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**Australian Institute of
Health and Welfare**

Demonstration projects for improving sexual health in Aboriginal and Torres Strait Islander youth

Evaluation report



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*Authoritative information and statistics
to promote better health and wellbeing*

Demonstration projects for improving sexual health in Aboriginal and Torres Strait Islander youth

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Australian Institute of Health and Welfare
Canberra

Cat. no. IHW 81

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Summary

- The Office for Aboriginal and Torres Strait Islander Health (OATSIH) funded six demonstration projects aimed at improving the sexual health of Aboriginal and Torres Strait Islander young people over 3 years (2008–2011).
- The aims of the projects were to:
 - increase the number of Aboriginal and Torres Strait Islander young people accessing services for the testing and treatment of sexually transmissible infections (STIs) and blood borne viruses (BBVs)
 - reduce the level of risk behaviours
 - contribute to the development of best practice approaches.
- The Australian Institute of Health and Welfare (AIHW), Kirby Institute and the six organisations developed a range of indicators to monitor and evaluate the demonstration projects. The AIHW collected six-monthly data on these indicators, and conducted site visits to evaluate the success of these projects.
- Due to limitations with data availability and quality, and the relatively short timeframe of the evaluation, it was not always possible to assess the effectiveness of projects in achieving program objectives and expected outcomes.
- The range of qualitative information collected for the evaluation, however, enabled the key features of the more successful projects to be identified. A ‘successful’ project in this context was one that successfully engaged with the community and young people, and as a result the project was accepted by these groups.
- The evaluation identified the following as key features of a successful sexual health program:
 - appropriate consultation with a broad range of stakeholders, including community Elders, young people and health professionals
 - engagement and developing partnerships with the community, organisations and services
 - culturally appropriate project design and implementation
 - project design, delivery and implementation that was flexible and adaptable
 - staff who were respected by the community, accessible to young people, engaged well with young people, and were the same gender as the target group.
- Recruitment and retention of staff was a significant challenge faced by many of the projects. Greater training and support need to be provided for the Aboriginal and Torres Strait Islander sexual health workforce to increase the available pool of people with the required skills.

Abbreviations

ABS	Australian Bureau of Statistics
ACMS	Aboriginal Corporation Medical Service
AHW	Aboriginal health worker
AIDS	acquired immunodeficiency syndrome
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ASHEO	Aboriginal Sexual Health Education Officer
ASHM	Australasian Society for HIV Medicine
AYHAW	Aboriginal Youth Health Access Workshop
BBV	blood borne virus
CAAC	Central Australian Aboriginal Congress
CDEP	Community Development Employment Project
DoHA	Department of Health and Ageing
GP	general practitioner
HIV	human immunodeficiency virus
JJC	Juvenile Justice Centre
MSA	Marie Stopes Australia
MoU	memorandum of understanding
NHS	Ngaanyatjarra Health Service
NPY	Ngaanyatjarra Pitjantjatjara Yankunytjatjara
NACCHO	National Aboriginal Community Controlled Health Organisation
NIASHS	National Indigenous Australians' Sexual Health Strategy
NSW	New South Wales
NT	Northern Territory
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PATSIN	Positive Aboriginal and Torres Strait Islander Network
Qld	Queensland

SA	South Australia
SESDGP	South Eastern Sydney Division of General Practice
STI	sexually transmitted infection
Tas	Tasmania
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
Vic	Victoria
WA	Western Australia
YHE	youth health educators

1 Introduction

This report presents the final evaluation findings of the program Improving Sexual Health in Aboriginal and Torres Strait Islander Youth Demonstration Projects. In 2007, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) sought expressions of interest from organisations or consortia to develop and implement demonstration projects aimed at improving the sexual health of Aboriginal and Torres Strait Islander young people. As a result, six demonstration projects were funded over 3 years (2008–2011) in Australia.

The AIHW was commissioned to undertake ongoing monitoring and the final evaluation of the demonstration projects, with technical advice provided by the Kirby Institute (previously the National Centre in HIV Epidemiology and Clinical Research). This report presents the results of the final evaluation, based on qualitative and quantitative information provided by the demonstration projects at regular intervals throughout the period of funding, as well as site visits at the commencement and conclusion of the projects. The purpose of the evaluation of the demonstration projects was to determine if the aims and objectives of the projects have been met, and to identify the key factors for success and lessons learned at the demonstration project sites.

1.1 Policy context

The demonstration projects were implemented under the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008 (the Strategy) (DOHA 2005a). This Strategy built upon the work of the National Indigenous Australians' Sexual Health Strategy (NIASHS) 1996–97 to 2003–04 (Commonwealth of Australia 1997), which provided the first comprehensive approach to preventing the spread of HIV, other sexually transmissible infections (STIs) and blood borne viruses (BBVs) in Aboriginal and Torres Strait Islander communities.

The 2005–2008 Strategy sought to improve access to testing, diagnosis, treatment and care of STIs and BBVs for Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander young people were identified as a key target group of the Strategy, and the need to implement services particularly concerning young people in primary health-care service delivery in partnership with other sectors was highlighted.

Due to an identified need for mainstream strategies to take greater responsibility for sexual health, the Strategy was prepared in parallel with the development of the following strategies:

- the National HIV/AIDS Strategy 2005–2008
- the National Hepatitis C Strategy 2005–2008
- the National Sexually Transmissible Infections Strategy 2005–2008.

The Strategy was intended to complement the content of these related strategies by highlighting the additional priorities and special issues that are unique to the prevention and treatment needs of Aboriginal and Torres Strait Islander people in relation to HIV/AIDS, STIs and BBVs.

An implementation plan was developed, which defined performance indicators to monitor and evaluate the success of the Strategy, assigned responsibility for particular actions under the Strategy and identified linkages among related implementation plans (DOHA 2005b).

A third sexual health strategy has since been developed for 2010–2013: the National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013 (DOHA 2010).

Although the goals of the 2005–2008 and 2010–2013 strategies are similar, the strategies have different objectives. The demonstration projects were designed to make a contribution to, and be consistent with, the 2005–2008 Strategy, and evaluation has therefore been undertaken in accordance with this Strategy.

1.2 The demonstration projects

OATSIH advertised for expressions of interest from organisations to run demonstration projects in a range of urban, regional and remote communities to improve the sexual health of young Aboriginal and Torres Strait Islander people. Eligibility criteria included the applicant being an organisation that provides sexual health services to predominantly Aboriginal and Torres Strait Islander populations, support from the organisation's board, and that proposed interventions are outcomes based around improving services and reducing risk behaviour, rather than research focussed. Organisations were asked to consider such factors as the needs of the population, community support for the proposed interventions, the history and relative success of sexual health interventions in the region, and the transferability of the proposed interventions to other regions and settings in their expressions of interest. All expressions of interest were assessed and prioritised and six organisations were selected.

The overarching objectives of the demonstration projects were to:

1. build on existing local capacity and health service relationships to create sustainable new health service models
2. develop innovative approaches to engaging young people including involving young people in project design, delivery and evaluation
3. increase the number of young people accessing services for testing and treatment of sexually transmissible infections and blood borne viruses
4. reduce risk-taking behaviour in Aboriginal and Torres Strait Islander youth
5. make a contribution to and be consistent with the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008 and Implementation Plan
6. make a contribution to the Aboriginal and Torres Strait Islander sexual health workforce
7. provide a guide for expansion of effective sexual health models into other areas of Australia.

Information about each of the projects according to the original expressions of interest is provided in Box 1.1.

Each demonstration project differed in the services it provided and what it hoped to achieve, therefore contributing to the overarching objectives in different ways. Some of the key differences between projects included the following:

- **Activities** – all projects involved an education component, but different models were used to educate young people about sexual health; some projects were funded to provide STI and/or BBV testing and treatment services, while some were funded to improve

health-seeking behaviour, improve education and health literacy of young people in the areas of STI and BBV, and others provided referrals to testing and treatment services.

- **Target group** – two projects specifically targeted Indigenous males and one project was for youth in juvenile justice detention centres.
- **Nature of the organisation funded** – the organisations included three Indigenous health services, a state government agency, a national organisation that provides sexual and reproductive health-care services and a division of general practice.

Box 1.1: The demonstration projects

Central Australian Aboriginal Congress – STI/BBV Education and Risk Reduction for Young Aboriginal Males in Remote and Urban Central Australia Project

This project sought to reduce rates of STIs and BBVs among Aboriginal males aged 12–25 in remote and urban communities in Central Australia, via employment of a senior Aboriginal man as project coordinator to train senior Aboriginal men in six language regions as ceremonial workers/peer educators.

Durri Aboriginal Corporation Medical Service (ACMS) – Hey Bruz Project

The aim of this project was to improve the sexual health of Aboriginal and Torres Strait Islander males aged 16–25 in the Macleay and Nambucca Valleys of New South Wales (NSW) through a targeted communication strategy. This included the modification of an existing sexual health and sexuality education program for females and an existing sexual health screening program to the target population, and implementation of an awareness program to identify and manage health worker sensitivities.

Justice Health – Improving Sexual Health in Aboriginal and Torres Strait Islander Youth in New South Wales Juvenile Justice Centres Project

This project sought to improve the sexual health of Aboriginal and Torres Strait Islander youth in custody in NSW Juvenile Justice Centres via the employment of a full-time Sexual Health Education Officer to develop culturally appropriate education and prevention strategies, coordinate assessment and treatment services in custody, enhance connections to community health-care testing and treatment and improve continuity of care following release from custody.

Marie Stopes Australia – Don't Let Your Community Get Bitten, Ask for a SNAKE Project

This project sought to improve the sexual and reproductive health of young Aboriginal and Torres Strait Islander people aged 16–30 across Australia through the national roll-out of the Marie Stopes SNAKE Condom project, across two stages.

Ngaanyatjarra Health Service (NHS) – Kungkaku Yangupalaku Healthy Relationships Project

This project aimed to improve the sexual health of young people on the Ngaanyatjarra lands by increasing young people's ability to make informed decisions to enable healthy relationships, reduce risk-taking behaviour and improve access to sexual health care and related services.

Box 1.1: The demonstration projects (continued)**South Eastern Sydney Division of General Practice (SESDGP) – Aboriginal Youth Safe Summer Survival Project (Ngarandhi) and Youth Health Clinic**

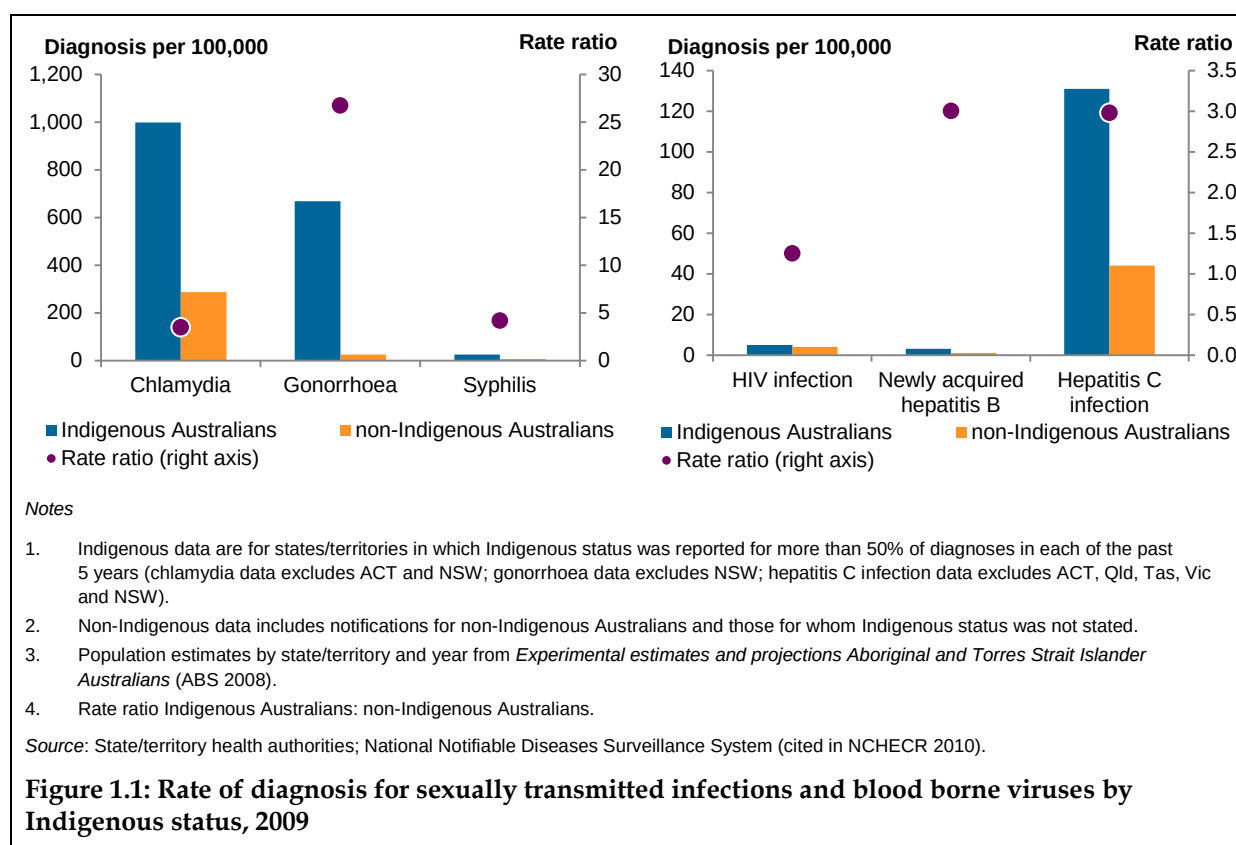
Part 1 was a peer education sexual health summer outreach project that targeted young people in the La Perouse and surrounding areas covered by the SESDGP. Part 2 involved implementation of a cultural awareness training program for local general practitioners (GPs) interested in providing services to Koori youth and the establishment of a Koori Youth Health Clinic at the La Perouse Aboriginal Community Health Centre.

1.3 Sexually transmitted infections and blood borne viruses among Aboriginal and Torres Strait Islander young people

Aboriginal and Torres Strait Islander young people are a key target population in both the 2005–2008 Strategy and the most recent 2010–2013 Strategy. This is because Indigenous youth:

- are reported with much higher rates of diagnosis of STIs compared with non-Indigenous youth
- may have levels of health education and health literacy that are lower than that of their non-Indigenous counterparts and older community members
- live in areas where endemicity is common for many STIs
- have higher rates of teenage pregnancies
- experience barriers to accessing health services (DOHA 2010).

Australian data (Figure 1.1) show higher rates of STIs and BBVs for Indigenous Australians compared with non-Indigenous Australians (NCHECR 2010). These differences have the potential to influence already increased levels of morbidity and mortality experienced by Indigenous Australians. If untreated, STIs can result in poor outcomes in pregnancy for women, infertility for both men and women, an increased risk of HIV transmission and serious health consequences for newborn babies (Western Australia Department of Health 2005).

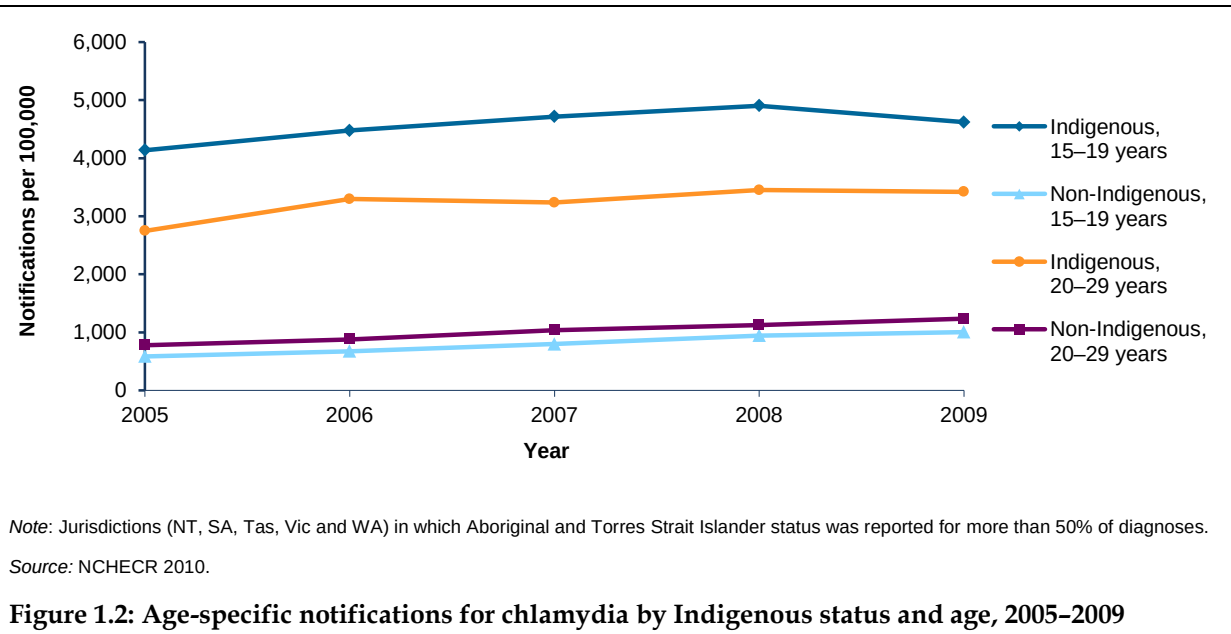


Sexually transmitted infections

Chlamydia

In 2009, chlamydia notification rates among Indigenous young people aged 15–19 and 20–29 were almost 5 and 3 times as high, respectively, as for non-Indigenous young people of the same age. Indigenous males and females aged 15–19, had rates 6 and 4 times as high as their non-Indigenous counterparts, respectively.

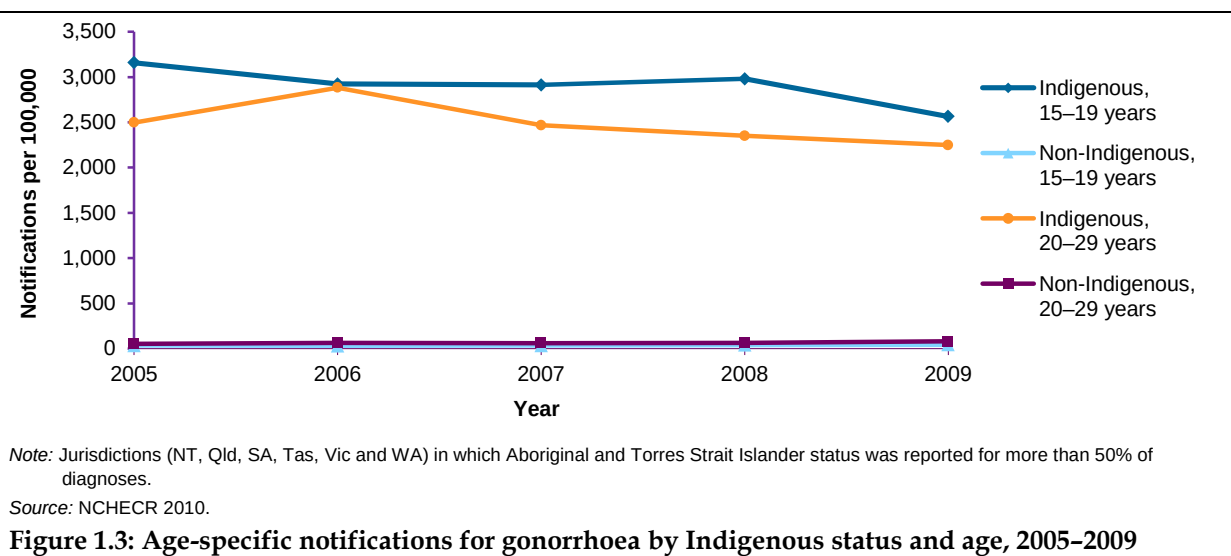
Between 2005–2009, chlamydia notification rates among Indigenous young people aged 15–19 and 20–29 increased by 12% and 25%, respectively, while in the non-Indigenous population the rate increased by 71% and 59% in the respective age groups (Figure 1.2).



Gonorrhoea

Gonorrhoea notification rates had the highest rate ratio differences among all STIs and BBVs. For Indigenous young people aged 15–19 and 20–29, the rate of diagnosis in 2009 was 53 and 28 times greater, respectively, than diagnosis rates in the non-Indigenous population. Rates among Indigenous males and females aged 15–19 were 41 and 24 times those of their non-Indigenous counterparts. For 20–29 year olds, the corresponding figures were 18 and 61 times higher.

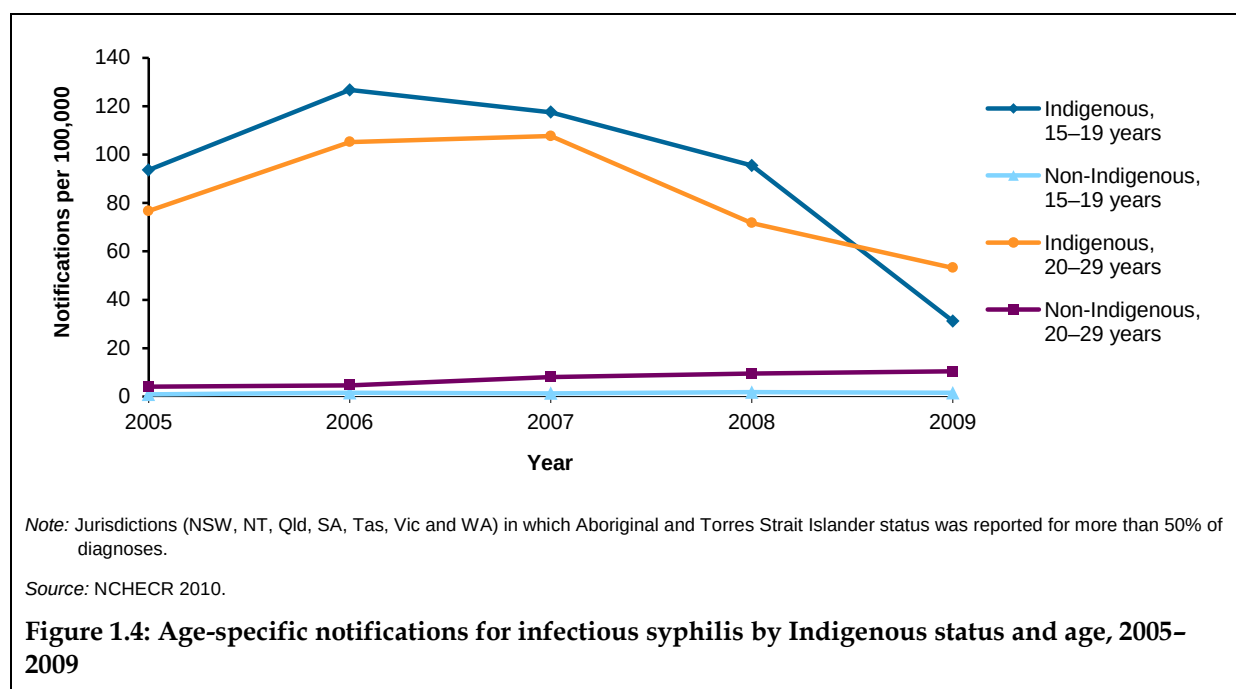
Between 2005 and 2009, gonorrhoea notification rates among Indigenous young people aged 15–19 and 20–29 decreased by 19% and 10%, respectively (Figure 1.3).



Infectious syphilis

Notification rates for infectious syphilis in 2009 were higher among Indigenous young people than among non-Indigenous young people.

Infectious syphilis in Indigenous people aged 15–19 dropped 4-fold, from 126.7 per 100,000 in 2006 to 31.2 per 100,000 population in 2009, and halved in the 20–29 year age group from 105.2 per 100,000 in 2006 to 53.2 per 100,000 in 2009. In the non-Indigenous population aged 15–19, the rate of infectious syphilis diagnosis was relatively stable at 1.6 per 100,000 in 2005–2009, whereas the rate in the population aged 20–29 more than doubled, from 4.2 per 100,000 in 2005 to 10.5 per 100,000 population in 2009 (Figure 1.4).

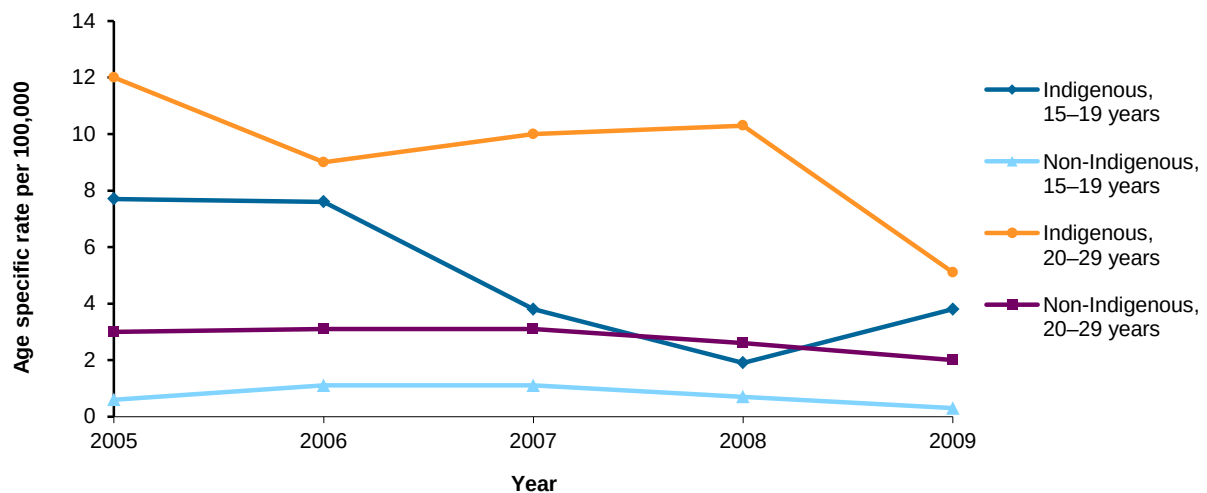


Blood borne viruses

Newly acquired hepatitis B infection

In 2009, the notification rates for newly acquired hepatitis B were higher among Indigenous young people than among non-Indigenous young people.

Newly acquired hepatitis B in Indigenous Australians aged 15–19 and 20–29 has decreased since 2005, while the non-Indigenous rates remained relatively stable over the same time period (Figure 1.5).



Note: Jurisdictions (NSW, NT, Qld, SA, Vic and WA) in which Aboriginal and Torres Strait Islander status was reported for more than 50% of diagnoses.

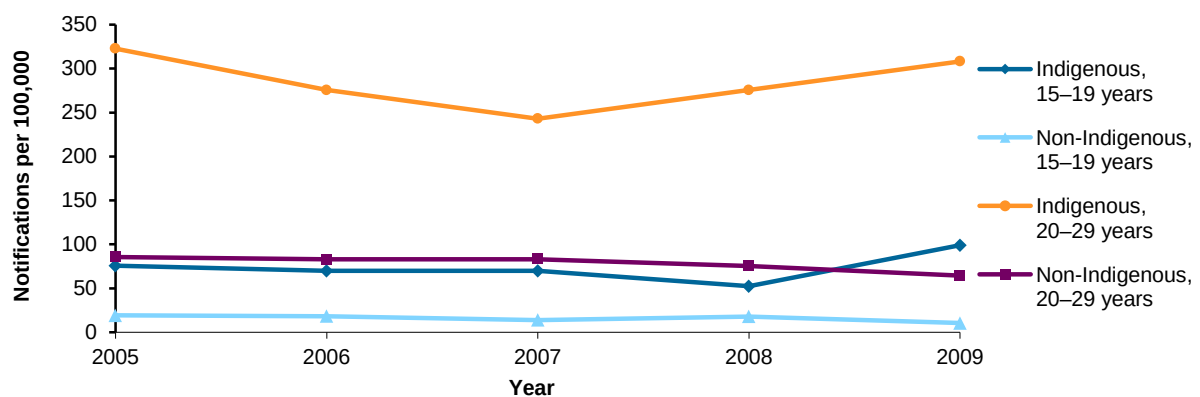
Source: NCHECR 2010.

Figure 1.5: Age-specific notifications for newly acquired hepatitis B by Indigenous status and age, 2005-2009

Hepatitis C infection

Notification rates for hepatitis C were also higher among Indigenous young people than among non-Indigenous young people. In 2009, the rate of diagnosis of hepatitis C infection for Indigenous males and females aged 15-19 were 15 and 5 times higher, respectively, than non-Indigenous males and females.

Newly diagnosed hepatitis C in Indigenous Australians aged 20-29 was substantially higher than all three other groups (Figure 1.6).



Note: Jurisdictions (NSW, NT, Qld, SA, Vic and WA) in which Aboriginal and Torres Strait Islander status was reported for more than 50% of diagnoses.

Source: NCHECR 2010.

Figure 1.6: Age-specific notifications for hepatitis C by Indigenous status and age, 2005-2009

HIV infection

In 2009, the population rate of diagnosis of HIV was similar for both populations. The Aboriginal and Torres Strait Islander population had a rate of 4 per 100,000 compared with 5 per 100,000 in the non-Indigenous population.

In Australia, the number of new diagnoses of HIV in Australia increased by 17% between 2005 and 2009, while the number of diagnoses in the Indigenous population has remained stable over the same period.

1.4 Report structure

The first chapter of this report provides background information on the demonstration projects and the prevalence of STIs and BBVs among Aboriginal and Torres Strait Islander young people. Chapter 2 details the approach and methodology used for the evaluation of the demonstration projects, including the program theory and outcomes, the data collection methods, and the strengths and limitations of the approach. Chapter 3 discusses the evaluation findings structured around the program components and related back to program objectives and expected outcomes. The final chapter, Chapter 4, presents the discussion and conclusion of the evaluation in relation to effective sexual health models and key elements of success.

2 Evaluation approach and methods

The AIHW was commissioned to monitor and evaluate the demonstration projects. The Kirby Institute was subcontracted to provide technical advice.

This chapter details the evaluation approach and methods used for the demonstration projects, including the program theory, data collection methods and the strengths and limitations of the approach. The characteristics of the demonstration projects are also considered, because differences between the projects are important contextual information for the evaluation findings in Chapter 3.

2.1 Demonstration project characteristics

It is important to consider the differences between the demonstration projects in terms of design, scope and target group, in order to frame the context for the evaluation findings. Table 2.1 provides basic information on the target age and gender groups of the projects, and also the intended population areas.

Most of the projects were for both young men and women; however, two projects (Congress and Durri) were specifically for young men. The Congress project was directed towards this group due to identified barriers to young Aboriginal men's access to STI and BBV clinical services, as well as appropriate education and health promotion. The Durri 'Hey Bruz' project was developed for young men due to an ongoing under-representation of this cohort for sexual health services and also to restore the balance of programs needed for young Aboriginal males, because a number of successful and sustainable programs already existed in the area for Aboriginal girls and young women.

The age ranges targeted also varied between projects, and even within projects. For example, some elements of projects, such as education modules, were delivered to a broad age range, whereas other elements of projects, such as STI and BBV testing, may have been delivered to a more narrowly defined age range within the target population.

The areas covered by the projects ranged from rural and remote to urban areas, and from specific communities to Australia-wide. The type of organisation delivering the demonstration projects also varied.

- Congress, Durri and NHS are community controlled health organisations that deliver services to communities in regional/remote areas in Central Australia, New South Wales and Western Australia, respectively.
- Marie Stopes International Australia (MSA) is a sexual and reproductive health-care provider in Australia and the Asia Pacific region. The demonstration project was delivered to Aboriginal communities throughout Australia.
- Justice Health is a statutory health corporation in NSW that provides health services to those in contact with the NSW criminal justice system. The demonstration project was delivered in Juvenile Justice Centres (JJC's) throughout NSW.
- The South Eastern Sydney Division of General Practice (SESDGP) supports and services general practices in the south eastern suburbs of Sydney. The demonstration project was implemented in the suburb of La Perouse.

Table 2.1: Characteristics of demonstration projects

Characteristic	Congress	Durri	Justice Health	Marie Stopes	NHS	SESDGP
Sex	Males	Males	Both	Both	Both	Both
Age range	12–25 years	16–25 years	10–21 years	16–30 years	10–25 years	14–26 years
Area covered	Remote and urban Central Australia	Macleay and Nambucca Valleys (NSW)	NSW Juvenile Justice Centres	Australian Aboriginal communities	Ngaanyatjarra lands (Central Desert region of WA)	La Perouse, South Eastern Sydney
Organisation type	Community controlled health service	Community controlled health service	Statutory health corporation	Sexual and reproductive healthcare provider	Community controlled health service	General Practice Division

2.2 Program theory and outcomes

The theory underpinning the objectives of the overarching program and a description of the outputs, outcomes and objectives of the combined demonstration projects is outlined below and provided in more detail in Appendix A. The program logic outlined the expected changes or outcomes that the projects were designed to achieve and that were the focus of this evaluation (Table 2.2).

Table 2.2: Program theory/outcomes hierarchy

Components	Outputs	Outcomes	Program objectives
Governance and management	Linkages enhanced and/or established and increased shared resources Increased capacity of Aboriginal and Torres Strait Islander staff to work in sexual health	Improvements in targeting sexual health activities Increase in culturally appropriate sexual health service delivery	Build on existing local capacity and health service relationships to create sustainable new health service models (1) Develop innovative approaches to engaging young people in project design, delivery and evaluation (2) Make a contribution to the Aboriginal and Torres Strait Islander sexual health workforce (6)
Education and resources on risk reduction	Resources developed and increase in sexual health promotion	Increased knowledge of sexual health issues	Develop innovative approaches to engaging young people in project design, delivery and evaluation (2) Reduce risk-taking behaviour in Aboriginal and Torres Strait Islander youth (4)
Service delivery	Increase in testing and treatment provided Increase in condoms provided	Decreased opportunities for STI and BBV transmission Increased access to condoms	Increase the number of young people accessing services for testing and treatment of sexually transmissible infections and blood-borne viruses (3) Reduce risk-taking behaviour in Aboriginal and Torres Strait Islander youth (4) Make a contribution and be consistent with the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008 and Implementation Plan (5)

The final program objective (7) was to provide a guide for expansion of effective sexual health models into other areas of Australia. This objective is considered in Chapter 4, which provides an overview of the evaluation findings and outlines the key elements of success.

2.3 Data collection

The evaluation was based on data and information collected from the projects via two processes:

- data on quantitative and qualitative indicators as part of the ongoing monitoring of the projects
- information collected from site visits at the commencement and conclusion of the program's funding period.

Monitoring data

The monitoring of the projects involved collecting information from organisations at 6-monthly intervals on the project activities, evaluation activities and how the projects were progressing. As part of the funding arrangements for the demonstration projects, organisations were required to report on a number of qualitative and quantitative indicators. The indicators developed by the AIHW in consultation with OATSIH and the services, were mapped against project objectives and designed to assist in monitoring the progress of the individual demonstration projects.

The AIHW developed Excel reporting templates and distributed them to each organisation before each reporting round. The templates included both qualitative and quantitative indicators. Each of the six funded organisations was responsible for collecting and collating the data required for the evaluation and submitting it to the AIHW every 6 months. The AIHW was available to provide advice to each organisation on collection and use of data, if needed.

The AIHW collated the information received from the demonstration project sites, produced a monitoring report for OATSIH for each of the five 6-monthly reporting periods (Table 2.3) and provided individual project monitoring reports back to each service.

The six demonstration projects reported on indicators for the first reporting round (31 October–31 December 2008), but not all services had fully implemented their projects by the end of this reporting round.

Table 2.3: Reporting round and period covered by monitoring reports

Reporting round	Period covered
Round 1	31 October to 31 December 2008
Round 2	1 January to 30 June 2009
Round 3	1 July to 31 December 2009
Round 4	1 January to 30 June 2010
Round 5	1 July to 31 December 2010

Data items and indicator development

The data items and indicators collected to monitor the projects were developed by the AIHW and the Kirby Institute in consultation with the organisations delivering the projects.

Organisations were required to report on both common and project-specific data items and indicators (See Appendix B for a list of common indicators). The data items and indicators on project activities were mapped against the overarching objectives of the program and grouped under the following components:

- governance and management (including Aboriginal and Torres Strait Islander workforce) (program objectives 1, 2, and 6)
- risk reduction: resources and education (program objectives 2 and 4)
- service delivery: access, testing, treatment, notifications and other services provided (program objectives 3, 4 and 5).

Between the second and third reporting rounds, the data items and indicators were reviewed to ensure that the best information for monitoring and evaluation was being captured. As a result, the reporting tools were modified in order to align indicators more closely with program objectives, to capture the process work contributing to outcomes and objectives and to form a more consistent reporting structure across all six projects.

Reporting

Reports were produced by the AIHW for each organisation following each reporting round. The reports included summary data for the quantitative and qualitative indicators, an analysis of time trends for quantitative indicators, feedback on data quality and advice to improve data quality.

Data from the 6-monthly reporting rounds, discussions during site visits and email correspondence were used for the final evaluation.

Site visits

Site visits to the administrative centres where staff were based were conducted by AIHW and Kirby Institute staff at the commencement and completion of the demonstration projects.

The purpose of the initial site visits in 2008 was to discuss reporting indicators for the duration of the project. Indicators were developed with OATSIH, the AIHW and the services themselves, and were mapped against project objectives.

For the second site visits in early 2011, staff from the AIHW and the Kirby Institute visited key personnel from each project to collect qualitative data via interviews about the effectiveness of the project. A briefing on the project to date with key questions was sent to the services before the site visit. Key discussion points were:

- whether the project had achieved its aims and how they were achieved
- data quality and limitations
- key success factors, challenges and lessons learnt
- any additional information the service wished to discuss.

Discussion notes were taken at the meetings and used for the final evaluation of each project.

The evaluation method

In general terms, the main objectives of any evaluation are to improve decision making, resource allocation and accountability. Their role is to improve information and reduce uncertainty. Ideally, the evaluation of the demonstration projects would be able to provide

clear information on the impact of each project on the stated program outcomes (Table 2.2). However, the ability of the evaluation to achieve this was limited in three key areas.

- the target populations were not always able to be clearly defined
- no control populations were included in the evaluation
- the evaluation was not able to fully capture baseline rates of service provision, sexual health knowledge or practices, or transmission rates of STIs and BBVs.

In addition, evaluating the impact of the demonstration projects on the longer term objectives was limited by additional factors such as:

- the relatively short timeframe of the evaluation
- a lack of up-to-date, disaggregated data on STI and BBV notifications
- difficulties associated with defining and measuring levels of risky behaviour.

To evaluate the demonstration projects, the AIHW had access to a range of quantitative indicators over time and qualitative data on project activities. Originally it was intended that the evaluation would measure the objectives including improvements in sexual health services, knowledge and practice. Due to the limited timeframe and the inherent limitations of the available data, the focus of the evaluation was greater in terms of the processes and activities undertaken by the projects. Importantly, there were no comparison groups to measure what would have happened in the absence of sexual health education. Data collected were unweighted data, so it was difficult to gauge the extent the projects reached the proposed populations. Instead, the data was used to look for trends over the duration of the project. However, some of the target populations were largely undefined (e.g. festivals) and depended on the timeframe of the project.

To some extent, the evaluation was also dependent on the perceptions and views of various stakeholders (health workers, program managers and chief executive officers) about whether there had been changes due to the project. As a result, these data are subject to bias in both the collection and the reporting process.

Although the evaluation collected useful data on how well the projects had been implemented and on process measures, such as activities and services delivered, the overall evidence on the effectiveness of the projects was not strong. This was partly due to baseline data on outcomes and comparison groups not being captured by the evaluation.

3. Evaluation findings

This chapter discusses the evaluation findings and assesses what the demonstration projects have been able to achieve in terms of the overarching objectives and outcomes. The evaluation approach and methods have been described in Chapter 2.

The evaluation findings are structured around the components to which the project objectives were mapped:

- governance and management (including Aboriginal and Torres Strait Islander workforce) (program objectives 1, 2 and 6)
- risk reduction: education and resources (program objectives 2 and 4)
- service delivery (program objectives 3, 4 and 5).

Each component was discussed in relation to specific project activities, and the components were then related back to program outcomes. Where possible, the potential impact on longer term objectives was also considered.

3.1 Governance and management

Governance and management strategies have been considered in relation to the following project activities:

- governance
- partnerships
- consultation and engagement
- workforce.

Each of these areas is discussed, and the achievements of projects in these areas are then considered and related back to program objectives 1, 2 and 6.

Objectives

1. Build on existing local capacity and health service relationships to create sustainable new health service models.
2. Develop innovative approaches to engaging young people including involving young people in project design, delivery and evaluation.
6. Make a contribution to the Aboriginal and Torres Strait Islander sexual health workforce.

Governance

Projects were successful in establishing appropriate governance arrangements to guide project implementation (Table 3.1).

Formalised governance arrangements were established for each project in order to oversee and provide direction for project activities. A steering committee (also referred to as an advisory committee or reference group by the various projects) was established by all projects, with the exception of an alternative management arrangement in the case of Marie Stopes.

In addition, NHS and SESDGP also established working groups, which provided more direct guidance in relation to day-to-day project activities. Midway through the project NHS developed a log frame to articulate and capture the process indicators for their project.

As part of their governance arrangements, Durri also developed an internal communications strategy which was improved during the course of the project.

The formation of governance arrangements involved building on existing local capacity and health service relationships. For example, the reference group formed by Congress was comprised of local senior Aboriginal men who represented the various language groups within the region and had knowledge regarding men's cultural practices across the different regions. They were able to guide projects and provide advice on issues associated with the daily activities involved in meeting cultural obligations.

Durri established a reference group consisting of local community representatives, and an advisory committee of Durri ACMS staff which included doctors, nurses, Aboriginal Health Workers (AHW) and a youth worker to help inform the Hey Bruz project.

Justice Health brought together staff from mainstream adolescent health services, BBV and sexual assault services, and Aboriginal health education, to form a steering committee.

Marie Stopes managed the SNAKE project through the existing MSA management team, rather than establishing a specific steering committee for the project. The project was led by an Indigenous program manager who sat on the steering committee of several Indigenous sexual health groups that provided advice in relation to the SNAKE project (see Box 3.1).

Table 3.1: Summary of demonstration projects' governance activities

Demonstration project	Summary of governance
Congress	Reference group consisting of senior Aboriginal men representing various language groups within the region
Durri	Reference group consisting of local community representatives Advisory committee of Durri staff, which included doctors, nurses, AHWs and a youth worker Internal communication strategy established
Justice Health	Steering committee consisting of Nurse Manager Adolescent Health, Service Director Adolescent Health, Nursing Unit Manager, Aboriginal Health Education Officer and the Manager of BBV and Sexual Assault Services
Marie Stopes	Project managed by the MSA Management team Two steering committees (VACCHO Sexual Health steering committee and the Wulumperi Aboriginal and Torres Strait Islander Sexual Health Unit steering committee at the Melbourne Sexual Health Centre) provided advice Project supported by the Positive Aboriginal and Torres Strait Islander Network (PATsIN)
NHS	Reference group Working group Community plans
SESDGP	Steering committee Working group

Box 3.1: Managing an Indigenous-specific program in a mainstream organisation

Marie Stopes Australia – SNAKE

MSA managed the SNAKE project through the existing MSA management team, rather than establishing a specific steering or reference committee for the project.

The project was led by an Indigenous program manager, who sat on the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) sexual health steering committee and the Wulumperi Aboriginal and Torres Strait Islander Sexual Health Unit steering committee at the Melbourne Sexual Health Centre, both of which provided advice in relation to the SNAKE project. The SNAKE project was also supported by the Positive Aboriginal and Torres Strait Islander Network (PAT SIN): a working group of Indigenous people living with AIDS.

Partnerships

All projects were successful in developing partnerships in order to use existing networks and resources, and to build on services and programs already operating in the community (Table 3.2). Most projects established a mix of formal and informal partnerships:

- **Formal partnerships**, including memorandums of understanding (MoU), contracts and formalised supportive/collaborative arrangements
- **Informal partnerships**, including informal linkages, networks and information sharing arrangements.

Partnerships were formed with various organisation types, the most common of which included:

- state government
- local government
- Aboriginal health corporations and community controlled health organisations
- Aboriginal Health and Medical Research Council
- health services or networks, such as medical health services and sexual health clinics
- mental health organisations
- men's groups and women's centres
- youth services
- educational institutions, such as high schools and colleges
- family planning organisations
- councils for STIs and BBVs, e.g. Northern Territory AIDS and Hepatitis Council, Hepatitis Council.

The extent and number of partnerships varied considerably according to the project. NHS established a large number of partnerships, and found that organisations with the same target demographic were useful to effectively reach young people (Box 3.2). There were several examples of successful collaborations which enabled the projects to build on existing programs or services. For example, Congress ran the Red Box project through Ingkintja (male health clinic), which increased access to health services and resources, and Justice Health successfully incorporated sexual health education into an existing program (see Box 3.3).

Table 3.2: Summary of demonstration projects' partnerships

Demonstration project	Summary of partnerships
Congress	Formal partnerships with: • Northern Territory Department of Health and Community Services – Clinic 34 • Willowra Yuendumu Nyirrpi Aboriginal Health Corporation Inc. • Western Aranda Health Aboriginal Corporation Informal partnership with Northern Territory Department of Health and Community Services – Central Australia Remote Division
Durri	Formal partnership with Kempsey Police and Community Youth Club Informal partnerships with: • Kempsey family community houses (west and south) • Back to Your Best program • Youth access centre • North Coast Area Health Service • Ted Hills Gym • Kempsey Men's Group • Melville High School • MacLeay Vocational College
Justice Health	Ongoing partnerships with: • Aboriginal Health and Medical Research Council • Department of Juvenile Justice • Hepatitis C Council • Department of Corrective Services • Department of Education and Training
Marie Stopes	Formal partnerships with: • VACCHO • Wurli Wurlinjang Health Service, NT • Goldfields Population Health, Kalgoorlie, WA • Tropical Health Population Unit, Qld Informal partnerships with: • Shine South Australia • Tasmanian Aboriginal Centre Inc. • Kimberley Aboriginal Medical Services Council, Kununurra, WA • NACCHO • Aboriginal Health and Medical Research Council • Family Planning Western Australia – Health Promotion Unit • Family Planning Queensland (Sunshine Coast, Toowoomba, Cairns) • Port Lincoln, SA • Marr Mooditj • Danila Dilba Health Service, NT • Mulungu Aboriginal Corporation Medical Centre, Qld • Royal Flying Doctor Service, Western Operations • Family Planning Victoria – SHADE initiative • Melbourne Sexual Health Clinic – Wulumperi Aboriginal and Torres Strait Islander Sexual Health Unit • Northern Territory Government • Northern Territory AIDS and Hepatitis Council

(continued)

Table 3.2 (continued): Summary of demonstration projects' partnerships

Demonstration project	Summary of partnerships
NHS	Partnerships with: • Shire of Ngaanyatjarraku • Shire of Ngaanyatjarraku Youth Development Team • Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council • FPWA (Family Planning Western Australia) • Centre for Sexual Health, Alice Springs • Warburton Youth Arts 'Wilurarra Creative' • Shire of Ngaanyatjarraku Community Development • Ngaanyatjarra Council Youth education extension – hospitality students • Orientation of new NHS staff – remote area nurses • Goldfields Esperance GP network mental health workers • Ngaanyatjarra mining – young leaders training • Australian Society for Indigenous Languages (SIL) • Sexual Health Network WA • Ngaanyatjarra Land and Culture • Sexuality Education Project Manager, Sexual Health and Blood Borne Virus Unit, Department of Health and Families, NT Government • Congress Alukura • Blackstone Women's Centre • Warakurna Women's centre • Warakurna Arts • Warburton School VET training • Quest Apartments Alice Springs • Northern Territory AIDS & Hepatitis Council • Central Australian Aboriginal Congress–Ingereke (Men's Health) • Clinic 34 – Sexual Health Clinic, Northern Territory • Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) • David Brooks – Anthropologist • Warburton Media and Ngaanyatjarra College • Ngaanyatjarra Media • Papulankutja Arts Centre • Ngaanyatjarra school principals of Warburton, Blackstone, Warakurna, Tjukurla, Wanarn, Jameson and Wingellina • Community Development Advisors in Tjirrkarli, Warburton, Wanarn, Warakurna, Jameson, Blackstone, Cosmo, Tjukurla • NPY Women's Council Emotional & Social Wellbeing • Department of Child Protection • STI/BBV programme, Department of Health, WA (for Good Lovin tour) • Warburton Interagency Meeting • Public Health Nurses at the Sexual Health and Blood borne Virus Unit in regional towns, Centre for Disease Control, Alice Springs and Kalgoorlie • Warakurna Interagency Meeting • Youth Health Policy Officer, Sexual Health and Blood Borne Virus Program, Department of Health and Families, Northern Territory Government • Australasian Sexual Health Conference and Ngarra Exhibition (ASHM)

(continued)

Table 3.2 (continued): Summary of demonstration projects' partnerships

Demonstration project	Summary of partnerships
SESDGP	Formal partnerships with: • Sydney Sexual Health Centre • La Perouse Youth Haven • South Eastern Sydney and Illawarra Area Health Service (SESIAHS) – HIV and AIDS Related Programs (HARP) Unit • Aboriginal Health and Medical Research Council of NSW Informal partnerships with: • AIDS Council of NSW • Aboriginal Medical Service • La Perouse Local Aboriginal Land Council • Fact Tree Youth Service Inc. • Guriwal Aboriginal Corporation • St George Youth Services • Shire Wide Youth Services • Albion Street Health Centre • Kirketon Road Health Centre • Waverley Action for Youth Services • Aboriginal Health and Medical Research Council

Box 3.2: Building partnerships

Ngaanyatjarra Health Service – Kungkaku Yangupalaku Healthy Relationships Project

NHS formed more than 50 partnerships throughout the duration of the Kungkaku Yangupalaku Healthy Relationships Project.

Partnerships were formed with a range of organisations, including local government, state government, health services (general, and also specific sexual health or mental health services), Women's councils and centres, community advisors, police services, Ngaanyatjarra Land and Culture, education and training institutions, and many others.

Most of the partnerships were informal and were based on collaboration, support and networking, but a number of formal partnerships were also formed.

The large number of partnerships that were formed fundamentally contributed to the success of the Kungkaku Yangupalaku Healthy Relationships Project. Partner organisations with the same target demographic were particularly beneficial, especially in terms of goal sharing and collaborating for events. For example, the weekly Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women Council Youth workers youth disco was used to introduce the project and sexual health workers to youth in a social setting where genuine relationships could be formed.

Box 3.3: Building on existing local capacity – Aboriginal Youth Health Access Workshop

Justice Health – Improving Sexual Health in Aboriginal and Torres Strait Islander Youth in NSW Juvenile Justice Centres

The Aboriginal Youth Health Access Workshop (AYHAW) was one of two education programs run under the Justice Health demonstration project.

This successful program, run by an Aboriginal health worker, was developed in 2009. It was designed specifically for young Indigenous males and was a finalist in the NSW Aboriginal Health Awards. The program was implemented in two detention centres: Frank Baxter and Orana Juvenile Justice Centres.

The AYHAW presented an opportunity for the Justice Health project to reach its target audience efficiently and effectively through an established and successful program. The Aboriginal Sexual Health Education Officer (ASHEO) for the Justice Health project conducted sexual health education modules as part of the AYHAW.

Nineteen young people completed surveys before and after participating in the program. Survey results showed an increase in understanding of sexual health and BBVs, and participants felt that the program had made them more aware of healthy life choices and safe sex practices for when they were released from custody.

Consultation and engagement

Project design

All organisations undertook consultation as part of designing and implementing the demonstration projects, and engagement of young people occurred as part of this process. The consultation and engagement process for each project is summarised in Table 3.3 and is based on information provided by the individual projects.

Much of the engagement in terms of project design was done before the funding of the demonstration projects and was used to support the original project proposals. For example, NHS developed 'Kungkaku Yangupalaku, stories for young women and young fellas – a look at sexual health for young people in the Ngaanyatjarra Lands and an education plan for the future'. Durri, Marie Stopes and Justice Health also undertook this work before the funding of the demonstration projects to support the project proposals.

NHS developed consultation plans for each of the 12 communities within their project reach. The importance of appropriate community engagement and consultation when undertaking a project was emphasised by the SESDGP in the Aboriginal Youth Safe Summer Survival Project 'Ngarandhi' and Youth Health Clinic, following a breakdown in the relationship with the community due to lack of consultation (see Box 3.4 for further details).

Other demonstration projects appear to have minimised these issues through ongoing consultation with communities from project commencement. Both NHS and Congress undertook extensive and culturally appropriate consultation within their communities. For example, NHS often undertook consultations in small groups that involved going out bush to gather bush tucker, campfires that provided a setting for discussion out of the community, talks during education sessions, a dinner meeting, or on an ad-hoc or opportunistic basis within the community.

Congress undertook a variety of consultation and engagement activities throughout their project including workshops, formal and informal meetings and focus groups. As a result of ongoing consultation, changes were made to how the project was implemented, examples of which included changes in the contents of the Red Boxes, further education sessions on the use of condoms to prevent BBV, liaison services with other health-care providers and the development of protocols for engaging mainstream health services with the project. The most significant change, however, was a redirection of financial support from the supervision and collection of Red Boxes to the provision of a 'post-business' camp to reduce risky behaviour among young men.

Table 3.3: Summary of demonstration projects' consultation and engagement activities

Demonstration project	Summary of consultation and engagement
Congress	Ongoing consultation throughout project. Senior and younger Aboriginal men were consulted at project commencement. Workshops were conducted to develop strategies and consensus on community education. Formal and informal meetings included ongoing meetings to formalise cultural practices. Focus groups and discussions with cultural officers in 19 communities.
Durri	Ongoing consultation with Indigenous males aged 16–25. Other consultation included employment agencies and informal discussion with community members, men's groups and a vocational college.
Justice Health	Indigenous young people consulted on design of project and development and implementation of strategies.
Marie Stopes	Appropriate consultation completed through partnerships.
NHS	Ongoing extensive consultation with all 12 communities.
SESDGP	Consulted with community through a number of existing age- and gender-appropriate committees that were already established (see Box 3.4)

Box 3.4: Building relationships with the community and young people

SESDGP – Aboriginal Youth Safe Summer Survival Project ‘Ngarandhi’ and Youth Health Clinic

The Ngarandhi project was SESDGP’s first attempt at working with the local Indigenous people: the La Perouse community. The initial proposal discussed working with Waverley Action for Youth Services (WAYS) to help SESDGP adapt and implement their peer education program, Safe Summer Survival. However, the partnership did not eventuate and SESDGP implemented the project themselves, with the support of Shire Wide Youth Services.

At some stages of the project, SESDGP appropriately engaged and consulted with the community through a number of age- and gender-appropriate committees. For example, SESDGP consulted with the DIVAS group who were young females aged 16–25 and LaPa Deadly’s community advisory 18–35 years age group. During these consultations, the project name, Ngarandhi, was created by the community and translates in Dharawal language to mean ‘Listen’. There was also an acronym developed – LAPAMOB which stands for ‘learning about protection and making ourselves better’.

Other stages of the Ngarandhi project, however, lacked appropriate community consultation and, as a result, some sections of the community were not supportive of the project in the early stages. For instance, during the project, there were meetings scheduled with the Peer Education Coordinator and community. However, many of these did not occur as planned despite continual assurances by the Peer Education Coordinator that the meetings were happening. As a result, there was a lack of community consultation, particularly for the development of surveys to be used by peer educators to determine whether there was an increase in sexual health knowledge. The initial survey that was developed did not have widespread community support.

During the second year of peer educators, the SESDGP Project Officer and the new Peer Education Coordinator spent a substantial amount of time rebuilding relationships and consulting with the community about appropriate data collection tools. SESDGP noted that there was an increase in the level of interaction, communication and direct contact with community members, which resulted in positive interactions and information exchanges with peer educators.

Project evaluation

Organisations undertook formal consultation within their communities, and evidence as collated from communities was obtained via consultation processes throughout the projects.

In terms of involving young people in project evaluation, projects were required to develop and administer some form of pre- and post-education surveys to recipients of education sessions in order to assess changes in knowledge of sexual health issues. Most projects used written surveys; however, oral feedback was provided in the case of Congress because written surveys were not appropriate.

Workforce

All projects made a contribution to the Aboriginal sexual health workforce by employing Indigenous staff and providing training where required.

Indigenous staff were employed in a variety of roles, including:

- project managers
- project coordinators
- Aboriginal health workers
- sexual health education officers
- peer education coordinators
- peer educators.

Table 3.4 summarises the contribution of the projects to the Aboriginal sexual health workforce.

Recruitment and retention of staff was a significant problem for most projects, with the exception of Congress and Marie Stopes. Initial recruitment of staff was often difficult, and resulted in delays in project commencement. In other cases, staff resigned or were absent for extended periods due to illness, and recruitment to fill these vacated positions was also difficult because of a skills gap, and this affected project implementation.

Table 3.4: Summary of demonstration projects' Indigenous workforce

Demonstration project	Indigenous workforce
Congress	Indigenous project coordinator/cultural mentor (1) Indigenous peer educators/ceremonial workers (28)
Durri	Aboriginal health worker (male) (1)
Justice Health	Aboriginal sexual health education officer (2: one female from Jul 2009–May 2010 and one male from Aug 2010 onwards)
Marie Stopes	Indigenous project manager (1) Indigenous project coordinator (1)
NHS ^(a)	Indigenous peer educators (27)
SESDGP	Aboriginal Health Program Officer (1) Indigenous peer education coordinator (1) Indigenous youth peer educators (15, comprised of six in year 1 and nine in year 2)

(a) NHS also employed two youth health educators (1 male and 1 female) who were non-Indigenous (an Indigenous youth health educator was employed at the commencement of the project but had to leave due to ill health). Both had been living and working in the community for over 12 months at the conclusion of the project funding.

Discussion

Objective 1: Build on existing local capacity and health service relationships to create sustainable new health service models

The formation of governance arrangements and partnerships contributed to projects' achieving this objective.

All projects established formal governance arrangements to guide the implementation of projects. Three projects provided further details on membership of these groups (Congress, Justice Health and Marie Stopes). It was evident from these three projects that existing local

capacity and health service relationships were used and built upon to create models for delivery of sexual health programs to young Aboriginal people in their respective settings.

All projects were successful in developing partnerships that used existing networks and resources, and built on services already operating in the community. Most projects established a mix of both formal and informal partnerships with a range of services, agencies or organisations, including local and state government, health services/organisations and youth services. Little information was provided explicitly by projects in relation to the success or otherwise of the partnerships; however, NHS stated that the large number of partnerships formed was integral to the success of their project, and that partnerships with organisations with the same target demographic were useful to reach young people effectively.

Objective 2: Develop innovative approaches to engaging young people including involving young people in project design, delivery and evaluation

All organisations undertook consultation as part of designing and implementing demonstration projects, and consultation with young people occurred as part of this process. However, few details were provided by projects in relation to how young people were engaged and the type of involvement that they had via this process. Much of the engagement in terms of project design was done before the implementation of the demonstration projects and was used to support the original project proposals; for example, NHS developed 'Kungkaku Yangupalaku, stories for young women and young fellas – a look at sexual health for young people in the Ngaanyatjarra Lands and an education plan for the future'. Durri, Marie Stopes and Justice Health also undertook this work before the funding of the demonstration projects to support the project proposals.

In terms of evaluation, projects were required to obtain feedback from recipients of education sessions using pre- and post-education surveys (oral feedback was provided by Congress). Further information on the methods used for this evaluation is included under 'Section 3.2 Risk reduction: education and resources' in relation to community education, where this objective is considered further and particularly in relation to engagement of young people in project delivery.

Objective 6: Make a contribution to the Aboriginal and Torres Strait Islander sexual health workforce

All projects made a contribution to the Aboriginal sexual health workforce by employing Indigenous staff and providing training where required. However, difficulties with recruitment and retention experienced by most of the demonstration projects suggest that there is a need for further training and support for the Aboriginal sexual health workforce to increase the available pool of people with the required skills.

3.2 Risk reduction: education and resources

Strategies related to education and resources have been considered in relation to the following project activities:

- community education
- resources
- engagement.

The contributions of the projects to each of these areas are discussed, and the success of projects is considered and related back to program objectives 2 and 4.

Objectives:

2. Develop innovative approaches to engaging young people including involving young people in project design, delivery and evaluation.
4. Reduce risk-taking behaviour in Aboriginal and Torres Strait Islander youth.

Community education

Projects conducted a range of education activities designed to educate young people about sexual health, in particular STIs and BBVs, with the goal of reducing risk-taking behaviour. Education activities were generally either education sessions (one-off sessions or a course), or were delivered in conjunction with other projects or events targeted at youth. The education activities provided by the projects are summarised in Table 3.5.

Table 3.5: Summary of demonstration projects' community education activities

Demonstration project	Summary of education activities
Congress	Community education sessions The cultural mentor developed an educational session plan involving 10 one-hour sessions delivered in an informal setting over a number of days and covering a number of topics. The sessions engaged a range of age groups from young males aged 15–18, to senior old men. The sessions were provided in a number of areas and language groups, often in more than one reporting round, by the peer educators. Attendance numbers were not recorded. There is evidence to support that health education sessions had an impact on the health seeking behaviour among Indigenous males. 'Stop the violence' program The 'stop the violence' program initiated by Ingkintja (male-only health clinic) was a week-long summit and attracted over 200 participants from around central Australia. Ingkintja's services were promoted during this event, which included STI testing, especially for young males.
Durri	Community education courses/sessions Twelve community education courses were delivered by the aboriginal health worker using a range of culturally appropriate education resources. Courses ran 1 day/week for 8 weeks, and covered sexual health, alcohol and other drugs, and included other areas such as nutrition. Young male participants were recruited by the health worker at sporting events and from walk-ins to the clinic. The sessions also included health checks, STI screening and condom distribution. The health worker also delivered a further eight education sessions (First Contact was one of these sessions).

(continued)

Table 3.5 (continued): Summary of demonstration projects' community education activities

Demonstration project	Summary of education activities
Justice Health	Education sessions A health promotion education program was implemented by nursing staff for all young people in custody. The program combined education modules, workshop and teaching packages to build knowledge and confidence around healthy living, parenting and specific prevention strategies for BBVs and STIs. The Aboriginal sexual health education officer (ASHEO) conducted the sessions on sexual health education, in addition to other modules. During the last three reporting rounds, there were 119 sexual health workshops provided to 1,574 juveniles, of whom 996 identified as being Aboriginal or Torres Strait Islander. Aboriginal Youth Health Access Workshop (see also Box 3.3) Independent to the Justice Health project, the 'Aboriginal Youth Health Access Workshop' program (AYHAW) was implemented at two juvenile justice centres. This program was specially designed for Indigenous males and implemented by an Aboriginal health worker. The ASHEO for the Justice Health project provided the sexual health education module, including sessions on STIs, BBVs, education and prevention, the effects of drugs and alcohol on sexual health, positive body image, parenting and responsible sexual choices. Other education activities A range of other education activities were organised or facilitated by the ASHEO: • Aboriginal Theatre Company play 'Chopped Liver', performed at Orana Juvenile Justice Centre • HIV-positive speaker workshops held at Orana Juvenile Justice Centre during AIDS Awareness Week • Aboriginal Health and Medical Research Council's 'Deadly Shots' program, focusing on hepatitis C • 'Contraception Choices' workshops held at Riverina Juvenile Justice Centre for young fathers in custody • The ASHEO was trained as a facilitator and presenter on the Juvenile Justice 'Love Bites' program: a harm minimisation program on risky behaviours, including STI and BBV issues.
Marie Stopes	SNAKE Toolkit A total of 279 Toolkits were distributed to communities throughout Australia, with the number consistently increasing with each reporting round. As part of the Toolkits, MSA provided training activities and SNAKE fests. <i>Training activities</i> MSA were invited to hold training activities in six states and territories during the SNAKE project. A total of 528 Aboriginal health workers and general health service/organisation staff members participated. Topics covered included education and demonstration sessions on SNAKE as a promotional tool, STI definitions, STI testing and treatments, condom use, intimacy, 'telling it like it is' DVD (teenage parenthood) and myths and facts about HIV. <i>SNAKE fests</i> Two SNAKE fests were held in the Northern Territory and one in Tasmania. SNAKE fests were held by communities using the SNAKE Toolkit provided by MSA, and included education sessions, dance, music and high profile guests. Although targeted at young people, the SNAKE fests were commonly attended by the broader community, which assisted in achieving a wider acceptance of the SNAKE brand. SNAKE website The SNAKE website was another education activity, which provided young people with access to accurate sexual health information in a culturally appropriate manner. SNAKE Forum: Young Aboriginal and Torres Strait Islander Women's Sexual and Reproductive Health and Rights MSA hosted Australia's first Indigenous women's sexual health forum, which was run over 3 days and attended by 32 women aged 18–28 from communities across the country. The forum aimed to build skills and knowledge around the areas of sexual and reproductive health and rights in an Indigenous context to promote positive changes in health in communities.

(continued)

Table 3.5 (continued): Summary of demonstration projects' community education activities

Demonstration project	Summary of education activities
NHS	Community education sessions Over the course of the project, 320 education modules were delivered to approximately 2,702 participants. Education modules were delivered in camps, day bush trips, workshops within the community and schools. The education modules included modules based on the FFWA Mooditj program, which is an education program aimed at educating Aboriginal young people aged 11–14 in sexual health and life skills. Some modules were modified to better reflect the age group and community needs and other resources were used. Other modules were developed for specific events, such as the annual STI screen where 14–25 year olds were targeted with gender-specific education on STIs and BBVs and their prevention, testing and treatment. Topics included identity, puberty, sexual health issues, feelings and emotions, relationships and life skills, and goal setting. Gender-specific education was also provided. Sessions were frequently delivered in schools and a large Kurrurnpa Rapa Nyinarnatjaku Walu camp was held for 11–14 year olds. Gender-specific education was also provided for reproductive health modules and for young people aged over 14. Specific training and education activities were also developed for men and women, sometimes in camps, and also for those who worked as peer support for delivering the education modules.
SESDGP	Peer educators There were 2 years of peer educators. A range of training activities were provided to peer educators, including sexual health education, alcohol and other drugs, gender diversity and sexuality and outreach work (approach and safety). The peer educators discussed sexual health with young people opportunistically and when requested via outreach activities. They also distributed information resources and answered questions. <i>Year 1 peer educators</i> The first year of peer educators were engaged and trained during October–31 December 2008 for delivery of education and outreach activities during the summer of 2008–2009. <i>Year 2 peer educators</i> The second year of peer educators were engaged and trained during 1 July–31 December 2009 for delivery of education and outreach activities during the summer of 2009–2010.

Impact of education activities

It is difficult to assess the impact that education activities had on young peoples' sexual health knowledge and behaviours. Information required to assess the impact of the education sessions on sexual health knowledge and behaviour, and trends in STIs and BBVs among the communities was mixed.

Projects were required to develop and administer pre- and post-education surveys to young people to assess the immediate effects of the education activities on sexual health knowledge (with the exception of Congress). The surveys were developed and implemented with varying levels of success among the projects. Information from surveys and other information collected is used here to assess the short-term impact of education activities.

From the information available, it appears that the projects were at least somewhat successful in increasing knowledge of sexual health issues, including STIs and BBVs, via education activities. It is difficult to assess the extent of success due to the difficulties faced by services in collecting information. Some services found this challenging because surveys were considered contextually inappropriate due to cultural differences and English not being the first language. As a result, some services developed alternative methods to assess knowledge during the project.

Congress

A survey was not suitable for use in the Congress project because English was a third or fourth language in many cases, which proved problematic when using forms to gather information. Oral feedback in the form of semi-structured qualitative interviews was found

to be a more appropriate form of assessment of behaviour change for cultures that have a history of story-telling to pass on information.

Congress provided anecdotal evidence that the education sessions increased health-seeking behaviour among young Aboriginal men in the short term, implying that their awareness of sexual health issues had increased.

Durri

Surveys were conducted by Durri at education sessions; however, the development and implementation of the surveys was a challenge, and results from the surveys were not available for this evaluation. General information provided suggests that the education sessions were successful in increasing knowledge. But, despite an increased awareness of STIs, the AHW had identified that there are still gaps in knowledge among young males, as well as stigma and embarrassment about STIs. It was stated that there is a need for ongoing sexual health education in this population.

NHS

NHS also found that conducting surveys to assess changes in knowledge was a major challenge for the youth health educators (YHEs). The use of Keepads (an interactive electronic tool with audio and video capacity allowing surveys and responses to be conducted and graphed instantly) seemed an appropriate resource because they allowed responses to be depersonalised and the technology was engaging for young people, and allowed surveys to be conducted in small groups. To some extent, the Keepads were an acceptable method of collecting survey data. However, there were some technical and process issues in terms of language, understanding of concepts, groups doing evaluations at the same time, young people copying each other's responses and having staff trained in using the technology. Box 3.5 provides more details on the initial difficulties that NHS encountered in conducting surveys, and ways in which they were overcome. As a result of these difficulties, other evaluation techniques were used, such as observational evaluation, case stories, feedback during and after modules with photo prompts, questionnaires using Keepads and question boxes.

Despite the problems with implementing surveys, information suggested that the education sessions were one of the most successful activities undertaken throughout the NHS project. No evidence from surveys was provided to support an increase in knowledge of sexual health, STIs or BBVs, but some case studies were provided that indicated increased knowledge. Given the duration of the project, it was not possible to determine if the education sessions had an impact on reducing risk-taking behaviour, but the project aimed to provide skills to achieve this long-term goal. Both YHEs did, however, note aspects of the education sessions that could be improved. These included:

- asking inappropriate direct questions reduced responses from participants and was considered 'shameful'. However, when asking the same question in an indirect manner, the response was greater.
- although the YHEs were facilitators and educators, sometimes the sessions went too far off track.
- discussing behaviour standards before a session starts so that all participants knew what was expected.

Justice Health

Pre- and post-education surveys were successfully conducted for the Justice Health project by the ASHEO. The 19 young people that participated showed an increase in understanding of sexual health and BBVs. When asked what was the most interesting or informative thing they learnt, respondents mentioned drugs and the role they play in sexual health, an increased knowledge of STIs and an increase in safe sex knowledge. When asked how the education sessions helped them prepare for life once released from custody, young people mentioned being more aware of healthy life choices and safe sex practices. All the Indigenous youths said they would recommend the program to other young people.

Marie Stopes

The SNAKE website had a consistent increase in the number of unique visitors for each reporting round. The most visited pages were 'Types of STIs', 'A-Z of sexual health' and 'Types of contraception', indicating that people were increasing their knowledge of sexual health issues. However, it is not possible to tell the Indigenous status or age range of those accessing the website. It is therefore not possible to tell whether the website was successful in increasing the knowledge of Indigenous young people in relation to sexual health issues.

The Indigenous women's sexual health forum, run by MSA, was highly successful, and pre- and post-education surveys indicated knowledge of sexual health and rights had dramatically improved.

Pre- and post-education surveys were given at SNAKE fest education sessions, but data on these surveys was not provided to the AIHW.

SESDGP

SESDGP developed a pre- and post-survey, the 'Outreach Survey', for peer educators to give to young people at the outreach activities. Some sections of the community considered aspects of the survey to be too intrusive, and as a result the survey was amended accordingly (see Box 3.4 for further details). Although the survey was redesigned, peer educators reported the survey to be a deterrent to providing information on sexual health and were therefore reluctant to use it.

Information from the first year of surveys could not be used due to the criticism from community members. However, data from the second year surveys, 'just for fun' were analysed. Results from the 53 returned surveys showed increases in correct answers for all questions. For some questions, participants already had a good understanding of the topic and therefore there was a not a large percentage point increase. For other questions, there were large changes in understanding and knowledge of sexual health after an education session. This included an increase in knowledge of how a diagnosis for chlamydia was assessed and that chlamydia was the most common STI among young people living in their area.

Box 3.5: Difficulties in administering surveys

Ngaanyatjarra Health Service – Kungkaku Yangupalaku Healthy Relationships Project

Collecting pre- and post-surveys during education sessions was difficult to accomplish at first, because it required adequate English literacy skills, contextual and social relevance, attention and engagement from young people. The YHEs attempted pre-education session surveys through the use of Keepads with little success, and commented that the young people became restless and disinterested especially when questions were asked directly.

As a result a 'Post Box' for questions after education sessions was implemented and found to be useful, with some questions reflecting an extension of what had been taught in the session. A small verbal questionnaire was trialled during the STI screen to determine STI testing knowledge, with 29 men completing the questionnaire. However, most answered yes to the first option, and when the answers were reversed still answered yes when the answer should have been no, demonstrating leading question bias.

Also, Yarnangu will politely say yes to most questions because they may not have the literacy levels or comprehension to give a valued answer. This added another layer of difficulty in using surveys. Therefore other approaches were required.

Resources

Several resources were developed specifically for the demonstration projects, and existing resources were also used where appropriate and adapted as necessary. Resources were generally either promotional or educational, and are summarised in Table 3.6.

Projects provided few additional details about the resources developed and/or used. Information on the usefulness or effectiveness of resources was either not collected by projects or was not provided to the AIHW. It is likely that the resources made a contribution to promoting the projects and communicating sexual health messages. The educational resources, in conjunction with the education activities, are likely to have contributed to raising awareness of sexual health issues. However, any effects of the resources on risk-taking behaviour in Aboriginal and Torres Strait Islander young people are unknown from the available information.

Table 3.6: Resources developed or used by demonstration projects

Demonstration project	Promotional resources	Educational resources
Congress	'Condoman' bumper stickers, drink bottles and caps	Flip chart resources developed by the men's sexual health educator at Anyinginyi (Tennant Creek). A modified flip chart was developed for ceremonial season for STI and BBV information Additional education resources supplied by Clinic 34 Red boxes
Durri	'Hey Bruz' condom packaging Condoms, dams and lubricant packs Condom dispensers Condom magnets for the AHW's vehicle as a promotion tool Condom health tins 'Use condoms and enjoy your freedom' sexual health campaign promotional materials	Poster from NSW Health and pamphlets on condom use which originated from NSW Health and Redfern Aboriginal Medical Service
Justice Health	—	A DVD was identified as being a valuable educational resource, but was not developed as part of this project
Marie Stopes	SNAKE condoms and lubricants (sachets), posters, postcards, T-shirts and hats SNAKE Yarns newsletters	SNAKE Toolkits—CD-ROM for training peer educators, and event management guide and resources for a SNAKE fest launch SNAKE website Educational brochures
NHS	Logo T-shirts and posters for Mooditj program and Kurrurnpa Rapa Nyinarnatjaku Walu camp Designed condom boxes with condoms Youth health educator project T-shirts and peer worker T-shirts Radio advertising for annual STI screen Poster for STI screen including competition Kurrurnpa Rapa Nyinarnatjaku Walu article in 'Never Give Up News' Flyers for Kungka's day workshops Project newsletter Poster for condom artwork competition Email promotion for annual STI screen on all outgoing emails Safe sex posters (paintings developed during annual STI screen) Positive self-esteem messages on lanyards Healthy relationships posters developed at creative health conference Warakurna men videos, songs and photos Healthy statement graffiti board Youth friendly clinic poster	DVD on what happens during STI screening/consultation DVD for staff on how to do a consultation Kurrurnpa Rapa Nyinarnatjaku Walu flip chart Kurrurnpa Rapa Nyinarnatjaku Walu DVD 'Who are you mob' play
SESDGP	Logo and artwork for project T-shirts for peer educators	Peer Educator's Handbook (developed with assistance from HARP unit, Shire Wide and St George Youth Services) 'Ngarandhi News'—a sexual health information resource 'Just for fun' quiz

Engagement

Project delivery

Four projects – Durri, Marie Stopes, NHS and SEDGP – described using innovative methods to engage young people in project delivery (engagement in project design and evaluation has been considered under ‘Section 3.1 Governance and management’). These approaches are described here.

Durri

The flexibility and adaptable approach of the AHW during the project was considered a key factor in the project’s success. Ideas and strategies were reassessed regularly throughout the project, with many activities implemented on a trial-and-error basis, and learning from these experiences.

An example of this was the tours of the Durri ACMS clinic for young Indigenous males that were planned as part of the original project proposal. It became evident that many young men did not feel comfortable being seen in the clinic. The AHW therefore took sexual health services to places where young men felt more comfortable, such as the local football club, which resulted in an uptake in screening.

To reach the target audience for education sessions, the AHW engaged Indigenous males at various locations including sporting events and World AIDS Day Australia 2010. In particular, the First Contact program was run in 2009 at a football carnival. The program was designed to provide sexual health education sessions at the end of each sporting day. This program was successful and the AHW was invited to return the following year (but was unable to attend).

In addition to selecting locations where young people felt comfortable, the AHW also implemented a reward system to encourage youth attendance at education sessions. Initially, rewards for attendance were given at the start of the sessions; however, this did not provide an incentive to stay for the duration of the session and many left shortly after. When the AHW decided to give the rewards for completing the sessions, retention of young people for the education sessions improved.

The project also tried text messaging for recall of clients to the clinic if they received an STI notification; however, this proved to be inappropriate for this population. Many young people swapped phones, which resulted in confidentiality concerns. It was considered by staff at Durri ACMS that text messaging may have been better used for health promotion messages.

These examples demonstrate that the AHW was successful in adapting the delivery of the sexual health screening and education sessions to improve engagement with young Indigenous males using innovative approaches.

Marie Stopes

Marie Stopes stated that Indigenous young people were engaged at a number of events throughout the duration of the SNAKE project; however, no further details were provided.

In the early stages of the project, Marie Stopes held a competition on the SNAKE website for Indigenous youth to redesign the campaign slogans, with the winners receiving prizes and winning designs featured on new posters. Although this may have raised awareness of the

SNAKE campaign among some youth, it is not known whether this was successful in engaging young people in the project.

Marie Stopes also recruited and provided training to youth to become peer educators (SNAKE charmers) to educate youth on sexual health issues and provide them with resources; however, peer educators proved difficult to recruit due to lack of incentives.

NHS

NHS developed a model for the Kungkaku Yangupalaku Healthy Relationships Project that established innovative ways of engaging with the whole community in order to run a successful program for young people. Extensive consultation was carried out to determine the most culturally appropriate education and training activities to maximise engagement. This involved a process of talking with Elders first and being directed by them as to whom to have discussions with and involve further. As a result, the project delivered gender-specific education/ training as well as a bush camp to both young people and adults and education sessions adapted from the FPWA Mooditj program. NHS also engaged many other agencies working with young people to facilitate success of this camp. A key feature of the Kurrurnpa Rapa Nyinarnatjaku Walu camp was that the camp took place on country that facilitated cultural exchange in a true two way process.

In addition to incorporating education sessions, the bush camp also included free time, sport, music and a disco to maintain a fun environment. The camp was attended by male and female youths and adults. The bush camp was highly successful and well received by young people, their families and communities, according to post-camp feedback. YHEs conducted evaluation using photo prompts in small groups and young people were able to recall what they learnt at the sessions.

A men's education/ training camp was also held. For young women, a painting task was undertaken to express the way they view their environment and community and its resources, and provided YHEs with an insight into young people's ideas. The painting was intended to help identify spaces and activities for education, condom dispensers and distribution places for condoms. Mapping activities were used to engage youth in expressing the way they viewed their environment and community and its resources, community spaces, and to identify sites for condom dispensers.

Education sessions were provided in a culturally appropriate way and incorporated arts, plays and music, and a space to facilitate discussions in order to engage young people. Consultation with community members and continual revision of education plans facilitated ownership and leadership among those who participated in the sessions. This consultation and flexibility in the delivery of the project resulted in successful engagement of youth.

Other strategies used to engage young people and communities included: movie nights, swimming, interactive Keepad surveys, hairdressing, bush day trips, football trips, barbeques, MP3 player competitions, bands/ music and school workshops.

SESDGP

Like Marie Stopes, SESDGP also recruited and trained young people as peer educators to conduct outreach activities to their peers. The peer educators engaged Aboriginal people aged 16–26, and supervised activities that promoted healthy lifestyles, increased sexual health education, strengthened relationships, and built the self-esteem and cultural pride of young people to develop community capacity.

The program proved beneficial to the peer educators, with all second year peer educators successfully gaining more permanent employment or traineeships following their involvement in the project. However, it is difficult to gauge the success of the program in engaging young people for the project.

It was found that employing peer educators who were not part of the community resulted in better engagement with the La Perouse youths; however, the use of surveys was found to be a deterrent to youth engagement. Peer educators reported greater success in engaging with community members for outreach and provision of sexual health information and resources without requesting a survey to be completed.

Discussion

Objective 2: Develop innovative approaches to engaging young people including involving young people in project design, delivery and evaluation

Four projects – Durri, Marie Stopes, NHS and SESDGP – implemented innovative approaches to engaging young people in project delivery.

The most innovative and successful methods of engaging young people tended to develop as a result of flexibility and adaptability in project implementation and delivery, and a responsiveness to the needs of the target group and wider community. Both Durri and NHS achieved this.

Durri was flexible and adapted the project delivery by taking sexual health education and services to youth-friendly spaces, rather than expecting youth to attend the clinic where many young men felt uncomfortable. The project also implemented incentives to encourage engagement in education sessions. These appear to have been successful in increasing the engagement of young people with the project.

NHS found that engaging with the whole community, starting with Elders, was beneficial in order to engage youths in a culturally appropriate and acceptable way, which also ensured support for the project in communities. The project engaged young people through a range of age-appropriate activities. NHS also undertook ongoing consultation and subsequent revision of project plans, also demonstrating flexibility and adaptability.

Both Marie Stopes and SESDGP implemented peer education programs to increase engagement with young people; however, neither of these programs appear to have been particularly successful. Marie Stopes experienced difficulties in recruiting peer educators, and SESDGP experienced issues with confidentiality due to the close-knit community of La Perouse and the invasiveness of the original survey administered to youth. It was found that employing peer educators who were not part of the community resulted in better engagement with youth; however, the use of surveys (even the revised survey) was found to be a deterrent to youth engagement.

Objective 4: Reduce risk-taking behaviour in Aboriginal and Torres Strait Islander youth

It is difficult to assess the impact of the education activities and resources in reducing risk-taking behaviour in Aboriginal and Torres Strait Islander youth. Only limited information was collected on the impact of education sessions through some post-education session surveys or anecdotal feedback.

Information on the usefulness or effectiveness of resources was either not collected by projects or was not provided to the AIHW. It is likely that the promotional resources made

some contribution to promoting the projects and communicating sexual health messages. The educational resources, in conjunction with the education activities, are likely to have contributed to raising awareness of sexual health issues.

From the information available, it appears that the projects were at least somewhat successful in increasing knowledge of sexual health issues, including STIs and BBVs, via education activities (to which the use of resources likely contributed). However, whether this increase in sexual health knowledge translated into behaviour change in the form of reduced risk-taking behaviour in the short and/or long term is not known from the available information.

3.3 Service delivery

Service delivery strategies have been considered in relation to the following project activities:

- client encounters with health services
- STI and BBV testing, notifications and treatment
- condom distribution.

The contributions of the projects to each of these areas are discussed, and the success of projects is considered and related back to program objectives 3, 4 and 5.

Objectives:

3. Increase the number of young people accessing services for testing and treatment of sexually transmissible infections and blood borne viruses.
4. Reduce risk-taking behaviour in Aboriginal and Torres Strait Islander youth.
5. Make a contribution and be consistent with the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy and Implementation Plan.

Each of the demonstration projects provided the delivery of various sexual health services to some extent. Table 3.7 summarises the services delivered by each project.

This section examines the number of young people accessing testing and treatment for STIs and BBVs. It is difficult to determine whether the projects increased the number of young people accessing services for testing and treatment of STIs and BBVs or reduced risk-taking behaviour. Baseline data for the target populations was not able to be established by the evaluation, in part due to the nature of some projects.

It is important to note that it is not appropriate to compare data across the projects, because the scope and reach of the projects varied considerably (see Table 2.1). Sexual health services were also impacted by many factors such as recruitment and retention of staff.

Table 3.7: Summary of sexual health services provided by demonstration projects

Service	Congress	Durri	Justice Health	Marie Stopes	NHS	SESDGP
Health services (including sexual health) ^(a)	✓	✓	✓	✗	✓	✓
STI and BBV testing	✓	✓	✓	✗	✓	✓ ^(b)
STI and BBV treatment	✓	✓	✓	✗	✓	✓ ^(b)
Condom distribution	✓	✓	✗	✓	✓	✓

(a) Client encounters may have been for any reason and not necessarily sexual health-related.

(b) No clients required BBV testing or treatment; however, this service was available.

Client encounters with health services

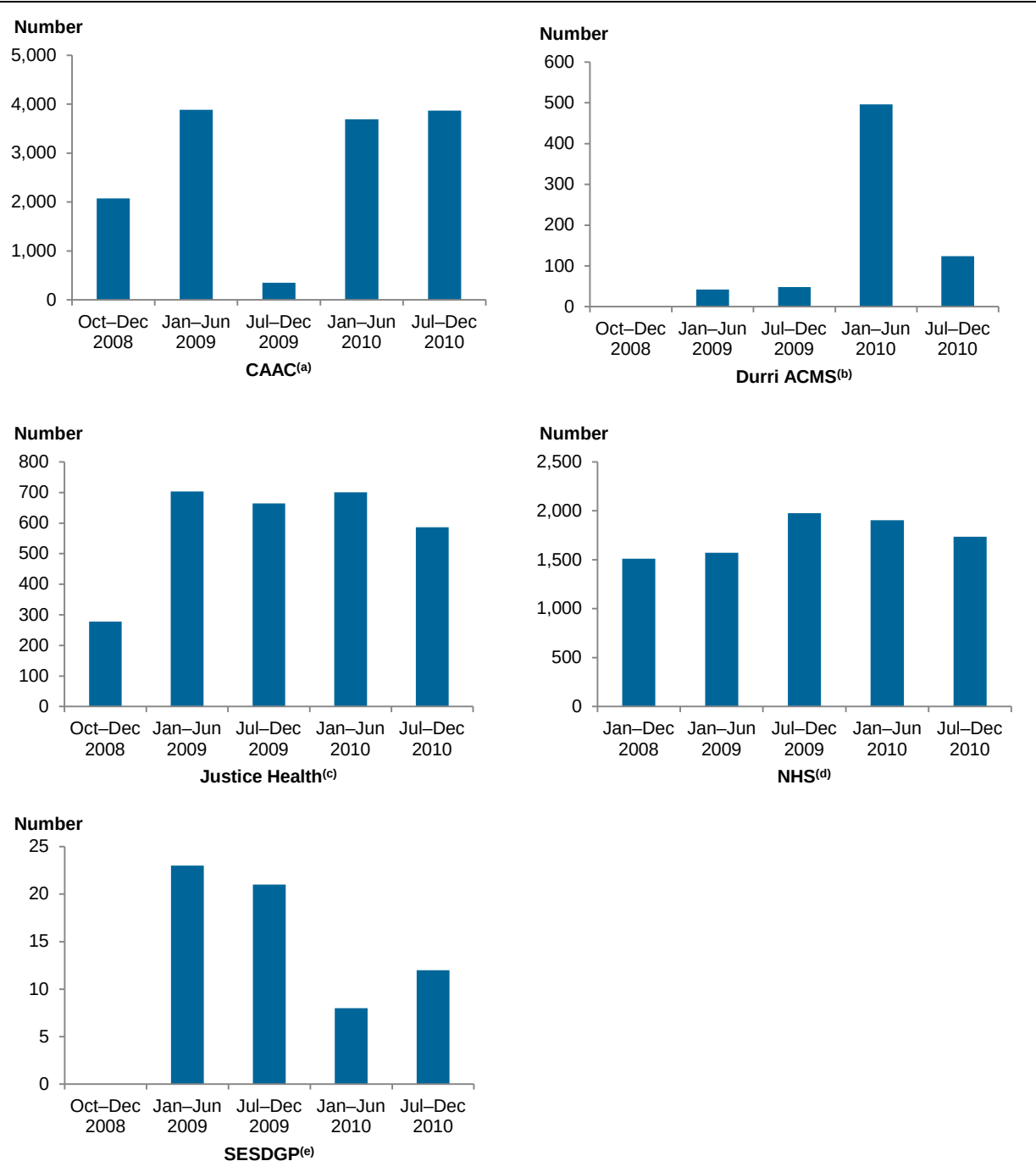
All projects, with the exception of Marie Stopes, offered some form of health service either specifically for sexual health issues or for any reason. Figure 3.1 shows the number of client encounters (or health assessments in the case of Justice Health) for each service in each reporting period. It is important to note that the data relate to the number of client encounters and not the number of clients (i.e. one client may have multiple client encounters), and also that the vertical axis scale varies between figures for different projects.

There was considerable fluctuation in the number of client encounters across reporting periods, with the exception of Justice Health and NHS. The impact of external factors, such as project staffing levels, on the number of client encounters may explain some of the patterns. For example, particularly high rainfall during the wet season significantly affected the ability of clients to visit the Congress clinic in reporting round 3.

In the absence of baseline or follow-up data, it is difficult to determine whether the projects were successful in increasing the numbers of young people accessing health services for sexual health issues. There are also a number of limitations to the data in terms of availability and quality, which make it difficult to assess whether any real increase in young people accessing health services occurred. For example:

- The client encounters recorded by Congress and NHS were not specifically for sexual health issues, but were for any health-related care.
- Justice Health data refers to health assessments performed for all juveniles in detention.
- Data for Congress and Durri were provided for all ages and not specifically for young people.
- Data for SEDGDP are only for the Maroubra and SSHC and the La Perouse clinic, whereas youth may have attended any other clinic.

The information collected and provided by projects therefore varies considerably, and data across projects cannot be compared.



- (a) CAAC: number of Indigenous male client encounters of all ages who accessed CAAC male health clinic for any reason.
 (b) Durri ACMS: number of Indigenous male client encounters of all ages who accessed Durri ACMS for sexual health issues.
 (c) Justice Health: number of Indigenous and non-Indigenous health assessments for 10–24 year olds conducted by NSW Justice Health.
 (d) NHS: number of Indigenous client encounters for all ages who accessed NHS for any reason.
 (e) SESDGP: number of Indigenous and non-Indigenous client encounters of all ages who accessed SESDGP clinics for sexual health issues.

Notes

1. Reporting round 1 (Oct–Dec 2008) covered a shorter period of time than reporting rounds 2–5, with the exception of NHS.
2. Vertical axis scales differ across individual figures.
3. Number of client encounters rather than number of clients (one client may have multiple encounters).
4. Marie Stopes did not have a health services component.

Figure 3.1: Clients accessing health services for each demonstration project, 1 October–31 December 2008 to 1 July–31 December 2010

Sexually transmitted infections and blood borne virus testing, notifications and treatment

Sexually transmitted infections and blood borne virus testing

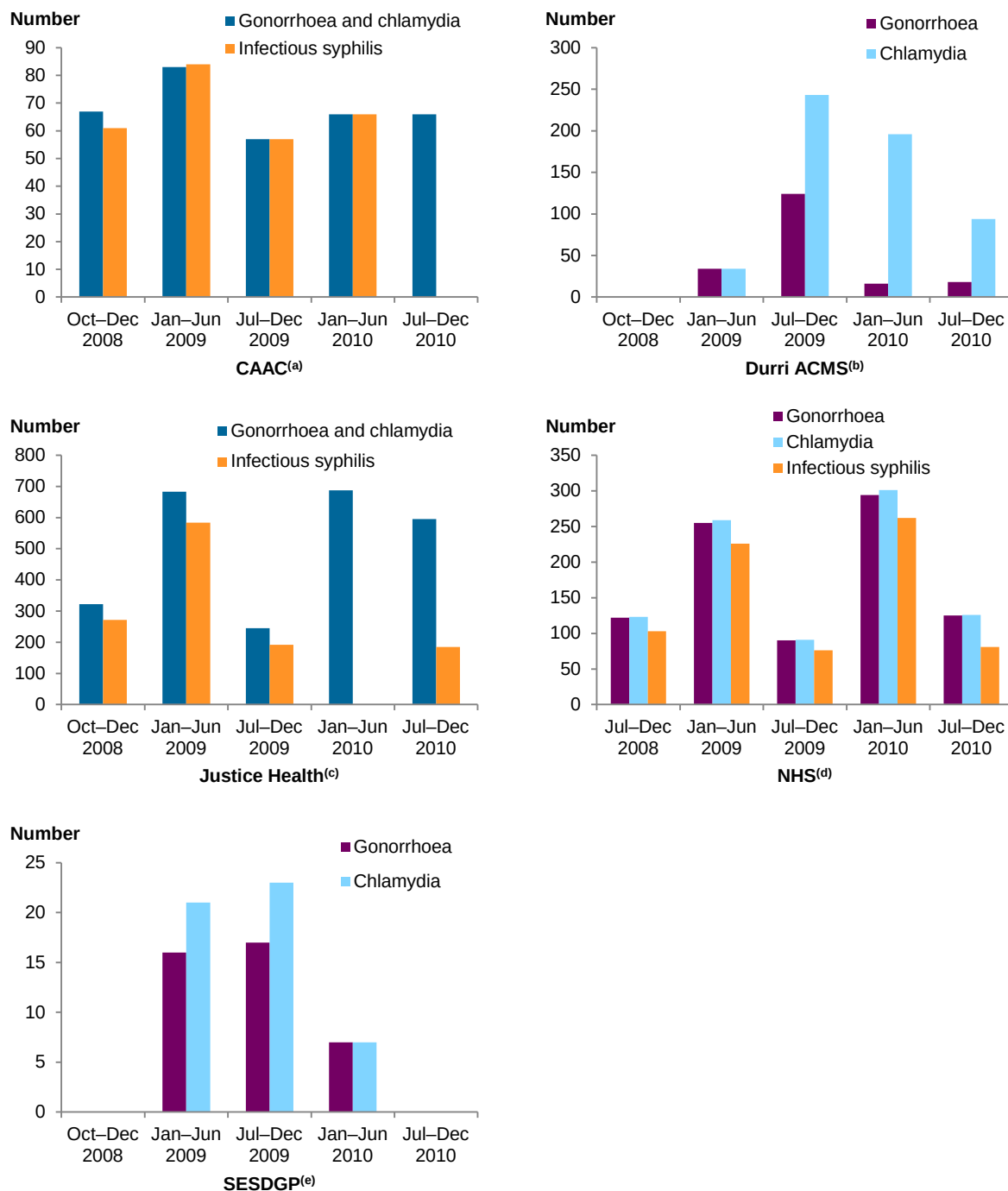
All projects, with the exception of Marie Stopes, had an STI and BBV testing component. STI testing was offered for gonorrhoea, chlamydia and infectious syphilis. Although NHS provided data on STI and BBV testing, it was undertaken at the clinics and through the Sexual Health Programme and was not the responsibility of the youth health educators. Testing for infectious syphilis was not taken up by clients in SESDGP (reflecting local low prevalence and incidence in this region) and Durri ACMS had data quality issues, so data has not been reported for these projects. BBV testing was undertaken for HIV/ AIDS, hepatitis B and hepatitis C, with the exception of Congress, which tested for HIV/ AIDS and hepatitis B only. Figures 3.2 and 3.3 provide the number of clients who had an STI and BBV test administered throughout the projects, respectively.

The number of STI and BBV tests fluctuated across reporting rounds. During the reporting periods, there appeared to be some increase in the number of tests performed by several projects; however, these patterns were not consistent throughout all reporting periods and differed for STI and BBV tests. Factors noted by projects as influencing the number of STI and BBV tests included:

- project and clinic staffing levels; for example, staff recruitment and retention, the experience levels of staff and the presence of same gender staff at clinics (i.e. male staff at clinic for males)
- an annual STI screen in the January to July reporting periods (NHS and Congress)
- the summer season (affecting access to clinics in remote areas) (Congress)
- operation of clinics offering testing (Durri and SESDGP).

In the absence of baseline or follow-up data on the number of tests before and after the projects, it is not possible to determine with any certainty whether the projects were successful in increasing access to STI and BBV testing among young people. There are also a number of limitations to the data in terms of availability and quality, which varied across reporting rounds for a number of projects. This makes it difficult to assess whether any real increase in young people's access to testing occurred.

The information collected and provided by projects therefore varies considerably, and data across projects cannot be compared.

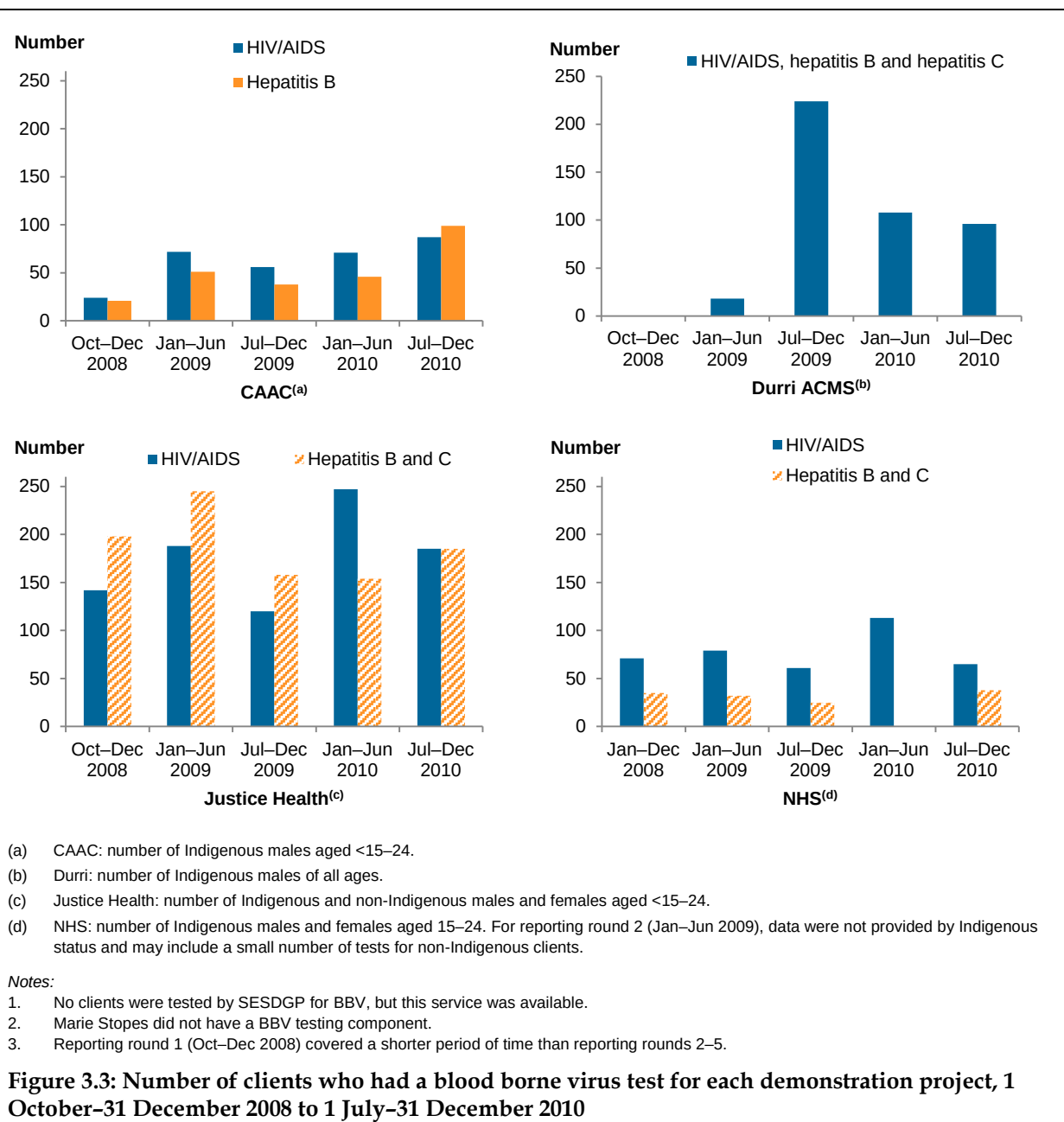


- (a) CAAC: number of Indigenous males aged <15–24.
 (b) Durri: number of Indigenous males of all ages.
 (c) Justice Health: number of Indigenous and non-Indigenous males and females aged <15–24.
 (d) NHS: number of Indigenous males and females aged 15–24.
 (e) SESDGP: number of Indigenous and non-Indigenous males and females aged 15–24.

Notes

1. Reporting round 1 (Oct–Dec 2008) covered a shorter period of time than reporting rounds 2–5, with the exception of NHS.
2. Vertical axis scales differ across individual figures.
3. Marie Stopes did not have an STI testing component.

Figure 3.2: Number of clients who had a sexually transmitted infection test for each demonstration project, 1 October–31 December 2008 to 1 July–31 December 2010



Sexually transmitted infections and blood borne virus notifications

Three of the five projects with STI and BBV testing components provided data on STI notifications. Data are not presented for BBV notifications because projects either did not report notifications due to data quality issues, the number of notifications was too small to report, or in the case of SESDGP, no BBV testing was carried out and therefore notification data was not available. Figure 3.4 therefore shows the number of STI notifications reported for Congress, Durri and Justice Health only.

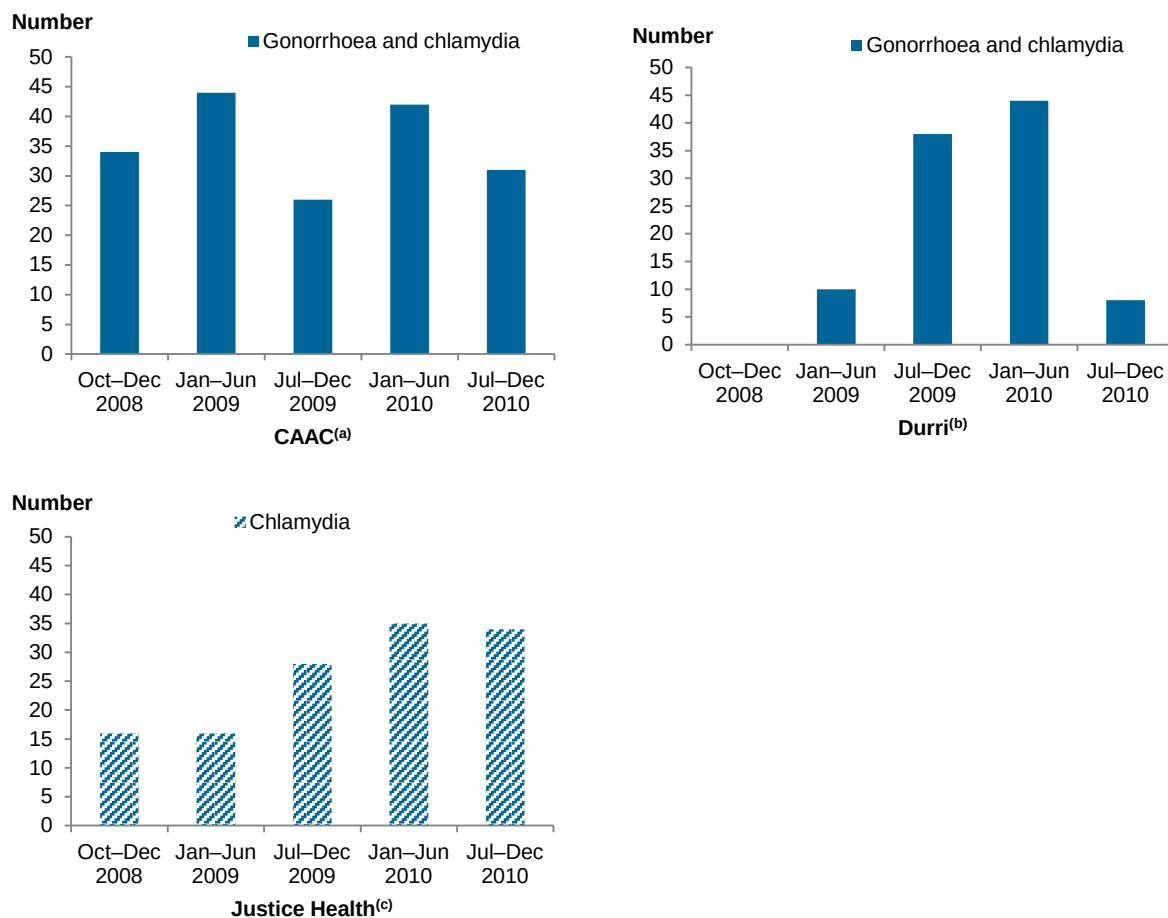
Due to the small number of notifications, data have been combined for gonorrhoea and chlamydia where necessary. It is important to note that the data relate to the number of clients and not the number of notifications. Therefore, if a client received a notification for gonorrhoea and a notification for chlamydia then this would only be counted as one notification. The same client may also receive notifications in multiple reporting periods.

Also important to note is that the vertical axis scale varies between figures for different projects.

The number of notifications is independent of the number of STI tests. As with the number of STI tests, the number of clients who had a test varied across reporting periods.

If the demonstration projects were successful in reducing risk-taking behaviour among Aboriginal and Torres Strait Islander young people, it would be expected that clients with STI notifications would decrease over time. In the absence of baseline or follow-up data on this before and after the projects, as well as a lack of information on the size of the target population for each project, it is not possible to determine whether this occurred. Further, an increase or decrease in the number of STI tests performed will result in an increase or decrease in the number of notifications, respectively, which would also need to be taken into consideration.

The limitations to the data for notifications in terms of availability and quality are the same as those for data on STI tests. The notification data collected and provided by projects therefore varies considerably, and data across projects cannot be compared.



- (a) CAAC: number of notifications for males aged <15–24.
 (b) Durri: number of Indigenous males of all ages.
 (c) Justice Health: number of Indigenous and non-Indigenous males and females aged <15–24.

Notes:

1. Marie Stopes did not have an STI testing component.
2. NHS did not report STI notifications.
3. Numbers of SESDGP STI notifications were too small to report.
4. Reporting round 1 (Oct–Dec 2008) covered a shorter period of time than reporting rounds 2–5.

Figure 3.4: Number of sexually transmitted infection notifications for each demonstration project, 1 October–31 December 2008 to 1 July–31 December 2010

Sexually transmitted infections and blood borne virus treatment

Three of the five projects with STI and BBV testing components provided data on STI treatment. Where available, Congress, Durri and Justice Health provided data on treatment for chlamydia, and Congress and Durri also provided treatment data for gonorrhoea. For NHS, treatment was carried out through clinical processes and was not the responsibility of the youth health educators employed as part of the project. As a result, treatment data were not provided. As with BBV notifications, projects did not report data for BBV treatments due to data quality issues or because numbers were too small to report.

STI treatment did not necessarily correlate with the number of notifications in the same reporting round, with the exception of gonorrhoea treatments for Congress.

The projects identified a number of issues with treatment, in particular the fact that the highly mobile population in more remote areas made it difficult to track down clients in order to receive treatment.

Contract tracing is part of the treatment process, but this evaluation did not seek information on this matter.

Treatment for STIs and BBVs is an outcome resulting from testing and notifications. Due to a number of issues that have been discussed in relation to client encounters, testing and notifications, it has not been possible to establish whether projects were successful in increasing the number of young people accessing services for testing and treatment of STIs and BBVs. These factors included:

- baseline data on client encounters, testing and notifications were not collected
- fluctuating numbers of client encounters, tests and notifications observed between reporting rounds in projects
- limitations relating to availability and quality of data
- lack of staff, staff turnover and gender of staff in clinics.

Condom distribution

Five of the six projects had a condom distribution component (all projects except for Justice Health, because it was not permitted to distribute condoms in juvenile detention). The distribution of condoms contributes to objective 4 of the demonstration projects (reduce risk-taking behaviour). Condoms were distributed free of charge in four of these projects, while Marie Stopes distributed some for free, but the majority were sold to health services and organisations for distribution.

Condoms were commonly distributed via health services, condom dispensers, education and outreach activities and venues frequented by young people. In the case of Marie Stopes, condoms were distributed for free at events organised and attended by SNAKE project staff.

It is difficult to determine the success of this component of the projects. An increase in the number of condoms distributed does not necessarily translate into increased use. However, it would be reasonable to expect that there was some level of increased condom use coinciding with increased availability of condoms among the target population during the period of program funding.

In order to verify this, in the short term, a survey of young people in the target population would need to have been conducted. This was out of scope for this project.

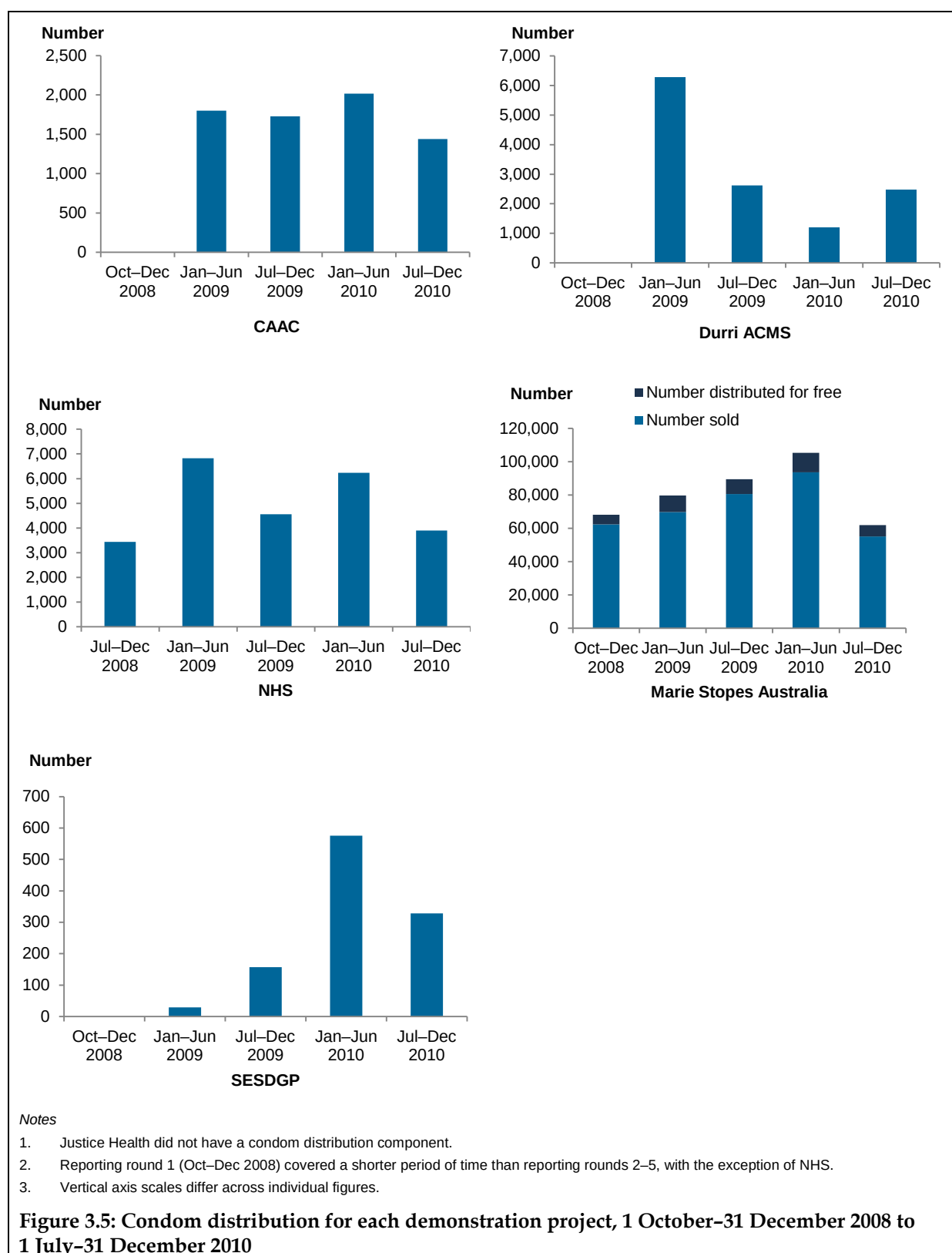
Not all services detailed how they recorded and collected information on the numbers of condoms distributed, and without this information it is possible that some of the data are not comparable.

Whether increased condom use was sustained following the end of the demonstration projects is not known. Longer term trend data on notifications for STIs and BBVs in the respective communities may be useful in assessing this.

It is not appropriate to compare condom distribution data between the projects, due to the differences in project scope and target populations, although it is possible to discuss general patterns.

Durri and Marie Stopes distributed condoms in each of the five project reporting rounds, whereas Durri, Congress and SESDGP did not commence condom distribution until the January–June 2009 reporting period (reporting period 2).

Condom distribution patterns fluctuated over the five reporting periods (Figure 3.5), and were influenced by factors such as an annual STI screen in NHS and Congress (January–June reporting periods), whether specific events or education programs were run during a particular reporting period and levels of project staffing during the reporting period.



Discussion

Objective 3: Increase the number of young people accessing services for testing and treatment of sexually transmissible infections and blood borne viruses

It has not been possible to establish whether projects were successful in increasing the number of young people accessing services for testing and treatment of STIs and BBVs.

To assess achievement against this objective, this evaluation has used information on client encounters with health services and STI and BBV testing, notifications and treatment. However, there were significant limitations in terms of data quality and availability, both within and across projects, which prevent conclusions from being drawn.

Firstly, there was no collection of baseline data before project implementation, and for many project activities there was no fixed target population, which makes comparison of data difficult. Secondly, the fluctuations in numbers across reporting periods for client encounters, and STI and BBV testing, notifications and treatment (where data are available), and the relatively short timeframe of the evaluation prevents inferences as to the success of the projects against this objective based on any trend or patterns in the data during the reporting periods.

Thirdly, there were a number of limitations in the data provided by projects in terms of availability and quality. For example, data were not always separately available for all projects for young people or by Indigenous status, and data were not always available for every reporting period.

Finally, the data reported were counts of episodes rather than counts of clients; that is, the data reflected the number of client encounters, which could have resulted in the same clients being counted multiple times in the data.

Due to these limitations, the evaluation has only been able to provide information on some of the factors that may explain patterns in the data for client access and testing, which will have subsequent effects on notifications and treatment. These factors included the:

- wet season having an impact on clinic access in remote locations
- operation of clinics offering testing, related to availability of staff and/or the availability of a clinic
- presence of same gender staff at clinics increased testing (i.e. male staff in a male clinic)
- annual STI screens increased the number of STI and BBV tests.

Objective 4: Reduce risk-taking behaviour in Aboriginal and Torres Strait Islander youth

It was not possible to establish whether projects were successful in reducing risk-taking behaviour in Aboriginal and Torres Strait Islander youth, based on information on condom distribution and STI and BBV notifications.

A decrease in STI and BBV notifications among the target population could, in theory, be used to determine whether the projects were successful in reducing risk-taking behaviour and therefore reducing the incidence of STIs and BBVs. However, limitations in terms of data availability and quality prevent the data from being used in this manner. These include the data issues discussed in relation to objective 3. A lack of information on the size of the target population and the lack of a fixed population for some projects meant that it was not possible to calculate a notification rate.

Objective 5: Make a contribution and be consistent with the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008 and Implementation Plan

The goal of the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008 (the Strategy) is to ‘reduce the transmission of and morbidity caused by HIV/ AIDS, STIs and BBVs in the Aboriginal and Torres Strait Islander community and to minimise the social and personal impacts of these infections’.

The Strategy sets out five objectives in order to achieve this goal, two of which are relevant to the demonstration projects:

- improve access to testing, diagnosis, treatment and care of HIV/ AIDS, STIs and BBVs for Aboriginal and Torres Strait Islander people
- improve awareness of HIV/ AIDS, STIs and BBVs in the Aboriginal and Torres Strait Islander community.

The demonstration projects that offered testing for STIs and BBVs (all projects except for Marie Stopes) contributed to the objective of improving access to testing, diagnosis, treatment and care by promoting testing services to Indigenous young people. This was followed up with diagnosis and treatment where required and possible. In the case of Durri, testing services were delivered in a setting familiar to young males (the local football club) rather than in the clinic environment, where youth did not feel comfortable.

In relation to the objective of improving surveillance and research activities, the demonstration projects contributed by collecting data on STI and BBV testing and notifications for Indigenous young people.

The education sessions and other community education activities that were delivered as part of the demonstration projects contributed to the objective of improving awareness of STIs and BBVs among Indigenous youth.

Aboriginal and Torres Strait Islander young people, the target group for the demonstration projects, are one of 10 key target groups of the Strategy. Other target groups in the Strategy that were also covered in at least one demonstration project included Aboriginal and Torres Strait Islander people in custodial settings (Justice Health) and people who have traditional language as their first language (Congress and NHS).

4 Discussion and conclusions

This section provides an overview of the evaluation findings and considers the key features of more successful projects. In doing so, it brings together the main challenges of and lessons learnt by each of the projects. It also covers the final objective of the program, which overarches all components of the projects:

Objective:

7. Provide a guide for expansion of effective sexual health models into other areas of Australia.

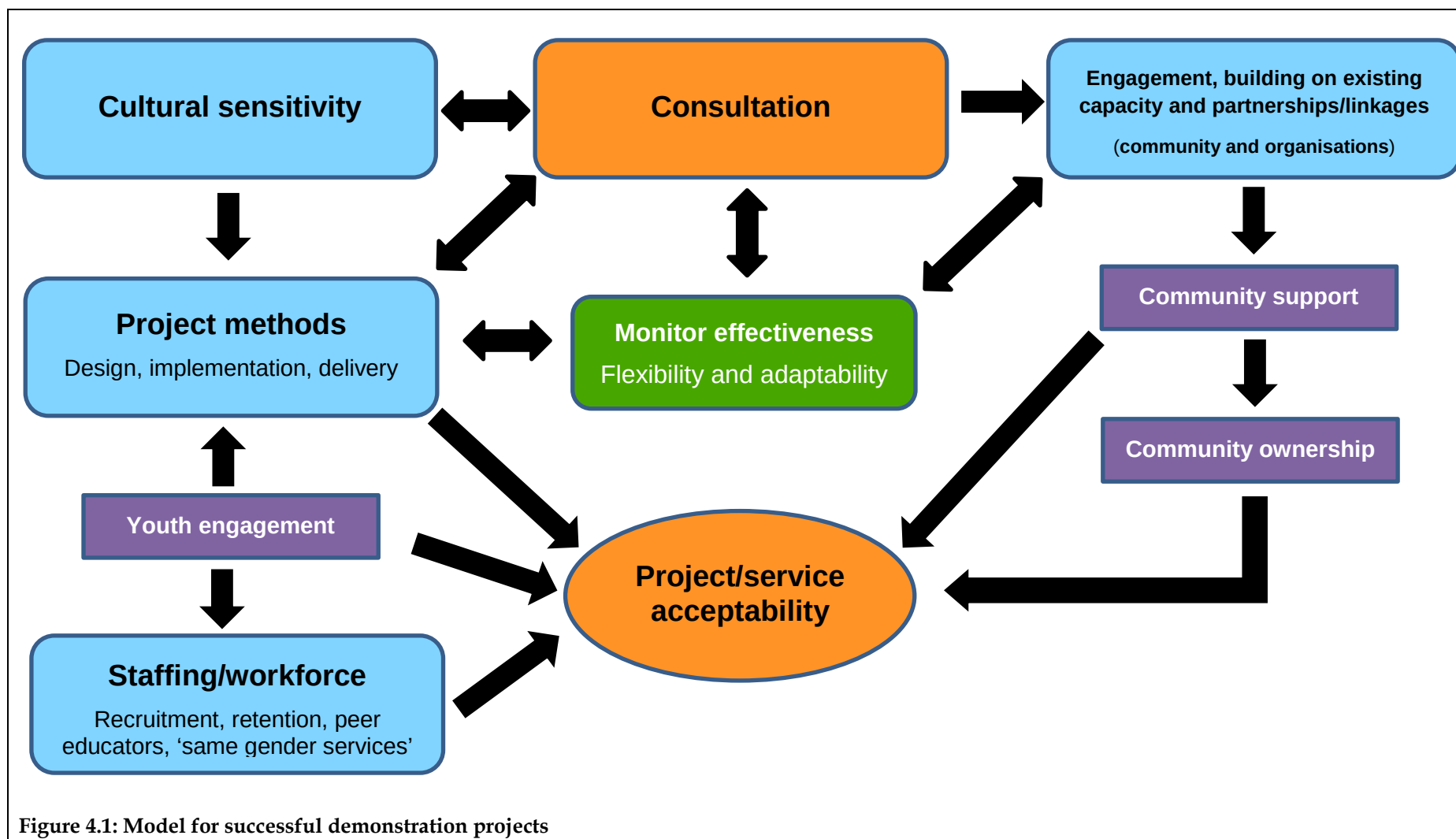
4.1 Findings from the quantitative data

The previous chapter discussed the difficulties with the quantitative assessment of the projects. Some of the limitations included: the lack of baseline and follow-up data; the need for longer trend data to analyse the impact of activities over time; fluctuating numbers of client encounters, tests and notifications between reporting rounds; and other factors that were not able to be controlled but affected the data. For example, the ability of patient information management systems to report testing positivity and treatment data, the employment of staff, the annual STI screen and lack of access to remote clinics during the wet season contributed to fluctuations in numbers in various reporting rounds for particular projects. This meant that, in many cases, the success of projects against the overall program objectives and expected outcomes was not able to be determined.

4.2 Key features of successful projects

The qualitative data collected for the evaluation, and information on processes and outputs enabled the key features of the more successful projects to be identified, and provided a guide for the development of effective sexual health models. A 'successful' project in this context was considered to be one that successfully engaged with the community and young people and, as a result, the project was accepted by these groups.

Sexual health, STIs and BBV infections are sensitive topics. The demonstration projects faced a particular challenge in tackling sexual health issues associated with stigma, embarrassment and shame among young people and the broader community. Therefore, projects that engaged with the community and youth, and were accepted by these groups, demonstrated some degree of success. The features of the more successful projects were determined from those factors that the projects identified as contributing to their success, as well as the challenges experienced and lessons learnt. This is presented diagrammatically in Figure 4.1.



Consultation

Consultation emerged as one of the core factors influencing a project's success. Projects undertook consultation formally through governance arrangements (advisory committees or reference groups) and via consultation with existing organisations and services, and informally with young people and the community. A summary of demonstration projects' consultation processes is presented in Table 3.3, and advisory committee and reference group arrangements were considered in 'Section 3.1 Governance and management'.

Consultation with a broad range of stakeholders, including community Elders, health professionals and young people, is important to maximise engagement. NHS found that consulting key people to ascertain community needs was vital to ensure that the project was implemented with, rather than imposed on, the community. This resulted in increased engagement. Both NHS and Congress made explicit mention of consulting with Elders. NHS commented that gaining permission from Elders to deliver sexual health education was vital for acceptance of the project and for developing partnerships with the community.

On the other hand, SESDGP had some difficulties with consultation in the initial stages of the project, which led to a lack of support for the project in some sections of the community and criticism of the initial survey that was developed. The survey was redesigned and relationships were rebuilt in the second year of the project. As a result of some initial setbacks, lessons were learnt regarding the ways in which appropriate consultation and engagement can be problematic when implementing a project in an Indigenous community.

Genuine consultation, which begins in the earliest stages of project design and continues throughout the life of the project on an ongoing basis, was therefore found to lead to:

- engagement with the community (including young people) and establishment of partnerships and linkages with existing services, programs and organisations
- culturally appropriate project design and implementation
- project delivery/implementation methods that increase project acceptability and engagement of youth.

These factors contribute to increasing the acceptance of the project and developing engagement.

Ongoing consultation is also a crucial component in monitoring the effectiveness of projects, and adapting project design and implementation in response to feedback via the consultation process improves acceptability of and engagement with the project.

Engagement

Engagement with the community and with organisations and services was successful in developing support and ownership, as well as establishing partnerships and linkages that built on existing capacity.

Engagement develops through appropriate consultation with a broad range of stakeholders and establishing and maintaining relationships with the community and project partners. This was found to lead to community support and ownership, which increased the acceptability of the project.

Engagement with organisations and services via partnerships allowed projects to build on existing capacity, and facilitated engagement with the community. Congress ran the Red Box

project through Ingkintja (male health clinic), which increased access to health services and resources. Justice Health successfully incorporated sexual health education into an existing award-winning program already being delivered to young people. In terms of engaging with the community, Marie Stopes found that partnerships with community controlled health organisations facilitated the development of relationships with communities, and NHS found that partnerships with organisations with the same target demographic were useful to effectively reach youth.

Successful engagement fosters community support for a project and can lead to community ownership of the project. NHS found that engagement with community members through consultation facilitated ownership and leadership among those who participated. Marie Stopes found that the level of community ownership in hosting SNAKE events and education/training was a key success factor in raising sexual health awareness.

Cultural appropriateness

Culturally appropriate project design and implementation occurs through consultation with community members and organisations/services.

Culturally appropriate projects are more likely to be supported by the community and to result in projects that are designed and delivered in a method that engages young people and increases project acceptability. Cultural appropriateness is particularly important for projects dealing with sensitive issues such as sexual health.

Delivering culturally appropriate projects in Indigenous communities is not a 'one size fits all' approach. What may be appropriate in one community may not be appropriate in another. For example, the Marie Stopes SNAKE condoms were used by Durri and were also considered for use by NHS. However, the SNAKE campaign slogan was not considered appropriate in the Ngaanyatjarra communities participating in the project and so were not used. A similar example is from Congress where Red Boxes were renamed 'Toolboxes', as the term 'Red Boxes' was not appropriate for cultural reasons in some communities.

Project design, delivery and implementation

The way a project is designed, implemented and delivered has a significant impact on engagement with youth and youth acceptance of the project. Engagement and acceptance of projects is achieved through the consultation process, engagement with community and the consequent development of culturally appropriate projects. However, even if this is done, the implementation of projects still needs to be monitored to ensure that they are doing what they set out to achieve, and the projects need to be modified as required.

Flexibility and adaptability

A key feature of successful projects was flexibility and adaptability in design and delivery after the implementation of projects. Durri found that the Hey Bruz project had to adapt ideas and consistently change strategies to maintain engagement with Indigenous young people. Many activities were implemented on a trial-and-error basis, and learning from these experiences. The flexible approach of the Durri AHW was integral to the success of the project. An example of this was the recognition by the AHW that young males were uncomfortable with being seen at the clinic due to the shame and stigma associated with STIs and BBVs. Education and screening was therefore moved to environments where young

people felt comfortable, such as the local football club. This increased engagement of young people and the uptake of screening.

At a community level, Marie Stopes found that each community had different needs or issues, and that the project needed to be flexible in its approach to assisting communities with STI education and prevention.

Distance

Distance was identified by a number of projects as being a limitation to project delivery. This was particularly the case for projects covering remote communities, including Congress, NHS and Marie Stopes. Travelling to remote communities was difficult due to time, resources and other practical constraints. Marie Stopes noted that the amount of travel and the number of communities visited was exhausting for staff, and that the project may have been too ambitious in the number of communities that it could engage to implement the SNAKE initiative.

NHS found distance to be the most challenging aspect for the Kungkaku Yangupalaku Healthy Relationships Project. Charter flights were the most efficient form of transport for accessing communities, but these incurred high costs. Driving was the only other transport option available, but was not always possible during the wet season due to unsealed roads.

Staff

Projects identified a number of issues in relation to staffing that affected the success of projects. These included the recruitment and retention of staff, issues with peer educator programs, and staff characteristics. These issues affected project delivery, engagement with young people and the acceptability of the project.

Recruitment and retention

The recruitment and retention of staff was the most significant challenge faced by projects. All projects experienced delays or reduced operation due to delays in recruiting suitable staff, staff absences and/or in retaining existing staff. This affected both the education and screening components of the projects.

Although Marie Stopes did not note recruitment or retention issues within their project team, they found that high turnover of staff in the communities in which they were delivering their project was a challenge due to the time taken to repeatedly engage and build relationships.

Difficulties with recruitment and retention suggest that there is a need for further training and support for the Aboriginal sexual health workforce to increase the available pool of people with the required skills.

Peer educators

Four projects – NHS, Congress, Marie Stopes and SESDGP – had a peer educator component. Each of the projects noted difficulties in relation to this component.

NHS experienced difficulties with recruitment/retention of peer educators due to problems with remunerating them for their work. In remote areas, there was difficulty obtaining the required identification documents to legally process payment for peer educators. Unless employed through the Community Development Employment Projects (CDEP) scheme, this meant that peer educators were unable to be remunerated for their work or gain recognition

for their involvement with the program. Despite many attempts, NHS also had difficulty accessing appropriate training courses for peer educators.

Congress initially employed peer educators; however, this changed to a voluntary arrangement due to resource constraints. It is unknown whether peer educators can be sustained without being paid, because this has been an issue in other demonstration projects that have had peer educators.

The peer educator component of the Marie Stopes and SEDGP projects has been discussed in relation to objective 2. Like NHS, Marie Stopes found that peer educators proved difficult to recruit due to lack of incentives.

In contrast to the other project organisations, SEDGP found that employing peer educators who were not part of the community resulted in better engagement with the La Perouse youths. Although this can be done in urban areas, it would be difficult in remote areas.

Staff characteristics

Projects found that having staff who were well-known and active in the community, who were accessible to young people and who were of the same gender as the target group, resulted in better engagement with youth.

Marie Stopes commented that sexual health is often a low priority in communities compared with other health issues such as cardiovascular disease, diabetes and drug and alcohol issues. Unless there was an appropriately trained health worker or someone who was passionate about sexual health, the SNAKE program was often overlooked or ignored.

The AHW employed by Durri in the Hey Bruz project was recognised as a driving force in successfully improving the knowledge and awareness of STIs, BBVs and other sexual health issues among young Indigenous males. In the short time that he was employed (18 months), he delivered 12 community education courses and nine other education sessions. He also devised and used a range of culturally appropriate education resources that were provided to Indigenous male youths. During the education sessions, screening for STIs and BBVs was promoted, and condoms were distributed. The AHW was also available at the clinic for young men to come and see him, obtain condoms and receive sexual health education.

The male ASHEO employed by the Justice Health project was considered to play a large role in the success of the education program. The connection and leadership he demonstrated to Aboriginal young people, particularly the young men, had a large impact on how the program was implemented and received. Staff members at Justice Health Centres wrote in support that he 'quickly builds rapport with students and has no management or discipline issues. He is enthusiastic and has an excellent and relevant knowledge base. The ASHEO is a very positive role model and has the ability to engender confidence and healthy vision amongst my students'. The Program Support Officer at Frank Baxter commented that 'his lessons were well constructed and informative and have given the students a sound understanding of health issues facing adolescent boys'.

Several projects noted the importance of having staff of the same gender as the target group to increase engagement with young people. If the project was aimed at both males and females, then it was important to have both male and female staff so that young people felt comfortable discussing sensitive topics such as sexual health. Congress found that a male nurse and receptionist at the clinic increased the number of male clients accessing the clinic. Justice Health noted that both a male and female ASHEO were needed so that education sessions could be delivered at all of their Juvenile Justice Centres. NHS also found that

having both a male and female YHE who lived and participated in the community where the project was being delivered, was critical to the success of the project, and meant that strong relationships with young people were more likely to be developed.

4.3 Conclusion

The AIHW collected data on a range of quantitative and qualitative indicators for the evaluation. There were difficulties, however, with the quantitative assessment of projects' success because of limitations in relation to the structure of the evaluation in terms of data availability, collection and quality. This meant that, in many cases, the success of a project against the overall program objectives, or in relation to expected outcomes was not able to be determined.

The success factors, challenges and lessons learnt from the demonstration projects did, however, provide a guide for the development of effective sexual health models in other areas of Australia. The evaluation found, through qualitative data, that the following were the key features of a successful sexual health model:

- consultation with a broad range of stakeholders, including community Elders, youth and health professionals
- engagement and developing partnerships with the community, organisations and services
- culturally appropriate project design and implementation
- flexible and adaptable project design, delivery and implementation
- staff who are respected by the community, are accessible to young people, engage well with young people and are the same gender as the target group
- evaluation techniques that are able to be adapted to local needs.

The recruitment and retention of staff was one of the most significant challenges faced by the projects. The evaluation therefore proposed that greater training and support for the Aboriginal sexual health workforce be provided to increase the available pool of people with the required skills.

Most services found the evaluation requirements challenging and further consideration would be required regarding training and support for project staff to develop evaluation tools and frameworks before any project implementation.

Appendix A Program logic

The original program logic developed for the demonstration projects (Figure A1) outlined the expected changes or outcomes that the projects were designed to achieve. The main outcomes were:

- improvements in targeting sexual health activities
- increased knowledge and awareness of sexual health issues
- increased access to testing, treatment and condoms
- improvements in culturally appropriate sexual health service delivery.

Longer term objectives were:

- improvements in sexual health service delivery
- reductions in risk-taking behaviour and increases in safe sex behaviour
- reduction in STI and BBV notifications
- increased Indigenous youth access to sexual health services.

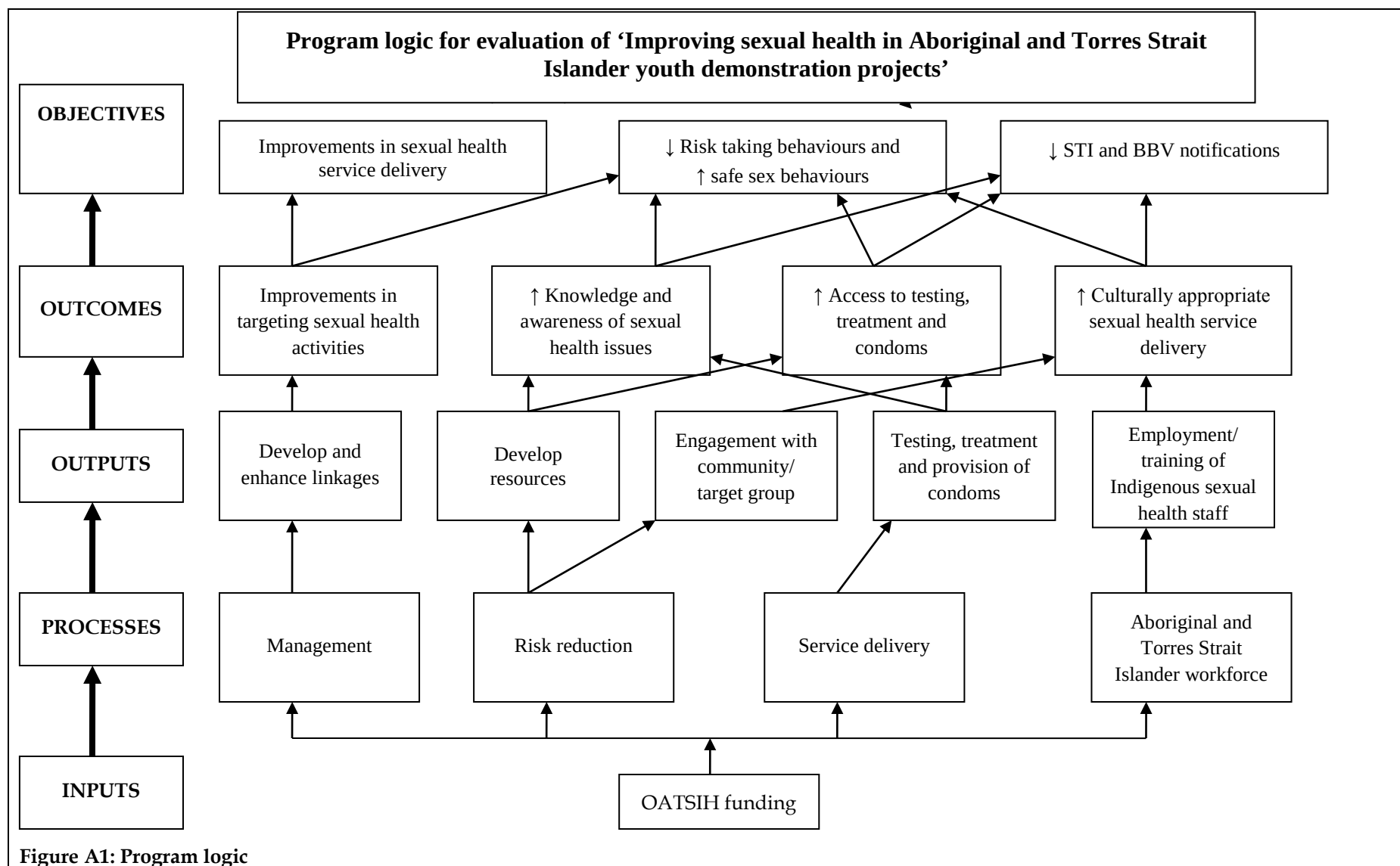


Figure A1: Program logic

Appendix B Common indicators

Table B1: Common indicators for demonstration projects

Government and management
Dedicated project officer/coordinator/manager
Steering committee/advisory or reference group
Internal communication strategy
Partnerships with other organisations
Consultation activities undertaken as part of the project
Number of communities consulted with for the demonstration project
Engagement with Aboriginal and Torres Strait Islander young people
Total number of Aboriginal and/or Torres Strait Islander staff currently employed
Delivered sexual health training for project staff/service staff (by training type and number of staff who attended)
Resources and education
Total number of condoms distributed
Number and type of sexual health resources developed (resource description, number developed and number distributed)
Conducted peer or other sexual health education sessions/workshops (by location, type of session and number of participants)
Total number of education sessions delivered
Total number of participants at education sessions
Total number of communities where education sessions were delivered
Developed a pre- and post-survey of young persons' sexual health knowledge
Distributed pre- and post-education session surveys to young persons
Number of surveys distributed
Number of survey responses received
Service delivery
Number of persons who accessed the health service for any reason (by sex, age group and Indigenous status)
Number of persons who had an STI test (by type of STI, sex, age group and Indigenous status)
Number of persons who had a BBV test (by type of BBV, sex, age group and Indigenous status)
Number of persons who received a notification of a positive STI test result (by type of STI, sex, age group and Indigenous status)
Number of persons who received notification of a positive BBV test result (by type of BBV, sex, age group and Indigenous status)
Number of persons who were treated for an STI (by type of STI, sex, age group and Indigenous status)
Number of persons who were treated for a BBV (by type of BBV, sex, age group and Indigenous status)
Can you describe any other activities/programs that are related to sexual health for young Aboriginal or Torres Strait Islander persons that your target group may be affected by?

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The Office for Aboriginal and Torres Strait Islander Health funded six demonstration projects aimed at improving the sexual health of Aboriginal and Torres Strait Islander young people during 2008–10.

An evaluation of the projects by the Australian Institute of Health and Welfare identified that successful sexual health programs consulted a broad range of stakeholders; engaged and developed partnerships with the community, organisations and services; were culturally appropriate and flexible in their design, delivery and implementation; and had staff who were respected by the community.