

# BLOOD BORNE INFECTIONS PROJECT

Aboriginal Health and Medical  
Research Council (AH&MRC) in  
association with Mandala  
Consulting



*Aboriginal Health & Medical Research Council*

*of New South Wales*

# OVERVIEW

- Background to the project
- Overall Project Plan
- Context
- Assessment of Risk
- Overall Findings
- Factors Influencing Access
- Building an Evidence Base
- Future Directions & Recommendations

# PROJECT GOAL

- To enhance accessibility and availability of appropriate services including education, prevention and treatment services for Aboriginal people who are at risk of or have contracted blood borne infections particularly HBV, HCV and HIV.

# PARTNERSHIP

- **Funding**
  - OATSIH (Department of Health & Ageing)
- **Project Collaboration**
  - AH&MRC and Mandala Consulting

# UNDERLYING PRINCIPLES OF BBI PROJECT

- Confidentiality
- Clarity and transparency
- Cultural awareness and sensitivity
- AH&MRC Ethics Committee approval

# KEY LINKING POLICY DOCUMENTS

- **National**

- National Indigenous Australians Sexual Health Strategy & Implementation Plan 1996-97 to 2003-04
- National HIV/AIDS Strategy 1999-00/2003-04

- **NSW**

- NSW Hepatitis C Strategy 2000-03 & Care & Treatment Services Plan 2001-03
- NSW HIV/AIDS Statement of Strategic Directions 2002-03
- NSW HIV/AIDS 2001-03 Health Promotion Plan

# OVERALL PROJECT PLAN

- Four Stages

1. Planning (Ref Group, Fact Finder, Lit Review)

2. Consultations (Statewide, ACCHSs and AHSs, >500 stakeholders)

3. Analysis

4. Final Report

# WHERE ARE WE UP TO?

Draft Report Completed

Endorsed by Board of Directors - AH&MRC

Currently with the AH&MRC Ethics  
Committee

# FINAL REPORT

- A number of strategic recommendations
- This project will inform the *"NSW Sexual Health Implementation Plan for Aboriginal and Torres Strait Islander People"*
- Potential for report to be linked with other key policy initiatives & groups at both national and state level

# ASSESSMENT OF RISK

## Why Address BBIs

General

Custodial

Cultural

# ASSESSMENT OF RISK

## Why Address BBIs?

- **General**
  - Existing work has addressed STIs and some HIV
  - Low levels of knowledge surrounding risks
  - Politically sensitive area of health & clear picture has been slow to emerge ( particularly in an Aboriginal context)
  - Availability of drugs & opportunistic behaviours
  - Young people & access to services
  - Economic social and cultural costs in the future for not addressing BBIs now.
  - Ensure that treatment is an option for those already with BBIs.

# ASSESSMENT OF RISK

## Custodial

-Indigenous Australians are 10 times more likely to be incarcerated than non-Indigenous Australians.

- 18% male
- 27% female
- 19% overall
  
- Prisoners are at greater risk of contracting HCV. In 2001, 9% of all HCV notifications in NSW were from inmates in correctional facilities

# ASSESSMENT OF RISK

- Custodial
  - Disproportionate incarceration rates
  - Shorter stays /Recidivism
  - Aboriginal inmates do not access health services as readily as non-Aboriginal inmates (CHS).
  - Aboriginal inmates may be exposed to IDU in prison and JJ settings
  - Aboriginal inmates may be exposed to HCV within prison.
  - Potential to return to communities with IDU practice and possibly HCV.

# CONTEXT

## Custodial

- In 1999, 32% of youth in NSW JJ Centres were Indigenous
- In 2003, numbers of Indigenous youth in JJ Centres accounted for:
  - 40% (boys)
  - 90% (girls)
- Indigenous juveniles are 19 times more likely to be detained (June 2002)

# ASSESSMENT OF RISK

## Cultural

- Social disadvantage greater
- Young population compared to Non Aboriginal population 47% vs 32% <25 (marginalised, disempowered)

- Cultural sharing (indoors and outdoors)

Aboriginal people are more likely than non-Aboriginal people to report re-use of someone else's syringe and equipment (27% vs. 14%) (ANCD 2003)

Higher STI rates- greater chance of transmission of HBV and HIV

# ASSESSMENT OF RISK

## Cultural

- Tattooing and body piercing (prisons & community settings)
- Violence
- ↑ in number of IDUs in all communities and at younger ages
- Sharing at home/community- household items
- Mobility

# ASSESSMENT OF RISK

- Aboriginal and Torres Strait Islander IDUs may also experience discrimination and stigma from within their own communities that may inhibit access to services and support for hepatitis C (Commonwealth Department of Health and Aged Care 2000:49).

# CONTEXT

Population

Epidemiology

HIV/AIDS

Hepatitis C

Hepatitis B

# CONTEXT

## Aboriginal Population

- 2.05% of the NSW population is Aboriginal & Torres Strait Islander (135 319)
- NSW has the largest Aboriginal & Torres Strait Islander population of any State or Territory in Australia (29%)
- Rural and remote population in NSW ~40% of total Aboriginal population
- Young population (47% <25 compared with 32%)

# CONTEXT

## Epidemiology

- HIV/AIDS

-High rates of STIs and lack of access to effective services place Aboriginal people at particular risk of HIV infection

-A sharp increase in newly diagnosed HIV among Aboriginal people (even though numbers are small)  
(2003 Annual Surveillance Report - NCHERC)

# CONTEXT

## Epidemiology

- **HIV/AIDS** (cont'd)

**Nationally major differences between Indigenous & non-indigenous people diagnosed with HIV/AIDS over past 10 years**

- higher proportion of cases attributed to heterosexual contact
- higher proportion occurring among women
- higher proportion of cases attributed to IVDU
- higher proportion diagnosed at a younger age
- A slower rate of decline in AIDS compared with non-Aboriginal people

# CONTEXT

## Epidemiology

- HCV
- Most common reported communicable disease in NSW (8072 cases in 2001)
  - In 2000, 10% of new diagnosis were Aboriginal where ethnicity was recorded
  - HCV rates amongst Indigenous IDUs varies (40 to 70% & over)

# CONTEXT

## Epidemiology

- **HCV** (cont'd)
- NSP surveys (1995 & 98) found a 56% prevalence of HCV in Indigenous IVDUs (51% in non-Indigenous community)

Preliminary findings- unpublished analysis (NCHECR, 2002) of Indigenous NSP survey data the proportion of IDUs who identified as Indigenous increased from 5% in 1995 to 8% in 2001. With a total of 7% over the period 1995-2001.

–One third reported incarceration in the previous year, a figure around twice as high as the non-Indigenous population.

# CONTEXT

- Indigenous IDUs < 25 years of age have an even higher prevalence of HCV than non-Indigenous IDUs (38% vs. 23%)

# CONTEXT

## Epidemiology

- HBV

- Hepatitis B is endemic in Aboriginal populations in both urban and remote communities (1% in general population Vs 10% in Aboriginal community)
- It is associated with poverty and also with imprisonment
- Transmission has primarily been perinatal, and interventions have been focused on infant & childhood vaccinations
- HBV vaccinations for Indigenous infants began in 1999 (The effects of this initiative will become more apparent as time goes on)

# OVERALL FINDINGS

1. **Strong statewide policy response to Indigenous risk of BBIs by NSW Health and some NGOs.**
  - Aboriginal health is a high priority in all key strategies
2. **Much energy is directed at developing policy and partnerships but these are less evident at the grass roots implementation level.**
3. **Community knowledge of BBIs is generally low**
4. **Many AHWs knowledge is less than optimal (eg. Antenatal)**
  - Urgent need for AMSs to take leadership to make BBIs a priority to respond accordingly

# OVERALL FINDINGS

## 5. Services

- Have good core service infrastructure in place for HIV/AIDS but less easy to identify for HCV.
- Some AHSs have initiatives to ↑ access and cultural appropriateness
- AMSs have good capacity to reach community
- Wide variation with differing impacts
  - Generally, use of infrastructures not utilised
  - Need to establish key community 'bridges'
  - ASHWs can only partly fulfil this role

6. Wide disparity in levels of access across NSW, most evident in the rural & metro split.

- 12 of 42 AMSs have ASHWs
- Very few Aboriginal people accessing HCV Treatment

# OVERALL FINDINGS

7. Confidentiality is the single biggest barrier to access, identified frequently and consistently by interviewees

## 8. Risk Populations

- Young Aboriginal people in all risk settings
- Adults and youth in Correctional facilities

### Risk Behaviours

- IDU
- Unsafe sex ( HIV, Hep B)
- Non sterile tattooing and body piercing
- Violence

# OVERALL FINDINGS

## 9. Use of ASHWs constitutes a sound model to increase Aboriginal access.

- ASHWs significantly contribute to implementing the NSW Sexual Health Strategy and other related strategies.
- 33 positions across NSW & 7 statewide positions
- Role of ASHW enormous (geographical area and roles)
- Variation in ASHW skills (competencies)
- Retention and recruitment issues
- Statewide support is provided and continuation is vital
- More often support at local level is lacking.

## 10. Resources

- Not Koori specific
- Limited and spasmodic access to material
  - There is evidence that HIV awareness is fading.
- Need another fresh confronting campaign

# OVERALL FINDINGS

12. The questions remains:

**“HAVE WE LEFT IT TOO LATE?”**

**&**

**“HOW DO WE REDRESS IT”**

# FACTORS INFLUENCING ACCESS

General Factors

Confidentiality

Community Knowledge

Service Location

Transport

Data

ASHWs

Evidence Base

Initiatives to Improve Access

# FACTORS INFLUENCING ACCESS

## 1. General Factors

- Disparity in levels of access across state
- Rural vs. Metro
- Lack of bulk billing practitioners particularly in rural & remote areas
- Clinical nature of BBIs
- Availability of ACCHSs and culturally sensitive services
- Access is directly affected by:
  - The services history (eg. confidentiality)
  - Length of service provision
  - Staff attitudes

# FACTORS INFLUENCING ACCESS

- **General Factors** (cont'd)
  - AMSs are generally better at ↑ access through specific programs and activities for Aboriginal communities
  - AHSs find Aboriginal specific programs targeting access a major challenge
  - Stigma associated with BBIs

# FACTORS INFLUENCING ACCESS

## 2. Confidentiality

- Shame
- Fear
- Family
- Other workers (cleaner)
- Self disclosure
  - who
  - when
  - where

## 3. Community knowledge

- Very limited
- Generally not aware
- Not considered priority
- Disease asymptomatic
- Lack of resources for consumers

# FACTORS INFLUENCING ACCESS

## 4. Service location

- Proximity (to Govt departments)
- Police and security
- Chemists (North-South)
- Management accountability for outreach services

## 5. Transport

- Cost (Rural vs. Metro)
- Daily Rx (Methadone)
- Remoteness

# FACTORS INFLUENCING ACCESS

## 6. Data

- Lack of adequate and accessible data
- Affects BBI as priority
- Affects collection compliance
- Affects community responsiveness
- Needs to be available at state and local level

## 7. ASHWs

- No. of ASHWs throughout the state
- ASHW location
- Geographical area
- Population to cover
- Gender
- Connected with community or not

# FACTORS INFLUENCING ACCESS

## 8. Evidence Base

- Data collection on BBI is happening in accordance with Public Health Act and NDD but not much information at the local level filters back (SESAHS-collect good local info)
- Aboriginality identification is an issue, the NSW Health Aboriginal Information Strategy is targeting hospitals in the first instance to improve collection
- Very little evaluation of data to assess effectiveness of interventions

# INITIATIVES TO IMPROVE ACCESS

- There is a wide range of initiatives and the object of our brief is not to evaluate.

1. Partnership - MNCAHS& AMS on Coast (Exec level)
2. Outreach - Wellington, CSAHS
3. ASHW - NSW Aboriginal & Torres Strait Islander Sexual Health Development Coordinator
4. Resources - NRAHS, DCS, individual ASHW projects
5. Board Engagement - Adoption of Portfolios, FWAHS initiative
6. Outreach - KRC
7. Youth - Wellington, Wagga, Katungal & Moruya
8. Multidisciplinary Sexual Health Team- MAHS
9. Supporting Clients- KRC

# FUTURE DIRECTIONS & RECOMMENDATIONS

3 Overarching Strategic Directions

&

8 Recommendations

# Overarching Strategic Directions

## 1. A holistic whole of Health and Wellbeing approach

- BBIs cant be addressed in isolation from other STIs, general health and physical body, social, cultural & emotional experiences of people.
- HCV attributed to IVDU >85% cases- yet HCV and other related BBIs is a Sexual Health responsibility
- Nexus between HIV, HCV and A&OD (disinhibition & unsafe sex)
- Interface between A&OD and Sexual Health

# Overarching Strategic Directions

## 2. Focussing on the major areas of risk

- of Young Aboriginal people in all risk settings
- Adults and youth in Correctional facilities
- Families & communities of those at risk

### Behaviours

- IDU
- Unsafe sex
- Non sterile tattooing and body piercing
- Violence

# Overarching Strategic Directions

- 3. Increasing Aboriginal Community awareness, understanding & ownership of BBIs issues
- communicating risk without being alarmist/sensationalist
- Influencing elders, Boards of Management
- Partnerships
- Ensuring supportive environments within communities

# 8 RECOMMENDATIONS

## 1. Getting the message out

- Report to be distributed far and wide

## 2. Statewide leadership

- NSW Health & AH&MRC to examine
- model of service delivery
- resource allocation
- Designated Aboriginal positions (AIDB, HCC)
- Partnerships and Collaborative arrangements
- Within the department, other Govt sectors-NWODB
- With other NGOs particularly HCC

# 8 RECOMMENDATIONS

## 3. Building Aboriginal community awareness, understanding and ownership of BBIs issues

- Project plan to be developed by the AH&MRC which would achieve the above with allocated funding to be derived from NIASHS.

# 8 RECOMMENDATIONS

## 4. ASHW Projects

- Continue/develop support initiatives
- Periodically review distribution of ASHWs
- Gather data on levels of financial support by AHS for ASHWs
- AHSs & ACCHSs review local support structures for ASHWs
- Increase Aboriginal staff in key service areas (AIDB, NSPs and NGOs)

# 8 RECOMMENDATIONS

## 5. Location of services

- AHSs to review the location of all services relevant to BBIs in view of the checklist within report

## 6. Resources to support health promotion & prevention activities

- Statewide multimedia campaign
- BBI resource sub committee
- More Koori Specific materials (particular groups within)

# 8 RECOMMENDATIONS

## 7. Aboriginal people in correctional facilities

- More holistic BBI health promotion
- Pilot models of continuity of care
- Extend agreements with between ACCHSs and CHS to cover JJs

## 8. Building an evidence base

- WG to adapt protocols for BBI data collection
- Review progress in implementing Aboriginal health Information Strategy
- Periodic surveys of NSP with Indigenous identifiers consistent with protocols
- Statewide strategy to evaluate Implementation Plan