priorities for research, and that the only National priority that could be set was the imperative that research be developed in ways that ensure that local communities own any research done. The workshop also produced suggested revisions for the Background Paper, a set of papers delivered by the speakers which will be published in a report, along with all the issues raised in the group process.

3.3 Reporting and Evaluation

(a) That IASHC work with the State and Territory Partnership Forums or sexual health committees to develop indicators for reporting on the implementation of the NIASHS (see section 8.1.1 of the NIASHS). Reporting requirements should enable IASHC to include the information below in their annual report to ANCAHRD.

- The existence of a jurisdictional Indigenous sexual health committee or equivalent structure.
- Indigenous representation on that sub-committee.
- The existence of a jurisdictional Indigenous sexual health strategy.
- The size and skill-level of the jurisdictional Indigenous sexual health workforce.
- The existence of specific Programs for ensuring effective service provision to specific population groups in the jurisdiction.
• The degree and effectiveness of collaboration between organisations, levels and sectors (the number and quality of partnerships) within the jurisdiction.

• The degree to which resource allocation, program design/delivery and workforce capacity reflect jurisdictional needs as evidenced by burden of suffering and demographic data and risk priorities in that jurisdiction.

(b) That each State and Territory Partnership Forum or sexual health sub-committee work with the Aboriginal community controlled health sector and other relevant groups to identify simple, sustainable, non-intrusive reporting requirements for funded Services and organisations to contribute to the evidence base and add value to planning decisions.

(c) That individual Services and organisations be supported to carry out simple evaluations to assess their services, strengthen their planning and help guide them toward their short and long term aims and objectives.

(d) That IASHC, in partnership with the Aboriginal community controlled health sector and other appropriate bodies, develop an evaluation strategy for an end-of-term evaluation of the NIASHS.

case study - evaluation

VACCHO & La Trobe University: Evaluation of the Well Person’s Health Check

Background: This paper presents a process evaluation of the Well Person’s Health Check (WPHC), a health assessment program for Indigenous Australians, delivered by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) in association with 8 Koori community organisations in rural Victoria and the Melbourne Sexual Health Centre. The WPHC provides a range of health checks and information, including lifestyle assessment, body measurement and blood pressure, sexual health assessment, eye and diabetes tests. It was developed to reduce the shame associated with sexual health risk assessment and screening by packaging it within a general health assessment.

Method: 671 participants in the WPHC from eight rural communities completed a 10 question feedback form in 2000-1, examining how they found out about the WPHC, why they participated, problems they experienced with any tests, what new information they gained, what new tests they had, their demographic information, and suggestions for improvements.

Results: Key findings of the evaluation were personal contact and encouragement were the most important ways that Kooris found out about the WPHC, and a key reason for participating; many participants had not had a BMI, PCR for gonorrhoea/chlamydia or a blood test for HIV before; many participants had not had access to good information about transmission risks for HIV and Hep C prior to the WPHC; and that sexual health screenings were highly acceptable to these communities as part of a general health check.

Conclusions: For many rural populations, the delivery of sexual health screening services is inhibited by issues of confidentiality and embarrassment. Embedding sexual health screens within general health screens means that people can participate without shame, and encourage friends and family members to participate. The program provided important prevalence information, and allowed for treatment of STDs, risk assessment and patient education to an unprecedented number of participants.
CHAPTER 4

CAPACITY BUILDING

capacity  "the abilities, skills, understandings, values, relationships, behaviours, motivations, resources and conditions that enable an individual or organisation to carry out its functions and achieve its objectives."

The NIASHS Review identified several key areas within Indigenous sexual health requiring concerted effort. The Review reported that the sensitive nature of sexual health can, at times, make it difficult for communities to recognise the existence and significance of emerging sexual health issues. This prevents health planners and service providers from generating an effective response to those issues within the community.

IASHC emphasise the importance of building the capacity of communities to respond to, and effectively address complex and highly sensitive sexual health issues. In the first instance, this means finding ways to raise awareness within communities of sexual health issues to ensure they are recognised as priorities. One suggested approach involves using key community members, perhaps elders, to break down barriers and engage the broader community in discussion on sexual health issues. An approach adopted by course facilitators and trainers at Shine SA involves reframing sexual health in a positive context that emphasises the positive values and attributes associated with good sexual health.

The Review also identified the need to build the capacity of Indigenous communities to address workforce and sexual violence issues, and to respond to the needs of specific population groups. IASHC identified similar priorities, emphasising the need for workforce development and improved service delivery to Indigenous prison inmates and their families and to other specific population groups.

Based on related national strategies and the findings of the Review, IASHC has identified the need to build capacity to address workforce issues, service delivery to people in prisons and service delivery to other sub-groups.

4.1 Workforce

A strong primary health care workforce is seen as a prerequisite for effective action in Indigenous sexual health. Recruiting and retaining such a workforce requires emphasis on the development of appropriate knowledge, skills and confidence through the delivery of accredited training in this field.

The Review identified the need for ongoing support and professional development for workers already trained in sexual health. It noted the value that many workers, particularly those operating in remote areas, placed on regional and state level workshops and conferences. Such forums help reduce the sense of isolation experienced by some workers and exposed them to the ideas and achievements of their colleagues.
A National Review of Aboriginal and Torres Strait Islander Health Worker Training is currently under-way with the results expected to inform future activity in this area. In addition, the National Strategic Framework for the Aboriginal and Torres Strait Islander Health Workforce which seeks to transform the workforce to provide the best possible health system response has recently been released for comment.

IASHC believes that specific issues must be resolved as a precondition for strengthening the Indigenous sexual health workforce. These issues include:

- the possible need for national accreditation of training and the adoption of national competency standards; and
- the possible need for offering incentives to ensure the recruitment and retention of a well trained and effective workforce.

IASHC notes the variations in circumstances, issues and priorities across Australia and recognises that each jurisdiction’s approach to workforce development will vary, defined by its own particular needs. Initiatives to strengthen the sexual health workforce should be considered in the context of jurisdictional and national approaches and the broader Indigenous health workforce.

4.2 Service provision in Adult and Juvenile Correctional Settings

The over-representation of Indigenous Australians in the prison system combined with exposure to common prison practices such as tattooing and injecting drug use make prisons places of high risk.

The Review reported on innovative services in some states and territories delivering sexual health services to Indigenous inmates of correctional institutions. IASHC notes that these services are being delivered through the Aboriginal community controlled health sector, non-government organisations and government health services. However, it is also noted that such innovative activities tend to be sporadic, are often poorly resourced and are primarily driven by the initiative of individuals and isolated services.

IASHC also notes the existence of significant barriers to effective service delivery in prisons. These include legislative and policy differences between jurisdictions and between the health and corrections sectors and the practical difficulties associated with servicing a large population with a high turnover of individuals.

IASHC suggests that coordinated action is required at a number of levels to enable the delivery of effective sexual health services within prisons. At the national level, the Commonwealth must work collaboratively with state and territory governments, the Aboriginal community controlled health sector and other partners to identify and promulgate effective models of care as well as agendas for research and action.
State and territory governments are responsible for the operation of prisons and the provision of health care to prisoners. In particular, they are required to make available sufficient human and financial resources to ensure an appropriate and effective response to the health needs of prisoners. In addition, state and territory governments must implement relevant policy and legislation and coordinate the activities of different government departments and non-government agencies to ensure a strategic and seamless approach to the delivery of health services in prisons across their jurisdiction.

The Aboriginal community-controlled health sector is well placed to provide the range of health services required by Indigenous people in prisons. Aboriginal community controlled health services (ACCHS) seek to provide ‘comprehensive primary health care’ comprising a range of preventative, promotive, curative and rehabilitative services. ACCHS adopt a ‘holistic’ approach to this work, ensuring health services are planned and delivered within the broader context of the social and cultural needs of the community and its individual members. In the case of prisons, ACCHS have a central role in coordinating a range of service providers to deliver appropriate and sustainable health services to Indigenous inmates and their families.

4.3 Service provision to other specific populations

The Review noted the views of some stakeholders that some sub-groups, particularly the more marginalised and less visible groups, were not receiving adequate services, particularly prevention services, under the NIASHS. The Review also reported health workers who believed communities were sometimes reluctant to acknowledge injecting drug use and homosexual activity.

IASHC acknowledges the existence of sensitivity around some issues and believe action is required to build the capacity of communities and services to deal effectively with these difficult and complex areas. IASHC have identified the following areas requiring such action:

- injecting drug use;
- drugs and alcohol;
- Lesbian, Gay and Transgender/Sistergirl people;
- commercial sex work; and
- youth, particularly those in detention and those disaffected with services.
CHAPTER 4 RECOMMENDATIONS

4.1 Workforce

(a) That the changing role of sexual health workers be acknowledged and that their roles be clearly defined in line with the Comprehensive Model of Primary Health Care, to include prevention, early detection and clinical management activities.

(b) That Indigenous sexual health workers be trained and accredited for appropriate outreach practice.

(c) That all jurisdictions develop strategies to increase the number of grass-roots workers (including Aboriginal health workers with skills in sexual health). Each State and Territory Partnership Forum or their sexual health sub-committee should consider developing a sexual health workforce recruitment and retention strategy as an integral component of a jurisdictional health workforce recruitment and retention strategy.

(d) That professional support structures for sexual health workers be developed and implemented, including but not limited to:

- mentor systems to support new workers;
- worker exchange programs that allow workers to move between different project and program areas and with different issues and organisations to broaden their experience, develop contacts and increase their understanding of other organisations;
- worker networks to encourage the sharing of information and reduce workers’ sense of isolation (see case study on page 10 for one such example); and
- structures that support the development and dissemination of models of culturally appropriate practice.

(e) That Aboriginal health worker organisations work with other professional organisations and educators to develop an agreed curriculum and appropriate modes of delivery for education and training courses for Indigenous sexual health.

(f) That Aboriginal health worker organisations and other professional organisations work together to develop core competencies and accreditation standards for Indigenous sexual health. (The NSW Health Core Competency Standards for Sexual Health Workers is a good example).

(g) That funding bodies note the negative impact of 12 month funding cycles on effective workforce recruitment and retention in Indigenous sexual health and explore options, including multiple year funding commitments, for increasing the security of funded sexual health worker positions.
SHine SA

Aboriginal and Torres Strait Islander Health Worker courses in Sexual Health

SHine SA conducts separate Sexual Health Care courses for Aboriginal men and women who work in a range of human service areas. The courses aim to provide Aboriginal men and women workers with the knowledge, skills, and confidence to improve sexual health within their own communities. The courses are nationally accredited and due to demand, have been expanded to accept community development workers, and workers from Victoria and Western Australia.

Topics covered by both courses include:

- Sexuality
- Values clarification
- Legal aspects of sexual health care practice
- The structure and function of the reproductive systems
- Methods of contraception
- Unplanned pregnancy choices
- Safer sex practices
- HIV/AIDS
- Sexually transmissible infections
- Infertility
- Rape and sexual assault

The Mens' course also covers:

- Traditional men's health
- Common conditions of the male

The Womens' course also covers:

- Prevention of cancer of the cervix
- Prevention of breast cancer
- Common conditions of the female reproductive system
- Traditional women's health
- Menstruation
- Menopause

www.shinesa.org.au
email: SHineSAcourses@dhs.sa.gov.au
4.2 Adult and Juvenile Correctional Settings

(a) That state and territory governments and private corrections companies ensure appropriate induction, training and ongoing support be provided to all health and corrections employees working with Aboriginal and Torres Strait Islander clients in custodial settings. Such training should cover specific sexual health issues.

(b) That correctional health services, in partnership with Aboriginal community controlled health services and other health services, review health delivery, including the delivery of sexual health services such as screening for STI and BBV and the ‘Well Persons Health Check’ to Aboriginal prisoners.

(c) That correctional health services establish partnerships with Aboriginal community controlled health services and other appropriate Health Services to ensure culturally appropriate primary health care delivery.

Case study – Service delivery in Custodial Settings

A proposed model of practice between Greater Murray Area Health Service, Sexual Health Services, and Nursing Staff Juvenile Justice Centres

There are many models of best practice varying from organisation to organisation. The following describes the model of practice currently in operation at Juvenile Justice Centre, Wagga. This model involves a partnership between Aboriginal Sexual Health CNC Greater Murray Area Health Service and clinic nurses employed at Juvenile Justice Centre.

When considering service provision the following questions must be considered:

- Why are we providing this service?
  (To improve the sexual health and well being of our youth and to detect undiagnosed sexually transmissible infections).
- Who are we providing the service for?
  (Is it for our own job preservation or is it for the health and well being of our youth, regardless if they have committed an offence?).
- When are we providing the service?
  (Weekly, fortnightly, monthly, 2 hours 4 hours - whatever works)

Provision of a sexual health service within Juvenile Justice Centres allows us the following;

1. Gives residents informed knowledge about sexually transmissible infections, how they develop and how to avoid catching them
2. Gives residents access to appropriate care and treatments;
3. Improve the sexual health and well being of our young residents: both Aboriginal & non-Aboriginal.
4. Facilitates safe sex;
5. Clarifies the connections between physical and/or sexual abuse and the emotional consequences;
6. Allows residents to establish supportive links within the community upon release;
7. Increases residents familiarity with health services and reduces their reluctance to access them.

Sexual health services delivered to residents of the Juvenile Justice Centres include:

1. Information on sexually transmissible infections (STIs) and blood borne viruses (BBV) including:
   - Description of the STIs and BBV
   - Transmission routes and factors
   - Expected outcomes following treatment
2. Physical examination, screening and assessment for STIs and BBV
3. Treatment and care/referral to specialist services where necessary
4. Contact tracing where notifiable STIs are diagnosed
5. Health promotion and harm minimisation information and strategies

The following guiding principles will help inform practice:

1. The program being offered must be agreed upon between staff in both Area Health and Juvenile Justice Services this unofficial partnership is to be respected at all times. A recognition of expertise (sexual health nurses) and the nurses are allowed to practice according to standards as determined by their speciality bodies and at the same time acknowledging the protocols of JJC services
2. Establish communication channels with Juvenile Justice staff (and keep them open) conveying all changes that may occur eg. introduction of new staff.
3. Maintain regular clinic days and hours where possible.
4. Shared care model of service provision includes the JJC staff in the clinic operation and consultations.
5. Explore ways in consultation with JJC nursing staff and residents to build support and trust.
6. An awareness of the politics between services is helpful - try very hard not to become involved, as this will affect service delivery.
4.3 Other population groups

(a) That, based on local and regional need, specialised programs be developed to support specific populations, for example young people, prisoners, injecting drug users and gay, lesbian and transgender people.

(b) That health services and other stakeholders work with locally based individuals and organisations to develop pro-active and innovative strategies for identifying and responding to the needs of specific groups.

(c) That individuals and organisations with a role in representing and advocating for groups form partnerships with health services and other relevant agencies to develop community plans to increase awareness and understanding of, and commitment to addressing, the specific needs of groups.

(d) That State and Territory Partnership Forums or sexual health sub-committees consider allocating a proportion of available resources to fund demonstration projects to trial new and innovative approaches in Indigenous sexual health.

(e) That ANCAHRD seek the endorsement of the Australian Health Ministers’ Advisory Council (AHMAC) for an audit of relevant public and private sector organisations to explore their current role in Indigenous sexual health and identify opportunities for expanding that role. Such an audit should include, but should not be limited to, mainstream health and related programs at all levels of government and non-government organisations funded to provide health and related services. Such an audit should pay particular regard to adult prison health services and juvenile support programs.
Appendix 1.

Recommendations of the final report of the Mid-Term Review of the NIASHS

1. The partnership members in each State and Territory should review the effectiveness of partnership arrangements to date in relation to implementation of the NIASHS, and identify measures that will lead to improved collaboration and more effective strategic planning. The Commonwealth should consider what practical steps might be taken to provide assistance in States and Territories where partnership arrangements have to date been relatively weak.

2. In States and Territories where there is not a clear identification of Indigenous sexual health priorities or a strategic framework to guide allocation of resources, State and Territory Forums should consider laying down appropriate guidelines. Forums which have not yet established a sexual health committee representing the various partners may wish to consider doing this.

3. For the foreseeable future Commonwealth funds should continue to be earmarked or ‘quarantined’ for use specifically in relation to Indigenous sexual health. Where there is clear evidence of effective collaboration and strategic planning by partnership members, consideration should be given to the commitment of some NIASHS funding for periods longer than one year.

4. OATSIH should review the implications for its State and Territory Offices and staff of significant changes which include the increasingly central role of the State or Territory partnerships. OATSIH should consider how it can most effectively communicate with and support State/Territory Offices to ensure that they can carry out their responsibilities in relation to NIASHS with maximum effectiveness.

5. Arrangements which involve OATSIH State or Territory Offices playing a primary role in consultation and decision making relating to implementation of the NIASHS should be seen as a short term expedient only.

6. The Indigenous Australians’ Sexual Health Committee (IASHC) should ensure that an updated communication document on the implementation of the National Strategy is prepared and disseminated, dealing with the roles and responsibilities of the key players, addressing other issues that may have caused confusion in the past, and providing a clear point of reference for the future.

7. OATSIH should undertake discussions with State and Territory health departments to minimise uncertainties relating to the level of State/Territory funding for Indigenous sexual health independent of the NIASHS and should work with the States and Territories to develop an agreed basis for reporting expenditures in this area.

8. IASHC and OATSIH should give priority to developing improved arrangements for monitoring progress and measuring performance, including the development of an evaluation framework as described under Term of Reference 6.
9. The IASHC should give priority attention to evaluation issues associated with the National Strategy. In particular:

- The IASHC should request each State and Territory partnership to draft a concise set of objectives for NIASHS in its own jurisdiction. To assist in this process and to promote compatibility among the objectives set in the various jurisdictions, IASHC should draft a set of objectives at national level.

- On behalf of the IASHC, OATSIH should identify sets of data which are potentially useful in the evaluation of the NIASHS.

- Each State/Territory partnership should be asked to consider:
  (i) principal roles and responsibilities in service delivery;
  (ii) the availability of relevant data and steps that may be required to improve the availability of data;
  (iii) appropriate evaluation procedures;
  (iv) performance indicators that will assist in assessing the value and effectiveness of NIASHS-funded projects and initiatives over time.

- To assist the partnerships in this process, IASHC and OATSIH should cooperate to develop a simple set of generic evaluation ‘modules’, which would offer some guidance on key issues or questions to be addressed for various broad types of initiative.

- OATSIH should develop proposals for a series of regional case studies on the implementation of NIASHS, as one valuable element of evaluation overall. Between them, the regions selected for this purpose should clearly reflect both the various jurisdictions and the diversity of situations within which the NIASHS is being implemented.

- The Commonwealth should convene a national workshop or a series of State/Territory/regional workshops on the issue of evaluation - possibly as part of a set of workshops or conferences designed to re-energise the Strategy generally.

- Evaluation should be considered at three levels - project-specific; State/Territory, and national.

10. The IASHC should consider developing information packages for planners, health service providers and communities on key issues relating to implementation of the NIASHS - for example, clear data on risks and problems associated with poor sexual health, information on successful experience in various locations in raising community awareness of sexual health issues, illustrations of effective approaches to early diagnosis and treatment in urban, rural and remote contexts, and other good practice in diverse settings.
11. The IASHC should consider specific ways of increasing the availability of sexual health and related services to Indigenous people in prison - including attention to the issue of funding for services to prisoners. It should also consider how future implementation of the NIASHS can most effectively support other groups of Indigenous people (for example injecting drug users, sex workers and men who have sex with men) who may be at particular risk of STI/HIV infection.

12. That IASHC’s specific role in relation to ongoing implementation of the NIASHS should be clarified through consultation between itself, ANCAHRD and OATSIH, and any appropriate resources allocated to enable it to carry out that role.

13. OATSIH should establish a process to bring together representatives of State and Territory Aboriginal and Torres Strait Islander Health Forums to discuss NIASHS implementation issues and the need for on-going collaboration among Forums in this context.

14. OATSIH should co-ordinate a process designed to clarify the roles of the various national committees and mechanisms which have an interest in Aboriginal and Torres Strait Islander sexual health, and to build closer links among these.

15. As part of the next stage of the NIASHS implementation process, a national forum or conference should be held to discuss key issues and to generate renewed interest in and support for the Strategy. State/Territory or regional workshops to promote strategic planning in relation to the NIASHS should also be held. Among other things, regional forums should consider issues such as professional isolation among Indigenous sexual health workers, and specific local issues or problems with which partners to the implementation of NIASHS may need assistance.
Appendix 2.

A Restatement of the Goal and Objectives of the NIASHS

IASHC has identified a single, ultimate goal of the NIASHS, which is to:

- raise the sexual health status of all Indigenous Australians

In addition, IASHC has used the Key Action Areas of the NIASHS to identify the following set of basic objectives.

Prevention

- To increase knowledge and understanding of sexual health issues in Aboriginal and Torres Strait Islander communities thereby reducing risk behaviour and increasing adherence to treatment and advice
- To reduce risk behaviour by providing Aboriginal and Torres Strait Islander communities with access to clean hardware (condoms/IV equipment/ceremonial equipment)

Treatment, Care and Support

- To improve the quality and access of sexual health clinical care and support services to Aboriginal and Torres Strait Islander Australians by facilitating the development and dissemination of evidence-based clinical care procedures.
- To increase the capacity of clinical care services to effectively diagnose, treat and support Aboriginal and Torres Strait Islander Australians living with BBV and STI.

Workforce Issues

- To improve the knowledge and skills of Aboriginal Health Workers in the areas of sexual health prevention, treatment, care and support
- To increase the numbers of Aboriginal Health Workers with knowledge and skills in the areas of sexual health prevention, treatment, care and support.

Research and Data

- To address Indigenous sexual health issues in a more strategic, effective and appropriate manner by increasing the relevant knowledge base and identifying and filling significant gaps in knowledge
- To improve planning and decision-making processes in the area of Indigenous sexual health through the collection, analysis and appropriate dissemination of more accurate and more meaningful data.
Appendix 3.

National Priorities 2001/02 to 2003/04

2001/02 marks the beginning of a new phase for the NIASHS. In 1999 ANCAHRD re-convened its Indigenous Committee, IASHC, to advise the Minister and Department on matters relating to the strategy's implementation and evaluation. When the review of the Strategy’s implementation was completed early in 2000, the Minister extended the strategy to 2003/4 and IASHC began developing the NIASHS Implementation Plan in response to the Review's findings. In 2001 IASHC initiated the "Mapping Indigenous Risk" Workshop to identify issues, needs and priorities for research in Indigenous sexual health.

The following priorities, together with the need for mechanisms to support jurisdictional reporting on them, have been identified by IASHC for action in the next three years.

- Progress towards all funding from all sources being tabled prior to joint planning processes.
- Progress towards jurisdiction-wide strategic planning for Indigenous sexual health.
- Progress towards jurisdiction-based sexual health planning committees to advise the Partnership Forum in each jurisdiction.
- Progress towards regional-based sexual health planning committees to advise the Partnership Forum in each jurisdiction.
- Progress towards strategic and jurisdictional approaches to workforce development.
- Progress towards the objectives of the Donovanosis Eradication Project (in participating jurisdictions - NT, QLD and WA).
- Accumulation of an evidence base, including performance information and models of good practice to support sexual health workers engaged in Indigenous sexual health service provision.
- Accumulation of an evidence base, including performance information and models of good practice to address the needs of Indigenous Gay and Transgender people.
- Accumulation of an evidence base, including performance information and models of good practice to address the needs of Indigenous injecting drug users.
- Accumulation of an evidence base, including performance information and models of good practice to support the development of effective sexual health services for Indigenous inmates of Corrections Institutions.
Appendix 4:

History and Origins of the NIASHS

(a) the origins of the NIASHS

While Australia’s timely, bi-partisan response to HIV/AIDS is rightly held up as a model of good practice, there was concern about the potential for HIV to have a particularly severe impact on Aboriginal and Torres Strait Islander communities. The best available figures for the early to mid 1990s suggested that while the total number of Indigenous people living with HIV was small, there were indications that the rate of infection was increasing, in contrast with non-Indigenous rates which were remaining stable or even declining. There was also evidence of a different pattern of transmission in Indigenous communities with a higher proportion of heterosexually acquired cases and a higher proportion occurring in women than in the non-Indigenous community. In addition, there were higher rates of STIs in the Indigenous population, particularly in rural and remote parts of Australia and research originally undertaken in Africa and since repeated elsewhere was showing the presence of STIs to be a significant co-factor in the transmission of HIV.

Two later studies also helped shape Australia’s response to HIV/AIDS in the Indigenous population. The first was undertaken by Grosskurth et al in Tanzania between 1991 and 1994 and was a natural progression from the African research that demonstrated the role of STIs in the transmission of HIV. This study, reported in The Lancet in 1995, demonstrated that strategies focusing on reducing STIs also dramatically reduced HIV transmission. The second study, undertaken by Dr Frank Bowden and Dr Christopher Fairley in the Northern Territory, strongly suggested that the high rates of STI in remote Indigenous communities was due to lack their of access to basic primary health care services.

The growing concern about the sexual health of Indigenous people prompted the then Australian National Council of AIDS (ANCA, now the Australian National Council of AIDS, Hepatitis C and Related Diseases, ANCAHRD) to convene an Indigenous Forum on Sexual Health in Alice Springs in May 1995. The key result of this Forum was the establishment of the ANCA Working Party on Indigenous Australians Sexual Health with the mandate to develop a strategic plan to promote and maintain the sexual health of all Indigenous Australians.

The culmination of the Working Party’s efforts was the National Indigenous Australians’ Sexual Health Strategy 1996-97 to 1998-99 (NIASHS), launched by the Minister for Health in March 1997 to complement the 3rd National HIV/AIDS Strategy. The NIASHS provides a comprehensive approach to preventing the spread of HIV and other sexually transmissible infections (STIs) in Aboriginal and Torres Strait Islander communities. It recommends action in four priority areas: prevention; treatment, care and support; workforce issues; and research and data collection. Further, it aims to strengthen the capacity of the primary health care sector, particularly the community-controlled primary health care structure, to respond to Indigenous sexual health and build partnerships with the mainstream health sector.
On the basis of accumulated evidence and a national consultation process, the Working Party concluded that an effective response to HIV/AIDS in Indigenous communities required a comprehensive approach to sexual health generally, incorporating a range of strategies delivered within an expanded and strengthened primary health care framework.

(b) the implementation of the NIASHS

Within the NIASHS the Working Party had outlined a broad set of principles to guide its implementation. These principles reflected both the partnership approach successfully adopted by the mainstream HIV/AIDS movement and the wider policy and structural reform process that was taking place in Indigenous health and that had its origins in the National Aboriginal Health Strategy (NAHS 1989).

The NAHS had identified the need for fundamental reform within the health system to effectively address the health status of Indigenous Australians. Fundamental to these reforms was the shift from a traditional disease-specific, 'top down' approach to a more holistic, horizontal, community-driven approach. The NAHS argued that appropriate and relevant responses to Indigenous health issues required much stronger Indigenous participation in planning and decision-making than existed at the time.

The development of the Aboriginal and Torres Strait Islander Health Framework Agreements between 1995 and 1999 further facilitated this reform. The Framework Agreements established a structure that encouraged a coordinated and collaborative approach between levels of government and Indigenous organisations and increased the capacity of the Aboriginal community controlled primary health care sector to participate in and control planning processes.

The Framework Agreements involve the Commonwealth, State and Territory Governments, the ATSIC and NACCHO. At the national level, the Framework Agreements provided for the establishment of the National Aboriginal and Torres Strait Islander Health Council to advise the Commonwealth Health Minister on Indigenous health issues. Under the Framework Agreements at the State and Territory level, partnership forums comprising representatives of each of the national signatories were established in each state jurisdiction to facilitate regional planning and to contribute to policy and planning processes around Indigenous health.

It was through these State/Territory Partnership Forums that the Working Party intended the NIASHS would be implemented. This arrangement was expected to facilitate the greater involvement of the Aboriginal community controlled health sector in decision-making and strategic planning in sexual health and to ensure that cross-sector linkages were embedded within the NIASHS implementation processes.

Ultimately, the partnership arrangements were expected to result in a comprehensive and Aboriginal community sector-based response to Indigenous sexual health that complimented and incorporated activity taking place within mainstream public health programs and non-government programs at all levels.
Appendix 5:

**ANCAHRD Structure Chart**

1999-2002 STRUCTURE FOR THE AUSTRALIAN NATIONAL COUNCIL FOR AIDS, HEPATITIS C & RELATED DISEASES (ANCAHRD)

![ANCAHRD Structure Chart Diagram]
Appendix 6:

Primary Health Care Access Program

The Primary Health Care Access Program (PHCAP) was announced in the 1999-2000 Budget, with funding of $78.8 million of four years to be implemented in areas where joint regional planning had been completed and the four former Aboriginal Coordinated Care Trial sites. The 2001-02 Budget announced an additional $19.7 million each year from 2003-04, taking the total recurrent base for the program to $54.8 million per annum. Some funding from this provision will be available in each States/Territory once joint regional planning is complete.

PHCAP has three objectives:

1. Increase the availability of appropriate primary health care services where they are currently inadequate;

2. Reform the local health system to better meet the needs of Indigenous people; and

3. Empowering individuals and communities to take greater responsibility for their own health.

The available funding will allow the program to be implemented in some local areas selected on the basis of need and capacity to utilise funds effectively to deliver the mix of services. The joint regional planning process provides the basis for considering the selection of these areas.

PHCAP will establish a framework for the expansion of comprehensive primary health care services, including clinical care, illness prevention and early intervention activities and management and support systems, in a planned and coordinated manner in line with regional planning.

PHCAP is a way in which the Commonwealth is contributing additional funds to start meeting the health needs identified in regional plans and provides a mechanism through which States/Territories and the Commonwealth can work together in a coordinated manner to meet their individual responsibilities for health service delivery and funding. PHCAP provides a mechanism to improving local health systems which include both mainstream and Indigenous-specific health services. Additional funding comes from both mainstream and specific funding sources.
Financial Framework

The Commonwealth has joint responsibility with State and Territory Governments for the provision of primary health care services. The Commonwealth has established a benchmark for the Commonwealth contribution to comprehensive primary health care, which it will work towards achieving over time. The benchmark will vary between regions to reflect the higher costs of service delivery in remote areas and the mix of funds within the benchmark will vary with the capacity to utilise Medicare.

The benchmark in remote areas, where the cost of service delivery is higher, will be up to four times the average use of MBS, while in other areas the benchmark will be up to two times the average use of MBS.

The Commonwealth benchmark will include existing funding for primary health care type services (such as base funding for AMSs) and increased use of the MBS system. PHCAP attempts to fill the gap between existing funding and use of MBS.

Funding to the approved sites will be stepped up over time in line with capacity to utilise the funds and the availability of funds.

Planning Framework

PHCAP will utilise Strategic and Business Planning framework in its implementation. Local areas selected for funding will be required to broadly map out needs and gaps in existing services across the whole local health system. At this level it is expected that fund holding and service delivery models for the whole local area will be developed.

Community involvement in the planning process is critical. It is expected that PHCAP planning would build on existing regional and local health plans.

Each service provider will be required to develop a strategic plan outlining how they will utilise initial funding, including, in some detail the expanded health services, service delivery model, community participation in determining needs, linkages with mainstream and other service providers and infrastructure required to deliver services.

On an annual basis, each service provider will develop a Business Plan outlining how they will deliver services in an operational context. This will include identifying means of measuring performance of their services against agreed targets.
Appendix 7:

List of Contributors

**IASHC Members & Proxys: (1999 to 2002)**

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WA Department of Health: Sandra Thompson, Heath Greville.
Appendix 8:

Glossary

Acquired immunodeficiency syndrome (AIDS)
A syndrome defined by the development of serious opportunistic infections, neoplasms or other life-threatening manifestations resulting from progressive HIV-induced immunosuppression.

AIDS councils
Community-based organisations established to provide education, support and care for people infected with HIV or at risk of infection.

Australian Federation of AIDS Organisations (AFAO)
The peak organisation representing State and Territory AIDS councils, the National Association of People with HIV/AIDS, the Australian Intravenous League and the Scarlet Alliance.

Australian Intravenous League
The national organisation representing educational and support groups for injecting drug users.

Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD)
The Commonwealth Government’s key advisory body on HIV/AIDS & Hepatitis C established to provide independent and expert advice to the Minister for Health on the implementation of the National HIV/AIDS & Hepatitis C Strategies. It is principally concerned with the identification of national needs, objectives and priorities and takes a public information role on matters associated with HIV/AIDS & Hepatitis C and related diseases. Parent committee to IASHC.

Australasian Society for HIV Medicine
A society of doctors, scientists and health care workers involved with HIV/AIDS.
Clinical trial
A research activity that is designed to test a drug or treatment to establish efficacy and safety and to identify groups of patients who can be expected to benefit from such drug or treatment.

Communicable disease
An illness caused by a specific infectious agent or its toxic products and that arises through transmission of that agent or its products from an infected person, animal or other reservoir to a susceptible host.

Community care
Care provided in the community as opposed to within an institutional setting. The care may be delivered by professional or volunteer carers, or both, and is often provided in the patient’s home.

Communicable Disease Control Centre
These are also known as Communicable Disease Units, in different states and territories health departments. Responsible for the control of communicable diseases in a specific jurisdiction.

Community development
An approach to working with the community that aims not only to actively involve the community in dealing with the problem at hand but also to increase the capacity of the community to deal with any future problems that arise.

Culturally appropriate
A term used to describe activities and programs that take into account the practices and beliefs of a particular social group, so that the programs and activities are acceptable, accessible, persuasive and meaningful.

Discrimination, HIV/AIDS-related
Any unfavourable treatment on the basis of known or imputed HIV status; any action or inaction that results in a person being denied full or partial access to otherwise generally available services or opportunities because of known or imputed HIV status. The definition includes discrimination on the grounds of known or imputed membership of certain groups most commonly associated with HIV and AIDS.
Early intervention

An approach to treatment characterised by action in the early stages of a condition; for example, treatment designed to delay the onset of AIDS in an HIV-positive patient.

Epidemiology

The study of the distribution and determinants of health-related states or events in specified populations and the application of this study to the control of health problems.

Gay man

A homosexually active man who identifies himself as gay or is attached to the gay community, or both. Individuals can alter both their self-definition and the level of their community attachment over time. Education and prevention programs typically distinguish between gay men and other homosexually active men.

Health hardware

Applies to the things that are necessary for people to adopt risk reduction behaviours, such as condoms. This concept was developed by Nganampa Health Council as part of their environmental and public health review within the Anangu Pitjantjatjara lands—Uwankara Palyanyku Kanyintjaku.

Health maintenance

Refers to an approach to HIV/AIDS that specifically promotes the benefits of testing for evidence of HIV infection and the subsequent continuing management and monitoring of an HIV-positive person’s health with the intention of delaying the onset of AIDS and reducing the severity of AIDS-related illnesses.

High-risk behaviour

see Risk practice.

Homosexually active man

A man who engages in male-to-male sexual behaviour, regardless of whether he identifies himself as gay, heterosexual or bisexual.
Hospital funding grants
Grants provided by the Commonwealth to the States and Territories under the Medicare Agreements to assist in the financing of hospitals.

Human immunodeficiency virus (HIV)
A human retrovirus that leads to AIDS.

Incidence
The number of new cases of a disease in a defined population, within a specified period.

Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases
Provides a forum for regular Commonwealth, State and Territory liaison and coordination on policy, finance, programs and activities related to HIV/AIDS. Membership comprises an independent chairperson nominated by the Australian Health Ministers Advisory Council, two representatives of each of the Commonwealth, State and Territory departments responsible for health, and one representative of each the departments responsible for health in Papua New Guinea and New Zealand. It is now called the Commonwealth–State–Territory Government Forum.

National Association of People Living with HIV/AIDS
The peak national organisation representing people who are HIV positive.

Needle and syringe exchange programs
Authorised programs that freely distribute, dispose of or sell needles and syringes.

Opportunistic infection
Infection with an organism or organisms that are normally innocuous but that become pathogenic when the body's immune system is compromised, as happens in AIDS.

The partnership
The close working arrangement between Commonwealth, State and Territory and local governments, the affected communities, and the medical, scientific and health care professions that has characterised Australia's approach to the HIV/AIDS.
Peer education

Any education process devised and implemented by members of a population subgroup specifically to alter the behaviours and attitudes of other members of that subgroup; for example, gay men delivering gay education programs.

Prevalence rate

The total number of all individuals who have an attribute or disease at a particular time or period divided by the population risks of having the attribute or disease at this time or midway through the period.

Risk practice

Any behaviour, sexual or otherwise, that is capable of transmitting STIs including HIV and Hep C.

Safe sex, safe sexual practice

Sexual activity in which there is no exchange of body fluids such as semen, vaginal fluids or blood.

Seroconversion

The development of a detectable level of antibodies that occurs after a person has been exposed to and become infected by a micro-organism, such as HIV.

Sex worker groups

Community-based organisations representing people who work in the sex industry.

Surveillance

The continuing scrutiny of all aspects of occurrence and spread of a disease. Its main purpose is to detect changes in trends or distribution in order to initiate investigative or control measures.

User groups

Community-based organisations representing the interests of injecting drug users.
Appendix 9:

Abbreviations

ACCHS - Aboriginal Community Controlled Health Services
AFAO - Australian Federation of AIDS Organisations
AGPS - Australian Government Publishing Service
AHMAC – Australian Health Ministers’ Advisory Council
AHMRC – Australian Health and Medical Research Council
AIDS - Acquired Immuno-deficiency Syndrome
AMS - Aboriginal Medical Service
AMSA NT - Aboriginal Medical Service Alliance in the Northern Territory
ANCA - Australian National Council on AIDS (now ANCAHRD)
ANCARD - Australian National Council on AIDS and Related Diseases (now ANCAHRD)
ANCAHRD - Australian National Council on AIDS, Hepatitis C and Related Diseases
ARING - Antimicrobial Resistance in Neisseria Gonorrhoea
ASHM - Australasian Society for HIV Medicine
ATSIC – Aboriginal and Torres Strait Islander Commission
AusAID - Australian Agency for International Development
BBV – Blood-Borne Virus
BMI - Body Mass Index
CARG - Commonwealth AIDS Research Grants
CCHO - Community Controlled Health Organisation
CDCC - Communicable Disease Control Centre
DoHA - Department of Health and Ageing
HCV - Hepatitis C Virus
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
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<td>IASHC</td>
<td>Indigenous Australians’ Sexual Health Committee (under ANCAHRD)</td>
</tr>
<tr>
<td>IASHWP</td>
<td>Indigenous Australians’ Sexual Health Working Party (under ANCARD)</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
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<td>IGCA</td>
<td>Inter-governmental Committee on AIDS (now IGCAHRD)</td>
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<td>IGCAHRD</td>
<td>Inter-governmental Committee on AIDS, Hepatitis C and Related Diseases</td>
</tr>
<tr>
<td>HAHU</td>
<td>Heads of Aboriginal Health Units (now SCATSIH)</td>
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<tr>
<td>JJC</td>
<td>Juvenile Justice Centre</td>
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<tr>
<td>MBS</td>
<td>Medicare Benefits Scheme</td>
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<tr>
<td>MSM</td>
<td>Men Who Have Sex With Men</td>
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<tr>
<td>NACCHO</td>
<td>The National Aboriginal Community Controlled Health Organisation</td>
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<td>NAHS</td>
<td>National Aboriginal Health Strategy</td>
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<td>NAPWA</td>
<td>National Association of People Living with HIV/AIDS</td>
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<td>NCHECR</td>
<td>National Centre in HIV Epidemiology and Clinical Research</td>
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<td>Non-government Organisation</td>
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<td>National Health and Medical Research Council</td>
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<td>NIASHS</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<td>OATSIH</td>
<td>Office for Aboriginal and Torres Strait Islander Health</td>
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<td>Polymerase Chain Reaction</td>
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<td>Primary Health Care Access Program</td>
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PHD - Population Health Division – DoHA
PIRS - Patient Information and Recall Systems
PLWHA - People Living With HIV/AIDS
QAIHF - Queensland Aboriginal and Islander Health Forum
SCATSIH - Standing Committee on Aboriginal and Torres Strait Islander Health
SFP - Special Funding Program
SHINE SA – Sexual Health Information Networking and Education, South Australia
STD - Sexually Transmitted Disease (more universally known as STI)
STI – Sexually Transmissible Infection
TB – Tuberculosis
VACCHO – Victorian Aboriginal Community Controlled Health Organisation
WHO - World Health Organisation
WPHC – Well Persons Health Check