An Evaluation of the Tri-State HIV/STI Project 2001-2002

A report commissioned by the Office for Aboriginal and Torres Strait Islander Health (Australian Government Department of Health and Ageing) on behalf of the Tri-State HIV/STI Project funding jurisdictions:

The State Governments of South Australia, Northern Territory, and Western Australia and the Australian Government

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Australian Institute for Primary Care
Foreword: Evaluating the Tri-State STD/HIV Project

The Tri-State STD/HIV Project (TSP), a joint initiative of Australian Federal, State (Western and South Australia) and Northern Territory Health Ministers, was implemented in 1994 to respond to three key imperatives: Indigenous people in the Central Desert region of Australia experienced endemic rates of STIs far in excess of non-Indigenous rates; health services in the region were under-resourced, with little collaboration; and the population was highly mobile. This report is an evaluation of the activities and outcomes of the program for the period 1996-2000.

The original aim of the TSP was to develop a coordinated approach to sexually transmitted diseases (STDs), now commonly referred to as sexually transmissible infections or STIs, in the cross-border region of Central Australia, so that by the year 2000, Indigenous people in Central Australia would experience: a 90% reduction in syphilis and chlamydia rates; no donovanosis or congenital syphilis; an 80% reduction in gonorrhoea rates; no child under the age of twelve years having a STI; HIV at or less than the Australian average. These were to be achieved by developing projects and programs in the following key result areas (KRAs): clinical management of clients with STIs; health care provider education and training; STI/HIV surveillance systems; education and prevention in communities; coordination of STI/HIV control activities including the facilitating the exchange of information.

Our evaluation brief included seven core areas: assess activities of TSP, within the context of STI/HIV control, with reference to the identified KRAs; determine progress towards attainment of the original objectives of the TSP; evaluate the TSP’s ability to respond to the needs of services in the region and identify barriers to the uptake of programs; determine the effectiveness and usefulness of TSP in relation to overcoming the identified barriers; identify areas of progress towards resolution of policy inconsistencies and structural issues between jurisdictions, which may impede effective patient management and care, monitoring and surveillance; comment on the dissemination of outcomes and lessons from TSP; and advise on the continuing need and/or role of the TSP, and make recommendations on objectives and key result areas, strategies for future action and appropriate funding, management and advisory structures for the project.

What we did

Our evaluation strategy included a quantitative analysis of STI/HIV surveillance data and the surveillance system, combined with a qualitative process evaluation. The evaluation examined the performance of the project, and barriers to its success across the project’s KRAs. Progress towards the project objectives was assessed on the basis of available surveillance data. Given the Centrality of the surveillance system to monitoring the performance for the TSP, the surveillance system itself was examined. The key domains of the system examined were its simplicity, flexibility, acceptability and timeliness.

The qualitative analysis included both the examination of key TSP documents, as well as group and key informant interviews with selected stakeholders. Key informant categories included members of the management board, representatives of the funding jurisdictions and health care providers. In addition we collected observation data at a regional planning workshop conducted by the TSP staff in December 2000. NVIVO qualitative analysis software was used to perform a thematic analysis of the data including key document, interview and observation notes. Two
workshops were held with the evaluation team to contribute to the analysis and to generate conclusions and recommendations. We regret that the scope of our consultancy did not allow us to collect information from the Aboriginal clients of the services whose staff we interviewed. We note the importance and value of building evaluation measures into sexual health projects in Aboriginal communities that allow service users the opportunity to comment on the services that are being provided to them, and to contribute to the development of services in their own communities (see for example, Willis, Greet et al. 2002).

Both quantitative and qualitative data revealed that the TSP operates in a highly complex social and cultural field, where issues of service under-resourcing as well as the genuine poverty of many of the health services’ clients contribute to a lively and sometimes heated exchange of stakeholder opinions on the best ways to proceed. In his recent book, The Weight of the World: Social Suffering in Contemporary Society, anthropologist and social theorist Pierre Bourdieu suggests that to understand the experience of people who live and work in such complex social spaces and institutions:

it is not enough in explain each point of view separately. All of them must be brought together as they are in reality, not to relativize them in an infinite number of cross-cutting images, but quite to the contrary, through simple juxtaposition, to bring out everything that results when different or antagonistic visions of the world confront each other. (Bourdieu 1999)

As evaluators, we initially tried to achieve a synthesis of the diverse views that were being put to us by the stakeholders we interviewed, but were troubled that in trying to condense the interview material to reach a single finding from these diverse points of view, we were doing a disservice to both our informants, and to the project we were evaluating. One example of this dilemma was that most of our informants viewed the Syphilis database as an effective public health measure, but some worried that by taking responsibility for their own health out of Aboriginal people’s hands, the database was not contributing to the health development of clients in the region.

Our solution to this dilemma was to present as many of our informants views as possible, conflicting though they sometimes are, and not to adjudicate between them. In this, we were encouraged by Bourdieu’s example and advice:

It should become clear that so-called “difficult” spots (housing projects or schools today) are, first of all, difficult to describe and think about, and that simplistic and one-sided images (notably those found in the press) must be replaced by a complex and multilayered representation capable of articulating the same realities but in terms that are different and sometimes irreconcilable.

Secondly, following the lead of novelists such as Faulkner, Joyce or Wolf, we must relinquish the single, Central, dominant, in a word, quasi-divine, point of view that is all too easily adopted by observers – and by readers too, at least to the extent they do not feel personally involved. We must work instead with the multiple perspectives that correspond to the multiplicity of coexisting, and sometimes directly competing, points of view (Bourdieu 1999).

**What we found**

Key successes of the program we identified were: enhanced integration of sexual health into comprehensive local primary health care delivery; expanded and coordinated active case finding; sustained regional commitment/approaches to STI control; and cross-border standardisation of sexual health procedures. Particular techniques including clinic audits, sub-regional population-based screening, and Centralised follow-up databases were effective at reducing ulcerative STI incidence.

The use of Polymerase Chain reaction (PCR) technology to detect chlamydia and gonorrhoea in urine was both effective and acceptable in community-wide screening, but sustained regional testing and follow-up efforts are needed if prevalence is to be reduced. Key barriers identified were inconsistent pathology services, and recruiting and retaining appropriate health staff, especially men.

The findings of this evaluation emphasise the contribution of STI information systems in the improved management of positive patients and their primary contacts, the need to develop locally appropriate models for active case detection and follow-up, the importance of education and support for practitioners in the field, and the value of regional forums for sharing information and experience in relation to STI control. While it was clear that the mission of TSP is to contribute to reduced rates of disease, their mode of contribution was through increasing the capacity of primary health services to
reduce disease rates. The goal and objectives of the program should therefore reflect these coordination and capacity-building functions, as should the KRAs.

The evaluation recommended that the TSP should have a single goal, which framed the elements of regional capacity building and coordination, and a revised set of strategic objectives, which included:

- To work towards the integration of sexual health services within comprehensive Primary Health Care structures particularly through supporting local primary health care services to improve their management of positive cases and their primary contacts;
- To coordinate an expanded and efficient program of active case finding in the region;
- To sustain regional commitment and approaches to STI control; and
- To advocate for cross border standardisation of processes and procedures in relation to sexual health.

Acknowledgements

Many people have contributed to the success of this report, including especially Annette Coppola and Dr Arun Menon who were the staff of the TSP at the time of the evaluation, as well as the members of its management committee and representatives of collaborating organisations who took the time to talk with us. The Office of Aboriginal and Torres Strait Islander Health provided us with great support in getting the report finalised and into press, and we wish to particularly acknowledge the contributions of Helen MacFarlane, Peter Harding and Bernard Pearce. At the Institute for Primary Care, key assistance was provided by Steve Einfeld.

We also wish to acknowledge the support of our institutions and colleagues including the Australian Research Centre in Sex, Health and Society and the Australian Institute for Primary Care (both at La Trobe University), and the VicHealth Koori Health Research and Community Development Unit and the Melbourne Sexual Health Centre (both part of the University of Melbourne).

October 2003.

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- Male workers

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Town

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### Acronyms & Terminology

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident &amp; Emergency</td>
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<td>ACR</td>
<td>Albumin-Creatinine Ratio</td>
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<td>AHW(s)</td>
<td>Aboriginal Health Worker(s)</td>
</tr>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
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<tr>
<td>ASH</td>
<td>Alice Springs Hospital</td>
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<tr>
<td>ASHRG</td>
<td>Aboriginal Sexual Health Reference Group</td>
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<tr>
<td>CAAC</td>
<td>Central Australian Aboriginal Congress Inc.</td>
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<tr>
<td>CADCC</td>
<td>Central Australian Disease Control Coordination Committee</td>
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<td>CARIHP</td>
<td>Central Australian Regional Indigenous Health Partnership Committee</td>
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<tr>
<td>CDC</td>
<td>CDC database</td>
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<tr>
<td>CDEP</td>
<td>Community Development Employment Projects</td>
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<tr>
<td>CFU</td>
<td>Cervical Follow-up Unit</td>
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<tr>
<td>Clinic 34</td>
<td>(Sexual Health Clinic in Alice Springs)</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer Price Index</td>
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<tr>
<td>CRC</td>
<td>Combined Research Centre for Aboriginal and Tropical Health</td>
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<tr>
<td>DMOs</td>
<td>District Medical Officers</td>
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<tr>
<td>GAMIT</td>
<td>Growth assessment and action in children</td>
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<tr>
<td></td>
<td>- Antenatal screening</td>
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<tr>
<td></td>
<td>- Management of chronic disease</td>
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<tr>
<td></td>
<td>- Immunisation</td>
</tr>
<tr>
<td></td>
<td>- Topical (skin disease).</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-Deficiency Virus</td>
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<tr>
<td>IMVS</td>
<td>Institute for Medical and Veterinary Science</td>
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<tr>
<td>IVDU(s)</td>
<td>Intra Venous Drug User(s)</td>
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<tr>
<td>JPET</td>
<td>Julalikari Program for Employment and Training</td>
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<tr>
<td>KRA(s)</td>
<td>Key Result Area(s)</td>
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<tr>
<td>MSA</td>
<td>Microsoft Access</td>
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<td>NHC</td>
<td>Nganampa Health Council</td>
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<td>NHS</td>
<td>Nganyatjarra Health Service</td>
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<tr>
<td>NHT</td>
<td>No History of Treatment</td>
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<tr>
<td>NIASHS</td>
<td>National Indigenous Australian Sexual Health Strategy</td>
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<td>NTU</td>
<td>Northern Territory University</td>
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<td>NVivo</td>
<td>Qualitative Research Software</td>
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<td>OATSIH</td>
<td>Office for Aboriginal and Torres Strait Islander Health</td>
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<td>PAP</td>
<td>Papanicolaou test</td>
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<td>PCR</td>
<td>Polymerase Chain Reaction</td>
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<td>PET</td>
<td>Presumptive Epidemiological Treatment</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHCAP</td>
<td>Primary Health Cover Access Program</td>
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<td>PHOFA(s)</td>
<td>Primary Health Outcomes Funding Agreement(s)</td>
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<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
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<td>RAH</td>
<td>Royal Adelaide Hospital</td>
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<td>RFDS</td>
<td>Royal Flying Doctor Service</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>SHU</td>
<td>Sexual Health Unit</td>
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<tr>
<td>SIS</td>
<td>Syphilis Information System</td>
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<tr>
<td>STD(s)</td>
<td>Sexually Transmitted Disease(s)</td>
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<tr>
<td>STI(s)</td>
<td>Sexually Transmissible Infection(s)</td>
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<tr>
<td>STM</td>
<td>Standard Treatment Manual</td>
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<tr>
<td>THS</td>
<td>Territory Health Services</td>
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<tr>
<td>TSP</td>
<td>Tri-State HIV/STI Project</td>
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<tr>
<td>UTI(s)</td>
<td>Urinary Tract Infection(s)</td>
</tr>
<tr>
<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisation</td>
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<tr>
<td>WACCHO</td>
<td>Western Australian Community Controlled Health Organisation</td>
</tr>
<tr>
<td>WBM</td>
<td>Women's Business Manual</td>
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**NOTE:** Convention for naming this project has changed over time, in keeping with accepted terminology (i.e. STD is now commonly STI). Initially this was the only project operating under the name “Tri-State”, however the development of new Tri-State projects has led to the specific naming of the Tri-State HIV Prevention / STI Detection Project, with the order of these terms also changing through the life of the project.
Executive Summary

Overview of the Tri-State Program

The main aim of the TSP is to develop a coordinated approach to STDS in the cross-border region of Central Australia, so that by the year 2000, Indigenous people in Central Australia would experience:

- A 90% reduction in syphilis and chlamydia rates;
- No donovanosis or congenital syphilis;
- An 80% reduction in gonorrhoea rates;
- No child under the age of twelve years having a STD; and
- HIV at or less than the Australian average.

These were to be achieved by developing projects and programs in the following key result areas (KRAs):

- Clinical management of clients with STDS;
- Health care provider education and training;
- STD/HIV surveillance systems;
- Education and prevention in communities; and
- Coordination of STD/HIV control activities including the facilitating the exchange of information.

Since 1994 the Commonwealth, Western Australia, South Australia and the Northern Territory governments have jointly funded the TSP. Since 1996, the funding from the participating states and territories totals $280,000 annually. The project is located within Health Development in Territory Health Services (THS) and has two full-time staff: a Coordinator and a Medical Officer.

Currently, two committees oversee the project. Representatives of the funders form the first of these, whose main function is to deal with funding related issues. The second is the Central Australia Disease Control Coordination Committee (CADCCC) STD/HIV subcommittee, which supplies technical advice and monitors performance. The TSP area of interaction was initially defined as the crossborder area of Central Australia. In recent years the TSP has had increased interaction with a number of health services outside the initial cross border area.

The evaluation brief

The Office of Aboriginal and Torres Strait Islander Health (OATSIH) initiated an evaluation of the TSP in September 2000. The objective of the evaluation was to assess the effectiveness of the TSP and build on the findings of the 1996 Scrimgeour and Tsey review. The evaluation would review evidence of the achievements and ongoing activities of the TSP and make recommendations regarding the future of the project. The terms of reference for the evaluation were as follows:

1. Assess activities of the Tri-State project, within the context of STD/HIV control, with reference to the identified key result areas.
2. Determine progress towards attainment of the original objectives of the Tri-State project.
3. Evaluate the Tri-State project’s ability to respond to the needs of services in the region and identify barriers to the uptake of programs.
4. Determine the effectiveness and usefulness of Tri-State’s projects in relation to overcoming the identified barriers (see 3 above).
5. Identify areas of progress towards resolution of policy inconsistencies and structural issues between jurisdictions, which may impede effective patient management and care, monitoring and surveillance.
6. Comment on the extent to which outcomes and learnings from Tri-State project activities are:
7. Advise on the continuing need and/or role of the Tri-State project, in particular, make recommendations on:

- appropriate overall objectives and key result areas for the project;
- key strategies for future action for the STD/HIV Tri-State to enhance STD/HIV services in the cross border region of Central Australia;
- an appropriate level of funding for the project and the relative contributions of the various funding bodies;
- the effectiveness of the funding bodies involved in the Tri-State and the role of the Territory Health Service as the auspicing jurisdiction; and
- appropriate management and advisory structures for the project.

The evaluation team included: Dr Jon Willis; Ms Gai Wilson; Associate Professor Ian Anderson; Professor Doreen Rosenthal; Associate Professor Anthony Smith; and Professor Christopher Fairley.

Methods

In order to address the Terms of Reference for the evaluation we undertook a qualitative strategy to develop an updated process evaluation combined with a quantitative analysis of STD/HIV surveillance data and the surveillance system.

We attempted to assess progress towards the Tri-State objectives on the basis of available surveillance data as presented in the Background Report. Given the Centrality of the surveillance system to monitoring the performance of the TSP, the surveillance system itself was examined. The key domains of the system examined were its simplicity, flexibility, acceptability and timeliness (Klaucke et al., 1988). The qualitative analysis included both the examination of key TSP documents, as well as group and key informant interviews with selected stakeholders. Key informant categories included members of the STD/HIV subcommittee of the CADCCC, representatives of the funding jurisdictions and health care providers. In addition we attended the Regional Planning Workshop conducted by the Tristate Project staff in December 2000.

We used NVIVO qualitative analysis software to perform a thematic analysis of the qualitative data.

Two workshops were held with the evaluation team to contribute to the analysis and to generate conclusions and recommendations.

Conclusions and recommendations

The evaluation concludes that the TSP is making a valuable contribution to the coordination and expansion of effective STD control in Central Australia, and that there is a demonstrated need for it to continue. The major strengths of the project are:

- Its contribution to STD information systems at local and regional levels that are contributing to improved management of positive patients and their primary contacts;
- The development of improved models for active case detection and follow-up;
- The education and support of practitioners in the field; and
- The provision of regional forums for sharing information and experience in relation to STD control.

We conclude that more focussed objectives and associated strategies, an improved management structure, and more effective links to policy and planning development in the region would strengthen the TSP.

Appropriate overall objectives and key result areas for the TSP

We suggest a revised set of strategic objectives and KRA's for the next three years. We recognise that it is inappropriate for us to be narrowly directive - there needs to be a full discussion of our suggestions aimed...
at generating and endorsing new objectives by key stakeholders. These objectives need to both reflect and inform other specific regional plans developed with, for example, Central Australian Regional Indigenous Health Partnership Committee (CARPH). Our first suggestion is that the form of the objectives should move away from setting specific disease targets to a more process based approach. There are two reasons for this. The first is that there may never be adequate evidence to link the activities of a single organisation with reduction (or otherwise) in disease rates. The second is the logical issue that TriState’s role is one of coordination and building the capacity for services that are delivered on the ground by a range of other organisations, and that reductions in disease rates are only directly attributable to the activities of these other organisations. While it is clear that the mission of TSP is to contribute to reduced rates of disease, their mode of contribution is through increasing the capacity of primary health services to reduce disease rates. The goal and objectives of the program should therefore reflect these coordination and capacity-building functions, as should the KRAs.

We recommend that the TSP should have a single goal, which frames the elements of capacity building and coordination and a revised set of strategic objectives, which includes:

- To work towards the integration of sexual health services within comprehensive Primary Health Care structures particularly through supporting local primary health care services to improve their management of positive cases and their primary contacts;
- To coordinate an expanded and efficient program of active case finding in the region;
- To sustain regional commitment and approaches to STD control; and
- To advocate for cross border standardisation of processes and procedures in relation to sexual health.

Key strategies for future action for the STD/HIV Tri-State to enhance STD/HIV services in the cross border region of Central Australia

Based on the findings of the evaluation we suggest that the key strategies of the TSP should reflect the best of current TSP practice and are framed within the revised goal and objectives. We recommend the following key strategies.

**Objective 1:**

To work towards the integration of sexual health services within comprehensive primary health care structures, particularly through supporting local primary health care services to improve their management of positive cases and their primary contacts.

**Local level strategies:**

- work with communities to develop self-maintaining information systems that allow them to ensure the quality of patient management and care. These information systems include a population register, records of who has been tested, who hasn’t, and the results of those tests. They should also enable communities to:
  - measure and improve the proportion of cases that get followed up;
  - see and measure reductions in time to treatment; and
  - improve the presumptive treatment of partners of positive cases, thus reducing reinfection. This should be an organic development of systems connected at a regional level by a series of linkages, rather than a top-down, imposed system. (As an example, an indicator for this strategy could be that after three years key information systems and data sets will be developed in two thirds of communities or for 80% of the population.)

- establish a system of audits with collaborating communities, moving to the point where maintaining local registers becomes a form of self audit

- work with communities to develop improved models of service delivery through demonstration projects, and training exercises

**Regional level strategies:**

- Work with pathology services and communities to maintain a surveillance database that can provide backup for local information systems, and provide patient treatment history and standard treatment information to local clinics.
This database should be supplemented with a regional population register.

- Use the surveillance database and population register to produce valid rates on a regional population basis for syphilis, gonorrhoea, chlamydia, trichomonas, donovanosis and HIV, including:
  - the population proportion who have been tested;
  - the population proportion who have tested positive;
  - the population proportion of positives who have been treated;
  - the mean and median time to treatment for positives; and
  - the percentage of primary contacts of positive cases who have been treated.

- Work with local communities and other relevant organisations to obtain the valid consent of patients for inclusion of their data in regional databases.

- Provide key input into the revision and ongoing development of standard treatment protocols.

**Objective 2:**

To coordinate an expanded and efficient program of active case finding in the region

**Strategies:**

- Promote and coordinate local annual screening programs at community level and in town for syphilis, gonorrhoea, chlamydia and trichomonas. The trichomonas test is imperative to efforts to reduce pre-term labour and women’s vulnerability to HIV infection.

- Work with communities to develop locally relevant models for screening programs within existing local resources. This work might take the form of demonstration projects and training exercises, as a modified form of the sub-regional screening program recently implemented through TSP.

- Ensure that communities understand their own testing patterns and practices, and that they receive and are able to interpret the results of their screening programs, through the implementation of improved technology, regional coordination of results, and training and education projects for staff at local and regional levels.

- Facilitate training for practitioners in the field in population health approaches to sexual health, enabling them to think of communities as a whole as Nganampa Health Council have done. This will assist the organic development of regional screening.

**Objective 3:**

To sustain regional commitment and approaches to STD control

**Strategies:**

- Facilitate regional planning of STD activities including sexual health promotion work with relevant stakeholders (CAAC, Alukura, ASH and Clinic 34) on the development of a Town strategy.

- Work with CARHPC on the STD portion of a regional communicable diseases plan.

- Facilitate quarterly meetings of an STD Information Networking group of local practitioners and technical experts as a clearinghouse for best practice information, for information sharing and problem solving, as well as a forum to review and advise on the implementation of regional plans.

- Work with the management committee to develop a dissemination plan and marketing strategy for the TSP.

**Objective 4:**

Advocate for cross border standardisation of processes and procedures in relation to sexual health

**Strategies:**

- Identify differences in standards for notification in the states and territory and advocate for cross border standardisation of these protocols.
• Identify differences in the pathology testing and reporting in the states and territory and advocate for the standardisation of testing procedures and reporting formats and time frames for both individual and aggregated results.
• Work with local communities and regional service providers to coordinate core health promotion messages and approaches.
• Work with the CRC for Aboriginal and Tropical Health and other relevant research bodies to develop priority research projects, which address regional research needs.

An appropriate level of funding for the project and the relative contributions of the various funding bodies

The TSP needs to be adequately funded for its ongoing core business – coordination, model development, policy and planning coordination with, for example, CARIHPAC and this will necessitate a funding increase. At the bare minimum, this needs to cover:

• The CPI increase since 1996
• Adequate salaries to attract and maintain high quality public health officers to the program;
• The Central follow-up position with all on-costs and associated management costs;
• Appropriate funding to cover the commonwealth's Donovanosis project officer;
• Additional administrative funding;
• Designated project funding; and
• The transaction costs associated with negotiating a funding agreement with four jurisdictions, in this case, primarily the salary costs of the coordinator.

We recommend that:

• Funding to the TSP be increased and that a three-year funding cycle be introduced. The relative contributions from the four jurisdictions should be modified with the Commonwealth, NT and WA contributing proportionally more and SA contributing proportionally less.
• The TSP produces one streamlined annual report for all jurisdictions that was based on a business plan with performance indicators.

The effectiveness of the funding bodies involvement in the Tri-State and the role of the Territory Health Service as the auspicing jurisdiction

At the moment, state and territory level commitment is dependant on internal funding priorities in each jurisdiction, which in turn rely on well-connected individuals with a good understanding of the activities and value of the program influencing funding decisions on an annual basis. In all jurisdictions, problems were being experienced or at least predicted.

There is a small range of alternative approaches to the problem. One way is to increase the Commonwealth’s leverage in the decision making process in each jurisdiction by linking State and Territory funding from the National Indigenous Australians Sexual Health Strategy (NIASHS) to guaranteed support for TSP via a mechanism like a Public Health Outcome Funding Agreement (PHOFA). OATSIH could also, perhaps, take on a greater responsibility for the strategic use of National Strategy funding.

Overall we believe that TSP should continue to be auspiced within THS, although there are a number of issues with the current arrangements. The advantages include that the NT has responded to the problems of funding arrangements with four jurisdictions, the co-location with the THS Sexual Health Unit has provided for a productive cross-fertilisation of ideas and expertise, as well as collegial support for staff. THS has also, obviously, benefited from the availability of a backup sexual health physician. In addition Alice Springs is Central in many ways to the functions of the TSP.

The challenge for TSP and its management body is to ensure that relationships with other key client bodies (notably Central Australian Aboriginal Congress, Nganampa Health Council and Ngaanyatjarra Health) are maintained at the same level as those with THS. Issues of blurred boundaries with THS must be resolved quickly as they arise. In particular, TSP should be meticulous about not delivering, or being perceived to deliver, health service functions that rightly belong to THS.

We recommend that:

• The NT continues to auspice the TSP.
We believe that currently the management and advisory structures for the project do not provide optimal direction, management and accountability. Although they are doing a good job in many ways, there is room for improvement in the areas of: linkages to state and territory health planning functions including funding; representation of client communities, particularly of Aboriginal people; and promotion of the program to partner governments.

We think that the management function should be consolidated into a single Management Advisory Group, with terms of reference which clearly delineate its management responsibilities which would include: to provide strategic leadership; to oversee annual strategic planning functions; to advocate for and promote the project; and to secure funding and review expenditure via an annual financial and activity reporting cycle. The membership of this group should be broadened to include Indigenous people from the TSP catchment, as well as representatives of the four key client services (Nganampa Health Council, Ngaanyatjarra Health, Congress and THS-Remote). It is important that the management group develop a strong sense of ownership of the program, and a determination to advocate on behalf of and defend the program.

We believe that two important strategies should be pursued by the TSP to link and coordinate its activities more effectively into regional policy and planning initiatives, as well as to continue the valuable networking and support role previously provided by technical advisory group meetings. The first of these strategies is for TSP to facilitate quarterly meetings of an STD Information Networking Group of local practitioners and technical experts as a clearinghouse for best practice information, for information sharing and problem solving, as well as a forum to provide technical review and advice on the implementation of regional plans. The second strategy is for key staff of the TSP to become active members of the Communicable Diseases Committee of CARHPC, and take the initiative in developing an STD regional subplan as part of the Communicable Diseases regional planning process.

We recommend that:

- The current management structure of the TSP be abolished and a single Management Advisory Group be established with terms of reference which include: to provide strategic leadership; to oversee annual strategic planning functions; to advocate for and promote the project; and to secure funding and review expenditure via an annual financial and activity reporting cycle. The membership of this group should include Indigenous people from the TSP catchment, as well as representatives of the four key client services (Nganampa Health Council, Ngaanyatjarra Health, Congress and THS-Remote).

- The TSP link and coordinate its activities more effectively into regional policy and planning initiatives and take the initiative in developing an STD regional subplan as part of the Communicable Diseases regional planning process.

- The TSP facilitate quarterly meetings of an STD Information Networking group of local practitioners and technical experts as a clearinghouse for best practice information, for information sharing and problem solving, and as a forum to provide technical review and advice on the implementation of regional plans.

- The TSP and their management committee develop a dissemination plan and marketing strategy for the TSP that includes: the preparation and wide distribution of an annual report; representation of TSP work at key forums; presentations at conferences; and the publication of a regular series of Working Papers.
Summary of Recommendations

1. Revised overall objectives and key result areas for the TSP

The TSP should have a single goal, which frames the elements of capacity building and coordination and a revised set of strategic objectives, which includes:

- To work towards the integration of sexual health services within comprehensive Primary Health Care structures particularly through supporting local primary health care services to improve their management of positive cases and their primary contacts;
- To coordinate an expanded and efficient program of active case finding in the region;
- To sustain regional commitment and approaches to STD control; and
- To advocate for cross border standardisation of processes and procedures in relation to sexual health.

2. Revised key strategies for future action for the STD/HIV Tri-State to enhance STD/HIV services in the cross border region of Central Australia

Objective 1:
To work towards the integration of sexual health services within comprehensive primary health care structures particularly through supporting local primary health care services to improve their management of positive cases and their primary contacts.

Local level strategies:
- Work with communities to develop self-maintaining information systems that allow them to ensure the quality of patient management and care. These information systems include a population register, records of who has been tested, who hasn’t, and the results of those tests. They should also enable communities to:
  - measure and improve the proportion of cases that get followed up;
  - see and measure reductions in time to treatment; and
  - improve the presumptive treatment of partners of positive cases, thus reducing reinfection. This should be an organic development of systems connected at a regional level by a series of linkages, rather than a top-down, imposed system. (As an example, an indicator for this strategy could be that after three years key information systems and data sets will be developed in two thirds of communities or for 80% of the population.)
- establish a system of audits with collaborating communities, moving to the point where maintaining local registers becomes a form of self audit
- work with communities to develop improved models of service delivery through demonstration projects, and training exercises.

Regional level strategies:
- Work with pathology services and communities to maintain a surveillance database that can provide backup for local information systems, and provide patient treatment history and standard treatment information to local clinics. This database should be supplemented with a regional population register.
- Use the surveillance database and population register to produce valid rates on a regional population basis for syphilis, gonorrhoea, chlamydia, trichomonas, donovanosis and HIV, including:
  - the population proportion who have been tested;
  - the population proportion who have tested positive;
— the population proportion of positives who have been treated;
— the mean and median time to treatment for positives; and
— the percentage of primary contacts of positive cases who have been treated.

- Work with local communities and other relevant organisations to obtain the valid consent of patients for inclusion of their data in regional databases.
- Provide key input into the revision and ongoing development of standard treatment protocols.

**Objective 2:**

To coordinate an expanded and efficient program of active case finding in the region:

- Promote and coordinate local annual screening programs at community level and in town for syphilis, gonorrhoea, chlamydia and trichomonas. The trichomonas test is imperative to efforts to reduce pre-term labour and women’s vulnerability to HIV infection.
- Work with communities to develop locally relevant models for screening programs within existing local resources. This work might take the form of demonstration projects and training exercises, as a modified form of the sub-regional screening program recently implemented through TSP.
- Ensure that communities understand their own testing patterns and practices, and that they receive and are able to interpret the results of their screening programs, through the implementation of improved technology, regional coordination of results, and training and education projects for staff at local and regional levels.
- Facilitate training for practitioners in the field in population health approaches to sexual health, enabling them to think of communities as a whole as Nganampa Health Council have done. This will assist the organic development of regional screening.

**Objective 3:**

To sustain regional commitment and approaches to STD control.

- Facilitate regional planning of STD activities including sexual health promotion.
- Work with relevant stakeholders (CAAC, Alukura, ASH and Clinic 34) on the development of a Town Strategy.
- Work with CAR IPC on the STD portion of a regional communicable diseases plan.
- Facilitate quarterly meetings of an STD Information Networking group of local practitioners and technical experts as a clearinghouse for best practice information, for information sharing and problem solving, as well as a forum to review and advise on the implementation of regional plans.
- Work with the management committee to develop a dissemination plan and marketing strategy for the TSP.

**Strategies for Objective 4:**

- Advocate for cross border standardisation of processes and procedures in relation to sexual health.
- Identify differences in standards for notification in the states and territory and advocate for cross border standardisation of these protocols.
- Identify differences in the pathology testing and reporting in the states and territory and advocate for the standardisation of testing procedures and reporting formats and time frames for both individual and aggregated results.
- Work with local communities and regional service providers to coordinate core health promotion messages and approaches.
- Work with the Combined Research Centre (CRC) for Aboriginal and Tropical Health and other relevant research bodies to develop priority research projects which address regional research needs.
3. An appropriate level of funding for the project and the relative contributions of the various funding bodies

- Funding to the TSP be increased and that a three-year funding cycle be introduced. The relative contributions from the four jurisdictions should be modified with the Commonwealth, NT and WA contributing proportionally more and SA contributing proportionally less.

- The TSP produce one streamlined annual report for all jurisdictions that was based on a business plan with performance indicators.

4. The effectiveness of the funding bodies involvement in the Tri-State and the role of the Territory Health Service as the auspicing jurisdiction

The NT continues to auspice the TSP.

5. Appropriate management and advisory structures for the project

- The current management structure of the TSP be abolished and a single Management Advisory Group be established with terms of reference which include: to provide strategic leadership; to oversee annual strategic planning functions; to advocate for and promote the project; and to secure funding and review expenditure via an annual financial and activity reporting cycle. The membership of this group should include Indigenous people from the TSP catchment, as well as representatives of the four key client services (Nganampa Health Council, Ngaanyatjarra Health, Congress and THS-Remote). The TSP link and coordinate its activities more effectively into regional policy and planning initiatives and take the initiative in developing an STD regional subplan as part of the Communicable Diseases regional planning process.

- The TSP facilitate quarterly meetings of an STD Information Networking group of local practitioners and technical experts as a clearinghouse for best practice information, for information sharing and problem solving, and as a forum to provide technical review and advice on the implementation of regional plans.

- The TSP and their management committee develop a dissemination plan and marketing strategy for the TSP that includes: the preparation and wide distribution of an annual report; representation of TSP work at key forums; presentations at conferences; and the publication of a regular series of Working Papers.
Introduction

An overview of the program

The Broome Ministerial meeting of 28-29 November 1990, on the delivery of health services in rural and remote tropical Australia, requested a report on the extent of the problem of sexually transmitted diseases across the States/Territory and on ways of controlling STDS in Central Australia. The Commonwealth convened a meeting in February 1992, which recommended the establishment of a Tri-State STD/HIV project as a pilot. The recommendation for this project was supported by the Australian Health Ministers Advisory Committee, all State and Territory Health Ministers and the Communicable Diseases Standing Committee of the National Health and Medical Research Council.

The key imperatives for the establishment of the Tri-State project were:

- Endemic rates of sexually transmitted diseases in Aboriginal people in Central Australia far in excess of that in non-Indigenous Australians.
- Under resourcing of health services with little intra- and inter-sectoral collaboration.
- A highly mobile population across state borders.

The main aim of TSP was to develop a coordinated approach to STDS in the cross-border region, so that by the year 2000, Indigenous people in Central Australia would experience:

- A 90% reduction in syphilis and chlamydia rates;
- No donovanosis or congenital syphilis;
- An 80% reduction in gonorrhoea rates;
- No child under the age of twelve years having a STD; and
- HIV at or less than the Australian average.

These were to be achieved by developing projects and programs in the following key result areas (KRAs):

- Clinical management of clients with STDS;
- Health care provider education and training;
- STD/HIV surveillance systems;
- Education and prevention in communities; and
- Coordination of STD/HIV control activities including the facilitating the exchange of information.

A committee was convened and a detailed plan developed containing a number of special initiatives. In August 1992, $135,000 was approved as the Commonwealth’s contribution towards the implementation of the project. The approval was conditional on WA, SA and the NT Governments meeting their agreed commitment. The Commonwealth’s initial contribution met all establishment and salary costs for funding in 1993-94 and the State/Territory contributions commenced recurrent funding in 1994-95. A Board of Management comprising representatives from the funding bodies was established to oversee the financial operations of the project. Since 1996, the funding allocations from the participating states and territories are listed in table 1 below:

Table 1: Financial allocations

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Allocation ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonwealth</td>
<td>80,000</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>80,000</td>
</tr>
<tr>
<td>Western Australia</td>
<td>60,000</td>
</tr>
<tr>
<td>South Australia</td>
<td>60,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>280,000</strong></td>
</tr>
</tbody>
</table>

This funding is allocated annually. Attempts in 1997, to obtain an agreement on a three-year funding program were unsuccessful. Funds are held and administered utilising the financial regulations set out by the THS Accounting and Property Manual. The project is located within the Public Health Unit (now Health Development). The project has two full-time staff: a Coordinator and a Medical Officer.

Currently, two committees oversee the project. Representatives of the funders form the first of these, whose main function is to deal with funding related issues. Meetings between the funding bodies occur at least twice a year to review the financial situation and the business of the project.

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2 Material in this section is drawn directly from Menon A & Coppola A, 2000. Tri-State STD/HIV Project: Background information for the proposed evaluation of the project.
The TSP coordinator provides the funding body representatives with quarterly financial reports that clearly document monthly expenditure against standard classifications produced on a financial cash flow document. Progress reports include: minutes of the most recent sub committee meeting and actions arising; three monthly progress reports of the current operational plan; and copies of relevant discussion papers written.

The second is the CADCCC STD/HIV subcommittee, which meets quarterly. It supplies technical advice and monitors performance.

The TSP area of interaction was initially defined as the cross border area of Central Australia. In recent years, however, as programs have been developed, the Tri-State Project has had increased interaction with a number of health services outside the initial cross border area. These are listed in Table 2 below.

Table 2: Health services interacting with TSP

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Health Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>NT</td>
<td>THS, Aherrenga Health Service, Mutitjulu Health Service, Urupuntja Health Service, Santa Teresa Health Service, Anyinginyi Health Service, Central Australian Aboriginal Congress, Pintubi Health Service, Apatula Health Service, Imanpa Health Service</td>
</tr>
<tr>
<td>WA</td>
<td>Ngaanyatjarra Health Service</td>
</tr>
<tr>
<td>SA</td>
<td>Nganampa Health Council</td>
</tr>
</tbody>
</table>

The current population base for the TSP area is described in Table 3 below:

Table 3: TSP population base

<table>
<thead>
<tr>
<th>Region</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice Springs-Remote</td>
<td>8537</td>
<td>2027</td>
</tr>
<tr>
<td>Alice Springs-Urban</td>
<td>5076</td>
<td>22427</td>
</tr>
<tr>
<td>Tennant Creek*</td>
<td>4146</td>
<td>2733</td>
</tr>
<tr>
<td>Anangu Pitjantjatjara</td>
<td>2588</td>
<td>–</td>
</tr>
<tr>
<td>Ngaanyatjarra Lands</td>
<td>2377</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>22724</td>
<td>27187</td>
</tr>
</tbody>
</table>

The evaluation brief

The objective of the evaluation was to assess the effectiveness of the Tri-State Project (TSP) and build on the findings of the 1996 review. The evaluation would review evidence of the achievements and ongoing activities of the TSP and make recommendations regarding the future of the project. The terms of reference for the evaluation were as follows:

1. Assess activities of the Tri-State project, within the context of STD/HIV control, with reference to the identified key result areas as follows:
   - STD/HIV surveillance systems;
   - Clinical management of clients with STD/HIV;
   - Health care provider education and training;
   - Education and prevention; and
   - Coordination of STD/HIV control activities and information exchange.

2. Determine progress towards attainment of the original objectives of the Tri-State project.

3. Evaluate the Tri-State project's ability to respond to the needs of services in the region and identify barriers to the uptake of programs.

4. Determine the effectiveness and usefulness of Tri-State's projects in relation to overcoming the identified barriers (see 3 above).

5. Identify areas of progress towards resolution of policy inconsistencies and structural issues between jurisdictions which may impede effective patient management and care, monitoring and surveillance.

6. Comment on the extent to which outcomes and learnings from Tri-State project activities are:
   - systematically communicated with other regions/services both within the participating jurisdictions and nationally;
   - effectively contributing to the development of models of good practice in other regions of Australia; and
   - recommend strategies for this to occur.

7. Advise on the continuing need and/or role of the Tri-State project, in particular, make recommendations on:
   - appropriate overall objectives and key result areas for the project;
   - key strategies for future action for the STD/HIV Tri-State to enhance STD/HIV services in the cross border region of Central Australia;
an appropriate level of funding for the project and the relative contributions of the various funding bodies;

- the effectiveness of the funding bodies involvement in the Tri-State and the role of the Territory Health Service as the auspicing jurisdiction; and

- appropriate management and advisory structures for the project.

Methods

In order to address the Terms of Reference for the evaluation we undertook a qualitative strategy to develop an updated process evaluation combined with a quantitative analysis of STD/HIV surveillance data and the surveillance system.

To ensure that the evaluation focussed on issues of primary concern to key stakeholders we initiated a set of discussions with the responsible OATSIH officer, Helen McFarlane, Dr Janet Knox and the Tri-State project staff and reviewed the background document developed for the evaluation by Tri-State. In addition we attempted to convene a special meeting of the STD/HIV sub-committee of the CADCCC to canvas relevant issues but were unable to do so given our tight timeframe and the limited availability of committee members.

Following these initial discussions a planning and methods workshop was held where the evaluation team reviewed the Terms of Reference and background documents and developed detailed methods for the quantitative and qualitative data collection and analysis. The evaluation team included:

- Dr Jon Willis;
- Ms Gai Wilson;
- Associate Professor Ian Anderson;
- Professor Doreen Rosenthal;
- Associate Professor Anthony Smith; and
- Professor Christopher Fairley.

The quantitative analysis

We attempted to assess progress towards the Tri-State objectives on the basis of available surveillance data as presented in the Background Report. Given the centrality of the surveillance system to monitoring the performance of the TSP, the surveillance system itself was examined. The key domains of the system examined were its simplicity, flexibility, acceptability and timeliness (K laucke et al., 1988).

The qualitative analysis

The qualitative analysis included both the examination of key TSP documents, as well as group and key informant interviews with selected stakeholders.

Documents were initially collected during a field trip to Central Australia and included key TSP material, such as operational plans and reports, policy papers, conference papers and data collection proformas. Some informants subsequent to interviews also provided additional documents. A detailed list is provided in Table 1.6.

A list of key informants and the interview schedules were generated based on the Terms of Reference, initial discussions with some stakeholders, a preliminary document analysis and the detailed discussion at the planning and methods workshop. Key informant categories included members of the STD/HIV sub-committee of the CADCCC, representatives of each of the funding jurisdictions sitting on the funder’s body as well as health care providers. The health care providers represented a selection of those identified in the tender document (Section C5), and included at least one health service from each state/territory, a mix of town and rural services and those services with both frequent and infrequent contact with the Tri-State project. A full list of interviewees is presented in Table 4. Key informant interviews were conducted either in person, during the field visits to Alice Springs, or later by telephone.

The interviews were semi-structured and designed to canvass views of stakeholders on the evaluation Terms of Reference. Interviewees received a letter, which outlined the evaluation, introduced the evaluation team and included a copy of the Terms of Reference. Eleven interviewees were conducted in person and four by telephone. All interviews were recorded by the interviewer who took detailed notes with most interviews being recorded by two interviewers.

In addition we attended the Regional Planning Workshop conducted by the Tri-State Project staff in December 2000. This workshop included presentations on a range of issues pertinent to the Tri-State project’s activities and STD control in Central Australia and

contributed valuable information, papers and documents for the evaluation (see Table 5). Two members of the evaluation team also took extensive notes and all of this material was included in the data analysis.

All interview notes and notes from the Regional Planning Workshop were transcribed and circulated to all members of the evaluation team. We used NVivo qualitative analysis software to perform a thematic analysis of transcribed notes from interviews and workshop presentations, and the background information document provided by TSP staff.

Axial themes included each of the terms of reference, as well as achievements and barriers. Additional data bases were created for comments recorded about each of the target diseases of the TSP, and thematically analysed according to four axial themes: achievements, results, barriers, and future directions. The coding trees for these analyses are included at Appendix one.

Two workshops were held with the evaluation team to contribute to the analysis of the statistical and interview data and to generate preliminary conclusions and recommendations.

Table 4: Interviews conducted for the evaluation

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Date</th>
<th>Type</th>
<th>Funders group</th>
<th>Health Service</th>
<th>Technical Reference Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael Carter (Aninginyi Congress)</td>
<td>15/11/2000</td>
<td>Interview</td>
<td>No</td>
<td>Frequent contact</td>
<td>No</td>
</tr>
<tr>
<td>Celina Bond (Barkly Public Health and Remote Health Unit)</td>
<td>16/11/2000</td>
<td>Interview</td>
<td>No</td>
<td>Frequent contact</td>
<td>No</td>
</tr>
<tr>
<td>Michael Howard and Douglas Josif (Ngaanyaljarra Health)</td>
<td>21/11/2000</td>
<td>Interview</td>
<td>No</td>
<td>Frequent contact</td>
<td>Yes</td>
</tr>
<tr>
<td>Janet Knox (Nganampa Health)</td>
<td>1/11/2000</td>
<td>Interview</td>
<td>No</td>
<td>Frequent contact</td>
<td>Yes</td>
</tr>
<tr>
<td>Andrew Ebringer (Remote Area Health Services)</td>
<td>17/11/2000</td>
<td>Interview</td>
<td>No</td>
<td>Frequent contact</td>
<td>Yes</td>
</tr>
<tr>
<td>John Boffa (Central Australian Aboriginal Congress) and Donna Ah Chee (Congress Alukura)</td>
<td>22/11/2000</td>
<td>Interview</td>
<td>No</td>
<td>Infrequent contact</td>
<td>Yes</td>
</tr>
<tr>
<td>Tiffany Lohs, Josef Schofield, Geoff Stewart and Nathan Aucote (Mutitjulu Health Aboriginal Corporation)</td>
<td>20/11/2000</td>
<td>Interview</td>
<td>No</td>
<td>Infrequent contact</td>
<td>No</td>
</tr>
<tr>
<td>Kath Fethers (Sexual Health Unit, THS, Alice Springs)</td>
<td>21/11/2000</td>
<td>Interview</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
</tr>
<tr>
<td>Jan Savage (STD/HIV program, CDC Darwin)</td>
<td>28/11/2000</td>
<td>Phone Interview</td>
<td>No</td>
<td>NA</td>
<td>Yes</td>
</tr>
<tr>
<td>Helen McFarlane and Peter Harding (OATSIH, Canberra)</td>
<td>28/11/2000</td>
<td>Phone Interview</td>
<td>Yes</td>
<td>NA</td>
<td>Yes</td>
</tr>
<tr>
<td>Philippe Porigneaux (Health Development, THS Darwin)</td>
<td>4/12/2000</td>
<td>Phone Interview</td>
<td>Yes</td>
<td>NA</td>
<td>No</td>
</tr>
<tr>
<td>Russell Waddell</td>
<td>23/11/2000</td>
<td>Interview</td>
<td>Yes</td>
<td>NA</td>
<td>Yes</td>
</tr>
<tr>
<td>Sandy Thompson (Sexual Health Unit, Perth WA)</td>
<td>28/11/2000</td>
<td>Phone Interview</td>
<td>Yes</td>
<td>NA</td>
<td>Yes</td>
</tr>
<tr>
<td>Annette Coppola and Arun Menon (TSP staff)</td>
<td>1/11/2000</td>
<td>Interview</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Eleanor Hook (TSP staff)</td>
<td>22/11/2000</td>
<td>Interview</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
### Table 5: Papers and workshops presented at the Regional Planning Workshop, 13-15 December

<table>
<thead>
<tr>
<th>Speaker</th>
<th>Title of Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 1, 13 December 2000</strong></td>
<td></td>
</tr>
<tr>
<td>Russell Waddell</td>
<td>Sexually Transmitted Disease: A control plan for Central Australia</td>
</tr>
<tr>
<td>Annette Coppola</td>
<td>Overview of Tri-State HIV/STD project</td>
</tr>
<tr>
<td>Annette Coppola</td>
<td>STD Patterns and consequences in Central Australia</td>
</tr>
<tr>
<td>Arun Menon</td>
<td>Barriers to effective STD control in Central Australia: A limited summary of issues</td>
</tr>
<tr>
<td>Group Discussion</td>
<td>Barriers to effective STD control</td>
</tr>
<tr>
<td>Valmai McDonald and Mona Phillips</td>
<td>Health Promotion issues in regard to regional strategies</td>
</tr>
<tr>
<td><strong>Day 2, 14 December 2000</strong></td>
<td></td>
</tr>
<tr>
<td>Helen McFarlane (OATSIH, Canberra)</td>
<td>Resources available at Commonwealth level</td>
</tr>
<tr>
<td>Colin Banks (OATSIH, Adelaide)</td>
<td>OATSIH funding in South Australia</td>
</tr>
<tr>
<td>Russell Waddell (DHS, South Australia)</td>
<td>State funding in South Australia</td>
</tr>
<tr>
<td>Sandy Thompson (SHP, Western Australia)</td>
<td>State funding in Western Australia</td>
</tr>
<tr>
<td>Diana Downs-Stoney (OATSIH, Western Australia)</td>
<td>OATSIH funding in Western Australia</td>
</tr>
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Table 6: Documents reviewed in the evaluation process

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<td>An evaluation of the Tri-State STD/HIV project (August 1996)</td>
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<td>John Boffa</td>
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<td>John Boffa and Michael Fisher</td>
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<td>Andrew Ebringer</td>
<td>A SWOT Analysis of a Regional Screening and Treatment Program for Sexually Transmitted Diseases in Central Australia. (August 2000)</td>
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Structure of the Report

In what follows, each chapter reports on findings according to the terms of reference. Chapter one examines the achievements of the TSP in each of the Key Result Areas. Chapter two looks at the activities of the TSP in relation to each of the original objectives. Chapter three examines regional needs and barriers in relation to the control of STDS. Chapter four looks at policy and structural issues that have inhibited the successful implementation of the TSP. Chapter five examines the dissemination of TSP outcomes and learnings. Chapter six contains our analysis of the ongoing need for and role of the TSP, and our recommendations for the future of the project.
Chapter One: Assess activities of the Tri-State project, within the context of STD/HIV control, with reference to the identified key result areas

In its original conception, the TSP was to meet its objectives by looking at the following key result areas (KRA):

- Clinical management of clients with STD/HIV;
- Health care provider education and training;
- STD/HIV surveillance systems;
- Education and prevention; and
- Coordination of STD/HIV control activities and information exchange.

We asked informants to identify what they believed to be the main achievements of the TSP in recent years. In this section of the report, we examine TSP performance in relation to these KRAs through an analysis of what our informants nominated as achievements of the program.

KRA1: Clinical management of clients with STD/HIV

Under the first of the Key Result Areas, Menon and Coppola (2000: 81) listed six projects including: the development of guidelines for STD/HIV control, audit of STD/HIV related clinical activity within Health Services and development of AMS specific strategies, development of a Universal Pathology Form, the maintenance of management protocols, participation in appropriate clinical research, and the Medical Waste Project. Our informants nominated three of these projects as achievements of the TSP in the period under review: audits, management protocols, and the Medical Waste Project.

Audits

The TSP has audited six health services where STD work is conducted. These six sites are Remote Health, Urapuntja Health, Aherrenge Health and Pintupi Homelands, Imanpa, and M utiljulu Health Services. The purpose of the audit was twofold: to provide information to improve the management of STDs at Primary Health Care level; and to establish a baseline for the future evaluation of any proposed strategy to improve the current situation.

Annette Coppola and Arun Menon (TSP) suggested that the information collected by the audits is used “... to identify gaps (auditing health services, including new audit methodologies) and regional screening processes and information systems”. They also believed that the audits were an important tool for increasing confidence amongst Health Care Providers in what TSP can do for or with health services (eg. providing assistance with developing performance indicators for health services to report to funding bodies).

The majority of informants felt that the audit was a very useful exercise because it raised awareness in the clinic of deficits in existing procedures, and areas where improved performance was required. The M utiljulu staff commented that the audit process was a good thing. They knew the problems, but it was good to have them on paper. The audit assisted them to move from a completely ad hoc approach to a functional paper-based system that allows follow-up to happen, and facilitates future audits. Sandy Thompson (WA SHU) agreed saying the audits evaluated what is going
on in clinics and encouraged practitioners to reflect on their activity.

Most also agreed that audits should continue to be carried out. Sandy Thompson said that TSP should keep auditing, feedback back and reauditing. The Mutitjulu staff pointed out that auditing is also useful in the event of new staff entering the clinic, because they can see what’s happening.

A few informants felt that the auditing process could be taken even further to enhance the services of health care clinics. Russell Waddell (RAH) suggested extending the auditing process to look at outcomes of treatment. For example, the audit could also document the percentage of patients presenting with UTIs were also tested for STIs, and what treatment they received. He believed that the aim of the audit should be developing from “this is what you need” to “within your resources, these are the targets you should be setting” for services. John Boffa and Donna Ah Chee (CAAC and Alukura) also felt that the audit is a good process, but they acknowledged that there were some ethical concerns with unauthorised people having access to patient notes. Their service had resolved the problem of allowing outsiders into patient notes by defining a standard that allows the review of patient notes for quality assurance purposes, but does not allow it for research unless there is individual informed consent from each patient.

Protocols

For a number of years TSP has been involved in the production on the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual for the revision of the fourth CARPA STM, has been involved in the writing of submissions for funding, will participate in the overview of the projects and will be actively involved in the review of all the current STD/HIV protocols.

All informants agreed that protocols are very useful for promoting standardised treatment: Kath Fethers (NT SHU) said standardised treatment leads to consistency. So although GPs around town all do different things, bush clinics all use the same protocols that can be reviewed and updated periodically. Ngaanyatjarra Health Service Staff agreed that CARPA protocols are a good thing. They noted that WA previously had a different protocol for syphilis, but that advocacy from TSP brought Ngaanyatjarra clinics into line with the rest of the Tri-State area.

Sandy Thompson said there was now agreement on protocols but cautioned that screening and follow up should be a clearly articulated part of the strategy for managing STIs, and not left as a special activity. She felt it was important that TSP should advocate for a more coordinated approach to screening, but not actually provide a screening service themselves.

Medical Waste Project

This project was initiated in 1997 after the Ngaanyatjarra Health Council asked the TSP to develop a regional waste disposal strategy. This was to address both the transport of medical waste from remote areas and negotiate for access to incineration for both town based and remote area health services.

In 1998 the Ngaanyatjarra Health Council designed equipment to transport medical waste from remote clinics to Alice Springs. TSP offer this equipment to all remote area health services and in 1999 this extended to TSP fully funding and coordinating the manufacturing of 46 carrier boxes to clinics in the region. Ngaanyatjarra Health Services chose not to participate. More recently, equipment that may allow for the incineration of needles has become available although this technology is still in the final stages of development. TSP funds have been allocated to allow two units to be purchased, trialed and evaluated.

Despite the resources that have been developed such as the safe sharps disposal, there are still some problems in relation to the Medical Waste Project. In particular, Ngaanyatjarra Health Service Staff pointed out that the sharps container wasn’t appropriate in WA as it doesn’t follow the WA guidelines, which require that this kind of medical waste must be buried and fenced. The Environmental Health Officer took NHS sharps back to Kalgoorlie with him for disposal. Although the NHS preference is for on-the-spot disposal, the current problem for them is transport, not containment.

The Mutitjulu staff identified a different problem with the sharps container, that of size. Although the TSP sharps disposal boxes come in 7 and 20 litre sizes, Mutitjulu had only had access to a 7-litre container. They described their sharps disposal box as a “good tucker box”, but otherwise a waste of time and money. Only two of the small sharps disposal containers used in their clinic can fit in the 7-litre TSP disposal boxes properly, and it is therefore too small to be useful. If it were bigger, they could send it in to Alice Springs Hospital by courier at a reasonable cost. Now staff members drop sharps disposal containers and other waste off on trips to Alice Springs, without using the TSP box.
KRA2: Health care provider education and training

Under the second of the Key Result Areas, Menon and Coppola (2000: 91) listed four projects including: the Men’s health resource project; support for Ngaanyatjarra Health Service to develop an STI program; support for CAAC health service to develop aspects of a STI program; and provision of information to Goldfields Public Health Unit and Bega Garnbiringu Health Service STI programs. Two of our informants nominated the Men’s Health resource project as achievements of the TSP in the period under review, and several talked of the value of the audits and other on-ground activities of the program as an opportunity for health care provider education and training.

Men’s Health Resource Project

The Men’s Health Resource project comprised the development of a form for Well Men’s Health Check, a patient education flip-chart resource for use during the check, and a training package for educators to use for training male AHWs and the broader community about the Well Men’s Health Check (still in development). Much of the work was done through two regional workshop for men (including AHWs), which were coordinated by TSP staff. Both Michael Carter, who attended the first workshop with three AHWs, and Ngaanyatjarra Health Service Staff commented on the success of the workshops. They thought the process of getting men together to standardise the form used for Well Men’s Health Check was a good idea, and gave a sense of ownership of the program to AHWs. Ngaanyatjarra Health Service Staff also commented on the usefulness of the resulting form and education resource.

Other Education issues raised

The educational utility of the audits of primary health care activities in relation to sexual health has already been canvassed under KRA1. These audits, together with screening activities carried out as part of the sub-regional screening program (see KRA4 below) and one-off assistance with screening at the local level at A Ngaanyatjarra community were identified as the most useful health care provider education and training activities in which the TSP was involved. While commenting on their value, our informants suggested ways in which their training potential could be augmented. In particular, Mutitjulu staff suggested that TSP could design tailored education packages and materials for staff inservice training based on actual data from audits and community screening. Kath Fethers, who worked on some of the subregional screens, agreed. She thought that the educative function of these activities needed more emphasis, and particularly that the education of Aboriginal health workers need a more concentrated effort.

Other suggestions about the potential role of TSP in education were in some conflict. Some thought that the staff of primary health care services, including AHWs, needed training in patient education and health promotion skills. Mutitjulu staff, for example, thought that TSP could assist with programs that taught skills and strategies in how to talk to patients about STIs, how to do education sessions with children, how to talk to young women about lower abdominal pain, about condoms, and about sex. They wanted to learn culturally appropriate ways of doing these things, including how not to tread on toes and how to work within a different culture. At the regional planning workshop, there were also suggestions that TSP need to work with clinics to develop ways of promoting sexual health and screening on the ground with the community. These things were seen as ongoing education needs for staff in clinics. Adolescents and school children were seen as specific targets, although the main needs identified for sex education were in schools, as part of encompassing life education program focused on adolescent health and development.

Alternatively, Ngaanyatjarra Health Service saw TSP’s education role as focused on resource development and evaluation. Mutitjulu staff thought that there was no need for a Central resource development agency, but that TSP could resource communities to develop programs, and help with coordinating approaches between services. John Boofa and Donna Ah Chee (CAAC) also saw some role for Centralised resource development and distribution, but also thought that some of the old resources need to be revived.

We have three main comments to offer in relation to this KRA. Firstly, there is a clear need for TSP to formalise and extend its program of health provider education and training. The most valuable contribution it can make is in the area of improving the local capacity of primary health care services in the area of routine screening for and management of STIs through an expanded program of audits, and through formalised training associated with practical activities, such as community screenings. The second point is that there is no regional consensus regarding TSP’s potential role in the evaluation, future
development, promotion and distribution of sexual health education resources. There is, however, clearly a need for regional coordination in this area that TSP could provide. In the case of health education resources, regional coordination would include the evaluation, refinement and distribution of health resources developed at the local level. The workshop process used to develop the Well Men’s Health Check resources was praised, and could be developed as a model for the development or refinement of other regional resources. A third obvious need is for primary health staff development in the area of health education and promotion, and TSP could provide the coordination required to achieving a consistent regional approach in this area, again through facilitating regional workshops, and evaluating and distributing existing training resources. We note that a number of informants made us aware of the range of other organisations within the region that already had staff training and health resource development roles. TSP could play a valuable role by concentrating on coordinating the inputs of these other organisations in the area of sexual health.

KRA3: STD/HIV surveillance systems

Under the third of the Key Result Areas, Menon and Coppola (2000: 94) listed five projects including: gonococcal antibiotic sensitivity surveillance; the Donovanosis Project; the Syphilis Information System; Trichomonas as a notifiable disease; and the Central Follow-up Database. Our informants nominated three of these projects as achievements of the TSP in the period under review: the Donovanosis project, the Syphilis Information System, and the Central Follow-up position.

Donovanosis Project

Annette Coppola and Arun Menon believe that the development of the Donovanosis Project was an achievement because it put genital lesions on the agenda, and introduced Centralised follow-up as a way of addressing mobility. Mobility and subsequent loss to follow up were previously the major problem with Donovanosis, because of the complexity of treatment required. They felt that two things made the project successful: a couple of years of talking about it so that it was acceptable; and having a protocol that people could follow. The project has also achieved national recognition, and forms the basis of the model that has been accepted by OATSIH for the national eradication of Donovanosis.

They added, however, that Donovanosis is still a problem, particularly since the project officer position ended. They did not feel that Donovanosis follow-up had been absorbed by TSP, or that the Central Follow-up position could simply take it over, as this position was overloaded by additional work because of problems with Western’s data. Eleanor Hook agreed that the Donovanosis project should be continued, but could be streamlined at SHU. She thought that this would not be workable within current staffing at SHU, but that if problems with Western’s data were ironed out, a single follow-up position could probably manage Centralised follow-up for Donovanosis along with other diseases.

Other people also praised the project. Russell Waddell (RAH) said that the Donovanosis register helped him maintain the profile of genital lesions. He thought the Donovanosis register should be maintained to monitor rates and to allow follow up. Similarly, Sandy Thompson (SHU, Health Department, WA) praised the Donovanosis Project. Only the Mutitjulu staff had nothing positive to report about the Donovanosis Project. They thought that Donovanosis was not a public health priority because of its low incidence – 1 case in 16 months. In Jeff Stewart’s view, Donovanosis follow-up was a waste of time and money.

The Syphilis Information System

The Syphilis Information System (SIS) was designed in 1997 and has operated since 1998. The main components of this database were to: establish who had syphilis tests; estimate the degree of seropositivity in the population; identify exposed individuals who had been adequately treated; identify exposed individuals who had been adequately treated but required follow up; identify exposed individuals with no history of treatment (NHT); and compile lists of exposed individuals who required treatment.

A number of informants commented on the usefulness of the SIS, particularly in relation to accessing patients’ treatment histories, doing contact tracing and follow ups. Mutitjulu staff said that the syphilis database is a great backup, and helpful for interpreting patient results, especially when treating someone from another community. Russell Waddell agreed that the Syphilis database was useful for getting treatment histories for patients who present to him at RAH. Dr Waddell added that that this is important because it prevents...
over use of treatments, and unnecessary painful treatments.

Michael Carter said that the Barkly had only become a part of the SIS that year. Prior to this the Aninginyi board had had sensitivities about security of data, and didn’t want to participate. He went on to praise the SIS, saying that everyone had had a good experience of it, including the doctors and midwife. He thought it had also helped people recognise TSP’s sensitivity around confidentiality. Celina Bond said that there was a more coordinated approach now to syphilis in the Barkly because of the database. She thought it made it easier to do contact tracing and follow up.

However, there were also complaints about the way that the SIS was managed. Russell Waddell felt that there were problems with the way data was collected, and that the database initially tried to collect too much data. He said that he had warned them that using access on a network was problematic and that there would be problems and crashes. Sandy Thompson, on the other hand, did not feel that the SIS was a useful database. She thought that it had consumed a lot of resources for no outputs and had been badly designed. She was glad that they had maintained a manual card system so the management of individuals hadn’t fallen over. She believed that the SIS had not reflected well on TSP.

John Boffa and Donna Ah Chee raised a number of concerns about the SIS. The Congress Cabinet strongly believe that if a patient presents at Congress for treatment and returns to complete all of the necessary follow-up, then their information should not be sent on to a Centralised database. Currently there is no legal requirement for this to occur in the NT (or perhaps any other jurisdiction) and therefore it does not happen for non-Aboriginal people. Congress Cabinet believes that Aboriginal people should not be treated any differently. If there is a need for such a Centralised database, then it should apply to everyone and not only Aboriginal people. This would require a legislative change in the Public Health Act. However, if people do not return for treatment after a positive syphilis test, their names and details should be given to the register and the Central follow-up program. Consent for this should be obtained at the time the blood test is taken by telling the patient that if they do not return for a follow-up appointment and do not leave a contact number then their result will be forwarded to the register. Such a system rewards individuals who are responsible for their own treatment – it is the view of Congress Cabinet that very few Aboriginal people would want their results being sent to a Central register if they can avoid it. At the present time, the system for obtaining individual consent for information going on to the register is problematic.

Centralised Follow-Up

Eleanor Hook, who held the Central Follow Up Position at the time of our visits, said that the position had “taken off”, and that feedback from bush was that it is useful. Her view was that the position had resulted in better follow up through the production of regular recall lists, which led to reduced time to treatment, and an increasing amount of consultation from bush nurses, especially regarding treatment. She also spoke of a number of tasks she had carried out in the position that have helped reduce the administrative burden often faced by the health care staff. Andrew Ebringer confirmed that the position had provided useful interpretation and treatment information for remote nurses. He also speculated that time to treatment has dropped since Eleanor Hook was appointed. He thought that part of the success of the program was having a dedicated person to handle all data, a job that had previously been done by DMOs in addition to their other duties. He also thought that having an Eleanor in the position, a registered nurse, had been beneficial. Annette Coppola and Arun Menon said that the value of the Central Follow Up position had been particularly demonstrated in the case of Ngaanyatjarra Health Service. Eleanor had been able to provide data to them about their testing and positive rates that they had not previously been able to provide to their funders. A number of other informants also commented on the reduced time to treatment as a major benefit of the Central Follow Up Position. Kath Fethers said that the personal contact had cut the interval to treatment, and the position also provided useful advice in relation to treatment, further testing (eg HIV) and contact tracing.

The Mutitjulu staff felt that Eleanor Hook was doing a good job but that her position was only useful because Westerns was not performing. For most diseases, that all the necessary information was on the notification – they did not see any benefit in having access to more information about a patient (for example, treatment history). They thought that if data from Westerns were more reliable, there would not be any need for the Central follow-up position. Annette Coppola and Arun Menon agreed that the position was there because the return of results was so poor, and pointed out that even with the Central Follow Up position, they were still not absolutely sure they were getting all results back from Westerns. They said that in one clinic audit, 10% of positive results had not been communicated back
to the clinic. There was still considerable work to be done to ensure accurate and timely results for the region. Arun has been negotiating to get a direct download of Western’s data via modem. He believes that this will give another level of error checking against the hard copies and aggregate lists they currently provide. The follow-up position was only one strategy that TSP was using to ensure that positive results get back to participating clinics, but it was an important part of the current strategy.

John Boffa and Donna Ah Chee agreed that the Central Follow Up Position is a useful role, even for urban clinics. However, they did feel that there was a problem with obtaining valid patient consent in relation to the Central follow-up database as well as other centralised regional data collections. They suggested that individual patients should consent to their results being reviewed by a third party, or recorded on a database. They did not believe that this level of consent was currently obtained. Arun Menon said that currently the TSP obtains “community” consent for inclusion on the database, and that TSP assumed that clinics had instituted locally relevant processes to obtain consent.

There was considerable praise for the position, and support for its continuation. Eleanor Hook thought that it could be streamlined in SU, although not within current staffing at SU. She suggested that there probably was not a whole position in this task, but a single position could probably manage this and a Donovanosis task. Sandy Thompson expressed concern over the long-term prospects of the Central Follow Up Position. She pointed out that the position had been created from short-term money, and was therefore short term. She also felt that the focus of the TSP should be on training and advocacy, rather than service provision. John Boffa and Donna Ah Chee agreed. They felt that the quality assurance role currently provided by the Central Follow Up Position really belonged with each health service, and that audits and training provided by TSP could help services to develop the necessary local systems.

KRA4: Education and prevention

Under the fourth of the Key Result Areas, Menon and Coppola (2000: 109) listed six projects including: regionalisation of the “safe ceremony” strategy, the Men’s health resource, Men’s health, Regional Men’s Health meeting, development of videos for pre and post test HIV information in six community languages including Warramungu, and the subregional screening program. The development of the Well Men’s Health resources, and the associated workshop have already been discussed under KRA2. Our informants otherwise nominated both the regionalisation of the Safe Ceremony strategy and the subregional screens as achievements of the TSP in the period under review.

Safe Ceremony strategy

Janet Knox, Sandy Thompson and the Mutitjulu staff all nominated the extension of the Safe Ceremony strategy as an achievement. Janet noted that the strategy was mainly developed by Nganampa Health Council, but that TSP had done a good job of distributing the ceremonial red boxes at a regional level. The Mutitjulu staff agreed that the “Men’s business boxes” were a good thing, but that it was difficult within the health service’s structure and size to fund a “business” health worker position to implement the strategy. They noted that they were in discussions with Nganampa about employing, training and supporting a worker, but that there were difficulties with funding the position, and providing appropriate motivation for the work. They noted that such a staff person would need some training, and that the materials in the box would need to be checked with them before each ceremonial trip.

These concerns were echoed at the regional planning workshop, where it was noted that men needed training about what is in the red box and how to use it. Distributing the ceremonial equipment was compared to the distribution of Schedule 8 drugs to cattle stations, with similar training and support needs. It was also pointed out that only Nganampa Health had the resources to pay men to do the “red box” work, and that simply providing the boxes did not make a complete strategy.

Sub-regional Screening

Although Coppola and Menon only nominated sub-regional screening under this KRA, they and other TSP employees have in fact done a considerable amount of work between 1996 and 2000 to promote a systematic approach to active case finding in the region. This has included the sub-regional screening program, assistance with screening programs in individual communities, and more general promotion of opportunistic testing ‘every time you catch a wee’. They said that promotion of such opportunistic testing has increased the amount of testing 5-fold for women, and 2-fold for men in the region.
The discussion of screening generated by far the most discussion among informants. Informants spoke of examples where TSP assisted them with screening in their communities and what role they thought TSP should play in screening. Ngaanyatjarra Health Service Staff spoke of the assistance TSP has provided NHS, including assistance with gonorrhoea, chlamydia and syphilis screening at Ngaanyatjarra community during 2000. TSP had assisted with most phases, including with doing the screening, developing population lists, analysing the results, and providing equipment. Mutiljulu staff also spoke of the assistance they had had from TSP and SHU for STD screening in May 2000, linked to the Nhanampa Health annual screening month. They said there had not been a coordinated STD screen before then, and it was the first time there had been a concerted effort in Mutiljulu to screen everybody, rather than just opportunistic screening. They added that being involved in the screen and seeing how they did the follow-up helped them to develop their own way. Both Jan Savage and Janet Knox though that the TSP promotion of screening, and of PCR technology for screening of gonorrhoea and chlamydia had been both innovative and successful. Janet Knox though that the promotion of screening and opportunistic testing had resulted in visible results (evidence) for staff that made efforts to control gonorrhoea and chlamydia seem real for the first time.

Not everyone was satisfied with the active role that TSP played in screening. Helen McFarlane said that regional screening was an important coordination goal for TSP, but that it did not have a role in screening delivery. In her view, TSP needed to avoid becoming a service provider of the TSH. TSP should be coordinating rather than doing the screening and follow up treatment. She said that the Commonwealth was not funding the TSP as a service delivery agency but as a project to assist services to design their own programs. Phillip Porigeau agreed, saying that the TSP should not be providing screening, but setting standards for screening. He felt that the current TSP involvement in screening was leading to confusion of its role with that of the sexual health unit.

Almost everyone we interviewed saw the value of full regional screening, but commented on how difficult it would be to achieve. Andrew Ebringer pointed out that the subregional screening rates were disappointing. In his view, the only way to achieve significant results was through regional screening. Ngaanyatjarra Health Service Staff agreed that regional screening should be on the agenda, and was acceptable practice and feasible for them with their current staff. However, they did acknowledge that there were lots of logistical problems with regional screening, including reliable pathology results, staff on the ground, transport and handling of information. They did not think that there was an issue with the value of regional screening. They also thought that mass treatment should be on the agenda for discussion.

Kath Fethers thought that regional screening could not be achieved with existing SHU and local health service staff. She pointed out the key problem of male participation rates, and said that it would not be successful if all the women were screened but no men. She said that a main problem was the lack of male workers. Russell Waddell also agreed that regional screening could not be achieved. He thought that it was too ambitious because treatment follow-up would be impossible. It would be impossible to provide adequate patient education, screening then follow-up without substantial additional resources. He thought that TSP's current sub-regional strategy is a better approach, and allows for patient education, screening, follow-up and contact management, which providing for increased awareness of STDs for clinic staff. He added that there is a need to build and develop local health infrastructure for sustainable services at the primary health care level.

At the regional planning workshop, there was only limited support for full regional screening. In a session designed to brainstorm a five-year regional STD control plan, participants noted that because resources are constrained, strategies needed to be sustainable at the clinic level. They suggested that the region needed to continue with current practices, but to work towards improve current service delivery. Strategies suggested included follow up training and regular support, for example from the Central follow up position, which helps improve practice. Other options suggested were: to always treat presumptively when screening; to improve current service delivery. Strategies included include related town camps in sub-regional screens; to improve coverage through well women's and men's health checks and opportunistic screening, combined with improved contact tracing and case management; and to coordinate targeted screening aimed at reducing prevalence, with ongoing evaluation and feedback (including in Alice Springs), combined with enhanced opportunistic screening, including of antenates.

There were two other issues related to screening that were raised during our consultation. Annette and Arun emphasised a number of times the importance of increasing opportunistic testing. In their view, there should be routine testing for renal disease (ACR), gonorrhoea & chlamydia (PCR), and UTIs (MC&S).
on every sample of urine collected. Their view was that TSP programs that aimed at improving screening rates at PHC level were providing the possibility for links into chronic preventable diseases strategies.

The other issue raised was that of PCR urine testing as a TSP achievement. Annette Coppola and Arun Menon reported that the introduction and evaluation of PCR screening had resulted in an expansion of screening and data collection in the region. A few informants commented on PCR screening as a useful new technology that has been implemented by TSP. For example, Jan Savage said that TSP’s work on testing new technologies like the PCR represented practical applied research. Janet Knox added that PCR has improved things. Previously, results on culture were always a bit indeterminate, but now people can see results, which has raised the profile of STD screening in the region.

KRA5: Coordination of STD/HIV control activities and information exchange

Under the fifth of the Key Result Areas, Menon and Coppola (2000:115) listed five projects including: work contracts; development of Central Australian STD strategy; CADCCC STD/HIV subcommittee; audits; and incorporation of STD control activity in correctional services into regional initiatives. Few informants mentioned work contracts, except to note that the attempt to get health services to enter into these agreements, although a worthy idea, was premature and ultimately unsuccessful. No informants mentioned the Central Australian STD strategy, or the correctional services initiative. However, our informants nominated both audits (discussed under KRA1) and the CADCCC STD/HIV subcommittee as achievements of the TSP in the period under review.

CADCCC STD/HIV subcommittee

Annette Coppola and Arun Menon spoke of the technical committee and its usefulness. They said this committee serves both technical and networking functions and that the combined meeting allows for sharing of technical expertise. Russell Waddell agreed, saying that he had benefited from the information exchange with other health services, and that learning and knowledge had been passed around through the meetings. Janet Knox acknowledged the importance of professional networks that have been fostered by TSP. She said that the strength of networks created by TSP, particularly through the technical committee meeting every three months, was a key outcome of the project. She thought that the value of the meetings was that they brought insiders together and outsiders in. She added that STD work would be more difficult without that network, as smaller health services were quite isolated. The coordination provided by TSP reduced both isolation and fragmentation in her view. A number of informants spoke of the isolation they experienced working in remote areas and spoke of distance as a barrier. For this reason, some spoke of the importance of networking in reducing their isolation. Ngaanyatjarra Health Service Staff also acknowledged that one of TSP’s successes had been their involvement of different groups and attempts to reflect the interests of different groups. Several other informants acknowledged the importance of the networking function. Philipppe Porigneaux said that TSP should play a key role in getting organisations together to talk about how to improve services. Sandy Thompson agreed, adding that it is good to get players to the table to discuss issues like regional screening.

There were some emerging problems with the forum, however. As a technical forum, its function is hampered by its growing size. There is room for new members – for example, there are no social scientists in the core technical group – but Annette and Arun did not believe that this forum could grow much bigger and remain useful. The solution they saw was to hold an additional forum for networking purposes, although this would require dedicated administrative support that they currently do not have. The lack of dedicated administrative support was seen as an impediment to a number of programs, and Annette said that currently they have to “beg, steal or borrow admin support”.

Also in relation to communication, most informants related positive experiences of TSP. Andrew Ebringer reported that TSP provide a good liaison for remote area staff. Although THS has protocols for screening and treatment, he thought that TSP provided dedicated resource people who could look at all results and provide treatment advice. Celina Bond agreed that it was really helpful to be able to contact others at TSP for help with information. She felt that it reduced her isolation.

There were also criticisms in relation to communication. Sandy Thompson said that TSP should produce annual reports because it helps the states to think that they are getting value for money.
She suggested that annual reporting might provide support for 3-year funding applications.

Coppola and Menon also reported that TSP have made a number of contributions towards building cooperation in the region, including developments towards a regional STD strategy and a major shift in sensitivities around STDs. They said there has been an incremental expansion of confidence in TSP. Among their achievements they included getting WA (Ngaanyatjarra Health) on board, although they acknowledged that NHS’s commitment to employing Oona Lynch and Michael Howard as a dedicated sexual health team had really helped. The main activities with NHS so far have been: involvement with the Central follow-up position; giving them new information for their funders; screening and analysis of screening at ANgaanyatjarra community; and now planning for a focus on STD-testing (like Nganampa’s focus month).

Informants were very positive in their appraisal of TSP with regards to the collaboration and cooperation they fostered between health services. Helen McFarlane noted that there had been a significant improvement in the level of cooperation with Territory Health Services. Jan Savage said that the fact that Nganampa Health’s work is a milestone could be partly attributed to the TSP in that the TSP has provided a professional public health framework in relation to STD/HIV in the NT for Ngaanyatjarra to work alongside. She thought that this collaborative focus was important as a complement to Nganampa’s work.

STDs on the agenda

Annette Coppola and Arun Menon offered the view that TSP had put STDs on the agenda. Jan Savage agreed, saying that the direction and management of STD/HIV has been constantly pushed onto the agenda by TSP, despite the lack of interest or energy from some areas. Janet Knox added that part of their success stemmed from the work TSP did in improving relationships between services, particularly THS-remote and Ngaanyatjarra Health. She said that Arun and Annette are good at doing things appropriately which won confidence in their program, and keeping things on the agenda by going to meetings. She felt that there was still considerable agenda raising work to be done, but that as a result of their recent work, clinic staff were now aware and interested. Annette and Arun thought that their audit work was very important as a tool for keeping STDs on the agenda at the local level. The kind of information they provided was unique, and the only part of each health service’s program where this sort of information was coming in. The audit information helped people to do their jobs better, and set priorities more effectively.

Other achievements

Our informants indicated a number of other achievements of the TSP which were not encompassed by the Key Result Areas. The main achievements they noted were: the innovation of the TSP; and the way they worked with small, realistic strategies.

Innovation

Annette Coppola and Arun Menon emphasised the need for continuing innovation in their work. They gave the example of their current involvement in screening, which they said was about product development, including population registers, ongoing evaluation and monitoring. They believed that in the current Central Australian environment, it was important to “roll up your sleeves and help”, because it made training more palatable for clinic staff. It was also the only way they could know what was going on. Using screening as a continuing health service education opportunity meant that they were there to ensure that the screening could be evaluated, and was not ad hoc.

John Boffa and Donna Ah Chee (CAAC) agreed that TSP were innovative but commented on the role they felt TSP should play. They said that TSP had successfully lead or pursued innovation and implementation of new technologies, but their role in research should be in cooperation with the CRC. The CRC Board provided a forum for discussion of priorities in research. The avenue for research proposals was to talk to CRC core partners, through CARIHP: for example, Johnny Liddle was on CARIHP and a board member of the CRC, so his opinion was a good litmus test. They thought that working through the CRC gave Aboriginal governance of the research agenda a real chance.

Ngaanyatjarra Health Service Staff also saw TSP providing a continuing focus for innovative research, such as PCR testing.

Small realistic strategies

Annette Coppola and Arun Menon spoke of a number of small, realistic strategies that they believe TSP have undertaken. These included: identifying problems
within PHC clinics, particularly with follow-up of positive cases, and offering practical assistance via the Central Follow Up position; looking at what can be done at the primary health level to build capacity without increasing workloads (for example, maintaining a simple list of what goes out to pathology and what comes in); and opportunistic screening. They spoke of the need to take small steps rather than large leaps, and to approach issues pragmatically because STDS are never going to be a major priority.

Eleanor Hook gave a number of examples of where TSP staff had worked with communities to achieve the strategies small gains. She said that they had been able to identify communities that have been struggling with recall. On two occasions, TSP staff members had gone to a community for four days to assist with follow-up. Another strategy involved that follow-up form she sent out with each notification. The form was designed to help with follow-up including, for example, the management of lower pelvic pain. A big burden of work for clinic staff was filling out the forms, so during the follow-up period following community screens she had extracted the necessary information herself from patient notes, and subsequently included it on all forms for that patient.

The audits also began as a small, realistic strategy that commenced in 1998. Annette and Arun said that the audits were an important tool for increasing confidence in what TSP could do for and with health services. They allowed TSP to provide useful information to health services, including information relating to performance indicators that health services were required to report to funding bodies. Mutitjulu staff agreed that the auditing process was a very useful strategy implemented by TSP. They said that their audit brought a lot of issues to the fore. On the basis of advice from TSP during the audit, they moved from a completely ad hoc to a functional paper-based system that allowed follow-up to happen, and which facilitated future audits. They now believed that it was possible for them to do their own audit from the follow-up system.

Kath Fethers also gave an example of the work of TSP that she thought was a realistic strategy. The follow-up trips to every community included separate meetings for men and women, with separate data sets for each. At these meetings, community members were shown the data comparing their community to the rest of Australia in relation to the percentage tested and the percentage positive. She felt that this reporting back was a really important aspect of the process, and prevented them being perceived as ‘just another bunch of people running in and collecting wee’.
Chapter Two:
Determine progress towards attainment of the original objectives of the Tri-State project

When it was established in 1993, the overall objective of the TSP was to ensure that by the year 2000, Indigenous people in Central Australia would have the following health status:

- A 90% reduction in syphilis and chlamydia rates;
- No donovanosis or congenital syphilis;
- An 80% reduction in gonorrhoea rates;
- No child under the age of twelve years having a STD; and
- HIV at or less than the Australian average.

In this section of the report, we look at these key indicators of activity and success, and discuss the progress of the TSP towards achieving these goals.

Syphilis Rates

In 1994, the syphilis notification rate in the Tri-State region was 519 per 100,000 population, and in 1999 the rate was 260 per 100,000 (see Figure 1).

This represents a fall of approximately 51%. While this does not represent the targeted 90% reduction, there are two points to note about these figures. Firstly, we cannot say with any sureness that the baseline rate was accurate. There are a number of factors to consider here. We have no idea what the testing rate for syphilis was prior to the introduction of the TSP, but we can deduce from the limited available evidence that the testing rate was low, and that therefore the notification rate seriously underestimated the rate of disease in the population. What we have noticed since the introduction of the TSP is that improvement in testing rates has lead to increases in notification rates, as previously undetected disease is now identified. With syphilis there is clear evidence that with improved follow-up and treatment of index cases and their contacts, the notification rate falls.

Our discussions with stakeholders revealed a general view that syphilis rates had improved, but that there was still work to be done. Janet Knox from Nganampa Health Council noted at the Regional Planning Workshop that STD trends, collated from annual STD screens in AP communities, indicated that the prevalence of syphilis had dramatically decreased in these communities. In 2000, there were only 7 new cases. This is a definite improvement from 1996, when one in three-to-four people in the 15-25 age range had gonorrhoea, chlamydia or syphilis. The syphilis rate has now improved to the point where Nganampa no longer include a blood test for syphilis in their annual screening. Michael Carter, from Aninginyi Congress in Tennant Creek noted a dramatic reduction in syphilis cases after they began using the syphilis database. In 1998-99, the year prior to joining the database, syphilis cases increased from 60 to 68. Although statistics were not available for 1999-2000 at the time of our visit, his impression was that there had only been 17-18 cases.
of syphilis - a huge reduction that he attributed primarily to participation in the database.  

However, there was also a view that much work remained to be done. In a presentation at the Regional Planning workshop, Annette Coppola (TSP) said that although the Tri-State region population forms only 1000th of the Australia population, 10% of the syphilis cases in Australia occur within the Tri-State area. Celina Bond (T H S, Tennant Creek) was unable to comment about trends in the syphilis rates, but noted that in one Barkly rural community there had been an increase in all STDs in the 15-17 year old women. Three out of five women presenting with STDS had syphilis, and all five had gonorrhoea, chlamydia or trichomonas. These infections were picked up in antenatal screening at the Tennant Creek Hospital, and represented a big increase for that age group. Sandy Thompson (SHU, WA) said at the Regional Planning Workshop that in WA there had been a dramatic reduction in syphilis cases in recent years, and that it was now possible to control it in WA. She said in our discussions that a dramatic drop in syphilis should be a TSP objective.

Achievements of TSP in relation to Syphilis

The syphilis database

The syphilis database (or register) has been the key contribution of the TSP in relation to improving management of patients with syphilis, and many of our key informants nominated it as one of the achievements of the TSP. At the Regional Planning Workshop, Annette Coppola said that the computerised syphilis information systems handles the results of 8000 tests annually, and provides not only a Central Syphilis register, but also allows for a coordinated approach to syphilis. This coordination makes it easier for PHC staff to do contact tracing and follow ups, and the base person in Alice provides backup and treatment information to staff in rural clinics. Mutitjulu Clinic staff said that the syphilis database is a great backup, especially if they are treating someone from another community. The database allows clinicians to get patients’ histories, which makes interpretation of syphilis serology easier. Russell Waddell agreed that the syphilis database was useful to him because he can get information about treatment history for patients who presents at Royal Adelaide Hospital, and he therefore doesn’t re-treat them. This is important because it prevents over use of treatments and an unnecessary painful treatment. Celina Bond said that the database made it easier to do contact tracing and follow ups.

Although most informants recognised the value of the database, many also pointed out that there have been problems with it in the past. Helen McFarlane said that the syphilis register was good but there were problems with the software. Janet Knox said that as an information system it was initially too ambitious and collected too much fine-detailed information. This lead to failures in the data system and program crashes. Nganyjarra Health Service Staff noted the direction taken by Arun and Annette has backed off from the hard-core statistical publishing direction. Because the database is now more focussed on addressing community needs, it works better. Russell Waddell said that the problems included the way data was collected, the volume of data collected, and its implementation in MS Access on a network. He had warned that there would be problems and crashes, and that there was no point having a syphilis register unless it worked. Jan Savage said that although the syphilis database was of some use, the problems with it in the past meant that it was viewed as less successful than other TSP initiatives.

A particular issue with the database has been that it has not been implemented on a regional basis. The reasons for this are related to the reasons that it has failed as a database: too much information was collected, and this was viewed as intrusive; and there was no assurance that it would work anyway, which meant that patients were giving up their confidentiality for nothing. John Boffa (CAAC) and Donna Ah Chee (Alukura) said that Congress had not wanted to be part of the syphilis database because there was no evidence initially that this approach would improve patient care, and it seemed to Congress Cabinet that there were insufficient assurances about the security of information collected. With the redesign of the database, it may be that some of these issues have been addressed, but other ethical issues raised by Boffa and Ah Chee remain problematic. The database also takes the responsibility from clients for managing their own treatment (particularly for the second and third B-LA injections, which have no public health impact as the patient is non-infectious after the first injection), and this is an unwarranted extension of the welfare state into clients’ lives. Although other key informants understood the importance of confidentiality issues

4 There were some additional factors involved in this reduction. Their previous strategy had targeted young women, whereas in 1999-2000 they targeted young men and involved elders in screening and follow-up. Because men didn’t come to clinics or attend school, it had been difficult to get them involved in routine screening. They had also been reluctant to talk about sexual health.
involved, they also believed that without Congress involvement, the effectiveness of the syphilis database was restricted.

Janet Knox noted that a recent achievement of the TSP has been the extended regionalisation of the syphilis database to Ngaanyatjarra communities and to the Barkly. Michael Carter from Aninginyi Congress in Tennant Creek said that being part of the database meant that they now had information about what was happening on a regional basis in the Barkly, and this was good. Russell Waddell commented at the Regional Planning Workshop that regionalisation of syphilis information was part of the cooperation necessary to effectively planning STD strategy on a regional basis.

Provision of information

A related achievement of the TSP in relation to syphilis was the provision of information. Celina Bond commented on the value of treatment information provided by TSP. Mutitjulu Clinic staff commented on the assistance they got with interpreting syphilis serology. Michael Carter suggested that the kind of information coordination that TSP now provides with syphilis information should be extended to other diseases. He also appreciated the aggregated regional data that Annette Coppola provided in a presentation she gave about Barkly STD status derived from the CDC database. He would also have liked a hard copy of the data presented.

Standard treatment protocol

Annette Coppola and Arun Menon said that they thought one of their key achievements was their continuing work on STD protocols, especially the syphilis protocol in the CARPA Standard Treatment Manual and the Women’s Business Manual. Ngaanyatjarra Health Service Staff agreed that the CARPA protocols are a good thing, particularly because WA had a different protocol for syphilis. Advocacy from TSP brought Ngaanyatjarra communities into line with other communities in the Tri-State region. Jan Savage noted, however, that putting in place management guidelines for syphilis is becoming more difficult as the prevalence decreases, and screening for syphilis seems more intrusive.

Barriers to Improving Syphilis rates

Pathology services

Pathology services are less of a barrier to improving syphilis rates than they are for other diseases because of the consistently good service provided by IMVS in Adelaide, and their capacity in terms of IT support and personnel. They are able to maintain an accurate database of syphilis serology, and were able to provide good support to the sub-regional screens.

A number of people commented that syphilis testing was the key factor in the failure of the Universal Pathology Form, an early TSP initiative. The idea was that a single pathology form could accompany any serology sample, which simplified the paper work involved for rural clinic staff when they were doing a complete STD screen. However, because HIV tests are generally done by Royal Darwin Hospital, syphilis serology by IMVS in Adelaide, and everything else by Westerns, the system depended on Western forwarding samples and information to the other pathology service providers. Westerns were unable to maintain this system, so now clinics have to use three forms: a Westerns form for gonorrhoea and chlamydia; a separate form for syphilis; and a coded form for HIV. The complexity of pathology services and the corresponding paperwork load mean that pathology continues to be a barrier.

Priority

A number of respondents commented on the fact that the low priority of STDs in all jurisdictions provided barriers to improving syphilis rates. Helen McFarlane said that the difference in syphilis notification requirements in the three jurisdictions was a symptom of the low priority of STDs on State and Territory health agendas. Although there are national notifiable disease priorities, these have not been taken up in all jurisdictions. She said that this lack of consistency of approach was why the TSP existed – “because it patches up the system issues”. As an example of this, Ngaanyatjarra Health Service Staff said that prior to 1996 Ngaanyatjarra health was not doing much about STDs. There was a blanket HIV screen in 1991, and had since been some ad hoc screening for syphilis.

Ethics

John Boffa and Donna Ah Chee raised issues of ethics in relation to the syphilis register. Congress Cabinet did not believe that information about Aboriginal patients who had returned for treatment and follow-up after a positive test should be included in Central databases. Their concerns include the fact that there is no legal requirement for such notification (non-Aboriginal people are not a part of the database), yet despite this adequate consent was not being obtained from individual patients at the time of testing for their information to be forwarded to the register in the event
of them failing to return for treatment and follow-up. They questioned whether the database militated against informed responsibility for health. For example, 1 Bicillin-LA injection makes one uninfectious, and the other two recommended in the standard treatment protocol stop the long term consequences of lack of follow up treatment. They felt that if people are properly informed about the consequences of not completing their full course of treatment at the time of their first injection and they fail to return for follow-up, then it is a waste of scarce public health resources to chase them. They felt that at present, however, many people were not being properly informed of the risks of not completing their treatment, partly because practitioners were assuming that the Centralised system “would take care of them”. They also felt that too much intrusive information was being collected. Russell Waddell also raised the confidentiality issue, and agreed that there were problems with the way data was collected, and that the database tried to collect too much information.

**Complexity of task**

Several informants raised issues about the complexities involved in reducing syphilis prevalence. Helen McFarlane mentioned the fact that each State and Territory has different notification requirements, and that part of the problem was that STIs are not viewed as a priority in all jurisdictions. Jan Savage also mentioned the complexity of managing STDs as a barrier. She gave the example that putting management guidelines for syphilis in place is difficult because screening people who are well often seems unnecessary to PHC providers, particularly because screening for syphilis doesn’t seem to be in the same order of things as checking blood pressures.

**Syphilis - future directions**

Very few suggestions were offered for new regional directions for syphilis management. Most people felt that the current programs were working with syphilis. Celina Bond suggested that doctors needed gentle reminders from time to time to review their knowledge of syphilis, and of how to interpret the pathology. At the workshop, syphilis remained one of the diseases that people thought should continue to be targeted through improved case finding and clinical management.

**Chlamydia Rates**

In 1994, the chlamydia rate was 483 per 100,000 population, and in 1999 it was 1496 per 100,000 population. This represents a rise of approximately 310 per cent. Central Australian screening data from 1995 to 1998 suggested that approximately 10% of men and 9% of women were infected (Menon & Coppola, 2000: 41), although other data presented suggested that the rates may be even higher in some sub-populations. For example, data presented from the audits of THS-Remote clinics suggested that 55% of men and 36% of women in the 15-19 age group who were tested were found to have either chlamydia or gonorrhoea.

The dramatic rise is almost certainly attributable to two things: high background prevalence, including a high proportion of asymptomatic infections; and the increase in screening across the region that has resulted from the implementation of the TSP. Rather than signalling the failure of the project, the rise in rates is an artefact of the continuing success of TSP efforts to increase screening, and so detect and treat infections.

The key strategies needed to reduce chlamydia rates on a regional basis include improved screening coverage (particularly of men and those aged between 15 and 29), improving follow-up of positive cases with reduced delays to treatment, and improving treatment of their primary sexual contacts. These need to be achieved through integration into PHC programs, and through improved regional coordination.

**Achievements**

The key achievements of the TSP in relation to reducing chlamydia rates have been:

- the introduction of PCR testing of urine, which Janet Knox said have allowed clinic staff to have...
better evidence of the value of their screening efforts;

- the promotion of both opportunistic and systematic screening at individual clinic and regional levels, which in some communities is beginning to have an effect on chlamydia rates. For example, in the AP lands where there have been annual screens since 1996, the chlamydia prevalence rate fell from 9.0% in 1996 to 7.2% in 1998, and then to 3.9% in 2000 (Menon and Coppola, 2000: 46). Due to TSP promotion and assistance, there has now been a similar community wide screening in a Ngaanyatjarra Health community;

- the use of clinic audits, which has both helped clinic staff to understand their own screening and treatment patterns, but also revealed where positive tests results have not been received back from pathology services; and

- the reduction of pathology information shortfalls through the use of the Central follow-up position, which means that participating clinics now routinely get positive results back, and are given advice about treatment.

**Results**

The best results in relation to Chlamydia have been achieved by Nganampa Health Council through their “8 ways to beat HIV” strategy. Janet Knox reported at the Regional Planning Workshop that chlamydia has been annually screened since 1996, and chlamydia prevalence reduced by 46% among the 12-40 year olds. In 1996, among 15-25 year old, 1 in 3 to 4 people had gonorrhoea, chlamydia or syphilis, T his rate had been reduced to 1 in ten people by 2000, although she acknowledged that this was still a very high rate. Key components of the Nganampa strategy included: improving access to STD services (including men's access); annual screening via a urine PCR for chlamydia for all 12-40 year olds; integration into PHC services (through making STD checks part of annual adult health check, as well as antenatal checks); improved case management; feedback to community, and resources in language; and better use of data to direct and evaluate programs.

In TSP audits of seven community clinics, reported by Aaron Menon and the Regional Planning Workshops, 1 in 4 men and 1 in 5 women had either gonorrhoea or chlamydia. These rates were much worse in the 15-25 year olds. Annette Coppola, also at this Workshop, said that in the under 20 year olds, 4 out of 10 women and 1 out of two men had either gonorrhoea or chlamydia. T he audits also revealed that: 25% of men and women with symptoms remained untreated; 12% of positive tests didn’t get to the clinic; 20% of those with positive tests were untreated; the median time to treat was four weeks for men and two weeks for women; and only one third of individuals had had contact tracing (though this is difficult to evaluate). T he audits also showed that there was generally poor diagnosis and management of lower abdominal pain.

Our informants generally confirmed that there is still much work to be done to reduce Chlamydia rates. Celina Bond, although unable to comment on whether there had been a general reduction in chlamydia rates in the Barkly since 1996, revealed that in one community there had been an increase in all STDS in the 15-17 year old women, including chlamydia. T he infections were picked up in antenatal screening at the hospital. Michael Carter at Aninginyi Congress said that in 1998-99, chlamydia incident cases at his clinic increased from 6 to 9. Ngaanyatjarra Health Services Staff noted that there had been screening for chlamydia at A Ngaanyatjarra community in 2000, and that rates during the screen were lower than expected. T hey noted that lots of men were away at business, but quite a number were later followed up anyway. At the Regional Planning Workshop Sandy Thompson noted that for gonorrhoea, there are many more notifications in Aboriginal people than in non-Aboriginal people, but for chlamydia the absolute numbers of infections are lower. T he Aboriginal: non-Aboriginal rate ratio for gonorrhoea is around 130:1, while it is around 14:1 for chlamydia. S he also noted that TSP objectives had failed to recognise that increased testing would result in increased detection of chlamydia and a higher rate of notified chlamydia.

**Barriers**

Our informants offered no specific barriers to the reduction of chlamydia rates. We note that the general barriers we identify in the next chapter apply to reducing the impact of chlamydia as they do to other diseases.

**Future Directions**

At the workshop, John Kaldor questioned what strategic goals were realistic for the reduction of gonorrhoea and chlamydia rates in the next three to five years. H e suggested that ultimately a reduction in
rates from 15% to 5% was achievable and desirable, but that intermediate goals should be set.

Also at the workshop, the success of Ngarampa’s program of annual urine PCR screening for 12-40 year olds on reducing chlamydia rates was highlighted. It is obvious that any successful future strategy will include a commitment to improving regional screening coverage, and the integration of annual screening for chlamydia (among other things) into programs at PHC level. We note that Helen McFarlane informed the Regional Planning Workshop of the continuing Commonwealth commitment to funding PCR for gonorrhoea and chlamydia nationally, along with trichomonas in the NT.

The other workshop discussion of relevance to chlamydia was Kath Fethers assertion that the idea of Epidemiological Presumptive Treatment had some merit. She suggested that the 15-30 age group could receive a one-off mass treatment, followed by mass screening plus improved ongoing case management. Another suggestion was presumptive treatment on screening, based on clinical history and membership of a high-risk group. She said that lots of presumptive treatment is currently happening, including syndromic management, and treatment without testing of primary contacts of positive STD cases. Such an approach would need to include core transmitters and high risk groups (for example, Alice Springs taxi drivers). She said that with 50% infection rates (aggregated gonorrhoea and chlamydia) mass treatment could be justified.

Donovanosis and Congenital Syphilis

In 1994, there were 46 donovanosis notifications in the Tri-State region, and in 1999 there were only 6. This represents a reduction of approximately 86%, and although not the 100% reduction envisaged in the objectives, is still a great result. It is also a strong vindication of the TSP model of STD control through Centralised surveillance and support for follow-up.

Achievements

Most of our informants nominated the Donovanosis Project as an achievement of the TSP. Annette Coppola and Arun Menon said that it put genital lesions on the agenda, and introduced Centralised follow-up as a way of addressing mobility. They nominated two things that made it successful: a couple of years of talking about it so that it was acceptable; and having a protocol that people could follow. Prior to this initiative mobility and subsequent loss to follow up were major barriers to controlling Donovanosis.

Janet Knox though that having a dedicated Donovanosis position (filled by Michael Howard, now at Ngaanyatjarra Health), the establishment of register, and follow up with azithromycin for active cases were the key ingredients of the project’s success. Many of our informants remarked on the success of this initiative, and a number of them also noted that this is the model that has been accepted by OATSIH for eradication of Donovanosis at the national level.

Annette and Arun also noted that PCR testing for Donovanosis has been a good research initiative, but that refining the test has gone off Menzies’ agenda. There had been some problems with the testing as well, particularly as clinics did not always include a consent form with swabs, which meant that under their research protocol, Menzies would not do the test. A number of people noted that the PCR test was not sensitive enough, and that the PCR was often negative even where clinical signs clearly indicated the infection was present. The trial has not so far resulted in a clinically useful outcome.

Results

At the Regional Planning Workshop, Annette Coppola noted that although the TSP region population forms only 1000th of the Australia population, 50% of the

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**Figure 3: Donovanosis Notification rate**

![Graph showing Donovanosis Notification rate from 1994 to 1999](image)

Source: Menon & Coppola, 2000:37
donovanosis cases in Australia occur within the TSP area. This does not mean that it is a commonly occurring infection, however. Michael Carter at Aninginyi Congress, for example, informed us that he was unaware of any cases of donovanosis notified by his service during his employment.

Barriers

Annette Coppola and Arun Menon said that the only barrier to further control of donovanosis was that since the project officer stopped, follow-up has not happened. This function has not been absorbed by Central Follow-up Officer, because this position is overloaded by additional work because of problems with Western’s data. Mutitjulu staff said that donovanosis follow-up was a waste of time and money. Donovanosis was not, in their view, a public health priority because of its low incidence. They had only seen 1 case in the previous 16 months. They also acknowledged the problems with the PCR test and consent forms from Menzies, and questioned whether the PCR test is a useful clinical tool.

Future Directions

Helen McFarlane noted that the Commonwealth is about to fund a Donovanosis eradication position and place it in TSP because of the value of the existing links which TSP has made across state and territory borders, and its role as an independent broker. This idea got some support from our other informants: Ngaanyatjarra Health Service Staff said they thought it a pity that the earlier Donovanosis project had not continued on; Russell Waddell indicated that he thought that maintaining the Donovanosis register to monitor rates and follow up was a useful task for TSP. Eleanor Hook thought that the Central Follow-up position should be continued, but that there probably was not a whole position in this task. She thought that a single position could probably manage Central Follow-up as well as the Donovanosis eradication task.

Congenital Syphilis

Neither the background information document (Menon & Coppola, 2000) nor any of our informants offered any concrete statistics on the incidence of congenital syphilis. Janet Knox said that there had been a reduction in congenital syphilis in live births, and that this was a definite result of improved syphilis surveillance. She also said, however, that there are still a lot of still births that are attributable to syphilis through Alice Springs Hospital. She said that problem in this case was not with syphilis surveillance or management, but with antenatal care. If women accessed antenatal care, they were placed on the syphilis register, and received treatment. She noted that while she was working at Sexual Health from 1996-1999, they were getting one high-risk baby every 6-8 weeks. While this high rate had been dramatically reduced in Nganampa Health communities, regional surveillance was still not good enough.

She indicated that Alice Springs hospital (particularly the Obstetrics and Gynaecology Department) could make an important contribution by improving their management of STDs. She also felt their work would benefit from increased integration with regional STD strategies. Kath Fethers noted that antenatal screening in the hospital was improving, but that it needed more staff time, and ongoing support and encouragement from SHU staff. She said one problem was that RM O’s and other staff turn over rapidly, so there was little chance of educating them about regional priorities in relation to STDs.

Other informants offered comments about congenital syphilis. Helen McFarlane noted that there had been some progress in reducing the rate of congenital syphilis, but that more was needed. Michael Carter at Aninginyi Congress said that there had been no recent change in congenital syphilis at his service. Celina Bond said that she hadn’t come across any congenital syphilis in Tennant Creek. She noted, however, that high risk pregnancies are mostly sent to Alice, especially primeneps, for a range of reasons including: there was no surgeon and no facilities at Tennant Creek Hospital to do a section; there was no anaesthetist (although Mike Pearson, the District Medical Officer, did it when there was a visiting surgeon); and there was a shortage of midwives. She said that all mothers delivered in Tennant Creek were heavily screened, and their STDs treated or they were shunted to Alice Springs. Any infant who needed special care was shipped post-partum, as there was no one there who could cannulate an infant.

Gonorrhoea Rates

In 1994, the gonorrhoea rate was 911 per 100,000 population, and in 1999 it was 2069 per 100,000 population. This represents a rise of approximately 227 per cent. Central Australian screening data from 1995 to 1998 suggested that approximately 15% of men and 11% of women were infected (Menon & Coppola, 2000: 41), although, as with chlamydia, other
AN EVALUATION OF THE TRI-STATE HIV/STI PROJECT

data presented suggested that the rates may be even higher in some sub-populations. For example, data presented from the audits of THS-Remote clinics suggested that 55% of men and 36% of women in the 15-19 age group who were tested were found to have either chlamydia or gonorrhoea (Menon & Coppola, 2000: 59).

As with chlamydia (see above), the dramatic rise is almost certainly attributable to two things: high background prevalence, including a high proportion of asymptomatic infections; and the increase in screening across the region that has resulted from the implementation of the TSP. Rather than signalling the failure of the project, the rise in rates is an artefact of the continuing success of TSP efforts to increase screening, and so detect and treat infections. The key strategies needed to reduce gonorrhoea rates on a regional basis, as for chlamydia, include improved screening coverage (particularly of men and those aged between 15 and 29), improving follow-up of positive cases with reduced delays to treatment, and improving treatment of their primary sexual contacts. These need to be achieved through integration into PHC programs and through improved regional coordination.

Achievements

As with chlamydia, the key achievements of the TSP in relation to reducing gonorrhoea rates have been:

- the introduction of PCR testing of urine, which Janet Knox said have allowed clinic staff to have better evidence of the value of their screening efforts;
- the promotion of both opportunistic and systematic screening at individual clinic and regional levels, which in some communities is beginning to have an effect on chlamydia rates. For example, in the AP lands where there have been annual screens since 1996, the gonorrhoea prevalence rate fell from 14.3% in 1996 to 6.1% in 1998, and then to 5.6% in 2000 (Menon and Coppola, 2000: 46). Due to TSP promotion and assistance, there has now been a similar community wide screening in a Nganyatjarra Health community. Annette Coppola and Arun Menon noted that their promotion of opportunistic testing “every time you catch a wee” had increased the amount of testing 5-fold for women, and 2-fold for men;
- the use of clinic audits, which has both helped clinic staff to understand their own screening and treatment patterns, but also revealed where positive tests results have not been received back from pathology services; and
- the reduction of pathology information shortfalls through the use of the Central follow-up position, which means that participating clinics now routinely get positive results back, and are given advice about treatment.

Results

At the Regional Planning Workshop, Annette Coppola pointed out that although the population of the TSP region forms only 1000th of the Australia population, 15% of the gonorrhoea cases in Australia occur within the TSP area. Clinic audits demonstrated that 1 in 4 men and 1 in 5 women had either gonorrhoea or chlamydia. These rates are much worse in the 15-25 year olds. For example, in the under 20 year olds, 4 out of 10 women and 1 out of two men have either gonorrhoea or chlamydia.

Janet Knox pointed out the value of the comprehensive Nganampa Health approach in reducing gonorrhoea prevalence rates. Since 1996, Nganampa Health has annually screened 12-40 year olds for gonorrhoea, the rate of which has been reduced by 62%. In other areas, results were mixed. Michael Carter noted that in 1998-99, gonorrhoea cases doubled from 8 to 16 at Aninginyi Congress. Nganyatjarra Health Service Staff noted that during their gonorrhoea screening in 2000 at a Nganyatjarra community, rates were lower than expected, although lots of men were away at the time and many women had been treated in the six weeks prior. Sandy Thompson said that in WA, nearly 50% of all gonorrhoea notifications came from the Kimberley region, with Pilbara and Goldfields having the next highest rates of notified cases. For Western
Australia overall, concern was more centred on WA health regions than focussed on the TSP region. However, Western Australian regions with high rates of STIs could learn from the TSP model in how to approach control of sexually transmitted infections.

Sandy also pointed out in relation to gonorrhoea rates that Nganampa Health had proved that these could be reduced, but questioned whether their results could be reproduced across a region. She said that part of Nganampa's success was owed to the fact that it had been well funded for a long time. By comparison, most of the TSP region remained under-resourced in PHC. She also noted that the TSP objectives had failed to recognise that increased testing would result in increased rates of gonorrhoea.

Barriers

As with chlamydia, our informants offered no specific barriers to the reduction of gonorrhoea rates. We note that the general barriers we identify in the next chapter apply to reducing the impact of gonorrhoea as they do to other diseases.

Future Directions

Many of the future strategies already noted for chlamydia apply equally to gonorrhoea. Janet Knox pointed out that almost anything clinics do is going to have an impact, and that anything that happens regionally is going to improve what is happening in Nganampa communities. In particular, she mentioned that the TSP subregional screening in Pitjan tjatjara communities in the southern NT would have a positive impact on gonorrhoea rates in neighbouring Nganampa Health communities in South Australia. She believed that it was important to increase testing and improve follow-up across the region, particularly in the Alice Springs area, where she thought that little was being achieved at the time in terms of STD control. She also thought that some form of mass treatment program, like that used with trachoma, was worth investigating, but noted that there were some sensitivities about the use of mass treatment. She particularly thought that targeted mass treatment of 15-30 years olds would be a useful strategy to explore.

HIV rates

Although no specific incidence rates were presented either by informants or in the background information paper, we note that to the best of available knowledge HIV rates in the TSP remain at or below the Australian average. At a state/territory level, all three jurisdictions have lower HIV rates than the Australian rate of 106/100,000 – the NT rate is 61/100,000, SA is 49/100,000, and WA is 56/100,000 (Menon & Coppola, 2000: 32). We note that overall nationally, the rate of infection in Indigenous people is little different from that of non-Indigenous Australians, however the proportion of heterosexually acquired infections is higher for Indigenous people, and particularly for Indigenous women (figures cited in Menon & Coppola, 2000: 37).

The Background Information Report reports some of HIV testing data from the TSP area in recent years. From their clinic audit data, Meno & Coppola tell us that

STD rates in children under 12

Janet Knox noted that there were not many infection in under 12s in the TSP region, and that many of the notifications in under 12s were likely to be gonococcal conjunctivitis. She noted that as far as sexually transmitted infections were concerned, these were mostly confined to petrol sniffer, and there was little that TSP could do in do to combat this problem other than encourage the detection and treatment of infections. She said that TSP's mandate was to deal with prevalence, not other issues. Sandy Thompson agreed that there was nothing in the TSP objectives about child sexual abuse and under 12 year olds. She did however acknowledge that child sexual abuse was an important issue, and noted that WA is encouraging services to address child sexual abuse.

Celina Bond said that in her short experience, there were no children presenting with STIs. She pointed out that the issue was really in the over 12s, some of whom were obviously very sexually active. Michael Carter at Aninginyi Congress agreed. He said that there had been one 11 year old presenting with an STD. In his experience, most first presentation were in 13-14 year olds in boys, after they had gone through Law. He imagined that the girls' statistics were about the same, but didn't know. The consensus was that sexually transmitted infections in under 12s was not a problem of public health significance in the TSP region.
129 tests per year were carried out, a rate of 31 tests per 1000 population. They note that most of these tests were done in the context of a Well Person’s Health Check, and that few antenates or those with STDs were tested. They note that in their estimation only 13% of men and 8% of women who should have been tested, but that it was unclear whether the tests were offered and refused, or simply not offered (Menon & Coppola, 2000: 63). More generally, they conclude that:

- The number of Human Immunodeficiency Virus (HIV) antibody tests conducted is small. The rate of testing has declined in 1999, and it appears individuals with symptoms, STDs and antenates are not being offered HIV tests as recommended in the protocols. (Menon & Coppola, 2000: 67)

- In relation to results from an analysis of the Central Follow-up Database from four participating health services for the first 17 weeks of 2000, full information was only available for 60 of the 92 men diagnosed with an infection and 107 of the 164 women diagnosed. Only 61 HIV antibody tests were done in this period – 21 (35%) in men, and 40 (24%) in women. Eleven men (15%) and 10 (7%) women refused the test, and 42 men and 55 women were not offered it (Menon & Coppola, 2000: 108).

**Achievements**

The core achievements of the TSP in relation to maintaining HIV at a low level in Central Australia have hinged around their success in relation to other STDs. There is now general acknowledgment that the presence of other STDs in an important cofactor in HIV infection, so reducing the prevalence of STDs will have a positive effect on prevention of HIV infection. Reductions in the prevalence of syphilis and donovanosis, and improvements in the detection and treatment of gonorrhoea and chlamydia will ultimately be important in reducing the risk of HIV infection in the region.

Their other area of achievement has been through the audit process, where they have made six health services aware of their performance in relation to HIV testing rates, particularly of those with an STD and antenates. The Central Follow-up position and subregional screenings have also been useful in the surveillance of HIV testing. Kath Feathers noted that the personal contact provided by the position has been a conduit for advice about further testing (eg HIV) for positive STD cases. She also said that the subregional screening has provided populations lists which means that TSP can now begin to calculate the per cent of HIV tests on positives on a regional basis. As part of the subregional strategy, in the week the screen, SHU staff go back to the communities and offer treatment and HIV test to positive results and their contacts, which has also increased the testing rate.

Janet Knox noted that issues around HIV testing were an important part of the Nganampa Health strategy. She said that these issues included: improved confidentiality; a policy for dealing with positive results and people; pre-test information on audio tape; testing offered to antenatal women (8%) and people presenting with STDs. Nganampa now does about 360 tests a year. In relation to quality assurance, prevalence, incidence, interval to treat, HIV testing and contact tracing are all evaluated on a yearly basis.

Mutitjulu staff noted that there is now good uptake of HIV testing for positive STD cases. However a pressing problem is that they have no strategy for what happens with a positive result. This problem was also acknowledged by a number of participants at the Regional Planning Workshop. Although the lack of strategy remains a problem, Helen McFarlane said that there had at least been some progress on legislative impediments to management of HIV patients.

**Results**

Both Celina Bond and Michael Carter said that there had been non Indigenous HIV cases in Tennant Creek to date. Three non-Indigenous people with HIV had been in town at various times, but had gone home elsewhere – presumably to die. Michael said that the old attitude was to run them out of town, but that Aninginyi have spent the last two years talking to older people about HIV to change this attitude.

Although the rate of infection is currently negligible, most people acknowledged HIV as a grave risk to the TSP population. At the workshop, Arun pointed out that in clinic audits it was shown that 48% of men and 49% of women had been diagnosed with at least one infection, which was important because of the threat of HIV. He also noted that although the testing rate had doubled since the audits, it was still very small.

**Barriers**

Most of our informants acknowledged that HIV was still a threat in Central Australia, and that, in Jan Savage’s words it hadn’t happened yet more because
of “good luck rather than good management”. Janet Knox said that there was still a long way to go with HIV work. She highlighted a number of issues: the low rate of testing; the real issue of fear and ignorance, because no-one at community level has seen anybody living with it; the lack of strategy for how clinics should deal with a positive result; and the lack of clinical knowledge. She pointed out some positive things: useful education resources had been produced (mostly by Sexual Health Unit, rather than TSP); the Ceremonial Red Boxes, developed by Nganampa but promoted and distributed by TSP, were useful as both health promotion and as primary prevention of BBV transmission at ceremonies; and audio-taped pre-test counselling had helped because it took responsibility off staff about getting informed consent.

Kath Fethers said that HIV is still a huge risk, but with STDs under control, Central Australia may be able to abort the inevitable HIV epidemic. She noted that not many places were still in that position. Ngaanyatjarra Health Service Staff pointed out that the isolation that has previously protected Central Australia is no longer effective, and that HIV is a growing threat because there are more people with HIV in touch with community people.

A number of people noted that HIV antibody testing was somewhat problematic because of the complexity of pathology services, particularly for bush clinics. HIV tests are generally done at different laboratories than all other serology. Mutitjulu staff, for example said that their routine pathology was done by Westerns, but that syphilis serology is done by IMVS in Adelaide, which has a good database of syphilis serology, and HIV antibody tests are done at Royal Darwin Hospital. This means separate tubes for syphilis, HIV and everything else.

At the workshop, a number of people acknowledged the confidentiality issues that continue to surround HIV testing. There was also some discussion of how privacy issues might affect an HIV positive person in an Aboriginal community - for example, storing treatments at home.

**Future Directions**

Informants had a range of ideas about future directions in this regard, not all of which were the clear responsibility of TSP:

- John Boffa and Donna Ah Chee pointed out the continuing need for some centralised management of HIV-positive patients in Central Australia, because it was not desirable for General Practitioners based in community health services to be doing this.

- Kath Fethers said that condoms need to be normalised. If there were HIV+ people, they would really stand out if they were the only ones using condoms. She acknowledged that people were very resistant to condom use.

- Kath Fethers also said that a population based studies in Mwanza reported in the Lancet showed that improved individual management of STDs resulted in a one third drop in HIV transmission.

- Russell Waddell noted the need for research into social and sexual networks in Aboriginal communities to increase our understanding of these, and to help in prevention work. He said this was especially necessary if HIV started to spread.

- At the Regional Planning Workshop, Valmai McDonald and Mona Phillips said that HIV strategies should account for: individual priorities; sharing information; support to take control; help to develop skills; and provision of resources. On the final day, the need for HIV+
protocols in communities was acknowledged as a priority in regional planning.

Chapter 3: Needs and Barriers

In this chapter, we examine issues raised under the third and fourth Terms of Reference of the evaluation, namely:

- Evaluate the Tri-State project’s ability to respond to the needs of services in the region and identify barriers to the uptake of programs; and
- Determine the effectiveness and usefulness of Tri-State’s projects in relation to overcoming the identified barriers.

As in other chapters, we examine these in terms of what our key informants said about them, and we have ordered them in terms of the extent to which they were perceived as needs or barriers by the majority of our informants.

Pathology services

Our informants identified a range of issues with pathology services, which we have discussed under the subheadings of: the network for the region of pathology services is too complex, accurate information about positive tests doesn’t get back to clinics, aggregated data is either inaccurate or not reported, communication and practice issues at Westerns; and interpretation of results.

The network for the region of pathology services is too complex

In interviewing informants from health services, it became obvious that the network of pathology services in the region is too complex, and that this is a continuing barrier.

The problems relate in the first place to the proliferation of forms. TSP attempted to reduce the problem by the introduction of the Universal Pathology Form (UPF). Janet Knox said that UPF was good in theory but failed in practice because Western’s didn’t send on the syphilis serums and form to IMVS, but simply performed the tests themselves. Ngaanyatjarra Health Service staff said that the failure of the UPF meant that services still have to use three forms: a Westerns’ form for gonorrhoea and chlamydia; a separate form for syphilis; and a coded form for HIV. Mutitjulu staff highlighted a second problem related to this complexity: the necessity of having to draw more than one serum sample if testing for both syphilis and HIV.

Accurate information about positive tests doesn’t get back to clinics

Many of our informants complained that a main barrier related to pathology services was the

Table 7: Complexity of regional pathology services

<table>
<thead>
<tr>
<th>Informant</th>
<th>Where are tests sent?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCR</td>
</tr>
<tr>
<td>Celina Bond</td>
<td>Westerns (A/S)</td>
</tr>
<tr>
<td>Kath Fethers</td>
<td>RDH (PCR)</td>
</tr>
<tr>
<td>NHS (depends on which way (A/S or the plane is going on the day))</td>
<td>Westerns (A/S or Kalgoorlie)</td>
</tr>
<tr>
<td>Mutitjulu</td>
<td>Westerns (A/S)</td>
</tr>
</tbody>
</table>
inconsistency with which Western's returned accurate test results to the clinics that ordered them.

Audits of a number of health services revealed that some patient results were simply never returned. John Boffa and Donna Ah Chee noted that while Alukura's patient data was fine, the audit of CAAC patient notes revealed considerable gaps in data. Mutitjulu staff reported that they don't get some results at all, and that their best source of positive results was the Central Follow-up Position. Although they had suggested to Westerns that they "each day put all our results in an envelope and post them", this had not been achieved. They also noted that the problem related not only to results; their clinic also did not get notified when there was insufficient serum or material to carry out a test.

In Tennant Creek both Celina Bond and Michael Carter said that Westerns often confused where results were to be sent. Some were sent to Clinic 34, some to Aninginyi and some to the District Medical Officer for the Barkly. Currently the three services work around this problem through improved local coordination, and by getting Westerns to routinely fax copies of all Barkly results, including Aninginyi's to Clinic 34. The other problem identified by Celina Bond was that sometimes test results were delayed beyond a clinically useful timeframe, although to an extent this resulted from the complexity of reporting arrangements. Although remote communities in the Barkly send specimens directly to Westerns, results and notifications were being sent to Clinic 34 for follow up. One community result for a test done at the beginning of October was only returned to Clinic 34 in mid November. This situation results in long delays to treatment. Celina noted that she had had no trouble or delays with her own specimens.

The inconsistency with which results are returned is compounded by a lack of what Mutitjulu staff referred to as "mechanisms for remembering". That is, at the local clinical level there is no system for recording what pathology specimens go out and what results come back. Arun Menon noted that this was a problem at most of the clinics that he had audited.

**Aggregated data is either inaccurate or not reported**

Annette Coppola and Arun Menon pointed out that Westerns were set up as clinical labs, and not with a public health data focus. As a result, they were not strategic about providing public health information, and in this respect compared unfavourably with IMVS. For example, in the last sub-regional screen, they provided inaccurate lists of the people tested; individual’s results were inconsistent from one summary to the next; and the results required hours to collate, something that the lab should have been doing. This is a barrier to improving or increasing screening coverage.

Janet Knox was also critical of Westerns, saying that the data they provided about how many tests in the region, what tests were done, and how many were positive were inconsistent. Kath Fethers said that the inability to obtain an accurate list of positive test results from pathology services was one of the main barriers to an extended program of regional screening. Although the current patchwork approach of sub-regional screening was not ideal in her view, it was a more feasible approach in the absence of reliable pathology results.

Michael Carter pointed out that the problem with Western's data was not the serology itself, but the presentation of aggregate data, for example yearly statistics for a health service. He pointed out that it was hard to do any analysis of health service performance without accurate aggregate data.

Ngaanyatjarra Health Service Staff agreed, saying that sometimes they received data from Westerns that was full of information they didn't need, full of inaccuracies, and which did not contain the information they wanted. Mutitjulu staff also commented on the quality and usefulness of annual aggregate reporting from Westerns. In particular they highlighted the fact that "lumps of statistical data" were not particularly useful, as they did not have the time or the skill to process it further. They also commented that their last annual report was not credible because they didn't know how many tests Westerns had left out.

**Communication and practice issues at Westerns**

Annette Coppola and Arun Menon noted that the quality of the service from Westerns is personality dependant: "one guy there is great, but when he went on long service leave, the aggregate data system fell down". They believe that Westerns' attitude is that they don't make money out of Central Australia, so they're not interested in providing a comprehensive service. Jan Savage characterised the issues at Westerns as partly poor communication and partly poor practice. She felt that since Westerns are making some money out of Central Australia, they should respond more constructively to problems with delayed results.
M utitjulu staff said that Westerns make no response to complaints or suggestions. N gaanyatjarra H ealth Service Staff said that aggregated data from Westerns is frequently wrong. O ne of their communities only got one result back from Westerns out of 20-30 tests. T hey felt that the problem at Westerns is that codes have to be manually entered by pathology assistant about where reports need to go, and that this doesn’t get done routinely. In communication terms, they said, Western’s always say that they can improve things but sometimes they even get worse. For example, Vince C aruso from Westerns’ management came to N gaanyatjarra H ealth and “promised everything”, but nothing happened. T hey noted that on occasion they had received conflicting or nonsensical advice from Westerns. For example, they have received advice on PCR results that they “need to do a male urethral swab”. K ath Fethers thought that the issue was equipment and staff skills and experience. She noted that during the subregional screening program, I M V S had the IT and the personnel to give them what they wanted, which compared very favourably to Westerns, who just left them with “a mountain of paper”.

A number of informants mentioned that currently pathology costs are “block-granted” by the Commonwealth, so that clinics don’t have to provide Medicare numbers to access pathology funding. We join them in questioning whether the pathology contract terms can be altered to require accurate and timely aggregate reporting as part of the service. Jan S avenge suggested that if Westerns can’t respond more constructively to regional needs, then they should not be allowed to keep this income.

O thers pointed out that although there is a part-time liaison officer at Westerns, and despite the involvement of TSP in screening and other testing in the region, there has not been much contact between TSP and Westerns to date other than a couple of meetings and some letters. It is clear that this communication situation needs to improve, and that pressure needs to be applied to Westerns to improve their service from a number of directions, including the Commonwealth officers who administer PCR funding.

Interpretation of results

A nnette C oppola and A run M enon identified the clinic audit process and the Central follow-up position as key elements in the TSP response to the problems generated by the pathology data. However they indicated that even with the Central follow-up position, they were still not sure they were getting everything back. In one clinic audit, 10% of positive results weren’t communicated back to the clinic. In the audit of Congress, data from Westerns was so flawed in relation to what testing CAAC had done, that Arun was forced to do a prospective survey of testing to find out what they were doing, and how well. In addition, the Central Follow-up person was doing a daily pickup of results from Westerns, phoning the positive results through to clinics, and sending hard copies of notifications to clinics as well. She then entered the positive results on the computer. T he database had initially included negative results as well, but this ended up being the bulk of the work. Eleanor H ook said that she was still entering negative data for N gaanyatjarra H ealth, as it helped them in their performance indicator reports to funding bodies. Even with this degree of attention, Eleanor was still aware of that clinics were missing some paper results, for example, trichomonas detected in PAP results. She and Arun believe that getting a direct download of the Western’s data via modem on a monthly basis will improve the situation. However sifting through this data will require considerable effort as it is not just the STD tests for the month for participating clinics, but all the pathology that Westerns performs that month. If successful, this data will give another level of error checking against the hard copies and aggregated lists currently produced.

TSP has done a lot of work around testing, and ensuring that positive results get back to participating clinics. They believe that Westerns could be persuaded to improve their performance eventually: the bargaining chip would be regional screening - with 60% coverage of the roughly 9000 15-39 year olds in the region, this would mean 5000 tests a year, and a considerable increase in Westerns’ income from the region. An alternative approach suggested by John Boffa and Donna Ah Ch ee was for all health services
to choose a different pathology service (eg IMVS, or Gribbles, or Peverills). The Commonwealth would then review their contract with Westerns. They thought that there had been discussions with IMVS about expanding their services in Alice Springs. Sandy Thompason also thought that TSP didn’t have the leverage to make changes at Westerns and should accept this. She thought that they should put more work into other strategies, including advocating for standardisation of practices at laboratories. She also thought they should pay more attention to surveillance.

Regional staffing and resources at PHC level

Our informants identified two main issues in relation to staffing as a barrier: staff numbers and staff turnover.

Staff numbers

Sandy Thompson pointed out that the TSP region is under-resourced at the PHC level. There are simply not enough people working to carry out comprehensive primary health care, including a sexual health program. Mutitjulu staff illustrated the problem: even though they have position for a doctor, two RNs and four AHWs, when you took staff vacancies, annual leave and training into account, there were basically only two full-time positions at Mutitjulu at any time to run all programs. In Tennant Creek, Celina Bond reported that there was only one DMO (male) to service the whole Barkly region including Elliott, and who also had to run the hospital. There was one GP (male) in town, and an RFDS doctor (female) visited four times a year. Recruiting specialist staff had been helpful for Nganampa health, and Ngaanyatjarra Health Service Staff said that employing a specific Coordinator for their Sexual Health Program (Michael Howard) and a Women’s Health Coordinator (Oona Lynch) was really helping Ngaanyatjarra Health with developing a sexual health program in their clinics. Mutitjulu Staff, among others, pointed out that not every service could afford to employ specialist staff.

From a regional point of view, this lack of PHC staff meant that there was insufficient staff to carry out treatment of STDS and contact tracing. Andrew Ebringer pointed out that there was neither sustainability nor productivity in an expanded program of screening without on-ground staff to carry out follow-up.

Kath Fethers said that this had become an issue with the results of subregional screening. People who had tested positive for gonorrhoea and chlamydia were then also tested for trichomonas, and most of them were positive. This left a huge amount of follow-up for clinic staff. She felt that it was absurd to leave these staff with all those positive trichomonas results to follow-up. Also, the staffing problems were not confined to bush clinics. She noted that the subregional screening had taken considerable focus off regular clinics in Alice Springs, and town-based education and health promotion. Although she acknowledged the value of TSP and SHU support for screening in bush clinics, she wasn’t sure that this was a sustainable strategy in the longer term.

Kath Fethers also highlighted the lack of Indigenous input at management level and clinical levels. She thought that getting Aboriginal people on staff at every point in the regional system would be a big step forward. The current program was problematic in her view because of this lack of Indigenous insight into behavioural issues, educational issues, sexual health liaison in clinic and hospital settings, and assistance with approaches to condom promotion.

Staff turnover

The situation of many of our informants illustrated the problem of staff turnover in the region. One informant, for example, had only been in her job for two months. Prior to her appointment, there had been no-one full time in her position since 1998, a 19 month vacancy. Another staff position had filled in during the vacancy, but three people had done that job since 1998. In another service, our informant said that he had been there for two years but was about to leave to go back to the city from which he had been recruited. The male Aboriginal STD worker and educator in his service, was also leaving at the end of 2000. Their female Aboriginal STD worker and educator had been there two years.

Our informant believed that staff turnover was less of a problem because of TSP. Although there were still long periods where there were no staff, at least data collection and coordination continued while positions are vacant. He felt that despite the recent staff stability at his service, their efforts were hamstrung by the fact that they only had a 100km service radius, and other service providers in the area were providing an erratic service due to staff turnover. Follow-up was not being done consistently. A third informant noted that she had only been working in her job since March 2000.
Several other people had held the position in the three years before she arrived, and there had been a four-month break before she started.

**Strategies**

**Audits**

Mutitjulu staff identified the audit process as a good way of dealing with staff instability. As a result of the audit, they had moved from a completely ad hoc to a functional, paper-based system that allowed follow-up to happen, and facilitated future audits. This was good for staff changes, because it allowed people to see what was happening. It had also allowed Nathan, their AHW, to do things by himself. Annette Coppola and Arun Menon agreed that the audits had been an important tool in increasing confidence in health services. The kind of information they provided kept STDs on the agenda, and helped people to do their jobs better and set priorities more effectively. They also helped TSP to identify problems in the field, and offer help. For example, the Central follow-up position had identified and assisted some communities who were having problems carrying out follow-up treatment.

**Staff education and training**

In light of the continuous staff turnover throughout the region, Sandy Thompson thought that there was a need to do workforce training and development in ongoing way. Celina Bond agreed that in-service training for new staff would be really useful, even up to four times a year. She noted that Annette Coppola had been involved in developing a better orientation program for new staff at Tennant Creek Hospital (although Celina herself had never had this training). She thought that education for nurses and health workers, both in Tennant Creek and on communities, should include an overview of the region, and reminders to doctors about the need to review syphilis and how to handle pathology. Kath Fethers thought that more emphasis could be placed on training during screening programs, but thought that this would need more Indigenous worker input. She noted that SHU currently run education programs for remote nurses, holding two women's workshops a year at which TSP helped with presentations. The last one was in early 2000, and there was another about to happen. About twelve nurses had attended the April workshop.

**Better Coordination and support**

Mutitjulu Staff praised the support they had received from TSP and SHU with their annual screening. They said that taking it on alone would have been too much. They thought it particularly good that they had had assistance with follow-up, and were able to complete their program during the same six-week period in which neighbouring Nganampa Health had conducted their annual screening. Russell Waddell also thought that because bush clinics are too busy, it was important that TSP were able to put two people on the ground to assist with screening and education programs. He thought that this helped to maintain the profile of TSP so that clinic staff would use them as a resource. It was especially important, in his view, because resources were contested and demands were high for other services (eg renal services). He thought that TSP's current strategy of education, screening, and follow-up had improved case management and increased STD awareness among clinic staff. He thought that this was a more sustainable strategy than regional screening in the current resource environment. He thought that a follow-up screen after 18 months would remind clinics, and help them integrate screening into their normal service delivery. He thought that any system that has to rely on outside people to operate was unsustainable, and that the focus should be on building and developing the necessary health infrastructure for sustainable services.

**Networking**

Many informants felt that networking for health workers was really important, particularly when they are the only ones working on Sexual Health. Michael Carter said that his Sexual Health workers were identified as "Pox Doctors" in their community, which was socially as well as professionally isolating. He noted that burnout in this field is really high, partly because of the isolation. He thought that health worker "shame" was an issue, and that there needed to be more cross-training of general health workers so that they're not shame about sexual health matters. Sandy Thompson also talked about the value of networking as a way of sharing valuable experience. She thought it was good that Bega and the Goldfields were learning about TSP work by attending CADCCC subcommittee meetings as observers. She said that it gave them the opportunity to learn from the TSP experience and apply this knowledge in their own region. She also thought it was good that staff were able to move around the region from job to job, taking their knowledge with them and spreading it around. It was important to provide security so that good staff stayed in the region.
Male workers

Most of our informants drew particular attention to the lack of male practitioners, including Aboriginal health workers, as a major barrier. At the regional level, Kath Fethers talked about the need for male and female specialist practitioners. She noted that Arun provides backup to her as an S100 prescriber when she goes on leave, and provides a male practitioner at clinic 34 in emergencies. Arun Menon and Annette Coppola commented on the fact that during the subregional screenings, it was important to have a male practitioner there as many bush clinics did not have them. They noted that Arun had often had to have a practical involvement in the screenings to fill this need.

Apart from a lack of male doctors and nurses, the shortage of male Aboriginal Health Workers was seen as a huge problem. Celina Bond noted the need to be aware of gender restrictions in her work. When the Aboriginal male STD person had resigned, she was forced to pull male health workers out of the Barkly Mobile Service and the Hospital to help with education sessions in Elliott because she had no male health worker on staff. Kath Feathers said that during the subregional screening it was useful to have Christine Franks working as a liaison with the women, but that there had been no equivalent male available. The screenings were less successful with men unless there was a male health worker available from the community. She said that the screening strategy would not work if they only tested the women and none of the men, but that there was an omnipresent problem of no male health workers.

Michael Carter thought that there were cycles in male staff stability cycles, and that in Tennant Creek at the time of our interview THS was on the upswing and Anyinginyi was going down. He noted that his male AHW, Brendan, was leaving at the end of 2000 to study management at NTU, but he had another guy lined up to do the job. Mutitjulu staff also talked about the importance of male AHWs in carrying out successful programs including male screening. They praised the audit process, which they said had helped them to routinise their sexual health programs, and allowed Nathan, their male AHW, to do things by himself. They also thought that although the men’s Red ceremonial boxes were a good thing, it was difficult with the health service’s structure and size to fund a ceremonial health worker position. They needed funded for a position, as well as funding and some way of motivating the worker.

Michael Carter talked about some successful TSP initiatives involving male workers. He mentioned that there had been successful meetings in Alice Springs about Well Men’s Health Check. He also attended the workshop at Hamilton Downs in 1999 with three male health workers from Aninginyi. There were about 40 male health workers there. The main outcome was the standardisation of the form used for this health check. Ngaanyatjarra Health Service Staff also thought that the workshop at Hamilton Downs had been successful, and that the resources developed from it were useful. Sandy Thompson also praised these men’s resources, including the well men’s health flip chart and checklist, as well as the ceremonial boxes work.

Michael Carter also talked about some initiatives that his health service had been involved in. They began with the observation that men weren’t participating in mass screening. They identified the barriers to men’s screening as mistrust, and the fact that their clinic was not set up as a men’s clinic. He said that this would be better in their new premises, which was designed with a separate men’s clinic and not just a separate door for men. To increase the participation of men, they had undertaken a number of initiatives: they had hosted a Barkly men’s health forum; instituted a Footy Players Health Check, a CDEP health check (including hepatitis immunisation), and Julalikari Program for Employment and Training (JET) health check. Their success was measured by improved statistics for syphilis, where there had been a large reduction in 1999-2000. He credited their success with their new strategy of targeting young men, and involving elders in screening and follow-up. He said that because men don’t come to clinics, and don’t attend school, it was hard to get them to come in to the clinic, and they didn’t generally want to talk about sexual health. Their new focus is on how to get information to young males and get them to participate in screening.

Other informants talked about other men’s sexual health initiatives. Kath Fethers said that SHI run educational programs for Aboriginal health workers, with men’s and women’s training held separately. Arun Menon had been involved in the men’s workshop in July 2000, and about five men attended. John Boffa and Donna Ah Chee reported that CAAC had a Men’s health program that had been conducting ad hoc screenings in town camps. Ngaanyatjarra Health Service Staff said that Ngaanyatjarra Health are looking at training “Certificate 2” male Field Officers (ie health workers) in Men’s Health, which would incorporate educating them in the safe ceremony strategy. This module has been developed by Ngaanyatjarra Health, and they are a registered training provider.
Lack of evidence

Most of our informants complained that they were operating from an insufficient evidence base in Central Australia, and that regional information systems did not currently allow for the development of a locally relevant evidence base. A. Coppola and Arun M enon said that a key problem was the lack of accurate population data, which made it difficult to develop a notion of what coverage was being achieved. They also pointed out that the poor performance of Westerns meant that they couldn’t easily tell how much testing was being done. They had worked with Congress to develop a prospective methodology to study testing patterns.

Kath Fethers said that TSP’s current approaches attempted to develop baseline information (e.g., prevalence) via audits, screening, and the SIS and follow-up databases. They were attempting to quantify the problem, and identify where problems were developing (e.g., in testing, interval to treatment, contact tracing). Part of the subregional screening process was the development of “as good as you can get” populations list that allowed the team to calculate coverage rates overall; target group coverage rates, especially the 15-29 year olds; the percent who were positive; the percent who were treated; the average time to treatment; the percent of contacts treated; and the percent of HIV tests on positives. Michael Carter pointed out the current difficulty with doing any analysis because of the lack of accurate aggregate data from pathology services.

Kath Fethers also pointed out that there is no understanding of risk behaviours or risk practices in target communities, including no notion of what is usual or unusual, whether people engage in oral or anal sex, and so on. She believed that this lack of basic cultural and behavioural data was a major impediment to sexual health promotion. Ngaanyatjarra Health Service Staff also suggested that there was a need for research on drug and alcohol usage, including some epidemiology. They thought that health education development needed to focus on those who travel back and forth to town. Mutitjulu staff also commented on the current gaps in prevention, and noted that they had no understanding of behaviours that lead to risk. However, they felt that local clinics should be supported to do this sort of research and health promotion development. Russell Waddell also thought that a better understanding of the epidemiology of STIs in the region was needed, and that more attention should be paid to social and sexual networks in Aboriginal communities. In relation to Presumptive Epidemiological Treatment (PET), he said that a set of criteria was needed that could indicate what prevalence would justify PET, and what groups should be targeted. He thought that there was currently inadequate hard evidence of the sort required to develop this sort of criteria. Sandy Thompson thought that TSP could advocate for research into behaviours, and individual and community practices. She felt that it was necessary to do this research and develop processes by which risk reduction could be measured via behavioural markers. These could then act as surrogate measures of progress.

Jan Savage noted that Central Australia lacked models for STI treatment and prevention that were tailored to this particular area. She argued that there was scope for trialing a range of approaches, including various screening approaches and highly sophisticated tests.

Community Resistance

Many of our informants mentioned that community resistance to participation in regional STD control programs, particularly from community-controlled health services had been a barrier in the past. Russell Waddell said that there had been a history of opposition to TSP. He thought that initially this was a personal opposition to Kerry Arabena because she was a Torres Strait Islander and not from Central Australia. He also thought that there had been a lack of listening, both on the side of TSP and from the health services. The community-controlled health services had a strong emphasis on letting the community make up their own mind, and medical staff had not always done all they could to help the community to reach a decision. Medical officers had not always passed information on to management. He thought that this had changed recently, particularly as health services were now employing more medical officers with Public Health training. Ngaanyatjarra Health Service Staff mentioned that a lack of participation from community-controlled health services had restricted the effectiveness of the syphilis database. Sandy Thompson also offered a perspective on this issue. She noted that TSP had offered services that Ngaanyatjarra Health couldn’t take up because community controlled services make their own decisions and don’t always decide to accept TSP services. She thought that the problem was that TSP was trying to do things but different services were at different stages of development regarding STI control. She thought that

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6 We note that there is probably better evidence for STI control in Central Australia than anywhere else in Australia.
the non-participation of Congress was a great failure for T SP, but not something T SP should be blamed for. The problem in her view was that T SP was not community driven, and that more direction was needed from Aboriginal people and communities. If this participation at governance level was in place, T SP would be better informed. She thought that currently T SP was “a lot of white people discussing Aboriginal problems”. She noted that the lack of participation from Congress which is a particular impediment when considering town as a setting for STI spread.

Some of our informants from community-controlled health services gave perspectives on this issue of community resistance. Michael Carter noted that Aninginyi Congress had only become a part of the syphilis database that year. Prior to this, the board had had sensitivities about the security of data, and didn’t want to participate. The database experience had been a good thing for Aninginyi, and there was now some recognition of T SP’s sensitivity around confidentiality. Everyone, including the doctors and midwife, had had a good experience of it. He also thought that more feedback from T SP about what they were doing would inspire more trust from the Boards and staff of community controlled organisations. He suggested that an informal quarterly newsletter or report, pitched at community level and with care taken about sensitive issues, would help promote the T SP so that Boards and health workers would know who they are and what they do. He said that health workers don’t like people who seem arrogant, and that there was a need to look at processes for establishing trust and rapport with them first. He also said that community-controlled health services share information about sensitivities, so care was needed in all dealings with health workers.

Mutitjulu staff gave a different perspective on ill informed or arrogant approaches. They said that they didn’t want to be told what to do by “a well-resourced Centralised agency” which had no sensitivity to the local situation. They gave the example of annual screening, saying that there was a fundamental flaw in adopting it as the main strategy for reducing STD rates. They said that it had worked at Nganampa Health because of a whole lot of factors that didn’t apply elsewhere: the staff at Nganampa was coordinated and skilled at screening at a regional level, and Nganampa also had Janet.

Knox, a venereologist, as well as male and female sexual health workers. The flaw was that funding at the same level was not available for other community-based services to reproduce Nganampa’s success, and no amount of regional coordination or local capacity building would remove this basic inequity.

John Boffa and Donna Ah Chee also talked about sensitivity issues in relation to screening. They said the problem arose from labelling of Aboriginal people with statements like “1 in 5 Central Australian men have an STD”. They also pointed out that there were problems with gaining patient consent for including their information in the Centralised Follow-up database, and that if patients didn’t want their results to go to a third party or onto a database, they should have the right and the ability to say no. Another problem they identified was that relying on computerised sources of information meant that practitioners were no longer obliged to get a proper history from patients, which was a negative in terms of health development. They thought that there needed to be more reflexivity about the trade off between client confidentiality and the benefits derived from a Centralised data system.

Some of these concerns clearly require addressing through a transparent discussion of problems and benefits from the databases. Eleanor Hook highlighted some of the problems in discussing the emerging process for filling out patient follow-up forms. Because filling out the forms was time consuming, and some clinics don’t get to them, Eleanor had reduced the workload by partially filling out the form herself before it was sent out to the clinic from patient information already on the database. Some of this information was collected from patient notes during subregional screening. She noted that there had been a lot of resistance to the forms, based on some initial concerns that the database was some kind of research project. It did not seem that gaining individual patient consent had been a part of the process. She did, however, also point out some of the benefits that are emerging from the system. The form collects some information about risk exposure, which will provide useful information on an aggregate basis that is not otherwise available. She also said that the database provided a useful tool for examining episodes of infection, something that is difficult to do in patient notes, and which provide a good perspective from which to consider the risk of PID.

Annette Coppola and Arun Menon said that there had been a major shift in sensitivities around STDs, and an incremental expansion of confidence in T SP especially around the confidentiality of disease registers. John Boffa and Donna Ah Chee talked about the process through which this confidence was being built. They gave the example of the recent audit of patient notes at Congress and Alukura.
Annette came for 2 weeks and went through hundreds of files over the last 12 months and Arun had done the same thing at Congress. The audit had been a good process, and helped clarify some of the sensitivity issues. The director at Congress, Johnny Liddle, had some problems with allowing outsiders into patient notes. In discussing these problems, and agreement was reached that such processes were acceptable for quality assurance purposes, but not for research purposes unless there was individual informed consent from patients. It was the first time an outside agency had been involved in a file audit, but set a useful precedent.

Donna and John thought that there was an ongoing role for TSP as a Centralised auditor.

Other people also raised issues about sensitivities. Russell Waddell said that getting the communities on side was one of the great successes on the TSP in recent times. Their successful approach was now to negotiate with health services and communicate with clinics to discuss ideas and then let them decide if they wanted TSP services. Sandy Thompson also noted that the relationship between TSP and Congress was improving, and that it would be a big win if Congress could be linked to addressing STIs in town. Andrew Ebringer said that one of the essentials for regional screening was community approval, support and information dissemination. Ngaanyatjarra Health Service Staff put regional screening back on the agenda: is it feasible staff wise; is it acceptable (bad history but good example from Nganampa Health region); does it have good results? Some community based worries about mass screening, but no great experience of it. Kath Feathers thought that the lack of Indigenous input at planning and management level was a big stumbling block for TSP. She also thought that at the practical level, getting some Aboriginal staff would be very useful, and help with developing understandings of sexual behaviour, developing educational materials, providing sexual health liaison in clinical and hospital settings, and with condom promotion. Andrew Ebringer discussed the political, cultural and ethically problems of mass treatment. He gave the example of the implementation of a pneumococcal vaccine trial in Central Australia, which foundered because it was an experimental vaccine, and the trial was limited to Aboriginal people.

Town

Andrew Ebringer said that town is the key, and that because of regional mobility in and out, Alice Springs is a “pool of pathology”. Janet Knox also said that town issues are key, but that in terms of STD control nothing much was happening in town. Kath Feathers acknowledged that town was a “whole other ballgame”. She felt that a town-based approach was required to achieve a reduced prevalence of STIs in the region. She reported that the anecdotal evidence suggested that a lot of people were getting STIs while in town, and that making them on to their regular partners at home. Annette Coppola and Arun Manen acknowledged the urban problem, and the need to develop an urban strategy. Their current approach has four parts: audit; improve clinical functioning; develop outreach programs/screening; and identify and work with high risk groups. They were currently doing an audit of CAAC and Alukura. They said that CAAC was anxious to improve their testing and treatment performance, and to develop a town-based treatment and screening program for men in town camps. The Sexual Health Unit (Clinic 34) were also keen to develop their town-based workload including working with GPs, working with the AS Hospital, and working with high risk groups.

The high risk groups targeted by Clinic 34 included those engaging in both formal and discretionary sex work (including sex for trade), and taxi drivers. John Boffa and Donna Ah Chee were more tentative about the importance of an urban Strategy. They said that CAAC Men’s health program had conducted ad hoc screenings in town camps, but had not turned up many positive results. They thought that there was a significant lack of data about the way Aboriginal people use the Emergency department at the Hospital, including what they were using it for. They felt that there were assumptions made that Aboriginal people used the ED inappropriately, and that these assumptions were inaccurate. They spoke of the need for more data about Aboriginal use of the ED to be made available. Sandy Thompson emphasised that without the participation of Congress, an urban strategy would fail. She thought it was very important that TSP and Congress were beginning to work together, and that would be a big win if they could link in with Congress to start addressing STIs in town. Unless Congress participated in an urban strategy, there would be impediments to reducing that impact of town as a setting for the spread of STIs.

Jan Savage said that a regional screening program would have to involve the Alice Springs town area, but questioned the capacity of TSP to coordinate screening in town. She thought that the cooperation of Congress in such an exercise might be difficult to achieve. Janet Knox thought that the hospital was a major part of the town problem. In her view, the hospital was not
effective at managing infections, and failed to fit in with other regional strategies and priorities. Jan Savage also commented on the role of the hospital in any town strategy. She noted that there were a number of issues with the hospital: the high turnover of staff; the emphasis on acute problems; the lack of emphasis on STIs; their need for targeted education and promotion of STIs as an issue; and problems with A&E. She thought that TSP needed to work with Public Health to increase the profile of STIs at the hospital, because professional education (for all health professionals) is a fundamental part of public health work and an area that TSP should continue on with, beyond the nurses orientation program. Kath Fethers said that a lot of bush people sought treatment at the A&E department at Alice Springs Hospital. She currently gets the positive results for people who were tested in A&E, but not treated. She tries to remind the A&E staff every three months about presumptive treatment, but staff turnover is high. She didn’t think that fixing A&E was the best option, but thought that there were few alternatives. She didn’t know whether it was worth while to harness the existing presentation patterns in A&E by putting a staff person there. She thought that for those patients presenting in A&E, follow up was the biggest issue. Doctors working there didn’t see the whole of each patient’s notes, so were unlikely to see positive results from previous visits. The system of single pages of patient notes in A&E was one of the problems there.

Kath also said that bush people currently didn’t use Clinic 34 for a range of reasons. There was no male worker at the clinic. Also many bush people were simply not aware that it was an STD clinic because there is a turtle on their sign, and they are not allowed to indicate clearly that it is an STD clinic. The clinic employed Christine Franks as an Aboriginal Liaison worker, but while she had good relationships with bush communities, she had not had much contact with the town community.

**Mobility**

Sandy Thompson though that the mobile population was one of the greatest barriers to successful control of STIs in the TSP region. Mutitjulu staff noted that the work that had been done on their population list through the community council demonstrates that theirs is a very fluid population, and that there were always lots of people from other places in the community. Andrew Ebringer gave the example of Yuendumu, where 30% of the population left in one 6-month period, and 15% arrived. Michael Carter at Aninginyi Congress also highlighted mobility issues, but noted that they were different in Tennant Creek because of people coming there from WA, north, south and Queensland. Ngaanyatjarra Health Service Staff said that there were problems for Ngaanyatjarra communities with mobility to places west and outside of the TSP area.

The problems with mobility relate to program coverage, to the special needs of what Ushma Scales has called “Townitja” (subpopulations who are highly mobile between remote communities and regional centres like Alice Springs), and to accessing the medical records of mobile populations. Andrew Ebringer noted that mobility was the greatest threat to successful screening, because it affected participation rates, made contact tracing difficult and increased delays to treatment on positive results. His solution to the problem of mobility was regional screening. Ngaanyatjarra Health Service Staff thought that there needed to be some research into the drug and alcohol usage and some health education needs of those who travelled back and forth to town. They said that HIV was a growing threat in Ngaanyatjarra communities because there were now more people with HIV in touch with these mobile community people. Russell Waddell said that patient information databases (like the SIS and the Central Follow-up database) were useful because doctors could access information about treatment history for patients who presented from other communities, who therefore were not retreated. This prevented the overuse of treatments, and unnecessary unpleasant treatment experiences for patients.

**Contact Tracing**

Andrew Ebringer pointed out that mobility affects the capacity to do contact tracing. Celina Bond gave examples of this difficulty. She said that transients from Queensland visit Tennant Creek Hospital, although A&E more than Clinic 34. There were general problems with following up these people for all specialist services. It was time-consuming and frustrating to follow them up for STD work. Eleanor Hook noted that the Centralised system of follow-up forms associated with her work had really improved contact tracing. If a clinic couldn’t find the client, Eleanor was able to use the information returned with the form to follow them up with other clinics in the region.
Delays to treatment

Andrew Ebringer said that one of the ways mobility affected disease prevalence was by increasing delays to treatment on positive results from screening programs. He noted that the TSP had recruited a dedicated nurse to handle all data in order to combat the influence of mobility on delay to treatment. He thought that the follow-up position worked very well, and that the dedicated person brought “the threads together”. He suspected that time to treatment had dropped since the position was put in place. Michael Carter at Aninginyi Congress also said that time to treatment was a big problem in Tennant Creek, mainly because of mobility (to Katherine, Mt Isa, Alice Springs).

Eleanor Hook said that her position grew out of the audits, and through relationships with bush staff. Although the position was meant to have a database, this hadn’t initially been implemented. Despite this, the position had taken off and feedback from bush was that it was useful in terms of better follow up (via recall lists, reduced time to treatment, and increasing amount of consultation from bush nurses, especially regarding treatment). She was using a form as part of her work with bush clinics, and gave examples of how useful it was in quality assurance in the area of time to treatment - she noted that in some cases bush clinic staff had ticked that the person was symptomatic, but weren’t treated. Eleanor was able to follow it up with them, and if they were new staff, she educated them about presumptive treatment. Ngaanyatjarra Health Service Staff said that the Central follow-up position was useful, but they were also attempting here to develop their own local database for early notification and reduction in time to treatment.

Participation rates

Andrew Ebringer pointed out that re-infection is a barrier when screening is incomplete. He thought that subregional screening was problematic because of a range of factors including low participation rates, leading to re-infection. He advocated full regional screening, in line with the Nganampa model of high participation and treatment rates. Without full participation, he thought that there was too much mobility to guarantee good results from partial screening programs. Several informants pointed out the issue of men’s participation in screening as a particular problem.

Michael Carter at Aninginyi Congress noted that one of their initiatives was to take screening out specifically to men. They had instituted different kinds of Well Men’s Health Checks which targeted men: a Footy Players Health Check; CDEP health check (including hepatitis immunisation); and JPET health check (Julalikari Vocational Training Program). Ngaanyatjarra Health Service Staff noted that during the screen at A Ngaanyatjarra community, lots of men were away at ceremonies. They had got around this problem by concentrating on follow-up of male partners of positive contacts among women who were screened, once they had returned to the community.

Many of informants thought that the low priority given to sexual health by health service providers in the region was a barrier to the uptake and success of TSP programs. Andrew Ebringer noted that STDs needed to be taken more seriously, because of the risk of secondary infertility and the fact that STDs are a cofactor in potential HIV infection. He noted that screening for and treatment of STDs has not been made a priority in THS services in the region. THS priorities for Remote Health in Central Australia are contained in the GAMIT philosophy. This philosophy provides a set of priorities for remote nurse practitioners. GAMIT stands for:

- Growth assessment and action in children (skinny kids);
- Antenatal screening;
- Management of chronic disease;
- Immunisation; and
- Topical (skin disease).

At a recent THS regional meeting, Andrew proposed that they add an S for STDs, but his proposal was rejected and STDs were not accepted as a priority. Nurses rejected the proposal because they didn’t have time or the manpower to add another priority. Andrew believed that for regional screening to occur, additional funding and positions would be needed.

Russell Waddell noted that STDs are not a priority, but only one of a multitude of medical problems that affect the client population in the TSP region. He thought it was important to recognise this and work
within existing priorities. Mutitjulu staff also said that STIs are not a priority for anyone. They thought that duplicating Nganampa’s results would not happen until equivalent resources are made available to other health services. Sandy Thompson noted that TSP had offered services that Ngaanyatjarra couldn’t take up because community controlled services made their own decisions and they didn’t always decide to accept TSP services. Although TSP was trying to do things, other players were at different stages of development regarding STI control.

Annette Coppola and Arun Menon recognised that STIs are never going to be a major priority. Their solution was to help services make small steps using pragmatic approaches. They also pointed out the value to health services of the information they are providing through audits and the Central Follow-up position. In their view, providing this kind of information kept STIs on the agenda, and helped people to do their jobs better, and set priorities more effectively. They noted that for many services, it was the only systematic information they were able to access about any part of their work.

Personalities

Some informants pointed out that the success of TSP programs, and sexual health programs in general, depended very much on who was in positions within different organisations, and whether they were interested or not. Janet Knox nominated personality or relationship issues as a key barrier. She said that if managers were on side, then programs worked well. She also pointed out that frequent staff changes meant that relationships were constantly having to be rebuilt, a related barrier. Kath Feathers noted that even where individuals within organisation were cooperative, without supportive leadership there could be changes made to practice. She also noted that staff turn over rapidly, and there was never enough time to educate new staff. Phillippe Porigneaux also noted personality problems as a barrier.

Complexity

The complexity of the situation in Central Australia was raised both directly and indirectly by our informants as a barrier. Jan Savage said that, “Central Australia is a unique and funny mix of a rich country with an extremely deprived population who theoretically have access to modern diagnostic activity and expensive drugs, which aren’t available in third world countries which have the same rates of STIs”. She pointed out that except for the program at Nganampa Health, there are few models for STD treatment and prevention that are tailored to the peculiar demands of Central Australia. This means that practitioners are using screening and highly sophisticated tests without being sure that they will be effective. Because of the dearth of models that have been trialed in Central Australia, she thought it was very much a matter of “suck it and see”. She did not think that the solution to STIs lay with a STD funded program – like any other aspect of Aboriginal health, issues like housing, employment and education were also implicated. She said that, “If you want to get really depressed you could say you won’t get anywhere until they are addressed.” More positively, she noted that the TSP has made progress.

Russell Waddell pointed out that problems arise from jurisdictional differences and even the lack of coordination between services within jurisdictions. Sandy Thompson noted that health services were at different points in their development, and had varying capacities to interact with each other at the regional level in the way they were being encouraged by TSP. Andrew Ebringer pointed out that there are advantages for Nganampa in the social and cultural unity of their area. He thought that in the wider region, TSP was the only organisation who could coordinate a regional screening program because of all the players involved.

Counselling

Kath Feathers noted that there is no counselling unit in the region that can deal with STIs, and that this is a gap in available services, and a barrier to the management of sexual health. She pointed out the STIs are never straightforward for people. She acknowledged that the Social and Emotional Health programs at CAAC and other services could be encouraged and trained to absorb this function in time, but that it was a specialist job and would require specialist program development and training.
Chapter 4: Policy Inconsistencies and Structural Issues

In this chapter we report on the findings of the review as they relate to the fifth Term of Reference, namely, to identify areas of progress towards resolution of policy inconsistencies and structural issues between jurisdictions which may impede effective patient management and care, monitoring and surveillance.

Commonwealth, State and Territory priority setting

The original conception of the National Indigenous Australian Sexual Health Strategy (NIASHS) was that it would be implemented through the various State and Territory Partnership Forums established under the Framework Agreements on Aboriginal and Torres Strait Islander Health. The recent mid-term review of the NIASHS suggested that not all has gone to plan. The review document notes that the Partnership forums have only been operating for a short time, and have large complex agendas. At this stage, it appears that partnerships in some jurisdictions have been weak or ineffective. In relation to the implementation of the NIASHS, none of the States and Territories adopted an initial formal plan for implementation, although there has been some progress in several jurisdictions towards developing Indigenous sexual health strategies. Although the allocation of funds under the NIASHS has generally been consistent with the strategies’ principles and priorities, the report suggests that State and Territory partnerships lack clear and detailed criteria for the allocation of funds. The report’s authors recommend that:

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. They note that in those jurisdictions where the state of relationship among the relevant parties is not currently conducive to effective partnership-based implementation, the Commonwealth should consider what assistance it can offer to foster more active partnerships.

The TSP region represents a special case in terms of priority setting for expenditure of NIASHS funds. It is the only project in the country where funds are committed from the multiple Commonwealth, state, and territory planning processes. With TSP, agreement has to be reached by the funding partners, and their agreement enshrined in four different and separate Indigenous sexual health strategies. This adds a layer of complexity to the annual funding arrangements that has little precedent, and which plays out in excessive administrative burden and uncertainty for employees of the project.

Some of the nature of this complexity was highlighted for us at the Regional Planning Workshop. On the second day of the workshop, representatives from OATSIH and State or Territory Health departments in each jurisdiction outlined the processes by which funding was allocated to Indigenous Sexual Health. As the Midterm review team noted above, although these processes within each jurisdiction were generally consistent with the principles and priorities of the NIASHS, the picture presented was of a largely uncoordinated patchwork of processes and programs.

Helen McFarlane, representing OATSIH at the Commonwealth level, said that of the total NIASHS

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8 Ibid, pg iii
9 Ibid.
funding available, WA gets 14%, the NT gets 15%, SA gets 6% and 19% is available at the national level, including funding for PCR. At the national level, funds are allocated to progress national priorities, and to expand the evidence base around Indigenous sexual health. Some examples of projects funded at the national level include: TSP; the Nganampa Health Council program; the National Donovanosis Eradication Strategy; and the National Indigenous Australians Sexual Health Committee. The national agenda includes: further research into early diagnosis and treatment, setting out approaches and parameters; current funding for the Well Person’s Health Check at Apunipima; and other ways for people to access early diagnosis and treatment.

South Australian priorities and processes were represented by Colin Banks (OATSIH SA) and Russell Waddell. Colin Banks said that most of the OATSIH funds were already committed, and that there were no buckets of money sitting around waiting for good submissions. Funding decisions about the distribution of NIASHS funds in South Australia were made by the Aboriginal Sexual Health Reference Group (ASHRG), (which, we note, had no formal status in relation to the Aboriginal Health Partnership Forum or the NIASHS). Most NIASHS funding has gone through a process of simple division to community controlled organisations in all parts of SA except the Nganampa area, and has been used solely for the employment of sexual health workers. Russell Waddell noted that other than the NIASHS funding, there was very limited funding available through Aboriginal Services Division via the HivAR Program within the DHS Communicable Disease Control Branch. This notionally funds a coordinator to run ASHRG, although the position has been largely unfilled, and its future is under review.

In WA, both Sandy Thompson (representing the WA health department) and Diana Downs-Stoney (OATSIH, WA) said that although there was lots of NIASHS money in WA, there were problems and tensions in decision making re allocation of the funding. Particular questions arose around whom should be given the funding, and what process should be in place for decision making. Again, in WA the Aboriginal Partnership Forum was not responsible for the allocation of NIASHS funds, as it is primarily divided up through the state department. The community controlled sector remains unhappy with this arrangement, and there are efforts being made to address the problem of making the funding process more acceptable to WACCHO.

The NT, represented by Kate Race (OATSIH NT) and Jan Savage (THS), was the only jurisdiction where the distribution of NIASHS funding, about $1 million a year, followed the implementation model outlined in the strategy. Since the establishment of the Aboriginal Health Framework Agreement in 1998, an Aboriginal Sexual Health Advisory Committee, which subdents the Aboriginal Health Forum, has made decisions, based on their own Strategic Plan and Terms of Reference. The Key Action Areas identified in their strategic plan are: increasing the number and capacity of Aboriginal Health Workers (especially men); men’s health; young people; IV DUs; and HIV positive people.

### Funding quantum

Issues related to the current funding proportions contributed by the jurisdictions were raised by three members of the funders’ group. Sandy Thompson noted that although Western Australia makes a significant proportional contribution to the annual funding of the TSP the majority of TSP’s activities are located within the Northern Territory. If Western Australia is to continue to support this proportional funding arrangement then a number of aspects must be provided for. These included that Tri-State continue to: share information and knowledge with services in Western Australia; support the attendance of Bega Garnbiriringu Health Service and the Goldfields Public Health Unit at TSP meetings, workshops and the current CADCCC STD/HIV sub-committee meetings; and continue to liaise and work with Ngaanyatjarra Health Service.

Philippe Porigneaux said that he was not aware of any problems with the Northern Territory’s continued funding of the TSP but added that he did not make funding decisions. He noted that sexual disease is on the government’s agenda.

In relation to South Australia, Russell Waddell commented that it is hard for financial decision-makers to see the value to South Australia of its contribution to the TSP. He believed that there were a number of reasons for this. To begin with there is a lack of knowledge about and understanding of the significance of TSP and Nganampa’s work in South Australia. In addition, the restructuring of the public health section of the Health Commission has weakened opportunities for him to provide direct input into financial decisions. Finally he noted that the majority of the TSP activities occurred in the NT.
He suggested that if the TSP were to address South Australia’s sense that they don’t receive value for their financial support of TSP, then the TSP would have to extend its services in some way to Coober Pedy. He said that in an ideal world the TSP could be replicated within South Australia as part of an expanded program. On a more realistic note he suggested that there is a need to increase the relationship and communication between Nganampa and TSP and Indigenous health services in Coober Pedy. Improved communication between these organisations would, he thought, lead to a greater profile for STDs, increased treatment and better follow-up. He thought that additional screening was also required in Coober Pedy and that, if the TSP received increased funding, it could coordinate sub-regional screening there.

A number of key informants considered the TSP to be inadequately funded. Andrew Ebringer noted that the TSP was underfunded especially if it was to expand its role based on the Nganampa model and that there is considerable competition for health and STD related funds. Jan Savage observed that every area of Aboriginal health is desperate for funds and that the TSP could do more if it received additional funds. She also noted that funding wouldn’t necessarily solve all the issues related to the TSP given the constraints associated with PHC services on the ground, and that there are “...a lot of time chasing dollars and providing reports.” This view was echoed by Janet Knox who said that there was a huge amount of administration required when working with four governments and that this created stress for the staff.

Nganyatjarra Health Service Staff from Nganyatjarra Health Service reflected that discussions and disagreements about value for money would go on, no matter what. They also noted that communicating and networking with health services via the coordination of regional meetings requires a fair amount of money.

Funding process

Most key informants commented on the current annual funding process, identified limitations and suggested changes.

Helen McFarlane noted that the TSP needs a three year strategic approach. She said that “The one year funding arrangements are not good for strategy development and that a “longer term strategic approach is needed.” She anticipated that the Commonwealth would support a three year plan.

Jan Savage suggested that the funding should be for five years based on the Commonwealth Public Health Outcomes Funding agreements. She also noted that the NT funder provider model is based on a 3-year term and that this could be an argument for a 3 year funding cycle for the TSP if a five-year cycle was unachievable. Janet Knox also thought that extending funding for a three year period was a good idea.

Russell Waddell also suggested a three year funding cycle. He considered the current annual funding process which requires him to produce a lengthy submission documenting the history, rationale for support and request for ongoing funding to be wasteful and time consuming. In addition he noted that the current mechanism for securing South Australia’s yearly contribution was fragile and should not rely on his personal connections given that he was no longer located within the Health Commission.

According to many key informants the number of funders also compounded the inefficiencies associated with an annual funding cycle. Helen McFarlane commented that the workload associated with four jurisdictions created difficulties for the staff and that “...they spend a lot of time chasing dollars and providing reports.” This view was echoed by Janet Knox who said that there was a huge amount of administration required when working with four governments and that this created stress for the staff.

The TSP staff also noted the time spent in negotiation with the jurisdictions and that in 1997 it took four months before the funding arrangements were finalised. Although it had been streamlined since, the time spent on these negotiations was still an issue for them. They also noted that extended funding negotiations carry the risk of spiraling demands. They said that it was always up to the TSP staff to follow up on the financial commitments of the States, NT and the Commonwealth. The NT advancing the TSP their annual $280,000 and the TSP then recouping funds from the other States and the Commonwealth had recently improved this. The staff noted that this system would be further improved if there were a three year cycle accompanied by a schedule of payments tied to dates and performance indicators.

The uncertainty associated with annual funding cycles was also mentioned by a number of key informants. The staff commented that it made it difficult for them to make future commitments to a community because “you don’t know if you’ll still be there”. Helen McFarlane said that it complicates the funding negotiations because “If one player pulls out or threatens to it can make the others jumpy.” She noted that this is also “unsettling for the TSP staff”. Funding uncertainty creates stress for the TSP staff thought...
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Janet Knox with Sandy Thompson noting that good staff require security and therefore TSP needs longer term funding. The staff also noted that it is difficult to attract people to one year contract positions.

A number of informants commented on the implications of the new purchaser-provider funding model, which has been initiated in the NT. One informant said that it didn’t make any difference because she would purchase services from the TSP whoever they belong to. Jan Savage said that it was unclear whether a collaboratively funded program like the TSP should be included in the purchaser-provider arrangements and that it added another layer of work.

Ngaanyatjarra Health Service Staff from NHS thought that the problem with the purchaser-provider model is that it is difficult to get outputs or outcomes on innovative or risky projects. They also noted that they would still purchase services from the TSP. The staff observed that the TSP had to fit into the NT’s bureaucratic processes.

Reporting

That the jurisdictions funding the TSP have different reporting requirements was an issue mentioned by a number of key informants. Janet Knox noted that each state and territory has different requirements and that these variations have resulted in the TSP staff spending time coming to terms with the particular forms and mechanisms. She argued that such bureaucratic processes should be devolved to administrators in the NT. The TSP staff said that the funders all work under different arrangements with different reporting requirements and that the effort required meeting these takes up too much time.

Jan Savage said that funders increasingly wanted reports on outcomes, which it is difficult for the TSP to provide given the limitations of available evidence. She did however note that “the ground work has been done” by the TSP.

Sandy Thompson also referred to outcomes. She said that although WA must be getting value for money and outcomes, it may be prepared to accept a strong strategy if it is not possible to guarantee outcomes.

The TSP staff suggested that one new system should be developed and trialed for three years, where each partner would receive the same reports, based on a business plan with strong performance indicators, supplemented by subcommittee reports.

Governance

Many informants during the review raised issues related to the governance of the TSP.

That the TSP is not community driven and needs leadership from Aboriginal people and communities was noted by Sandy Thompson. If this was happening, she thought, the TSP would be better informed. “TSP is a lot of white people discussing Aboriginal problems”.

The difficulties associated with establishing a management structure for a program that has four funders was mentioned by Helen McFarlane. She said that the existing management arrangements need improving because the current structure divides the funding and the technical functions. She suggested that the technical group, the CADCCC STD/HIV sub-committee, needs to have a greater focus on management especially as the purchaser/provider arrangement in the NT means that the funder doesn’t necessarily have any content knowledge. The NT is the only jurisdiction where the funder doesn’t also sit on the sub-committee. “This is cumbersome” because the “players on the technical sub-committee are committed but they can’t always guarantee to provide the funds”.

The TSP staff also noted that it is advantageous to have a situation where good technical people are involved in funding decisions so they have the authority to make recommendations to finance, and the commitment to follow these through. They said that at the moment, the funding group was good because the technical representatives are mostly the same as the funding people. However this may not always be the case and they noted that in the NT people with strong technical knowledge are not necessarily involved in funding.

Further they observed that the CADCCC STD/HIV sub-committee might become unwieldy and problematic if it grows any larger. It currently provides strong technical advice to the TSP staff and, in turn, to a growing number of health providers keen to benefit from the information sharing that occurs. They noted the important networking role that the CADCCC STD/HIV sub-committee fulfills but wondered if there needed to be an additional forum to address this. They suggested that it would be possible to formally divide the CADCCC STD/HIV sub-committee into a smaller core group of technical advisors, which could be supplemented by a social scientist, and a larger group focussed on information sharing and networking. They said that if such an additional meeting were to
occur it would require dedicated administrative services as the TSP currently has an inadequate level of administrative support. Jan Savage noted that there is a core group of representatives who always come to the sub-committee meetings and others who don’t come so often. Management would be strengthened by “some more formality around processes” said Helen McFarlane. She suggested “a regular agenda item on the CADCCC sub-committee on management of the project, and how it is going and some annual report.”

The relationship between the TSP governance structure and the THS was raised by Phillipe Porigneaux. He said that the TSP has a management group, which makes decisions about the direction of the TSP, but it is not clear how those decisions are meant to fit within THS. For example, some of these decisions have to be implemented by him in THS, such as appointing the follow-up position staff person. This was a difficult decision to implement because at the time there was a staff freeze in place in THS. He suggested that there was a need to increase communication between THS and TSP and the TSP management group. The TSP staff also noted these difficulties and that, at times, the institutional arrangements in THS had been experienced as obstructive.

Jan Savage noted that there was also a need for better communication within the THS, for example, between the Darwin and Alice Springs THS Sexual Health people. She said that this was particularly necessary if she is to advocate effectively on sexual health issues. She suggested that some strategies to address this could include regular visits between Darwin and Alice Springs.

The relationship between the Central Australian Regional Indigenous Health Planning Committee (CARIPHC), CADCCC and the TSP was also viewed as problematic by a number of key informants. Helen McFarlane observed that the TSP should have an advocacy role with CARIPHC and in the development of the Primary Health Care Access Program (PHCAP). She commented that there “doesn’t seem to have been a good flow of information between the TSP and the development of the PHCAP and CARIPHC.” She thought that it was important for the TSP to be involved in these developments because the TSP can identify the “critical success factors and make sure they are not left off the planning priorities”. She said that she was “not sure whose responsibility it is to ensure that this communication occurs. The TSP seems to be out of the loop. Why is this? Is it the NT’s role or the THS’s role to have kept TSP in the loop?”

John Boffa and Donna Ah Chee noted that the current governance model is that TSP’s subcommittee is placed, with other communicable disease subcommittees, under CADCCC, which in turn sits under CARIPHC. The TSP can provide input to CARIPHC via the chair of CADCCC. John Boffa suggested that this is cumbersome for the TSP and that it should have a more direct relationship with and endorsement from CARIPHC. He also said that the TSP’s relationship with CADCCC is problematic as CADCCC doesn’t meet very often, the TSP staff don’t stay for the whole CADCCC meeting and he, as CADCCC representative, has not always attended the STD/HIV subcommittee meetings. He suggested that a better idea is the development of a regional plan in the same format as the other CARIPHC plans. He noted that SA and WA have no involvement with CARIPHC, as it is a NT jurisdictional initiative, although Nganampa attends as an observer.

Sandy Thompson said that the THS Remote Health and CARIPHC should have more commitment to STDs and a more coordinated approach. And that the TSP should advocate for this.

The TSP staff also commented that the TSP is not effectively represented at a Territory level. As it is not involved in the Sexual Health Advisory Committee of the NT Aboriginal Health Forum nor inputting into NIASHC.

Helen McFarlane commented that “The last evaluation said that the Commonwealth should phase out its interest in TSP but no-one has taken that on board and the Commonwealth has a key role in brokering other regional initiatives.”

Jurisdictional medical issues

A range of medical issues associated with differences between the jurisdictions was identified by some key informants. Helen McFarlane observed that the states don’t always co-operate. “Some of this has got to do with Federation of course.” She said that the TSP is good at identifying the issues and barriers associated with operating across jurisdictions and in bringing these to the attention of the Commonwealth. She added, “this is why we have the TSP - because it patches up the system issues.”

Helen McFarlane observed that the TSP has highlighted the absence of national standards for the
notification of STIs. She said that the different jurisdictions have different notifiable disease requirements, for example, syphilis notification and that there has been very little progress on this. She also commented on the fact that the states and territories have different disease priorities and that in some states and territories the priority given to STIs varies from little to none. She added that “The TSP is probably doing as much as it can on this” and that “The jurisdictions need to see it as their responsibility”.

Sandy Thompson commented on the issue of data on STIs. She said that the TSP should be compiling the diagnosis/notification data for the Tri-State region in order to evaluate what was happening and evaluate the TSP performance against their objectives. This is not routinely done.

Helen McFarlane also noted that pathology laboratories have different testing procedures in relation to the interpretation of the PCR because the test was implemented prior to the establishment of a national standard of interpretation.

In addition Helen McFarlane said that there are no national standards for health worker training and credentialing although there has been some progress on acknowledging the mobility of healthworkers and issues associated with healthworker training credentials between the states.

The need for changes to Medicare in relation to trichomonas was identified by a number of informants. Annette Coppola and Arun Menon said that there is a problem with recouping costs for PCR testing on the same swab as gonorrhoea and chlamydia. Currently practitioners have to do two swabs on different days despite there being no technical problem with doing the three tests on the same swab. This would be alleviated if there were a new Medicare number for the 3-test swab.

Location within THS

Key informants raised a number of issues about the location of the TSP within TSP. Some concerns with and confusion about the role of the TSP have arisen in part as a consequence of its physical location in the Health Development Unit and the Sexual Health Unit of THS. Some of these concerns are also related to issues such as the inadequate funding of PHC services, TSP’s strategies to build relationships with local clinics and communities and the history of tensions between community-controlled services and the THS.

Sandy Thompson commented on “the close relationship between the TSP and the THS Sexual Health Unit”. She said that this perception is strengthened when TSP undertakes the screening and follow-up work that, in her view, the THS should be doing. The TSP shouldn’t prop up the NT services, as it isn’t the TSP’s role to do the job of ordinary PHC services. She added that this work takes time, leads the TSP to not being strategic and it is impossible to service the whole region in this way. She concluded that the TSP should advocate for, rather than provide, a direct service.

Helen McFarlane said that the TSP “mustn’t be a service provider for the THS” because it is the NT’s role to fund screening and follow up treatment. She noted that it is not part of the TSP brief and “it is seen as a direct service for the THS by the other states and the Commonwealth”. She emphasised that the Commonwealth is not funding the TSP as a service delivery agency or a “fly in fly out service delivery team”. Rather the TSP should be focusing on co-ordination and assisting services to design their own programs. She added that the Commonwealth is not sure that the decisions to screen and do follow up “have been made carefully”. This is especially so given that “since TSP was funded the Commonwealth has made significant increases in funding available for sexual health”. She said, “If there are gaps in services delivery and treatment that the TSP is noticing then they need to feed that information into the states and the Commonwealth and not fill the gap themselves”.

Phillippe Porigneaux’s comments also raised the issue of TSP’s core role, its screening work and its close connection to the Sexual Health Unit. He said that the TSP should be co-ordinating disease information, setting standards for screening and advocating. The TSP shouldn’t be providing screening because it is not funded to be a screening service for the NT. He added that this work confuses TSP’s role with that of the Sexual Health Unit and that at times it is not clear who is setting the agenda. He also noted that these difficulties are compounded if he is not kept informed.

That the TSP is sometimes seen as a THS project in Alice Springs was also observed by Jan Savage. She noted that “it should be in Alice Springs” but that the other funders “may see it as too NT dominated because most of the work and attention is focused on 1 jurisdiction”. She suggested that the other states could
“develop a set of proposals for activities in their areas with funding tied to them and the T H S need to listen.”

Michael Carter at Aninginyi Congress also said “people see it as tied too closely to T H S, so people see it as a part of T H S.” However this was not a service delivery issue but one related to the history of T H S funded services and their relationship with communities and community controlled services. He specifically referred to “problems in Tennant Creek with T H S treating Aboriginal people badly” and to “huge flare ups between town and the hospital”.

That the T H S benefits from easy access to the T S P was observed by a number of key informants. Kath Fethers noted that the T S P medical officer provides backup when she is on leave and provides a male practitioner at Clinic 34 in emergencies. Helen McFarlane said that the T H S has used the T S P resources without always compensating the program. In addition the T S P does provide valuable screening and follow-up work. Eleanor Hook said that the Central follow-up position should be continued, and should be streamlined into SHU to improve SHU’s services.

The close relationships with the Sexual Health Unit and the location in Health Development have facilitated some aspects of the T S P’s work. The T S P staff noted that the T H S have streamlined funding for the T S P by advancing them the full annual budget.

NT focus

During the review many informants referred to the fact that, although funded by four jurisdictions, the activities of the T S P are predominantly focused within the NT. Sandy Thompson and Jan Savage observed that the dilemma for the T S P is that most of the activity occurs in the NT and that the T S P has been very useful for the NT. Helen McFarlane said that this reflects the reality that the majority of the T S P’s services need to be delivered in the NT. She also observed that the T S P has expanded beyond the original area and that there is the danger of overload as the staff try to respond to the demands for their services throughout the region.

Despite the concentration of the T S P’s activities within the NT, the Commonwealth values the T S P’s links across the states and territory and it’s role as an independent broker. This is reflected in the Commonwealth’s decision to fund a Donovanosis eradication position and place it with the T S P.

The issue of cross border benefits was raised by Sandy Thompson, who said that WA must benefit from their funding of the T S P. Eleanor Hook noted that WA does benefit from the follow-up position as she enters positive and negative results for Ngaanyatjarra, phones the community and once a week sends the information to Michael Howard who does the follow up with communities.
Chapter 5: The contribution of outcomes and learnings from Tri-State project

We were asked to comment on the extent to which outcomes and learnings from Tri-State project activities are:

- Systematically communicated with other regions/services both within the participating jurisdictions and nationally;
- Effectively contributing to the development of models of good practice in other regions of Australia; and
- Recommend strategies for this to occur.

Responding to this term of reference was not as straightforward to us as the others. The information that we obtained from our informants in regard to dissemination of the outcomes and learning of the TSP demonstrated that there is a critical distinction that managers of the TSP need to make. When they talk of systematic communication and effective contributions to model development, should this take the form of articles in academic journals or practical contributions to clinical practice? This is a critical distinction because the TSP has moved in recent years from an organisation geared for the production of journal articles to one entrenched in the production of pragmatic solutions to problems of clinical practice. They have moved from a focus on clinical research to a focus on quality assurance. This change was identified by a number of our informants from community controlled health services, and was praised as a move in the right direction. As evaluators, we have been convinced that this shift in emphasis has been part of the increasing success of the TSP in expanding their program into services previously thought of as “difficult”. The syphilis database is a good example of this. This is success, however, that has been won at the expense of a more systematic program of self-promotion to a wider audience and a reduction of the research profile of the organisation and the people working for it.

This is not to say that the recent work of the TSP has not been important, or that it should not reach a wider audience. Some of the recent modelling achievements— for example, the audits as a method, Centralised follow-up, or the sub-regional screens— should probably attract the same sort of attention as the PCR trials led by Steve Skov. The difference with the recent way of doing things at TSP, an approach that elsewhere in this report we have referred to as “small, realistic strategies”, does not set up interventions as studies, but as pragmatic problem solving or training exercises aimed at building expertise and relationships with local communities and health services. Although they were not designed as research, and have not generated the kind of data from which research articles are written, we believe that they are still publishable. We do not believe that TSP should be criticised for not pursuing a research program necessarily aimed at academic publication. It is clear from our informants that their record of gaining cooperation for programs pitched as quality assurance has worked where a research pitch would certainly have failed. We do believe, however, that simple clear descriptions of intervention programs, or audit data that shows an improvement or deterioration in services over a period of time, could provide the basis of important and influential publications.

We also believe that the recent style of work at TSP reflects a pragmatic assessment of what can be achieved with the limited resources at hand. There is considerable time and effort involved in setting up interventions as trials compared to the preparation required to deliver training or work with local staff to solve local problems. There is also considerable time involved in the preparation of intervention data for academic dissemination via journals and conferences that is not required in producing reports for more local consumption. We note that the current program staff members have made good use of limited time in the production of such reports.
A more limited focus on academic publication has not meant that the TSP has not continued to make important contributions in recent years. Russell Waddell pointed out that the work of the TSP along with Nganampa Health has had an important influence on key strategies – for example, the National Indigenous Australians Sexual Health Strategy. A particular part of this influence has been the emphasis on community-based strategies and screening. We note that current efforts involving the Well Person’s Health Check through Apunipima (Cape York Health Council) and the Victorian Aboriginal Community Controlled Health Organisation (VACHO) owe their model to work initiated by TSP. TSP staff noted that their development of the Donovanosis Project put genital lesions on the agenda in Australia, and introduced Centralised follow-up as a way of addressing mobility. The model they developed has recently been accepted by OATSIH as the basis for a new program to eradicate donovanosis in Australia. Nganyatjarra Health Service Staff from Nganyatjarra said that Wiluna and Public Health in Kalgoorlie are now looking to TSP as a model. We also note that their new emphasis has not precluded a continuing role in clinical research, as the involvement of the TSP in the development of a PCR test for donovanosis attests.

Other informants suggested that more should be done to ensure that other parts of Australia pick up on the “critical success factors” in the control of ST/D/HIV that TSP is learning about. Helen McFarlane felt that TSP could be publicising more of what it is learning. She thought that there needed to be more cross fertilisation with other areas in Australia. Although some of this was happening informally, she believed that more formal communication would also be beneficial – for example, more papers at conferences and more published papers. She suggested that TSP needs a systematic dissemination strategy to publicise their gains and lessons learned. Some of our other informants also felt that TSP needed to improve their promotion of local successes.

Michael Carter from Aninginyi Congress felt that TSP could develop a stronger clearinghouse function, and also publicise some of the successful programs that member organisations have designed and implemented. He suggested that even modest strategies that were successful needed to be promoted. Nganyatjarra Health Service Staff from Nganyatjarra Health agreed that TSP should evaluate local health promotion programs and why they work and don’t work, and promote good programs and resources more effectively.

We recommend that the TSP and their management committee should develop a dissemination plan and marketing strategy for the TSP that could address the following elements:

- The preparation and wide distribution of an annual report of the TSP and its programs;
- The effective representation of the work of TSP at key forums, including the Sexual Health Advisory Committee of the NT Aboriginal Health Forum, and the National Indigenous Australian Sexual Health Committee;
- The presentation by TSP staff or associates of two to three conference papers a year at the conference of the Public Health Association Australia, the conference of the Australasian Society for HIV Medicine, and the conference of the Australian College of Sexual Health Physicians; and
- The composition and publication of a regular series of Working Papers by TSP staff and associates, based on the reports and discussion papers they develop as a routine part of their work. Our idea is that reports like Coppola’s “Trial of the Universal Pathology Form” (1997) and Menon and Coppola’s “Infertility Investigations in Six Selected Communities within the Tri-State Area” (1999) contain data of interest to a wider audience, and should be edited for publication as Working Papers for wide dissemination. The possibility of setting up a website, or using existing sites such as Edith Cowan University’s Aboriginal Health Clearinghouse site, to assist with dissemination should be explored.
The evaluation concludes that the TSP is making a valuable contribution to the coordination and expansion of effective STD control in Central Australia, and that there is a demonstrated need for it to continue. The major strengths of the project are:

- Its contribution to STD information systems at local and regional levels that are contributing to improved management of positive patients and their primary contacts;
- The development of improved models for active case detection and follow up;
- The education and support of practitioners in the field; and
- The provision of regional forums for sharing information and experience in relation to STD control.

In the following pages, we offer a range of suggestions for strengthening the project over the next three years, through more focussed objectives and associated strategies, an improved management structure, and more effective links to policy and planning development in the region.

### Appropriate overall objectives and key result areas for the project

Most of our informants commented on the fact that the objectives for the TSP were problematic. Helen McFarlane pointed out that the original objectives “were a creature of their time”. There were also comments that as objectives they were not well thought through. For example, they failed to account for the fact that improved screening would lead to the rate increases that we have seen with chlamydia and gonorrhoea. The Scrimgeour and Tsey evaluation identified that the objectives were too ambitious, and our informants have both confirmed that view and expanded on it, branding them as unrealistic and unachievable. We concur that the objectives have always been unachievable within the resources allocated, and agree with informants who suggested that they need a serious rethink. Informants suggested objectives that develop capacity, that are effective and sustainable, and that are more clearly targeted at the areas of greatest need. It was also clear that objectives needed to be achievable within a reasonable resource allocation, and within a designated time frame.

As a consequence of these unworkable objectives, TSP has not been able to benefit from and effectively use objectives in formulating activity plans. The result is the lack of mesh between existing objectives and key result areas for the project. Although these tools would normally be used to construct a strategic planning matrix as in Table 8 below, this has not effectively happened in the TSP, so that activities in each KRA are not specifically focussed on achieving one or other of the objectives.

What is additionally missing in the TSP planning model is a set of key performance indicators, so that activities in each KRA can be assessed against objectives, as in

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<th>KRA1</th>
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Table 9. This would also provide the basis of, for example, a triennial work plan (see section on funding below).

The final missing element in the TSP planning model is an appropriate annual review and reporting framework, so that progress against objectives can be reported back to funding bodies and to the communities that the program serves, and strategic directions fine-tuned.

In the following section, we offer suggestions for a revised set of strategic objectives and KRA's for the next three years. We recognise that it is inappropriate for us to be narrowly directive - there needs to be a full discussion of our suggestions aimed at generating and endorsing new objectives by members of both the technical reference group and the funders representative group. These objectives need to both reflect and inform other specific regional plans developed with CARIHPC.

Revising the TSP objectives

Our first suggestion is that the form of the objectives should move away from setting specific disease targets to a more process based approach. There are two reasons for this. The first is that there may never be adequate evidence to link the activities of a single organisation with reduction (or otherwise) in disease rates. The second is the logical issue that Tri-State's role is one of coordination and building the capacity for services that are delivered on the ground by a range of other organisations, and that reductions in disease rates are only directly attributable to the activities of these other organisations. While it is clear that the mission of TSP is to contribute to reduced rates of disease, their mode of contribution is through increasing the capacity of primary health services to reduce disease rates. The objectives of the program should therefore reflect these coordination and capacity-building functions, and the performance indicators should be couched in terms of better coordination and increased capacity. While this may appear to be a significant shift from the original objectives, it is a realistic acknowledgment of our increasingly sophisticated understanding of disease dynamics and barriers to health service delivery in Central Australia. In recognising the value of these new understandings, we must also acknowledge the contribution of TSP to their development, and the model role that TSP has played in formulating a sophisticated response.

The fact that this response has evolved organically rather than strategically should not distract us from its value: our stakeholder informants and our own analysis highlight that key aspects of TSP’s current approach are vital to the ultimate mission of reducing disease rates.

We suggest that the TSP should have a single overall goal that frames the elements of capacity building and coordination. In its original conception, the goal of TSP was to develop a coordinated approach to STDS in the cross-border region, so that by the year 2000, Indigenous people in Central Australia would experience a range of reduced rates of target diseases. We believe that the elements of this goal - coordination, STDS, cross border region and Indigenous Central Australians - should be retained. We think elements relating to time and disease targets are inappropriate for the overall goal of TSP. Specific time frames should be addressed through specific objectives, and we have already argued that disease targets are inappropriate. The outcome addressed in this overall goal should be concerned with improved capacity and coordination. As well, the scope of the program should be more clearly delineated: what is the “cross-border region”? It is clear from our discussions with informants that there is no consistent view of where the boundaries of the cross-border region lie.

Table 9: Basic Strategic Planning Matrix incorporating Key Performance Indicators

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In the absence of this clarity, the project has responded to needs across a burgeoning geographical range, creating serious resource issues and unrealistic expectations. There are various epidemiological and political arguments for what this region should encompass, but pragmatically, it depends on available resources.

**Strategic objectives:**

- To work towards the integration of sexual health services within comprehensive Primary Health Care structures particularly through supporting local primary health care services to improve their management of positive cases and their primary contacts.
- To coordinate an expanded and efficient program of active case finding in the region.
- To sustain regional commitment and approaches to STD control.
- To advocate for cross border standardisation of processes and procedures in relation to sexual health.

The goal and objectives need to be operationalised through key strategies linked to concrete indicators. We don’t believe it is our role to provide the details of these strategies for the next three years, as it is important for these to be generated by the key stakeholders of the project.

However, based on our findings from the evaluation, we would like to give an example of how the best of current TSP practice could be reconceptualised in the context of the new goal and revised objectives. Figure 5 shows the linkage between capacity building and regional coordination elements of the goal operationalised through the first of the revised objectives, and four key strategies drawn from existing TSP practice. These strategies are: clinic audits of equipment, facilities, skills and practices leading to training in best practice; clinic audits of patient records leading to the development of self-sustaining local patient data management systems; the coordination of regional testing data from multiple labs; and the Central Follow up position which provides an essential linkage between regional testing data and patient management information at the local clinical level.
Figure 5: Linkage between capacity building and regional coordination elements of the goal operationalised through the first of the revised objectives.
Key strategies for future action for the STD/HIV Tri-State to enhance STD/HIV services in the cross border region of Central Australia

While we do not wish to pre-empt stakeholder discussions about future key strategies, we would like to offer a framework through which these strategies might be developed.

Objectives:

Objective 1:

To work towards the integration of sexual health services within comprehensive Primary Health Care structures, particularly through supporting local primary health care services to improve their management of positive cases and their primary contacts.

At the regional level:

- Work with pathology services and communities to maintain a surveillance database that can provide backup for local information systems, and provide patient treatment history and standard treatment information to local clinics. This database should be supplemented with a regional population register.
- Use the surveillance database and population register to produce valid rates on a regional population basis for syphilis, gonorrhea, chlamydia, chlamydia, trichomonas, donovanosis and HIV, including:
  - the population proportion who have been tested;
  - the population proportion who have tested positive;
  - the population proportion of positives who have been treated;
  - the mean and median time to treatment for positives;
  - the percentage of primary contacts of positive cases who have been treated.
- Work with local communities and other relevant organisations to obtain the valid consent of patients for inclusion of their data in regional databases.
- Provide key input into the revision and ongoing development of standard treatment protocols.

At the local level:

- Work with communities to develop self-maintaining information systems that allow them to ensure the quality of patient management and care. These information systems include a population register, records of who has been tested, who hasn't, and the results of those tests. They should also enable communities to:
  - measure and improve the proportion of cases that get followed up;
  - see and measure reductions in time to treatment; and
  - improve the presumptive treatment of partners of positive cases, thus reducing reinfection.

This should be an organic development of systems connected at a regional level by a series of linkages, rather than a top-down, imposed system. (As an example, an indicator for this strategy could be that after three years key information systems and data sets will be developed in two thirds of communities or for 80% of the population.)
Objective 2:
To coordinate an expanded and efficient program of active case finding in the region

- Promote and coordinate local annual screening programs at community level and in town for syphilis, gonorrhoea, chlamydia and trichomonas. The trichomonas test is imperative to efforts to reduce pre-term labour and women’s vulnerability to HIV infection.
- Work with communities to develop locally relevant models for screening programs within existing local resources. This work might take the form of demonstration projects and training exercises, as a modified form of the sub-regional screening program recently implemented through TSP.
- Ensure that communities understand their own testing patterns and practices, and that they receive and are able to interpret the results of their screening programs, through the implementation of improved technology, regional coordination of results, and training and education projects for staff at local and regional levels.
- Facilitate training for practitioners in the field in population health approaches to sexual health, enabling them to think of communities as a whole as Nganampa Health Council have done. This will assist the organic development of regional screening.

Objective 3:
To sustain regional commitment and approaches to STD control

- facilitate regional planning of STD activities including sexual health promotion
- work with relevant stakeholders (CAAC, Alukura, ASH and Clinic 34) on the development of a Town strategy
- work with CARHIPC on the STD portion of a regional communicable diseases plan
- facilitate quarterly meetings of an STD Information Networking group of local practitioners and technical experts as a clearinghouse for best practice information, for information sharing and problem solving, as well as a forum to review and advise on the implementation of regional plans.
- Work with the management committee to develop a dissemination plan and marketing strategy for the TSP.

Objective 4:
advocate for cross border standardisation of processes and procedures in relation to sexual health

- Identify differences in standards for notification in the states and territory and advocate for cross border standardisation of these protocols
- Identify differences in the pathology testing and reporting in the states and territory and advocate for the standardisation of testing procedures and reporting formats and time frames for both individual and aggregated results.
- work with local communities and regional service providers to coordinate core health promotion messages and approaches
- work with the CRC for Aboriginal and Tropical Health and other relevant research bodies to develop priority research projects which address regional research needs.

An appropriate level of funding for the project and the relative contributions of the various funding bodies

We see three options for future funding levels:
- A small increase based on Consumer Price Index (CPI) since 1996. TSP has clearly not been funded at an appropriate level of funding, as there hasn’t even been a CPI increase since 1996. In real terms, the program has suffered funding cuts since 1996. This level of funding has and will severely constrain the TSP’s capacity to achieve its objectives.
- A moderate increase that would allow TSP to actually meet achievable objectives via a reduced set of Key Result Areas, as outlined above.
- A more substantial increase which would allow TSP to increase the boundaries of their activity to more adequately deliver coordination of information and population based disease control and prevention activities as far as
Given the current funding environment, our preferred option is the second one. The TSP needs to be adequately funded for its ongoing core business - coordination, model development, policy and planning coordination with CARIHPC and this will necessitate a funding increase. At the bare minimum, this needs to cover:

- The CPI increase since 1996;
- Adequate salaries to attract and maintain high quality public health officers to the program;
- The Central follow-up position with all on-costs and associated management costs;
- Appropriate funding to cover the Commonwealth's Donovanosis project officer;
- Additional administrative funding;
- Designated project funding; and
- In addition, the transaction costs associated with either a one-year or three-year funding cycle need to be factored in. Obviously, if the partners chose a one-year cycle, these costs are greater. These costs refer to the costs associated with negotiating a funding agreement with four jurisdictions, in this case, primarily the salary costs of the coordinator.

We recommend a three-year cycle, for the following reasons. Firstly, the time taken to secure one-year funding could more efficiently be used to contribute to project outcomes. Secondly, complex funding negotiations often carry a risk of increasing project deliverables beyond reasonable capacity within current resource levels. This is compounded by the fact that the area covered has increased since 1996, and that the TSP project team are responsive and committed. A three-year funding cycle could assist in managing these issues more effectively. Thirdly, the NT's funder-provider model is based on a three-year funding cycle, and if the TSP is to more effectively integrate with the policy and planning schedules of CARIHPC, then it should also be operating on a three-year funding cycle. Fourthly, the nature of effective strategic planning requires a longer timeframe, which is difficult to maintain within a one-year cycle. Clearly, a three-year period provides greater opportunities for comprehensive and thorough strategic planning, and would again more effectively link TSP into the CARIHPC processes. A three-year funding agreement with the four jurisdictions should obviously include a schedule of dates and payments linked to performance indicators and appropriate reporting.

The Commonwealth should increase their relative contribution so that TSP can continue to inform the Commonwealth about models for the resolution of cross-border barriers to the control of STDs. These models are often applicable in other regions of Australia, and to other sets of problems where the Commonwealth is responsible for brokering cooperation between state and territory governments. A good example of this is the Donovanosis project, which has now been taken up by the Commonwealth as a national program. We note, also, that the Commonwealth intends to use the TSP as one of the auspices for this national program, and that the Commonwealth's contribution to the TSP should increase to reflect the costs of auspicing this program.

The Northern Territory should increase their relative contribution. Given that both perceived and actual benefits accrue to the THS by virtue of the location of TSP within it, and that the bulk of the on-the-ground work appears to be in the NT and to a lesser extent WA, it is clear that the NT benefits to a greater extent than other partners, and particularly SA. In part this disparity will be addressed by the TSP increasing the proportion of their work in coordination and model development as opposed to direct service delivery, and all partners will benefit from this refocus. However, the fact remains that for the foreseeable future, the NT is going to remain the main focus of TSP work, and even though there are collateral benefits for other partners, THS will be a major beneficiary of this work.

South Australia should contribute proportionally less, although in practical terms this means that they should continue to fund the program at the current level. The argument for this contribution is more subtle than for the other partners, partly because so little of the TSP's work occurs in SA. There are three clear benefits to continued SA involvement. The first is improved regional coordination of STD control activities will reduce the prevalence of STDs in all communities in the region, including Nganampa communities. South Australia is well served by Nganampa Health Council, and the benefit to SA of partnership in TSP is in the coordination function that addresses the mobility of SA residents in and out of the NT and WA. The second benefit is improved coordination and service delivery models that will spin off to areas outside the current TSP catchment. The third benefit is that practitioners in SA will be able to access the syphilis database, as well as Central follow-up (CFU) information for patients from the TSP area, even when...
the practitioners themselves are not within the TSP area. This will contribute to a defacto inclusion of (minimally) Coober Pedy in the TSP area, and Russell Waddell has noted the usefulness of access to treatment databases in his treatment of patients from the TSP area who present in Adelaide.

Western Australia should contribute proportionally more because of the increasing commitment to supporting the work of Ngaanyatjarra Health in the development of their comprehensive STD strategy, and the networking and information provision role with Bega Garnbiiringu Health Service and the Goldfields Public Health Unit.

The effectiveness of the funding bodies involvement in the Tri-State and the role of the Territory Health Service as the auspicing jurisdiction

At the moment, state and territory level commitment is dependant on internal funding priorities in each jurisdiction, which in turn rely on well-connected individuals with a good understanding of the activities and value of the program influencing funding decisions on an annual basis. In all jurisdictions, problems were being experienced or at least predicted.

There is a small range of alternative approaches to the problem. One way is to increase Commonwealth’s leverage in the decision making process in each jurisdiction by linking State and Territory funding from the NIASHS to guaranteed support for TSP via a mechanism like a PHOFA. The risk of this approach is that the States and Territories may be forced to defund or cut other valuable programs in order to comply, which may have a deleterious effect on Indigenous sexual health in areas outside the TSP region. Alternately, the convenor of the funding committee could ensure that funder representatives from the states and territory are people who are not only strongly committed to the project, but also are able to influence finance decisions on sexual health funding within their jurisdictions. We are conscious that these people simply don’t exist in all jurisdictions, and those solutions that depend on particular people or personalities are not solutions at all.

An alternative, but less likely approach is suggested by the lack of strategic coordination in the application of NIASHS moneys in the two states and the Territory. All three jurisdictions have different mechanisms and priorities for the distribution of these moneys, none of which have a direction connection with priorities established under the National Strategy. It does seem that the only strategic use of this funding is that of the Commonwealth, who fund inter alia part of TSP and the Nganampa Health Council’s sexual health program. Since the rejection of vertical funding, it may not be popular to remind the Commonwealth that it has the capacity and the particular responsibility to directly intervene in the health of Indigenous Australians. However, OATSIH could perhaps take on a greater responsibility for the strategic use of National Strategy funding by directly funding local bodies rather than routing it through state health departments.

There is a clear feeling among our informants that ministerial commitment to the project has been lost. In real terms, the future of the TSP may depend on recapturing the imaginations of ministers, which may require a concerted lobbying effort, as well as the influence of powerful friends, including the National Indigenous Australians Sexual Health Committee. The TSP staff will need to contribute to this project, through activities associated with a dissemination and marketing strategy.

Territory health service as the auspicing jurisdiction

Overall we believe that TSP should continue to be auspiced within THS, although there are a number of issues with the current arrangements. The advantages include that the NT has responded to the problems of funding arrangements with four jurisdictions by providing the total annual budget for the program in advance of payments being received from the other partners. This means that previous cash flow issues no longer occur. The co-location with the THS Sexual Health Unit has provided for a productive cross-fertilisation of ideas and expertise, as well as collegial support for staff. TSP has also benefited from seconding arrangements with THS, which have in small measure alleviated some staff concerns consequent on funding insecurity. THS has also, obviously, benefited from the availability of a backup sexual health physician (which has been, in turn, a function of the good nature and public spiritedness of the people filling this position).

In addition an argument should be made that Alice Springs is central in many ways to the functions of the TSP. It is the regional centre, and consequently a focus of population mobility in the region. It is the location of the only tertiary hospital and a centre for health service delivery in the region. If we look at the distribution of the TSP’s target population, 60% of
the population and three quarters of the health services with which TSP interact are in the Alice Springs region (including both urban and remote).\(^1\) THS is the largest health service in the region, and physically locating TSP at the Alice Springs Hospital, next door to Remote Area Health Services, and within the Sexual Health Unit has ensured that good relations have been established with this important client.

The problems that are identified with locating TSP within THS are threefold: there is not enough emphasis on providing services in WA or SA; there is a blurring of boundaries between THS and TSP; and the historical communication difficulties between THS and community controlled health services have at times spilled over into the relationships of TSP with these services.

The challenge for TSP and its management body is to ensure that relationships with other key client bodies (notably Central Australian Aboriginal Congress, Nganampa Health Council and Ngaanyatjarra Health) are maintained at the same level as those with THS. Issues of blurred boundaries with THS must be resolved quickly as they arise. In particular, TSP should be meticulous about not delivering, or being perceived to deliver, health service functions that rightly belong to THS.

Appropriate management and advisory structures for the project

We believe that currently the management and advisory structures for the project do not provide optimal direction, management and accountability. Although they are doing a good job in many ways, there is room for improvement in the areas of: linkages to state and territory health planning functions including funding; representation of client communities; particularly of Aboriginal people; and promotion of the program to partner governments.

The main problem we see is that there are two management advisory groups – the CADCCC STD/HIV subcommittee and the funders group – neither of which are structured to effectively manage the project. The Funders group meet twice a year to review the financial situation and the business of the project. Their main function is to monitor financial expenditure, and they see progress reports on the operational plan. The CADCCC STD/HIV subcommittee clearly provides excellent technical advice to a growing numbers of attendees, who value the networking opportunity and support that the committee affords. However neither committee provides the kind of strategic leadership that is reflected in annual cycles of either strategic planning or review. Despite some of the membership being well-connected to a range of state and national level health planning bodies and processes, the structure and business of these committees does not seem to allow for this knowledge of the current policy environment to assist the development of strategic directions for the TSP.

For example, the implications for TSP of the NT movement to Primary Health Care Access Program (PHCAP) and regional health planning have not been formally explored, despite a regional planning document being in existence since 1997. Even the implications of the program having to operate under two different purchaser provider models (WA and NT) from this year have not been explored. Through our interviews and review of key documents it seems that the problems arise from the narrow focus on STDs in the technical group, and the concentration on the minutiae of expenditure and problems of securing funding in the funders group.

We think that the management function should be consolidated into a single Management Advisory Group, with terms of reference which clearly delineate its management responsibilities which would include: to provide strategic leadership; to oversee annual strategic planning functions; to advocate for and promote the project; and to secure funding and review expenditure via an annual financial and activity reporting cycle. The membership of this group should be broadened to include Indigenous people from the TSP catchment, as well as representatives of the four key client services (Nganampa Health Council, Ngaanyatjarra Health, Congress and THS-Remote). It is important that the management group develop a strong sense of ownership of the program, and a determination to advocate on behalf of and defend the program.

We believe that two important strategies should be pursued by TSP to link and coordinate its activities more effectively into regional policy and planning initiatives, as well as to continue the valuable networking and support role previously provided by technical advisory group meetings. The first of these strategies is for TSP to facilitate quarterly meetings of an STD Information Networking group of local practitioners and technical experts as a clearinghouse.

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for best practice information, for information sharing and problem solving, as well as a forum to provide technical review and advice on the implementation of regional plans. Because this is no longer a management group, it has the potential to grow without becoming dysfunctional, and hence meet the information and support needs of a larger group of participants. The second strategy is for key staff of the TSP to become active members of the Communicable Diseases committee of CARIHPC, and take the initiative in developing an STD regional subplan as part of the Communicable Diseases regional planning process. These relationships are represented in figure 6.

Figure 6: Revised Organisational Chart for the Tri-State Project
Appendix One: Analysis themes

Project: Tri-State evaluation

**Number of Themes: 98**
1. child under 12
2. Chlamydia
3. congenital syphilis
4. donovanosis
5. gonorrhoea
6. HIV
7. Syphilis
8. (1) / key informant interviews
9. (1 1) / key informant interviews/ Helen McFarlane
10. (1 2) / key informant interviews/ Jan Savage
11. (1 3) / key informant interviews/ Janet Knox
12. (1 4) / key informant interviews/ Andrew Ebringer
13. (1 5) / key informant interviews/ Annette and Arun
14. (1 6) / key informant interviews/ Michael Carter
15. (1 7) / key informant interviews/ Ngaanyatjarra Heath
16. (1 8) / key informant interviews/ Mutitjulu
17. (1 9) / key informant interviews/ Philippe Porigneaux
18. (1 10) / key informant interviews/ Russell Waddell
19. (1 11) / key informant interviews/ Sandy Tompson
20. (1 12) / key informant interviews/ Kath Fethers
21. (1 13) / key informant interviews/ Eleanor Hook
22. (1 14) / key informant interviews/ John Boffa and Donna ah Chee
23. (2) / achievements
24. (2 1) / achievements/ cooperation
25. (2 2) / achievements/ audit
26. (2 3) / achievements/ syphilis database
27. (2 4) / achievements/ agenda
28. (2 5) / achievements/ public health perspective
29. (2 6) / achievements/ screening
30. (2 7) / achievements/ Central follow up
31. (2 8) / achievements/ PCR
32. (2 9) / achievements/ communication
33. (2 10) / achievements/ data coordination
34. (2 11) / achievements/ protocols
35. (2 12) / achievements/ Donovonosis project
36. (2 13) / achievements/ linking to regional priorities
37. (2 14) / achievements/ small realistic strategies
38. (2 15) / achievements/ sharps
39. (2 16) / achievements/ isolation
40. (2 17) / achievements/ boundaries of the TSP region
41. (2 18) / achievements/ resources
42. (2 19) / achievements/ flexibility of TSP
43. (2 20) / achievements/ innovation
44. (2 21) / achievements/ research
45. (2 22) / achievements/ training
46. (2 23) / achievements/ specialist support
47. (2 24) / achievements/ health promotion
48. (3) / barriers
49. (3 1) / barriers/ pathology
50. (3 2) / barriers/ lack of evidence
51. (3 3) / barriers/ complexity
52. (3 4) / barriers/ town
53. (3 5) / barriers/ capacity
54. (3 6) / barriers/ communication
55. (3 7) / barriers/ personalities
56. (3 8) / barriers/ mass treatments
57. (3 9) / barriers/ mobility
58. (3 10) / barriers/ participation rates
59. (3 11) / barriers/ contact tracing
60. (3 12) / barriers/ delays to treatment
61. (3 13) / barriers/ reinflection
62. (3 14) / barriers/ priority
63. (3 15) / barriers/ agenda
64. (3 16) / barriers/ male workers
65. (3 17) / barriers/ community resistance
66. (3 18) / barriers/ regional staffing and resources at P
AN EVALUATION OF THE TRI-STATE HIV/STI PROJECT

Criticisms of TSP

Search Results

Single Text Lookup

Terms of Reference

1 - KRAs

STD surveillance systems

Clinical management

Provider education and training

Community education and prevention

Coordination of control activities

Syphilis and Chlamydia

Donovanosis and congenital syphilis

O b j e c t i v e s

Gonorrhoea

Children under 12

HIV rates

Response to regional needs

overcoming identified barriers

resolution of structural issues

funding quantum

resolution of structural issues

reporting

resolution of structural issues

governance

resolution of structural issues

location within THS

resolution of structural issues

NT focus

resolution of structural issues

jurisdictional medical issues

resolution of structural issues

funding roundup at workshop

Dissemination of learnings

Future directions

mass treatment

Achievements

database

follow-up

audit

PCR

screening

Response to regional needs

Future Directions

Project: Chlamydia

Number of Themes: 11

Achievements

database

follow-up

audit

PCR

screening

Future Directions

Project: Donovanosis

Number of Themes: 4

Achievements

Results

Barriers

Future Directions

Project: Gonorrhoea

Number of Themes: 4

Achievements

Results

Barriers

Future Directions
Project: HIV

**Number of Themes: 4**
1. (1) / Achievements
2. (2) / Results
3. (3) / Barriers
   - (4) / Future Directions

Project: Syphilis

**Number of Themes: 14**
1. (2) / achievement of TSP
2. (2 1) / achievement of TSP/ database
3. (2 2) / achievement of TSP/ improved management
4. (2 3) / achievement of TSP/ provision of information
5. (2 4) / achievement of TSP/ standard treatment protocol
6. (2 5) / achievement of TSP/ extended regionalisation
7. (2 6) / achievement of TSP/ screening
8. (3) / result
9. (4) / barriers
10. (4 1) / barriers/ pathology services
11. (4 2) / barriers/ priority
12. (4 3) / barriers/ complexity of task
13. (4 4) / barriers/ ethics
14. (5) / future directions