

# STI/HIV Contact Tracing within Aboriginal Communities in NSW: A Supplementary Report





## PREFACE

This report has been commissioned by the NSW Sexually Transmitted Programs Unit (STIPU) and funded by the AIDS/Infectious Diseases Branch of NSW Health. It is designed to be supplementary to the review released in June 2010 entitled 'Partner Notification of Sexually Transmitted Infections in NSW: an informed literature review';

<http://www.stipu.nsw.gov.au/pdf/ContactTracingLiteratureReview.pdf>

This aim of the current work is to further inform the understanding of Sexually Transmitted Infection (STI) contact tracing issues and practices for NSW Aboriginal people. Whilst this report can be read as a stand-alone document it is not designed to replace the 2010 literature review (CTlitrev). When appropriate, this report makes reference to the CTlitrev document.

As with the CTlitrev, one aim of this report is to describe what is likely to be occurring in terms of STI contact tracing in NSW, however specifically here with respect to Aboriginal people. This review also explores ideas and proposals for tools raised by Key Informants (KIs) which may enhance contact tracing amongst NSW Aboriginal communities. It is recognised though that there are many different types of Aboriginal communities in NSW, so implicit in any recommendation is the need for local assessment and evaluation.

Similar to the CTlitrev, this report highlights the need to consider contact tracing as only one part of the wider approach to STI control and management. In particular KIs in the current review emphasised the continuum of STI management relevant to NSW Aboriginal communities. This includes effective STI education incorporated into a whole health approach; STI screening; contacting index patients with positive test results; contact tracing of sexual partners; and contacting index patients for follow-up. Hence, whilst this report was commissioned to focus on contact tracing of sexual partners, it must be emphasised that there are considerable areas of overlap and that effective contact tracing tools will need to incorporate this holistic view of STI management.

In considering contact tracing as only one part of overall effective STI management within NSW Aboriginal communities certain themes emerged in this review that have been previously explored on a comprehensive basis. In particular findings or recommendations from the following two reports were frequently expressed by KIs: 'Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or Who Have Blood Borne Infections' [1] and 'Cultural Respect & Communication Guide: A resource to assist sexual health service delivery to Aboriginal communities' [2]. This report does not seek to rewrite the findings or advice contained in these documents, but aims to complement their content with an assessment more specifically focussed on the contact tracing and how this fits into the wider framework of sexual health management.

## ACKNOWLEDGEMENTS

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## ACRONYMS AND ABBREVIATIONS

ACCHS	Aboriginal Community Controlled Health Service(s)
ACT	Australian Capital Territory
AHEO	Aboriginal Health Education Officer(s)
AH&MRC	Aboriginal Health and Medical Research Council
AHW	Aboriginal Health Worker(s)
APT	Accelerated Partner Therapy
ASHHW	Aboriginal STI, HIV and Hepatitis Worker(s)
CNC	Clinical Nurse Consultant
CTlitrev	Original Report: 'Partner Notification of Sexually Transmitted Infections: an
GP(s)	General Practitioner(s)
HIV	Human Immunodeficiency Virus
KI(s)	Key Informant(s)
LHD	Local Health District(s)
NSW	New South Wales
NT	Northern Territory
PDPT	Patient Delivered Partner Therapy
PHU	Public Health Unit(s)
QLD	Queensland
SH	Sexual Health
SHC	Sexual Health Clinic(s)
SHN	Sexual Health Nurse/ Nurse Practitioner / Clinical Nurse Consultant(s)
SA	South Australia
STI(s)	Sexually transmitted/transmissible Infection (s)
STIPU	(NSW) STI Programs Unit
TAS	Tasmania
VIC	Victoria
WA	Western Australia

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## 2 EXECUTIVE SUMMARY

Contact tracing of Sexually Transmitted Infections (STIs) is a voluntary process by which sexual contacts of index cases are notified of their potential exposure to a disease. The STIs most relevant to New South Wales (NSW) Aboriginal communities are HIV, syphilis, gonorrhoea and chlamydia. Improved contact tracing may be one method of reducing the impact of STIs on the Aboriginal communities in NSW.

### Key findings of the review

- There is limited evidence with regards to the preferred or most commonly used health service types accessed for sexual health issues by NSW Aboriginal people. However available information suggests that a variety of services are utilised. In particular, to maximise contact tracing amongst NSW Aboriginal communities there is a need to ensure awareness of contact tracing obligations, methods and resources in not only Aboriginal controlled community health services (ACCHS) and sexual health clinics (SHC), but also at GP Clinics, Family Planning, maternity services and emergency departments, particularly in areas of NSW where there are higher proportions of Aboriginal people.
- In SHC, ACCHS and correctional services both Provider and Patient Referral options are routinely offered to Aboriginal people for all STIs, particularly outside of urban areas. In other community health settings and general practice Patient Referral remains the most common form of contact tracing initiated – if it is initiated at all. Whilst encouraged in some states, Key Informants (KIs) in this review were concerned that emphasising Contract Referral may cause misunderstanding in Aboriginal communities as to the voluntary nature of the process.
- ACCHS and SH clinicians in some communities may be less likely to involve Aboriginal STI, HIV and Hepatitis Workers (ASHHW) in Provider Referral than other types of health workers, including other types of Aboriginal Health Workers (AHW) or non-Aboriginal health professionals. Experienced clinicians reported that they generally assess who they believe to be the most appropriate health worker to involve on a case-by-case basis. Local solutions to increase STI and contact tracing knowledge for all AHW enable experienced ASHHWs to develop their own tailored roles. Ways to ensure that patients are offered the choice of

involving an ASHHW or other health workers need to be considered. Less experienced practitioners working in ACCHS should be made aware of the subtleties required for health worker involvement in provider referral amongst Aboriginal communities.

- Specific cultural issues such as shame and stigma, cultural competency of practitioners, population mobility, shared phones and the concept of Men's and Women's business may be more or less applicable according to region and age of patients, and therefore local interpretation of such factors to inform local solutions should be paramount.
- Patient Delivered Partner Therapy (PDPT) may be used by some experienced clinicians when managing STIs amongst heterosexual Aboriginal patients. However caution may be required in using PDPT for chlamydia in some areas of NSW if rates of heterosexually acquired gonorrhoea amongst Aboriginal communities in these regions are higher.
- Partner Referral is likely to be enhanced by improving patient awareness of STIs in general, via written information or online resources, as well as by scheduling follow-up. Online services can also be used to undertake both Provider and Patient Referral and new Aboriginal-specific resources are in the process of being developed. The use of Facebook as a method to provide sexual health messages and potentially communicate with contacts of younger index patients could be considered. Practice nurses continue to offer a potential means of increasing contact tracing in mainstream general practices.

### **Recommendations to improve contact tracing of STIs amongst Aboriginal people in NSW**

- **Aboriginal Sexual Health Induction Package**

This review supports the development of a sexual health induction package for new clinicians in ACCHS, general practices and other health services in communities where there are higher proportions of Aboriginal people. Such a package could include a summary of cultural competency considerations relevant to contact tracing for Aboriginal people, contact tracing resources for both patients and practitioners, and locally-tailored contact details of other services/practitioners willing to assist in the contact tracing process if required. A **proforma template** (which assists clinicians unskilled in sexual health history-taking and management (including contact tracing reminders and supports)) could be included in this package.

- **Chlamydia Card**

The review found that contact tracing should be considered as one part of a wider approach to STI management, including the need to adequately inform some index patients of the need to screen and/or treat asymptomatic STIs. KIs supported incorporating a combined approach of screening, treating and informing contacts onto a single information card for the common condition of Chlamydia.

- **Ongoing support for enhanced HIV surveillance project (supporting GPs)**

Given the relatively high rates of HIV diagnoses amongst Aboriginal people outside of specialised STI settings, this review supports the continuation of the NSW HIV enhanced surveillance and GP support project.

- **Expansion of enhanced surveillance to Gonorrhoea**

The evidence in this review supports an enhanced surveillance project for gonorrhoea in NSW.

- **Evaluation and enhancement of IT resources as a means to support contact tracing**

KIs in this review suggested high rates of use of social networking sites by younger Aboriginal people in NSW. Evaluation of using such sites for sexual health education, including the benefits of contact tracing should be undertaken.

- **ASHHW roles and sexual health partnerships**

The challenging nature of the ASHHW role was briefly explored in this review with respect to contact tracing of STIs. The findings support the formalisation of relationships between ASHHW and local sexual health services to optimise partnerships and ensure appropriate and sensitive Provider Referral contact tracing be undertaken if required.

- **Ongoing basic sexual health training in general AHW training**

This review supports ongoing basic sexual health training, including training in the evidence for different types of contact tracing, for all general Aboriginal Health Workers.

- **Increasing the knowledge of Practice Nurses about contact tracing resources**

Up-skilling practice nurses may be a means to increase knowledge within general practices regarding appropriate forms of contact tracing, particularly in regional areas.

## 3 METHODOLOGY

### 3.1 WRITTEN MATERIAL REVIEW

An additional literature review to that undertaken for the CTlitrev was conducted for English language studies, guidelines, reports, book chapters and other grey matter, specifically focussing on contact tracing amongst Australian Aboriginal communities. Databases included Medline, Embase, Pubmed, Informit and Google Scholar (see appendix) with an unlimited timeframe.

The CTlitrev literature was also reevaluated for relevant general documents, and updated for any more publications during the interim.

Other sources of written information were sought from KIs and workers in the field. Documentation on STI management relevant to Aboriginal people in NSW, as well as in other Australian states and territories, was also reviewed.

### 3.2 KEY INFORMANT DISCUSSIONS

Phone and face to face discussions with approximately 45 individual KIs took place (several KIs were interviewed on two different occasions) using a semi-structured interview tool and open group discussion. The group face-to-face discussions lasted between 90 and 150 minutes. Duration of phone interviews ranged from approximately 15 to 70 minutes with an average of 50 minutes. KI interviews aimed to both clarify what was happening at the different service providers and geographical locations, as well as to discuss ideas which may help to improve the processes.

The KI discussions included:

- Face to face meetings in Sydney at the 2011 ASHHW meeting. Individual and small group discussions with ASHHW and Aboriginal Sexual Health clinicians from around NSW (6 individual interviews as well as larger group discussion (10))
- Face to face group/individual meetings at both Aboriginal Community Controlled Health Services (ACCHS) and Regional Sexual Health Clinics (SHC) at:
  - **Grafton** (including a visiting health worker from **Coffs Harbour**) and **Dubbo** (including visiting health workers from **Orange**). Participants included both clinicians and health educators including General Practitioners (GPs), Clinical Nurse Specialists, Nurse Unit Managers, Practice Nurses, Aboriginal Health Education Officers (AHEO) and Aboriginal Health Workers (AHWs) (including ASHHWs and a Sexual and reproductive health worker), an Area Aboriginal Hepatitis C treatment coordinator and a Healthy For Life Midwife (20 participants in total).

- Phone interviews with:
  - Clinicians (GPs or Clinical Nurse Specialists) working at **ACCHS: Mt Druitt, Forster, Albury, Grafton and Wellington** (6)
  - SHC clinicians or coordinators: Central Sydney, Parramatta/Mt Druitt, Broken Hill, Lightning Ridge/Collarenebri/Goodooga and Port Macquarie/Kempsey (5)
    - Also involving outreach services to the **Walgett and Broken Hill ACCHS**
  - GPs with experience working with high caseloads of Aboriginal patients: **Sydney** (with frequent locums at central and east-coast Australian ACCHS) & **Tamworth** (with relationships with **Inverell** and **Moree ACCHS**) (2)
- Public health and population health program staff (sexual health): **Murrumbidgee, Hunter New England and Mid North Coast/Northern NSW** (3)
- An Aboriginal Hepatitis C treatment/access coordinator **Hunter New England** (1)
- The Justice Health state clinical coordinator (1)

### 3.3 ADDITIONAL SOURCES OF INFORMATION

Additional sources of information assessed were:

- Summarised responses from the 2010 Aboriginal STI, HIV and Hepatitis Workers (ASHHW) network forum on contact tracing.
- Responses to an email outlining practical suggestions emerging from the ASSHW 2011 training.
- Additional regional KI Interview data from the CTlitrev where contact tracing in relation to Aboriginal people was discussed.
- Clarification of project points and direction via phone conversations with representatives of the NSW Health AIDS/Infectious Diseases Branch, the AH&MRC, the Australian Federation of AIDS Organisations, the Australasian Society for HIV Medicine and Communicare IT systems.

### 3.4 LIMITATIONS OF THE REVIEW

For the CTlitrev no studies were identified that compared different contact tracing processes in relation to Aboriginal people in Australia. The brief assessment in the original review was drawn from audits of clinics with predominantly indigenous patients, key informants and opinion pieces by people working in the field. The literature available for this report is therefore similar to that of the CTlitrev: the additional written material review for this report also did not identify any comparative studies on contact tracing processes amongst Aboriginal people.

Some additional publications were identified from other states and territories which discussed contact tracing in the setting of STI outbreaks or enhanced surveillance: these are incorporated into the review if their content was considered relevant to the current NSW context. The relevance of some of the interstate studies should be considered in the context of the higher endemic nature of some of the STIs, and endemic syndromic STI management amongst the populations studied in the

literature, as well as their relative geographic isolation in comparison to most NSW Aboriginal communities. The most pertinent information was obtained by KI interview. The approaches and issues of STI contact tracing with several types of health workers in a number of different geographical areas around the state were assessed. However whilst the themes arising from the interviews were frequently very similar it was noted that some local variation did occur (in modes of contact tracing in particular). This variation is most likely due to the experience, comfort levels in sexual health management, and community acceptability of the particular health workers involved. The local variation emphasises the fact that this review cannot fully map contact tracing patterns across the state.

A further limitation in the review is that most KIs had an interest in sexual health and felt confident in discussing contact tracing as part of the sexual health management. Whilst their opinions were canvassed about their observations and opinions with respect to contact tracing amongst other health workers in their districts, only a limited number of KIs with no particular interest in sexual health were interviewed. This report therefore provides only a limited account of contact tracing practices for STIs among Aboriginal populations in low caseload and/or non-sexual health specialist settings.

The review is structured in the same way as the CTlitrev, where KI information is incorporated into the findings sourced from written materials. The report commences with an appraisal of STI epidemiology relevant to Aboriginal people and a review of contact tracing basics. We then reevaluate the value of contact tracing specifically with respect to Aboriginal people. The sections that then follow relate to sexual health access, contact tracing awareness, the types of contact tracing likely to be offered from the different services and some specific cultural considerations. Enhancement strategies and recommendations complete the report.

## 4 ABORIGINALITY AND STI EPIDEMIOLOGY IN NSW

### 4.1 ABORIGINAL POPULATION OF NSW

The estimated residential population of Aboriginal people living in Australia based on 2006 census data was 517,043<sup>1</sup>. New South Wales had the largest Aboriginal and Torres Strait Islander population of any State or Territory, estimated to be 152,685 people; 29.5% of all Aboriginal and Torres Strait Islander people in the country, and 2.2% of the total NSW population.

Consistent with NSW Health policy this report uses the term 'Aboriginal' in preference to 'Aboriginal and Torres Strait Islander' when referring to Aboriginal people in NSW, to recognise Aboriginal people as the original inhabitants of NSW.<sup>2</sup>

Forty-three percent of NSW Aboriginal people live in major cities and an additional 33% in inner regional areas. Only approximately 5% of NSW Aboriginal people live in remote (4%) or very remote (1%) areas of the state.

### 4.2 STI EPIDEMIOLOGICAL POINTS RELEVANT TO NSW ABORIGINAL PEOPLE

Infectious syphilis is the only notifiable STI by both diagnosing clinician and laboratory in NSW. Chlamydia, gonorrhoea, HIV and hepatitis B are notifiable by laboratories<sup>3</sup>.

According to the Kirby Institute's most recent Surveillance and Evaluation Report on Bloodborne Viral and Sexually Transmitted Infections in Aboriginal and Torres Strait Islander people (2011), reporting of Aboriginal status in NSW for chlamydia and gonorrhoea diagnoses is considerably less than 50% [3]. Therefore there are no reliable estimates of these conditions amongst Aboriginal people in the state. Nationally, Aboriginal and Torres Strait Islander status was not reported for 51% of chlamydia diagnoses and 35% of gonorrhoea diagnoses [3].

In the states and territories where Aboriginal and Torres Strait Islander status was recorded for more than 50% of diagnoses (NT, SA, TAS, VIC and WA), the rate of chlamydia amongst Aboriginal and

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<sup>1</sup> Sources of statistics used in this section: Australian Bureau of Statistics. *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021*. Cat. No 3238.0. Release Date 08/09/2009.

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/3238.0Main%20Features11991%20to%202021?opendocument&tabname=Summary&prodno=3238.0&issue=1991%20to%202021&num=&view=> and New South Wales Government Department of Human Services *Two Ways Together Report on Indicators 2009*. <http://www.daa.nsw.gov.au/publications/Two%20Ways%20Together%20-%20Report%20on%20Indicators%202009.pdf>

<sup>2</sup> NSW Department of Health 2005. Aboriginal and Torres Strait Islander Peoples – Preferred Terminology to be Used. NSW Health Policy Directive, PD2005\_319.

<sup>3</sup> <http://www.health.nsw.gov.au/publichealth/infectious/notification.asp>

Torres Strait Islander people was 3.7 times that of non-indigenous people (1257 versus 340 per 100,000 population)[3]. Chlamydia is diagnosed predominantly in young people in both Aboriginal and Torres Strait Islander people and non-Indigenous people (80% of diagnoses among people aged 15-29 years) and the rates continue to rise in both groups. Rates were higher amongst Aboriginal and Torres Strait Islander people in remote and very remote areas of these other jurisdictions than in regional and urban areas.

In the states and territories where Aboriginal and Torres Strait Islander status was recorded for more than 50% of diagnoses (NT, QLD, SA, TAS, VIC, ACT and WA) the rate of gonorrhoea amongst Aboriginal and Torres Strait Islander people was 26 times that of non-indigenous people (804 versus 30 per 100,000 population)[3]. The female to male ratio of 1.1:1 amongst gonorrhoea cases amongst Aboriginal and Torres Strait Islander people in 2010 suggests transmission predominantly through heterosexual contact. This is in contrast to the male to female ratio of 3.7:1 in the non-indigenous population where transmission is understood to be predominantly through male-to-male sex.

In NSW infectious syphilis diagnoses are rare amongst Aboriginal people. Infectious syphilis rates amongst Aboriginal and Torres Strait Islander people across Australia are much higher in outer regional, remote and very remote areas, with a male to female gender ratio of 1.5:1 [3]. This is in contrast to infectious syphilis rates amongst non-indigenous people, where the majority of notifications are made in urban and regional centres with a male to female gender ratio of 16:1. In the non-indigenous population, infectious syphilis is predominantly transmitted through male-to-male sex.

There were 229 cases of newly acquired hepatitis B diagnosed in 2010 in Australia and 19 of these were in Aboriginal and Torres Strait Islander people (46 were not notified of Aboriginal and/or Torres Strait Islander status)[3]. From 2006-2010 NSW had one of the lowest age-standardised rates of newly acquired hepatitis B infection amongst Aboriginal people compared to all the other jurisdictions.

In 2010 in Australia, of the 1043 HIV diagnoses, 1021 identified as non-Indigenous and 22 were among Aboriginal and Torres Strait Islander people[3]. The population rate of HIV diagnoses was similar for both populations. In addition for both populations the rate was much higher in major cities compared to remote areas. During 2006 – 2010, 103 cases of HIV were diagnosed among Aboriginal and Torres Strait Islander people. Forty eight (48.5%) of these cases were diagnosed among men who have sex with men, 19.4% among IDU and 21.4% of cases were diagnosed among women.

After excluding HIV cases whose infection was acquired in a high prevalence country, nationally a higher proportion of Aboriginal and Torres Strait Islander HIV infections were attributable to injecting drug use (19.4% among Aboriginal and Torres Strait Islander cases versus 2.5% of non-Indigenous cases), and a higher proportion of infections were among women (21.4% among Aboriginal and Torres Strait Islander cases versus 8.0% of non-Indigenous cases)[3].

During the period 2006-2010 NSW reported the highest percentage of HIV diagnoses among Aboriginal people out of the Australian states and territories (38%) [3].

In addition, during the period Jan 2008-March 2011 for all HIV diagnoses among NSW Aboriginal people, 57.7% were among men who have sex with men, 19.2% among people who inject drugs, and 15.4% of diagnosis were among women [20].

NSW data from 2011 shows 1.5% of newly diagnosed infections were reported to be in Aboriginal people. The reported risk exposure category was men who have sex with men in 80% of cases; similar to non-Indigenous people (84%) [36].

It should be emphasised that the actual numbers of HIV diagnoses amongst NSW Aboriginal people are very small so these proportional differences need to be interpreted with caution.

There is limited epidemiological data from NSW regarding the rates of common bacterial STIs amongst Aboriginal people. However assumptions can be drawn from data from other jurisdictions which suggest there is a particular need to focus on improved control and management of chlamydia and gonorrhoea for NSW Aboriginal people. Therefore much of this review focuses on these common bacterial STIs. However given the higher proportion of HIV infection among IDU and women nationally continued monitoring of emerging epidemiological HIV patterns within the NSW Aboriginal people is warranted. This may include determining HIV testing rate within Aboriginal people in NSW. Also, it is important to note that Aboriginal people who inject drugs may be less likely to screen for HIV in health check-ups and/or disclose their injecting risk practices to health professionals.

## 5 CONTACT TRACING: A REVIEW OF THE BASICS

As outlined in the CTlitrev there are several principles underpinning partner notification services in most countries. Significantly the process is required to be confidential, voluntary and non-coercive [4-6]. Ideally the intervention should also be free, comprehensive, integrative, evidence-based, culturally, linguistically and developmentally appropriate, and accessible and available to all [7, 8].

### 5.1 DEFINITIONS

Types of contact tracing processes are traditionally divided into three groups:

#### PROVIDER REFERRAL

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Provider Referral is when a trained health care worker elicits contact details from the index patient and notifies their sexual partner(s) of exposure to an STI. This can be anonymous or not, depending on the wishes of the index case.

#### PATIENT REFERRAL

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In Patient Referral index cases are asked to notify their sexual partner(s) themselves.

Patient Referral can be enhanced in several ways. For example, cases can be given information, letters, STI testing kits or medications to give to their partners. Patients can also be followed up with further appointments or phone calls to assess how the notification went. Online resources can be used, including those by which patients can notify partners anonymously themselves. Further, clinicians may elicit the names of partners to remind them of whom to contact, or provide counselling or motivational interviewing to aid them in the process.

Patient Referral requires the patient to be well-informed and self-efficacious [9].

#### CONTRACT REFERRAL

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In contract referral index cases enter into a voluntary 'contract' with an appropriate health professional to notify their sexual partner(s) with the understanding that if the partners have not sought testing or treatment within a given time frame the provider will undertake the partner notification [10].

The possible enhancements of Patient Referral blur the distinctions between the three approaches. There are also variations in how contact tracing is initiated in the first place. For example it may be the diagnosing clinician who discusses notifying contacts with the index patient themselves, or this may be a part of education and contact tracing services undertaken by someone else in the clinic. Moreover in Provider Referral diagnosing clinicians may elicit names and then provide that list to

someone else to follow-up. Alternatively the provider facilitating contact tracing may be employed in a different area, such as in a public health unit (PHU), and therefore be physically removed from immediate clinical environment. Further, professionals who undertake contact tracing may come from different professional backgrounds such as medicine, nursing, social work and counselling. Different types of Aboriginal Health Workers (AHW) may also be involved in contact tracing via Provider Referral. These variations may influence the effectiveness of the partner notification process: For example different health professionals may be more or less skilled in eliciting names of sexual contacts or notifying the contacts once identified.

## 5.2 TERMINOLOGY

In CTlitrev the term ‘partner notification’ was used interchangeably with ‘contact tracing’. The term ‘contact tracing’ has been identified as preferable for the process by the NSW Contact Tracing Working Group. In this review several Aboriginal KIs expressed concern with the term ‘contact tracing’, suggesting that although this terminology may be suitable for health professionals involved in the practice, the semantics of the term continued to suggest an intrusive process which may be misconstrued by patients. It was also reported that the term might be interpreted to imply that the government needed details of sexual partners.

In general most KIs involved in contact tracing interviewed for this report suggested that they would be very unlikely to use the term ‘contact tracing’ and more likely to say something along the lines of ‘we/you need to tell your partners/the people that you’ve had sex with.’ Several KIs suggested that this distinction be made to clinicians working with Aboriginal people who were less familiar with initiating contact tracing.

## 6 THE VALUE OF CONTACT TRACING

### 6.1 WHY CONTACT TRACE

As outlined in the CTlitrev the reasons for undertaking contact tracing vary by disease, especially blood borne virus versus bacterial STIs. For chlamydia, gonorrhoea and syphilis the primary aim is to ensure effective treatment of contacts and to prevent re-infection of the index case. A secondary goal with all STIs is to reduce burden of disease in the population [6, 11].

In the CTlitrev the evidence of contact tracing as a case detection strategy was discussed (section 3.1). Contact tracing also has particular value in identifying those people who are likely to have infection but be unlikely to be screened for STIs.

Interpreting the evidence for the effectiveness (and cost-effectiveness) of contact tracing as a population level intervention to reduce STI burden is more challenging than that of a case finding strategy (see section 3.2 in CTlitrev). In particular the focus of STI population-level management is to identify core transmitters, most of whom are more likely to be casual partners than regular current partners. Most KIs in this review reported that their emphasis was on treating the index patient and notifying current regular contacts: additional notification was recognised as ideal, but practically for the most part (in the common bacterial STIs in particular), not very likely.

In relation to addressing both the primary and secondary aims of contact tracing, a number of KIs noted that contact tracing is of limited effectiveness if the contact (and/or the index patient) is unwilling to accept that they could have an asymptomatic STI. This was highlighted by the concerns of a few ASHHW who questioned at what point does it become harassment when they have informed someone of a positive screen and that they are a contact/or an index patient, and still the person won't go and see anyone about it? In this context, contact tracing is only effective in the setting of a sufficiently informed population that understands the risks of untreated STIs and has sufficient access to services that they trust.

### 6.2 WHY NOT CONTACT TRACE

Miller, when discussing STI management in remote Aboriginal communities, suggests that the effectiveness of contact tracing is likely to be reduced when there is a high prevalence of STIs; a highly mobile population; community concerns about confidentiality; large numbers of contacts; anonymous partners; and STDs with long incubation periods [12]. Some of these points may be valid for certain age groups in some NSW Aboriginal communities, but the patterns vary considerably. Moreover KIs suggested that for certain cases, for example in younger people, even if individual contacts are identified it may be preferable to offer selected screening to their peer group or school class (**irrespective of Aboriginal status**), especially in certain communities or schools. This was

suggested as a potential strategy to counter-balance difficulties with ensuring confidentiality amongst such groups, whilst simultaneously normalising the approach to managing STIs. Two KIs mentioned that sometimes a younger index patient might be only able to recall a first name and a school and in this context such an approach may be the only feasible one. Moreover this method would have the added advantage of being more likely to capture core-transmitters and the wider sexual network, leading to better localised population control [13].

Being aware of the potential for harm in contact tracing means that health providers also need to routinely assess the risk of interpersonal violence, as well as diminution of trust in a service provider, when undertaking contact tracing [13, 14]. Fear of interpersonal violence has been shown to equate to a fear of informing partners in non-Indigenous studies [15]. This can lead to a catch-22 situation in the setting of a regular partner in a violent relationship that is re-infecting the index case; in such extreme cases several clinical KIs discussed having turned a 'blind eye' as to whether the partner would be fully informed in the setting of patient-delivered partner therapy (see 9.1).

Finally Provider Referral as a mode of contact tracing can be time consuming, particularly if done face-to-face. A couple of KIs who regularly do their own contact tracing amongst local Aboriginal people in more remote areas mentioned that they do spend a lot of time on this (for bacterial STIs) and are not always sure of its value. KIs suggested that perhaps it would be preferable to concentrate on immediate partners and get the index patient back in for screening, so as to build up individual trust and increase education of the patient and their social network for the general management of STIs.

### 6.3 CHOICE

The CTlitrev reviewed the evidence for the different types of contact tracing and concluded that overall Provider Referral (or at least offering patients a choice between Patient and Provider Referral) appears to result in more sexual partners receiving care. The review also found that for the most part in the wider NSW community Provider Referral was not generally offered for the common bacterial STIs, due to time and cost constraints. In the setting of probable increased rates of bacterial STIs amongst NSW Aboriginal people, being offered this choice between Patient and Provider Referral would appear to be minimally appropriate. However in terms of other forms of contact tracing the literature suggests that clinicians need to be mindful of punitive coercion with STI management in the past for some Aboriginal and Torres Strait Islander communities in parts of Australia [13, 16]. KIs suggested that for Aboriginal people contract referral in particular may be open to misinterpretation and the whole process viewed as coercive<sup>4</sup>.

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<sup>4</sup> In the CTlitrev a KI working with Aboriginal communities in another state expressed concern that it remained not always clear that contact tracing is a voluntary process. In this review attention was drawn to a training

Moreover in the setting of Provider Referral the encounter must foster mutual trust, with the interviewer being well-informed, non-judgemental and acceptable to the client [16, 17]. This means that clinicians initiating contact tracing need to be sufficiently culturally competent to understand that different types of health workers may be more or less appropriate to be involved in contact tracing for Aboriginal people. Moreover the patient needs to be offered a choice of who undertakes Provider Referral if that type of contact tracing is chosen. This issue is discussed further below.

Contact tracing is part of effective STI management, and may have a role in population control at the wider level. The risks and benefits of contact tracing need to be considered however, and ensuring that it is judiciously employed as part of wider sexual health management and education of the relevant population is important. In particular contact tracing will be ineffective in a population which does not understand the potential risks of asymptomatic STIs and/or untreated STIs or if there is limited access to trusted health service providers. For Aboriginal people in NSW the notion of choice of providers and choice of type of contact tracing is essential.

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module page which was felt may confuse clinicians as to the true voluntary nature of the process: [http://www.ashm.org.au/e\\_learning/contact\\_tracing/module\\_8/player.html](http://www.ashm.org.au/e_learning/contact_tracing/module_8/player.html) Section: 'Basic Principles of Contact Tracing in Aboriginal Communities.'

## 7 CONTACT TRACING IN THE NSW CONTEXT WITH RELATION TO ABORIGINAL PEOPLE

### 7.1 WHO IS ACCESSING WHAT FOR SEXUAL HEALTH MANAGEMENT? (WHERE TO FOCUS PRIORITIES FOR UPSKILLING IN CONTACT TRACING)

Whilst there are a number of ACCHS around the state it is acknowledged that they are not everywhere where Aboriginal people live in NSW, nor do all Aboriginal people choose to access their local ACCHS. In terms of ACCHS, most KIs believed that *some* regular patients may choose not to access their regular ACCHS for sexual health issues, for various reasons including shame, stigma, family being employed at the service, and sometimes perceived past issues with the health service's confidentiality (real or not). This highlights the need for choice of services which applies to the non-Aboriginal community as well, as noted by other authors [1, 18, 19]. It was suggested that patients of larger ACCHS (with more clinicians) may be more likely to seek sexual health care at that health service than those of smaller ACCHS, or if the service served a more heterogeneous Aboriginal community. However there is no available evidence to evaluate this suggestion.

For sexual health management an alternative to ACCHS in areas across the state are the public Sexual Health Clinics (SHC). In these settings patients may remain anonymous and Medicare cards are not required. As noted in the 'Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or Who Have Blood Borne Infections' report [1], the acceptability of SHC amongst Aboriginal people may depend on a number of factors including accessibility, discrete entrances and the service name. Accessibility is a relative issue though, and factors such as distance may influence accessibility in a number of ways; it was pointed out by KIs that patients were known to travel from Orange to Bathurst and vice versa to access sexual health services outside their own town. SHC often have outreach services also.

There was mixed KI opinion about whether a SHC would be more likely to be accessed by Aboriginal people if co-located with other services (so it was not obvious to an observer what form of health care someone was seeking). However the body of opinion suggested that patients would be more willing to access a sexual health service that was colocated with other services. Examples were given of Aboriginal clients (who normally attended a local ACCHS) bypassing local sexual health services and accessing community health over the border, or Family Planning services, for sexual health needs.

Issues of acceptability and accessibility with respect to ACCHS and SHC suggest that, as for the non-Indigenous population, much STI management for Aboriginal people may be taking place at other

services, including bulk-billing GPs<sup>5</sup> (especially larger, more anonymous clinics), Family Planning, women's health services and ED Departments<sup>6</sup>. The use of mainstream GPs by Aboriginal people in NSW for sexual health issues has been identified before [18]. Recent enhanced surveillance in one Northern regional area for chlamydia and gonorrhoea supports the contention that other community health services are also being accessed for sexual health management. These data show that less than 20% of the cases came from the SHC, with other services, such as the local emergency department, women's health and maternity services detecting a meaningful proportion of STIs. The Aboriginal status of the patients in this enhanced surveillance was not known, however the KI who undertook the surveillance indicated that anecdotally higher proportions of Aboriginal patients were attending the emergency department for sexual health issues than the SHC in that town (which also has a local ACCHS.)

Evidence on the high proportion of STIs being diagnosed in general practice was discussed in the CTLitrev (section 4.1). In summary the majority of diagnoses of STIs in NSW appear to be taking place outside of SHC and GP clinics specialising in STIs, including for blood borne STIs such as HIV. Similarly for diagnoses amongst Aboriginal people, data from NSW HIV surveillance between January 2008 and March 2011 shows that 69% of HIV diagnoses were made outside of SHC or by non-STI specialised GPs [20]. (Although 15% of these HIV diagnoses were made in a hospital setting that may include outpatient clinics.) The same HIV data supports the notion that Aboriginal people are accessing a variety of services for sexual health care, with the highest proportion of HIV diagnoses (27%) being made by non-STI specialised GPs working outside of ACCHS, and 23% by GPs working in ACCHS.

The limited amount of evidence regarding access of different health services for sexual health issues suggests that a variety of services are utilised by NSW Aboriginal people. In particular, to maximise contact tracing amongst NSW Aboriginal communities, there is a need to ensure awareness of contact tracing responsibilities, methods and resources in not only ACCHS and SHC but also at GP Clinics, Family Planning, maternity services and emergency departments, particularly in areas of NSW where there higher proportions of Aboriginal People.

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<sup>5</sup> Noting that not all Aboriginal people require to be bulk-billed and that GPs who do not routinely bulk-bill frequently may do so for certain groups of people whom they perceive to be in need of this, which may include Aboriginal patients (KI).

<sup>6</sup> Recognising that in some of the communities discussed concerns about confidentiality and seeing working family members may also be apparent at small regional hospitals.

## 7.2 CONTACT TRACING AWARENESS AND PROCESSES

### 7.2.1 AWARENESS OF ROLES AND RESOURCES

#### ACCHS CLINICIANS / GENERAL PRACTITIONERS

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As per the CTlitrev the consensus amongst KIs was that most experienced GPs have some understanding of the need contact tracing in STI management but may be unclear of their role or uncomfortable about addressing this with all patients, irrespective of ethnicity. A recent enhanced notification audit from Western Australia confirms that even for chlamydia, where 77% of respondents indicated contact tracing would be done, 47% of these (61% of the whole) indicated that this would be performed by the WA Department of Health, although most WA PHU units do not routinely undertake this [21]. Reasons for the lack of awareness by GPs as to their role in contact tracing were discussed in the CTlitrev.

Enhanced chlamydia surveillance in a Southern NSW regional area, evaluated subsequently to the CTlitrev, has confirmed that in general amongst the community medical practitioners there was poor recording of data and poor contact tracing initiation. However the processes required for enhanced surveillance itself was perceived to have increased awareness of the need for both. The issue of high numbers of overseas-trained GPs regionally, and a perceived reluctance and discomfort amongst some of them to manage sexual health issues in general, was also raised several times by KIs.

The three ACCHS GP KIs versed in sexual health were generally aware of their roles and the resources available for contact tracing. Two however suggested that other GPs in their practices would be likely to send patients to them for STI management (including contact tracing), emphasising the point previously made about the experienced clinician who is comfortable in managing sexual health issues. These GPs were also all female, and female GPs have been suggested in the CTlitrev to (in general) be more comfortable with sexual health management (which may reflect patient comfort in addressing sexual health issues with female practitioners more than males). Three ACCHS nursing KIs also conveyed the opinion that the type of sexual health management, including initiating contact tracing and offering a choice of Provider Referral, depended on the doctor in question. The ASHHW KI working in ACCHS confirmed this viewpoint. Experience and time spent in the community were perceived to be factors affecting the doctors' competency of sexual health management. High clinical staff turnover was noted to be an issue for some ACCHS.

These observations underscore the need for raising awareness of sexual health in general among clinical newcomers and locums, including the need for opportunistic screening of STIs and contract tracing responsibilities, methods and resources. This point was stressed by a number of KIs.

## EMERGENCY DEPARTMENTS

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As per the CTlitrev several KIs reported that, without specific sexual health staff intervention, contact tracing initiation may not occur from emergency departments. This is particularly likely to be the case in regional and remote centres if there are locum doctors regularly serving the community.

## CORRECTIVE SERVICES

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Adult and adolescent corrective services across NSW have public health nurses specifically trained in sexual health assessment and management, including contact tracing. Aboriginal Health Workers also provide cover for adolescent (not adult) corrective services, although their role does not normally include contact tracing.

### 7.2.2 WHO IS OFFERING WHAT SORT OF CONTACT TRACING?

#### GENERAL PRACTITIONERS (OUTSIDE OF ACCHS)

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For common bacterial STIs KIs presumed on the most part that GPs across the state, unless particularly versed in sexual health, would be suggesting Patient Referral if discussing contact tracing. KIs did not think that Provider Referral would be generally offered to Aboriginal clients requiring partner notification services in this setting. On the contrary, a couple of KIs felt that initiating contact tracing, even if the GP was aware of their role, may be confounded by the GPs' concerns about their lack of skills with cultural competency. One regional SH nurse KI reported that local GPs had specifically raised this as a concern during STI education sessions. One had specifically reported they were reluctant to discuss the issue at all as they were concerned that they may offend cultural sensibilities. More generally the problem of time that Provider Referral can take is an issue in general practice.

Direct evidence for the amount of Provider Referral versus Patient Referral being offered in NSW is not available. There is however a recent enhanced surveillance publication from South-East Queensland for the period 2003-2008, where 92 (10.1%) of the notifications were for Aboriginal people (41 males)<sup>7</sup>. This report notes that contact tracing was reported as initiated in 76.5% of cases [22]. However out of all contact tracing initiated 96.3% was Patient Referral and only 3.8% Provider Referral (with a small percentage of both types of referral). There was no difference in contact tracing initiation between Aboriginal and non-Aboriginal patients (unpublished data). Further

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<sup>7</sup> There was a response rate of 72%

analysis also revealed that where contact tracing was performed, Provider Referral was likely five times more likely to be undertaken with Aboriginal patients than non-Aboriginal patients. However from an overall perspective this still means that the vast majority of contact tracing for gonorrhoea patients amongst Aboriginal people is via Patient Referral. The enhanced surveillance report also highlights the fact that for bacterial STIs in the general community, Provider Referral is rarely performed.

There are however exceptions to this pattern. SH and PHU KIs from more remote parts of the state with a higher proportion of Aboriginal people suggested that they may have arrangements with local GPs to follow-up all positive STI results, and in such circumstances Provider Referral would generally be offered (although may not be accepted). Some PHUs also routinely follow up all gonorrhoea cases with GPs, although as noted in the CTlitrev, this is variable across the state. There is also currently a NSW mentoring program for syphilis diagnoses where a local SHC clinician will contact the diagnosing GP to offer syphilis management support after a positive pathology test is logged (with the information being passed on by the local PHU). This support includes discussion of contact tracing, and assistance in the form of Provider Referral may be offered. Initial evaluation of this project suggests that over half of the doctors contacted by SHC required assistance. Of these more than three quarters required assistance with staging of disease and a third with disease transmission (personal communication).

For HIV and hepatitis B, most KIs agreed that GPs would be more likely to pay further attention to notification of contacts, and that most cases would be likely to be referred to specialised services which could assist in this. Attention should be drawn however to the CTlitrev where it was highlighted that even in the case of HIV some GPs were unaware of their roles in initiating contact tracing in such circumstances. The GP HIV mentoring project via ASHM has received generally positive feedback to date, and given the sequelae of HIV and the higher proportion of females being diagnosed amongst Aboriginal people nationally (who may generally be less likely to be offered screening for HIV) the project would appear to be an inexpensive way of ensuring quality BBV STI management for these communities, including contact tracing.

Whilst it is recognised that GPs have a very wide variety of illnesses to manage, of which sexual health is but one small part, KIs from a few different areas reported generally positive feedback from GPs when localised up-skilling in STI management (including contact tracing) was undertaken on a semi-regular basis. Increased referrals to local SHCs for more complex cases, and a better understanding of specific STI management issues (including cultural competency) were noted. Regional enhanced surveillance for bacterial STIs in a couple of areas was also reported to have increased both awareness and quality of contact tracing at the community medicine level.

## ACCHS CLINICIANS

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The KIs interviewed from ACCHS suggested that for the most part their patients, Aboriginal or not, would be offered the option of Provider Referral for contact tracing. It was suggested however, that along with awareness of roles, whether a patient was offered Provider Referral would depend on the clinicians' experience and comfort with sexual health. Time was not felt to be as limiting as in private general practice, given the team-based environment and access to other health staff that ACCHS clinicians generally have.

## EMERGENCY DEPARTMENTS

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A couple of regional SHN have arranged access to their local emergency department pathology to ensure adequate STI management including contact tracing. Another SHN KI is developing collaboration with a clinical nurse consultant at her local emergency department to better manage STIs. It is likely that outside of these settings if contact tracing is initiated at all from emergency departments it would be by suggesting Patient Referral.

## SEXUAL HEALTH CLINICS

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Remote and outer regional SHC KIs reported that they would offer both types of contact tracing to all patients with a diagnosed STI, irrespective of their Indigenous status. Urban SH practitioners generally stated that for bacterial STI Patient Referral was more likely to be suggested, including for Aboriginal patients. However the type of contact tracing offered would likely depend on the patient's perceived comfort level. BBV STI Provider Referral is generally referred to social work in urban clinics, as discussed in the CTlitrev.

## CORRECTIONAL SERVICES:

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In NSW correctional services patients with positive STI results are offered both Patient Referral and Provider Referral to follow-up with sexual contacts. A challenge with Patient Referral was that sexual partners may not be alone when they come to visit. Another barrier is the concern that an index patient may have about phone calls being monitored from corrective services.

There is a process in place to inform index patients of a positive STI test if they have already been released from corrective services prior to the results being available. However this process consists of a letter being sent, which may not be the most appropriate means for Aboriginal index patients.

The high rates of hepatitis C antibody-positive patients mean that contact tracing is not routinely addressed in the corrective services setting<sup>8</sup>.

In SHC, ACCHS and correctional services both provider and Patient Referral options are likely to be offered to Aboriginal people for all STIs, particularly outside of urban areas. In other community health settings and general practice Patient Referral is still likely to be the most common form of contact tracing initiated – if it is initiated at all. The wide variation in comfort level of community physicians in taking a general sexual health history, as well as in initiating contact tracing, needs to be addressed when developing resources for clinics where there are high case-loads of Aboriginal people.

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<sup>8</sup> Whilst the sexual transmission of Hepatitis C is controversial and therefore the disease is not a focus of this review [6], it is recognised that Aboriginal people in Australian jurisdictions for which this is sufficient data have higher rates of Hepatitis C antibody than non-Aboriginal people [3]. Aboriginal people are also over-represented in prison and injecting drug using populations, both of which are high priority groups for Hepatitis C [24]. Contact tracing of Hepatitis C amongst Aboriginal people (both within and external to correctional institutions) may therefore be a valid area for further exploration.

### 7.2.3 HOW IS CONTACT TRACING CONSIDERED TO BE BEST PERFORMED?

#### PATIENT REFERRAL

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Whilst both Patient Referral and Provider Referral may be offered to Aboriginal patients in ACCHS, SHC and correctional services the majority of KIs suggested that patient referral was most frequently chosen by index patients. A number of KIs also raised concerns about whether patients would be likely to inform their sexual partners, on par with similar concerns raised by clinicians with respect to the non-Indigenous community. Again females were considered to be more likely than males to inform sexual partners.

As per the evidence outlined in the CTlitrev, clinical KIs in this report suggested that they had more success with Patient Referral if names were elicited from the index patient (even first names as a reminder) and then the patient was booked a follow-up appointment. Three regional clinical KIs suggested that eliciting names of sexual partners from younger index patients as part of *pre-test counselling* was of particular benefit, irrespective of Aboriginal status. As one KI phrased the situation; 'Kids seem to get amnesia when they get a diagnosis of chlamydia'. Already having names as reminders was felt to help in the contact tracing process after a diagnosis was made.

There was significant general discussion about how Aboriginal-specific sexual health and contact tracing resources could aid in the Patient Referral process. This is discussed further below.

As with the non-Aboriginal community, clinical KIs felt more confident that index patients would inform their sexual partners if they were well informed themselves. Stressing to the patient that informing their contacts implied respect for both their own whole health, their current sexual partners' health and the health of their past partners, was reported as beneficial in increasing the likelihood of index patients informing their sexual partners. This approach was also noted to be a way of challenging the notion that the infection was the contact's and not the index patient's problem, an issue that has been highlighted in the literature [23, 24]. Along with an emphasis on respect, it has also been suggested that focussing on the serious sequela of infections, and the rights of the contacts to be treated, may assist Patient Referral in the well-informed index patient [12].

## PROVIDER REFERRAL

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The types of Provider Referral offered in NSW vary on a case-by-case and community-by-community basis. Some KIs suggested that they would try and elicit names and phone numbers and call the contacts themselves. As per the CTlitrev, others proposed that in their areas phones were not so appropriate (as more likely to be shared property) and that a non-specific hand-delivered letter or verbal message from the clinician asking the contact to come in for review was much more preferable.

Letters delivered by mail were not considered appropriate in most places; a KI from one ACCHS reported an incident where a letter explicitly outlining STI contact had been inappropriately sent to a house from that service. However, as mentioned previously, even clinicians from ACCHS may be unaware of this issue.

As per the CTlitrev the requirement to get full names, nicknames and dates of birth is considered particularly important due to the increased frequency of shared names in some Aboriginal communities.

In correctional services if a patient opts for Provider Referral then the names of the contacts are passed on to the justice health coordinator, who might call the contact herself or pass the name on to the local SHC. One issue in terms of Provider Referral in this setting though is that incarcerated persons generally do not have access to their mobile phones, which is where the likely details of the contacts will be.

## THE ROLE OF ASHHW & OTHER AHW IN CONTACT TRACING

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(See also Section 11 (Partnership) below)

The 'Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or Who Have Blood Borne Infections' report and KI interviews highlight that the role of the ASHHW in NSW is broad and complex and varies from position to position [1]. Part of the variation appears to be due to placement (SHC versus PHU versus ACCHS) and part due to experience, the communities which they serve and personal preferences for different aspects of the role, including clinical work. Incorporated into the original role description of the Aboriginal STI, HIV and Hepatitis Workers was the idea that they could assist other services, workers and agencies in (Provider Referral) contact tracing. To this end the regional ASHHW coordinators have produced both educational material and offered training in contact tracing to the ASHHW network as well as more generally to other AHW.

One of the issues in involving ASHHW in contact tracing is that, depending on the community, they may be specifically identified as a sexual health worker, and therefore draw attention from other community members if seen talking to someone during business hours or in a particular setting. Various ASHHW discussed ways and means to avoid this problem, usually by having the discussion in the guise of one about something else (for example football), or afterhours, or even by placing a bet at the TAB knowing that the contact was likely to be there at the same time. Another option sometimes pursued (particularly for younger patients) was to offer screening to a group of them when one was known to be named as a contact, as outlined earlier. The need for ASHHWs to dissimulate their reasons for talking to people is discussed in the literature as a particularly challenging part of the role [25]. An extension of this dissimulation is the fact that some ASHHW choose to identify themselves with more generic titles, which they feel enables them to do their job more effectively and with greater discretion. A potential problem with this scenario is that ASHHW may be consumed into other roles if they tailor their own more broadly. Pragmatic KIs indicated however that the title of the role is not as important as the reporting, and whilst having a dedicated worker in the position does tend to promote work in the area, flexibility remains an essential aspect of achieving good work in more stigmatised areas of health.

If ASHHW are involved in the contact tracing process it appears more likely that the clinician or PHU will give them the names of who to inform. Involvement in the process from the start appears limited, with the exception of those ASHHW who have a more clinical role themselves. Whilst it may often be the patient's choice not to discuss their sexual partners with an ASHHW, it remains important for clinicians to be aware that some patients may prefer this, and at least to offer the choice. Given the challenging nature of the ASHHW role, involving them early in the process, or at a minimum being explicit about the nature of the infection and the priority it should be given, would aid in the time prioritisation of the trace. As would ensuring that the ASHHW was informed when someone had presented for sexual health assessment (especially if they are PHU based).

Practically speaking there are only a limited number of ASHHW around the state and they are not in all ACCHS. The need therefore for other AHW and health workers to be able to be involved in Provider Referral for contact tracing is recognised, as per the 'Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or Who Have Blood Borne Infections' report amongst others [1]. Moreover in three ACCHS with ASHHW (either past or present), clinicians explicitly stated that they *would normally choose not to involve* ASHHW for Provider Referral and considered the ASHHW role in their clinic to be more of a brokerage / educational role. These KIs expressed the opinion that whether a worker is asked to contact trace would depend on the index patient (if face-to-face tracing was necessary). It might be a senior AHW who would be asked to drop off a letter or ask if the contact would come in and see the doctor – the advantage of this approach being that the

request could involve any form of health issue, not necessarily sexual health. Alternatively, a younger AHW may be more appropriate, depending on the index patient. Non-Aboriginal LHD staff may also be involved in some areas, particularly if they have a standing in the local Aboriginal community.

Involvement of ASHHW by experienced clinicians in Sexual Health and ACCHS settings may be less likely if there are concerns that this would cause issues in their communities. Local solutions such as increasing STI and contact tracing knowledge for all AHWs, enabling experienced ASHHWs to develop their own tailored roles, and ensuring that patients are offered the choice of involving an ASHHW or other health worker need to be kept in mind. Less experienced practitioners working in ACCHS should be made aware of these subtleties.

## 8 SPECIFIC CONSIDERATIONS AROUND CONTACT TRACING WITH RESPECT TO NSW ABORIGINAL COMMUNITIES

### 8.1 SHAME AND STIGMA RELATED TO SEXUAL HEALTH

Shame and stigma in relation to sexual health issues for NSW Aboriginal people have been discussed in other reports [2, 18]. Stigma surrounding sexual health issues is not unique to Aboriginal people in NSW however: KIs recited several examples of non-Aboriginal clinicians at ACCHS suggesting that in-house sexual health staff and services were inappropriate as they might stigmatise that service. Several ASHHW themselves have had the relative value of their positions questioned by both Aboriginal and non-Aboriginal health workers in more recent times as well as in the past. These examples highlight the need for ongoing social awareness, marketing and normalisation of sexual health issues in the whole community, in order to address rising rates of some STIs.

A number of KIs pointed out positive trends in mental health awareness and normalisation by strategic use of highly-regarded advocates, especially in the sporting world. In this review several KIs commented on how football players, teams, contests and competitions for football gear had all been employed to market normalisation of sexual health issues, including in some instances screening and contact tracing. A number of KIs also noted that there appeared less shame in their communities regarding sexual health particularly over the last couple of years, and attributed this to efforts to normalise sexual health via social marketing and increased screening, both in Aboriginal and non-Aboriginal community settings.

As with any sensitive topic, the savvy clinician is aware of indirect ways that a patient might raise the need for a STI check-up; two KIs independently mentioned that if girls in their community came to the clinic asking if they were due for their pap smear, then they were frequently interested in having an STI screen.

### 8.2 CULTURAL COMPETENCY OF PRACTITIONERS

Whilst clear and thorough resources exist to assist sexual health service delivery to Aboriginal communities [2], several KIs noted that mainstream practitioners may still express particular concerns about their cultural competency in discussing sexual health management issues with Aboriginal patients, including contact tracing. On the other hand it was suggested by a number of KIs that when discussing sexual health in general a focus on risk of STIs due to age-group or sexual orientation may be preferable than highlighting risk due to Aboriginality *per se*. Several Aboriginal KIs commented that it was better to discuss contact tracing and sexual health management in general with patients in the same way as one would with a non-Aboriginal person of a similar age or social demographic group, than not to discuss it at all for fear of 'getting it culturally wrong'.

In terms of contact tracing basics, this highlights the need to balance awareness of basic cultural norms against the possibility of poor clinical management due to undue sensitivity by some clinicians regarding cultural communication.

### **8.3 MOBILITY**

A mobile and transient Aboriginal patient base was one reason given as to why GPs did not undertake partner notification in the McCarthy study discussed in the CTlitrev [26]. However, in this context AHW are considered to be very good at locating people. KIs also mentioned that the ASHHW network would be likely to be involved if there was a particular need to trace a contact with an STI exposure in another jurisdiction.

### **8.4 MEN'S BUSINESS AND WOMEN'S BUSINESS**

A number of KIs, both Aboriginal and non-Aboriginal, suggested that the concept of Men's and Women's business when considering contact tracing was not always applicable to many of their contemporary Aboriginal communities, and especially youth within them. The preferred gender of the health worker or clinician for all types of sexual health management was reported to depend on both the individual being treated and the various workers in the community. Examples were given of Aboriginal men being happy to see women, including female AHW and ASHHW. Some proposed that Aboriginal men in their community may prefer to see female practitioners rather than male ones for sexual health issues. On the other hand one KI from an ACCHS said that she frequently involved a non-Aboriginal male (general) nurse of high-standing in the community to contact trace both males and females, as this nurse was often approached by both genders with questions regarding sexual health.

These examples suggest that, contrary to the more traditional information outlined in the original CTlitrev, the preferred gender of the health worker for sexual health management may be more fluid amongst modern NSW Aboriginal communities. In particular it suggests that assumptions about male health workers always being appropriate for male patients may not be valid in some communities. Therefore ideally a clinician would be aware of local health workers of both genders who could be involved in contact tracing, and potentially offer patients a choice in the gender of health worker should Provider Referral be undertaken.

## 8.5 MOBILE PHONES

As mentioned in the CTlitrev, the potential for mobile phones to be shared amongst Aboriginal people in certain communities means that it may be less appropriate to call potential contacts via these, especially in the setting of Provider Referral. KIs were not however universal in being concerned about mobile phone use for contacts, and a couple reported younger index patients texting (SMS) their sexual contacts whilst in the room with the clinician. Given this, as usual the index patient should be asked what might be the most appropriate method for contact tracing – and if a mobile phone is suggested then the patient’s attention could be drawn to the websites where SMS are free (see below and CTlitrev).

Mobile phones were also frequently discussed in the setting of informing index patients of the results of a test. Different KIs had developed different approaches to the use of phones in this context. Most asked first if a phone number was the most appropriate means, and if so discussed what type of message or call might be expected and from what number. For example, a generic discrete text stating ‘all ok’ or alternatively ‘you need to come back in to discuss test’. In terms of phone-calls, several KIs confirmed that calls were rarely answered from blocked numbers and sometimes not from numbers that were unknown. One KI mentioned that she addressed this issue by sending an SMS saying who she was (generically) and that she would call in 5 minutes, and then did so.

Specific considerations regarding STI contact tracing in Aboriginal communities have previously been raised: these include shame and stigma, cultural competency of practitioners, population mobility, shared phones and the concept of Men’s and Women’s business. This review found that such issues may be more or less applicable according to region and age of patients, and that local interpretation of such factors should therefore be paramount.

## 9 ENHANCEMENT STRATEGIES AND NEWER TECHNOLOGIES

### 9.1 ACCELERATED PARTNER THERAPY

The CTlitrev outlined the current published evidence regarding Accelerated Partner Therapy (APT) options including Patient Delivered Partner Therapy or PDPT (section 7.1.3). Some additional studies have been published in the last year, however little has changed in the way of evidence except to highlight the fact that PDPT may not be more effective than a well-informed index patient in terms of numbers of contacts traced [27, 28].

APT can include pharmacy, online or over the phone assessment by a practitioner of an index patient's contacts, however there is limited evidence on the effectiveness of APT and none is from Australia to date, so applicability to the NSW Aboriginal communities is unclear [29].

The main form of APT used in Australia is PDPT, and the CTlitrev drew attention to the fact that this appeared to be more frequently employed by rural and regional practitioners. PDPT is more often employed if the clinician and the index patient do not feel that the sexual partner(s) are likely to attend for STI management themselves.

PDPT is still a grey area legally in Australia. Whilst technically not illegal, many community clinicians, particularly those without an STI interest, suggest that they are uncomfortable in performing PDPT given the potential for medication side effects and dis-concordant infections [30]. The CTlitrev also discussed that due to resistance patterns, PDPT is only suitable for chlamydia in Australia. This means that it is only really appropriate for heterosexually acquired disease given the potential for higher likelihood of other STIs amongst men who have sex with men.

In this context, the potential for other STIs such as gonorrhoea needs to be considered carefully when thinking about PDPT in NSW Aboriginal communities, given the paucity of epidemiological data regarding gonorrhoea infections, but the likelihood of higher rates of female cases of this infection. Ideally clinicians dispensing PDPT for sexual partners will be aware of local STI patterns and the potential for discordant infections in patients being found to have STIs [31].

In this review a number of experienced KI clinicians, especially in ACCHS and regional SHC, suggested that they did use PDPT on a case-by-case basis, but it was more likely to be given for current sexual partners. Dispensing treatment for more than one partner was rare. Normally medication rather than a script was dispensed, especially by SH clinicians. However one ACCHS GP mentioned that with

the 'Close the Gap' scripts<sup>9</sup> they felt more confident about the script being filled, both in the case of index patients and contacts.

Some KIs also said that on rare occasions they knew that an index patient may not explicitly tell their partner about the sexual nature of the infection when asking them to take the medication. They may just say to their partner something along the lines of, 'the doc wants you to take this as well, I've got something down there.... thrush or something...'. Such a practice might occur in the setting where there was an implicit understanding that the partner would specifically prefer not to know. KIs also suggested that this may be done to minimise the potential for interpersonal violence and that in such instances each situation needed to be carefully evaluated as to the rights of both the index patient and the partner to be disease free.

Whilst PDPT appeared to be dispensed more frequently to female index patients, male index patients were also mentioned by KIs in this context. The pattern for females to be more responsive to APT has been discussed before in the CTlitrev and continues to be noted in newer studies [9].

Finally the notion that PDPT can increase social awareness of STIs and their common asymptomatic nature needs to be considered. A KI for the CTlitrev who used PDPT mainly for outreach clinics suggested that partners treated in the past appeared to be more likely to present for screening, given that they had been previously unaware that they might have an infection (but may have noticed improvement after treatment), and that chlamydia was treated so easily.

## 9.2 RECALLS AND TELEPHONE REMINDERS

The CTlitrev outlined the evidence for recalls and telephone reminders as a way of improving Patient Referral rates. SHC KIs in this review invariably made some sort of follow-up arrangement with index patients, during which they would be likely to inquire about how the (Patient Referral) contact tracing process had gone. Some, but not all, ACCHS KIs mentioned that planned follow-ups or telephone reminders were made for patients who had chosen Patient Referral.

## 9.3 NEWER TECHNOLOGIES / ONLINE SERVICES

Newer technologies for both Patient and Provider Referral were reviewed extensively in the CTlitrev. An evaluation of InSpot (<http://www.inspot.org/>), an American site targeting heterosexual patients for internet based contact tracing, noted a relatively poor uptake by index patients. An editorial suggested that the uptake of online services could be more dependent on the nature of the sexual

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<sup>9</sup> Close the Gap scripts are a Medicare initiative whereby Aboriginal and Torres Strait Islander patients have improved access to Pharmaceutical Benefit Scheme medications with either a reduced or nil patient co-payment for these medications if endorsed by the prescriber.

relationships (transient versus regular) rather than the nature of the target audience (i.e. heterosexual versus homosexual) [32, 33].

An evaluation of the Australian site 'Let them Know' (<http://www.letthemknow.org.au/>) for the period December 2008 to October 2009 reported a substantial number of messages being sent to sexual contacts, with SMS being 25 times more likely to be sent than emails [34]. This evaluation also noted that there were few reported concerns raised about hoax emails with the service, which was identified as a potential issue by concerned clinicians in the CTlitrev.

An online site specifically catering for Australian Aboriginal and Torres Strait Islander people is also being developed by the Australian Federation of AIDS Organisations in consultation with the Anwernekenhe National Aboriginal and Torres Strait Islander HIV/AIDS Alliance. This is called 'Better to Know' (<http://www.bettertoknow.org.au/>). Whilst already functional, the social marketing for this site has not yet been undertaken. Marketing will include posters and small cards. As with 'Let Them Know', the option to let a sexual partner know of contact with an STI via either email or SMS is available on the website. However unlike 'Let Them Know', 'Better to Know' only offers the option of anonymous notification. It will be valuable to assess the uptake of this service, particularly given the concerns surrounding mobile phones discussed earlier and the predominance of this method on sites such as 'Let them Know'.

An alternative online development to monitor will be whether sites such as Facebook (<https://www.facebook.com/>) could play a role in the future in terms of contact tracing. A number of KIs mentioned that in their communities virtually everyone under the age of 25 was on Facebook, even if such youth didn't have an independent email address. Facebook identities and addresses are also constant, whereas email addresses often change with jobs or schools. Sites such as Facebook capture social networks and may offer an alternative to identifying sexual partners for Provider Referral when index patients report that they can only recall the first name of their sexual contacts. In considering such an option it is envisaged that a private non-specific message requesting that the sexual contact communicate with the clinic could be sent by an appropriately trained health-worker using a generic log-on. Reaching contacts via online services for Provider Referral was discussed in the CTlitrev in section 7.2.4.

## **9.4 PAMPHLETS AND OTHER FORMS OF INFORMATION TO TAKE AWAY**

Evidence assessed in the CTlitrev suggests that written information about STIs and contact tracing can increase contact tracing in partner referral (section 7.2.2). KIs for this review also suggested that clear and Aboriginal-specific information would also be likely to improve the rates of asymptomatic

index patients returning to follow-up on screening test results. Hence such pamphlets should obtain information for the index patients as much as for the contacts [24]. One locally produced resource by an ACCHS on the North Coast was mentioned as useful by a clinical KI not affiliated with the ACCHS.

## 9.5 PROFORMA OR CHECKLIST FOR CLINICAL MANAGEMENT INCLUDING CONTACT TRACING

The CTlitrev in section 7.2.3 outlined the evidence for proforma or checklists in sexual health management including contact tracing. KIs in both reviews suggested that these may aid in assisting both the clinicians unfamiliar in sexual health history-taking to cover all the appropriate issues (including contact tracing). Proforma also assist to normalise the process and enhance confidence of both patient and practitioner. The need for standard STI clinical management forms has also been specifically noted with respect to Aboriginal and Torres Strait Islander people [31].

The Communicare clinical software being used by some ACCHS around the country has such a proforma included in the package. This dataset was developed with the Kirby Institute as part of their STRIVE project: (<http://www.med.unsw.edu.au/NCHECRweb.nsf/page/ATSIHP-STRIVE>).

The proforma assists in sexual health history taking as well as appropriate jurisdiction-specific management, including reminders about prescribing guidelines, contact tracing and recall for follow-up. In addition, if a contact is named who attends the same clinic the system suggests that a manual recall be added to their file. The name of the index patient is not linked.

Communicare staff report that as of December 2011 the STI dataset that includes this proforma has not been requested by any ACCHS in NSW (due to the recall system, although free in the package this dataset needs to be specifically ordered). Evaluation of the STRIVE project in other states and territories will assist in assessing the value of this dataset in the NSW setting, however three different clinical KIs at ACCHS reported that there were unlikely to move from their current clinical software (generally Medical Director) due to established use. One KI (who has used Communicare in another state) reported that although useful for data-collection purposes, in his opinion the software was not yet as user-friendly for a clinician.

## 9.6 PRACTICE NURSES

The CTlitrev outlined the potential role of practice nurses for contact tracing improvement, particularly in mainstream general practices. The funding changes that would enable this were introduced on January 1, 2012, therefore practice nurse income is no longer specifically linked to various procedures and can encompass a larger range of roles (<http://www.medicareaustralia.gov.au/provider/incentives/pnip.jsp>).

One remote KI in this review reported that the practice nurses in her area may feel uncomfortable in taking on sexual health screening and contact tracing themselves, whilst another KI from a more regional centre reported that certain practice nurses in her region were discussing with the GPs in their clinic the potential to offer screening based on age.

As with the CTlitrev, it was proposed that even without an independent clinical role practice nurses were in the position to act as a conduit for information transfer between local sexual health services and the GPs in their clinics.

Patient Delivered Partner Therapy may be used by some experienced clinicians when managing STIs amongst heterosexual Aboriginal patients. However caution may be required in using PDPT for chlamydia in some areas of NSW if rates of heterosexually acquired gonorrhoea amongst Aboriginal communities in these regions are higher. Partner Referral is likely to be enhanced by improving patient awareness of STIs in general, via written information or online resources, as well as by scheduling follow-up. Online services can also be used to undertake both Provider and Patient Referral and new Aboriginal-specific resources are in the process of being developed. The use of Facebook as a method to provide sexual health messages and potentially communicate with contacts of younger index patients could be considered. Practice nurses continue to offer a potential means of increasing contact tracing in mainstream general practices.

## 10 OTHER SPECIFIC GROUPS

### 10.1 RECURRENT INFECTIONS (MALES / FEMALES)

KIs generally reported that for recurrent infections they would spend more time trying to encourage contact tracing with the index patient. Although several pointed out that the infection may be from a new partner, in which case a focus on general sexual health education was more appropriate. Some KIs have used PDPT in such situations, as previously mentioned.

### 10.2 CROSS BORDER ISSUES

No particular cross border issues were noted by KIs. KIs in the North, West and South all suggested that they had means of identifying assistance in contact tracing across the borders should there be a particular concern with more serious infections. The increased funding for rural sexual health in Victoria was noted.

### 10.3 MEN WHO HAVE SEX WITH MEN

Several KIs proposed that, as with non-Aboriginal men, assumptions about sexual behaviour and risk of certain STIs, as well as gender of contacts, should not be made by clinicians on the basis of whether index patients are married or not. In explaining this, Aboriginal KIs suggested that the high rates of incarceration of Aboriginal men may mean that heterosexually-oriented Aboriginal males may have higher rates of exposure to STIs more common amongst men who have sex with men due to homosexual sex whilst incarcerated. In addition it has been reported elsewhere that Aboriginal men who have sex with other men may not identify as such [1].

In terms of men identifying as men who have sex with men several KIs suggested that in their communities those men who had 'come out' where ultimately well accepted, although similarly to non-Aboriginal communities pockets of homophobia were still common. Specific regional health workers focussing on the health issues of men who have sex with men were considered a good resource, including for assistance with contact tracing.

### 10.4 PREGNANCY / ANTENATES

All the KIs at the ACCHS that were interviewed reported that antenates were generally screened for chlamydia and syphilis (+/- gonorrhoea) at their clinics. Regional chlamydia screening via hospital-based maternity services was not universal however.

One ACCHS KI at a service with consulting GP-obstetricians (and therefore shared-care to term) noted a 'surprisingly high' rate of repeat chlamydia infection in their antenates (anecdotally around 20%). Due to the neonatal risks of active chlamydia this observation emphasises the need to offer

assistance to such index patients with respect to contact tracing as well as actively follow-up on re-infection.

## **10.5 SEX WORKERS**

KIs interviewed for this report had minimal contact with Aboriginal sex-workers, however several KIs raised concerns about more informal arrangements of the 'sex-for-favours' type in their communities, particularly amongst younger girls. In such cases, as with some younger people in general, it was considered preferable to undertake general screening and sexual health education of social networks of girls either via youth clubs or specific elder-approved group sessions.

## 11 PARTNERSHIP OF SERVICES IN TERMS OF CONTACT TRACING AND SEXUAL HEALTH AWARENESS IN GENERAL

The advantages of placing ASHHW in ACCHS to increase familiarity with sexual health issues amongst Aboriginal communities are acknowledged. However several KIs expressed concerns that without structured partnerships with sexual health services the ASHHW may not be gaining the familiarity with STIs which is required by workers who are proposed as specialists in their field. This includes an understanding of the interplay between STI screening and contact tracing, and the relative importance of contact tracing for different conditions. Such knowledge would enable ASHHW to prioritise the time they spent on various aspects of their role. Both ASHHW and SH KIs expressed these concerns and these issues have been noted before [1, 18].

KIs raised differing opinions as to whether the new Medicare Locals at the community care level would have a beneficial effect or otherwise with respect to maintaining sexual health on the agenda as a relevant health issue to invest in. One KI suggested that the increased population health role of Medicare Locals was an opportunity for regional centres to develop population-specific sexual health management (including screening and contact tracing of particular conditions based on regional patterns). Another KI raised concerns that given ongoing community stigma, sexual health may be overshadowed by other agendas, with the devaluation of certain roles including those of ASHHW. As a consequence KIs emphasised the need for lobbying by centralised bodies about how the new Medicare Locals might affect sexual health practices around the state in order to maintain awareness of the issues and prevent potential devaluation of these.

## 12 RECOMMENDATIONS

The basic issues with respect to contact tracing amongst Aboriginal communities in NSW are similar to those identified for the wider community in the CTlitrev. For example, one of the main concerns with contact tracing is whether it is initiated at all. Again, a GP may not initiate contact tracing due to the fact that sexual health is only one small part of their focus, be they in an Aboriginal-specific community clinic or not, and yet most STIs are diagnosed at the community general practice or other non-specialised settings.

For Aboriginal people, adequate STI management may be additionally confounded by GPs' concerns regarding skills in cultural competency, increased sexual health stigma in some communities, and different modes of technology use, including an increased likelihood of shared mobile phones. The higher proportion of Aboriginal people in regional areas where GPs are likely to be non-specialised overseas-trained doctors is an added issue. Hence recommendations for improving contact tracing amongst Aboriginal communities need to focus on the basics of improving awareness of roles and resources of clinicians, particularly in areas where there are high proportions of Aboriginal people in the population, whilst encouraging ongoing normalisation of sexual health issues and community education via the ACCHS and ASHHW network.

It was emphasised numerous times in this review that although important, the fact that sexual health issues remain only a fraction of what GPs and most ACCHS clinicians do means that real time assistance, simple readily available tools, and regular reminders about resources and methods remain the most feasible way to improve sexual health STI management and contact tracing patterns. This is likely to be the case for all types of patients outside of the specialist sexual health services.

## 12.1 ABORIGINAL SEXUAL HEALTH INDUCTION PACKAGE

KI discussions raised the possibility of a brief induction package around sexual health for new clinicians in ACCHS, general practices and other health services in communities where there are higher proportions of Aboriginal people. Some KIs suggested that such a package should be distributed to all clinicians, not those just newly arrived to the area or practice. This would assist in familiarising older and non-specialised GPs in appropriate and up-to-date STI management for the general community, as well as Aboriginal-specific considerations. Medicare Locals were raised as the means by which such packages could be both modified for local services and distributed to the relevant clinicians. Various suggestions as to the contents of the package included:

- Summary of cultural competency points both for sexual health history taking and specific considerations in terms of contact tracing for Aboriginal people (including choice; teamwork if undertaking Provider Referral (and how to appropriately involve health workers); the potential issues of mobile phones, mail and similar names, the requirement to avoid using the term 'contact tracing' directly with patients; and ASHHW coordinator contact details for assistance/questions.) A maximum of two pages was suggested for this summary.
- Some 'chlamydia cards' (see below)
- Some 'Better to Know' cards
- A list of websites of available sexual health resources in NSW and nationally
- The STIPU STI testing toolkit, the chlamydia GP tool and the STI contact tracing tool for general practice: <http://www.stipu.nsw.gov.au/resources.html>
- An up-to-date guide of pharmaceutical management, including for pelvic inflammatory disease
- The template for a Medical Director proforma on a USB stick (see below).

Ideally there would also be localised contact details of other providers willing to assist in Provider Referral and further information (SH or PHU staff) and resources/staff within the clinic, especially if an ACCHS.

## 12.2 CHLAMYDIA CARD

A wallet-sized Aboriginal-specific resource was independently proposed by two different AHW KIs early in the consultations for this project. This was conceived as potentially one component of a wider ‘chlamydia campaign’ – one suggestion for a title being ‘Chlamydia and Us: How to keep the Mob safe’.

Consequently a mock ‘chlamydia card’ is outlined below – this incorporates the various suggestions made by different KIs as to how to incorporate the benefits of sexual health screening and contact tracing whilst highlighting the simplicity of assessment and treatment. The aim is to keep the information clear, concise and relevant to the population. Piloting such a card has received universal endorsement by the interviewed KIs. It is envisaged that the card could be a doubled-over piece which folds to a normal card size and can therefore be put in the wallet or pocket for discretion. Several KIs mentioned that although larger resources may contain more information, they sometimes found these in the bin by the front door. One KI mentioned that a card-sized resource for a sexual health program for younger Australians (irrespective of Aboriginality) had been well-received.

The following is an example of the types of messages which KIs would like incorporated into such a card. They have also suggested that on the back could be a space for a date to be written about when it is safe to have sex again and also when to get follow-up.

- *Chlamydia is a **common** sexually transmitted disease & **most people who have it don't know it.***
- *So you **may have had it a long time** and given it to your current sexual partner(s) – they might not have given it to you.*
- *Chlamydia can mean that both men and women can't have babies*
- *A urine (wee) test can diagnose Chlamydia – you won't need to take your clothes off*
- *The **treatment is a couple of tablets**, and you can take this medicine even if you take other medicines or drugs, including alcohol.*
- *And **you need to tell your sexual partners** so that they can be treated too, as well as stop you getting it again!*
- *Don't forget that using condoms can prevent you from getting chlamydia and other sexually transmitted infections.*

### 12.3 PROFORMA

As outlined above, numerous KIs supported the idea of a proforma for sexual health history taking and management, including contact tracing. Communicare Systems' sexual health dataset may be one such proforma to evaluate at ACCHS. It was emphasised however that it would be beneficial if Aboriginal people were asked the same types of questions wherever they chose to attend for their sexual health needs. Moreover the benefits of standardised tools and forms are not restricted to Aboriginal people and in addition it may be preferable to not focus on Aboriginality as a risk factor for increased STIs. Therefore a generalised proforma is proposed, which highlights the need to confirm sexual behaviour and other risk factors, as well the circumstances in which Provider Referral should explicitly be considered (including with Aboriginal patients), as in the contact tracing tool for GPs: [http://www.stipu.nsw.gov.au/pdf/May\\_2011\\_Contact\\_tracing\\_tool\\_final\\_version.pdf](http://www.stipu.nsw.gov.au/pdf/May_2011_Contact_tracing_tool_final_version.pdf)

The practicalities of such a proforma are more challenging than for an induction package or chlamydia card, but one option could be to develop a Medical Director template and have this distributed to GPs on USB. Localised contact details for Provider Referral assistance would make such a resource more appealing to clinicians. The AH&MRC have also produced a manual for early detection and treatment of STIs and blood-borne viruses amongst Aboriginal people in which there are flow-charts for sexual health assessments of varying complexity [35].

### 12.4 SUPPORT FOR GP RARER DISEASE PROJECT EXPANSION TO GONORRHOEA / ENHANCED SURVEILLANCE

From the information available the GP mentoring projects for HIV and syphilis in NSW have been well-received to date. This review would support their continuation.

The evidence assessed in this report would further support such a project for gonorrhoea diagnoses in NSW. This form of mentoring could incorporate enhanced surveillance, including Aboriginal status, which would enable valid epidemiological assessment of gonorrhoea infections amongst NSW Aboriginal communities; information which is currently lacking. Such a project would be also likely to increase knowledge and confidence in general sexual health management amongst GPs less familiar with diagnosing STIs.

## 12.5 EVALUATION AND ENHANCEMENT OF IT RESOURCES

Evaluation of NSW uptake of newer IT resources such as 'Better to Know' after an adequate induction period should be undertaken.

Given the very high reported use of sites such as Facebook by younger Aboriginal people, ongoing assessment of social networking sites in the evolution of younger Aboriginal peoples' development of interpersonal relationships, and the means by which such sites may be used for sexual health messages should be undertaken: ([http://burnet.edu.au/projects/69\\_facespace\\_using\\_social\\_networking\\_to\\_promote\\_safer\\_sex\\_to\\_higher\\_risk\\_groups](http://burnet.edu.au/projects/69_facespace_using_social_networking_to_promote_safer_sex_to_higher_risk_groups)).

## 12.6 ASHHW ROLES AND SEXUAL HEALTH PARTNERSHIPS

The information gathered from KIs in this review supports localised flexibility in ASHHW roles and titles depending on their particular employment circumstances and personal preferences. Such flexibility should not be at the expense of specialised sexual health knowledge and partnerships with local sexual health services however. Both SH staff and ASHHW KIs suggested that a certain period of time working directly with local sexual health staff at initiation of an ASHHW position would be ideal, along with regular scheduled days thereafter.

KIs also raised the possibility of formalising the processes by which SHN may spend time at local ACCHS, as well as local larger GP clinics, hospital emergency departments and relevant outpatients. Such active partnerships may be on an infrequent basis as part of sexual health 'road-shows' or on a more regular arrangement depending on regional resources.

Potential outcomes of SH clinical staff and ASHHW/ACCHS Clinical staff improved partnerships in terms of contact tracing include:

- Increased sexual health knowledge of ASHHW and other ACCHS clinical staff as well as the value and types of contact tracing
- Opportunity of ASHHW to gain confidence in taking on a clinical role should they so choose
- Reinforcement of ASHHW specialist knowledge status at the ACCHS, including amongst clinical staff
- Avoidance of ASHHW being subsumed into other programs that they are not funded for whilst allowing some flexibility
- Familiarity of ACCHS staff and community with local SHC staff – thereby increasing normalisation of sexual health issues and need to have partners informed, as well as developing relationships for external Provider Referral is required
- Increased opportunity for SH staff and ASHHW to collaborate to up-skill local GP practices on both basic STI management and cultural competency issues, including skills in contact tracing

Potential outcomes of SH clinical staff and ASHHW (Population Health or ACCHS) structured relationships with emergency departments/local larger GP practices and Family Planning.

- Increased knowledge of sexual health issues amongst local clinicians (especially useful in the setting of an overseas trained workforce) including legislative requirements of STI management by local clinicians (such as contact tracing)
- Increased optimal STI management amongst Aboriginal people who may be attending other services
- Prevention of incomplete STI management at local emergency departments due to lack of contact tracing
- Ensuring adequate quality of details for Provider Referrals if undertaken for ASSHW

## **12.7 SEXUAL HEALTH NORMALISATION AND INCORPORATION INTO GENERAL AHW TRAINING**

The involvement of AHW without specific sexual health training in contact tracing was highlighted by KIs. This supports the need for ongoing basic sexual health training for all AHW, potentially as part of the national accreditation process.

## **12.8 PRACTICE NURSES**

Whilst there was mixed feedback at this early stage, ongoing education of practice nurses in general STI screening, management and contact tracing should be considered, particularly in regional areas.

## 13 APPENDICES

### 13.1 ADDITIONAL SEARCH STRATEGY

#### Medline search terms

##### 1<sup>st</sup> search

Contact tracing AND

Sexually Transmitted Diseases AND

AND Aboriginal OR

Aborigine OR

Health service, Indigenous OR

Oceanic Ancestry Group OR

Or Indigenous

⇒ 3

#### Embase search terms

1<sup>st</sup> search: 'contact tracing'/exp OR 'contact tracing' AND ('sexually transmitted disease'/exp OR 'sexually transmitted disease') AND ('aboriginal'/exp OR 'aboriginal' OR 'aborigine'/exp OR 'aborigine' OR indigenous) AND 'australia'/exp

⇒ 6

#### Pubmed terms

1<sup>st</sup> search: ("Contact Tracing"[Mesh] AND "Sexually Transmitted Diseases"[Mesh]) AND "Oceanic Ancestry Group"[Mesh]

⇒ 2

2<sup>nd</sup> search: ("Contact Tracing"[Mesh] AND "Sexually Transmitted Diseases"[Mesh]) AND ("Aborigine, Australia" OR Aboriginal OR "Australian Aborigines" OR indigenous OR "Oceanic Ancestry Group"[Mesh])

⇒ 4

#### Informat

"contact tracing" AND "Sexually Transmitted Diseases" AND (Aborigine OR Aboriginal OR Indigenous)

⇒ 16

#### Google

("contact tracing" OR "partner notification") AND (Aboriginal OR Aborigine OR indigenous)

Database	No. result retrieved	No. discarded after reading abstracts	No. remaining
Medline	3	1	2
EMBASE	6		
Google web/scholar	6		
Informat	16		
References	5		
Conferences	2		

**Discard duplicated ( less 6)**

⇒ 21 remaining (FOR FULL REVIEW AS TO RELEVANCE)

## 13.2 LETTER OF INTRODUCTION

new south wales sexually transmissible infections programs unit

**nswsti**  
**PROGRAMS UNIT**

Dear Colleague,

### **STI/HIV Contact Tracing within Aboriginal Communities**

A comprehensive literature review on contact tracing in NSW released in 2010 highlighted the lack of published information on contact tracing within Aboriginal Communities.

With support from the NSW Aboriginal Sexual Health, HIV and Hepatitis Advisory Committee (ASHHAC) and NSW Contact Tracing Working Group, the NSW STI Programs Unit has commissioned Burnet Institute, Melbourne to undertake a supplemental report on contact tracing within Aboriginal Communities.

This report aims to inform future contact tracing with NSW Aboriginal people and health care workers including issues such as confidentiality, stigma, fears around domestic violence, and use of technology.

Additional published Australian Aboriginal contact tracing literature will be sought and key informant interviews will inform this review.

As an experienced worker, a researcher from Burnet Institute may be in contact to schedule an interview with you or a staff member.

Your support of this initiative would be greatly appreciated.

Please contact Leanne Burton on 0427 929 805 or Robert Monaghan on 02 6640 2479 or 0407882519 if you have any questions about the project. The 2010 contact tracing review can be found at [www.stipu.nsw.gov.au/pdf/ContactTracingLiteratureReview.pdf](http://www.stipu.nsw.gov.au/pdf/ContactTracingLiteratureReview.pdf).

Yours sincerely

Dr Chris Bourne, MM  
(sexual health),  
FACHSHM  
Head, NSW STI  
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Dr Natalie Edmiston,  
MBBS, MPH, FACHSHM  
Chair, NSW STI  
Contact Tracing  
Working Group

Robert Monaghan,  
NSW Aboriginal Sexual  
Health Coordinator,  
NSW Contact Tracing  
Working Group &  
ASHHAC  
Representative

### 13.3 KEY INFORMANT INTERVIEW TOOL

Theme	Point	Suggestions/discussion/questions
<b>Position of interviewee.</b>		
<b>Understanding of government's/ unit's role/duties in CT</b>		
<b>Types of contact tracing</b>		
	Regular partner - ? What types of referral? How would a worker judge this?	
	Newer technologies – internet, mobile phone	
<b>Confidentiality</b>		
<b>Partnership</b>		
	GP (non ACCHS)*	
	Sexual health nurse*	
	Parole*	
	DOCs*	
	??	
	Local partnership with hospital	
	Local partnership with other GPs	
<b>Accuracy of Contact Details</b>		
<b>Gain community trust and respect / Educate the community</b>		
	Education of the community about contact tracing? Suggestions?	
<b>Gender Issues</b>		
<b>Patient support</b>		
<b>Patient education / encouragement</b>		
	Use of language, tools, posters – for an index patient. Problems with different beliefs?	
	What types of assistance for contacts?	
<b>Specific groups</b>		
	Recurrent infections	female

		male
	Incarcerated contacts (prison / detention)	
	Contacts who have moved elsewhere	
	Cross Border issues	
	Patient delivered partner therapy	
	Men who have sex with men	
	People who inject drugs	
	Pregnant	
<b>Different diseases</b>		
	HIV	
	Syphilis	
	Gonorrhoea	
	Hepatitis B	
	Hepatitis C	
	Chlamydia	
	Trichomonas	
<b>Notes/ideas for improvement</b>		

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See also the references contained in the CTlitrev.

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