

MATTERS ARISING

“Let’s not talk about sex”: reconsidering the public health approach to sexually transmissible infections in remote Indigenous populations in Australia

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The WHO recommends whole-of-community antibiotic treatment for chlamydial eye disease (trachoma).

A recent article suggested the same approach should be taken to manage endemic chlamydial disease when the same organism is sexually transmitted. This controversial approach has sparked debate. (MJA 2008; 188: 182-184)

Sandra C Thompson, Darryl M Kickett and Timothy G Leahy

TO THE EDITOR: Bowden and Fethers’ provocative recommendations for mass antibiotic treatment to reduce the prevalence of sexually transmissible infections (STIs) in remote Aboriginal communities is based on the failure of the current approach of screening and treatment of individuals to reduce STI prevalence.¹ However, approaches that address a single health issue in isolation will not succeed in improving Aboriginal health.

The biomedical approach proposed could reduce the likelihood of a sexually active person becoming infected with an STI, but, in our experience, many Aboriginal people object to the “sheep-dip approach” of mass indiscriminate treatment. Moreover, it is ethically difficult to justify giving a cocktail of four antibiotics with potentially adverse side effects to all people in a population when only one or two out of 10 will benefit. The proposed staggering of doses would only increase the difficulty and reduce compliance. The people who don’t participate in current programs are the same people who would be least likely to comply with a new program.

The greatest merit of Bowden and Fethers’ proposal is in addressing the social determinants of poor health. The ancillary “life skills” programs they suggest could also be useful, and to this we could add interventions with the core groups² and multifaceted interventions to reduce the use of alcohol and other drugs that fuel disinhibited and violent behaviour, including sexual abuse.

Most importantly, tackling STIs in isolation will fail to bring about improvements in the many areas of Aboriginal health requiring attention. Arguably, given the profound health inequalities experienced by Aboriginal Australians, the best approach would be to resource culturally secure, comprehensive primary health care services adequately,³ at a level greater than that available for urban middle class Australians. This has not yet been achieved in remote areas. Yet the complexity of Aboriginal social and health issues demands the most experienced and skilled health professionals rather than the current workforce,

which is characterised by high turnover and consists too often of overseas-trained medical staff, nurses on short-term contracts and Aboriginal health workers, many of whom suffer from illness or family trauma.

Before contemplating mass community treatment, priority must be given to improving the social determinants of health, enabling Aboriginal people to have control over their own lives. This would effectively involve Aboriginal leadership at community level generating Aboriginal-led solutions. This would have a longer-term effect on health improvement and ensure good access to quality primary health care that could respond to the complex needs of Aboriginal people.⁴ It would require continuity of care from committed, appropriately trained health professionals who understand and work within the values and priorities of Aboriginal people. Aboriginal people want primary health care that delivers culturally secure, empowering and holistic care.⁵ Mass treatment fails in this. Enhancing multidisciplinary primary care with linkages to the community outside the clinic could help address the many other causes of chronic illness that contribute to the shameful gap in morbidity and life expectancy between Indigenous and non-Indigenous Australians.

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1 Bowden FJ, Fethers K. “Let’s not talk about sex”: reconsidering the public health approach to sexually transmissible infections in remote Indigenous populations in Australia. *Med J Aust* 2008; 188: 182-184.

2 Yorke JA, Hethcote HW, Nold A. Dynamics and control of the transmission of gonorrhoea. *Sex Transm Dis* 1978; 5: 51-56.

3 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; 83: 457-502.

4 MacKinnon M. A First Nations voice in the present creates healing in the future. *Can J Public Health* 2005; 96 Suppl 1: S13-S16.

5 Steenbeek A. Empowering health promotion: a holistic approach in preventing sexually transmitted infections

among First Nations and Inuit adolescents in Canada. *J Holist Nurs* 2004; 22: 254-266. □

Michael S Gracey and Randolph M Spargo

TO THE EDITOR: The proposal by Bowden and Fethers¹ to abandon “screen, treat and contact trace” methods of managing endemic sexually transmissible infections (STIs) in remote Indigenous communities and replace them with mass treatment programs in groups with defined threshold prevalence levels is flawed. Primacy must go to the question of why some STIs are so prevalent. Why deal only with the consequences rather than the causes of STIs? Without resolving these questions, the problems will persist.

Bowden and Fethers’ approach has serious shortcomings. A major one is sweeping aside the concepts of one-on-one advice, counselling, opportunities to cooperate with health staff, avoidance of hazardous behaviours, and maintenance of effective follow-up. These cornerstones of public health strategies to control STIs depend on the ability of health professionals to establish meaningful relationships with Indigenous people.

Transient populations move frequently between towns and remote communities. Therefore, the authors’ strategy neglects the serious risk to remote communities from inadequately controlled reservoirs of STIs that allow the diseases to be repeatedly reintroduced from rural or remote towns.

The authors say, ironically, “Let’s not talk about sex”, but an essential part of the public health response to STIs must be to talk about sex. It is our observation that many Indigenous people are more comfortable talking about this subject than other Australians.

Another risk in the authors’ approach is to overlook detection of HIV infection. Their proposal could also be interpreted by many Indigenous people as suggesting that they no longer need worry about STIs because the new blanket approach from their health carers will protect them from all such infections.

Our long experience working in remote northern Western Australia suggests to us that a mass treatment approach would not resolve

the problem of STIs. Control of many of the main chronic diseases of Indigenous people living in remote areas can be significantly enhanced by increased Indigenous community involvement, decision making, and trusting collaboration with health professionals.² Crucially, additional government commitment is urgently needed to provide enough locally stable and adequately trained staff, facilities, and related resources to control these persisting problems in remote Australia.

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1 Bowden FJ, Fethers K. "Let's not talk about sex": reconsidering the public health approach to sexually transmissible infections in remote Indigenous populations in Australia. *Med J Aust* 2008; 188: 182-184.

2 Gracey M, Bridge E, Martin D, et al. An Aboriginal-driven program to prevent, control and manage nutrition-related "lifestyle" diseases including diabetes. *Asia Pac J Clin Nutr* 2006; 15: 178-188. □

David J Scrimgeour

TO THE EDITOR: It was pleasing to see Bowden and Fethers raising the issue of public health approaches to sexually transmissible infection (STI) control in remote Indigenous communities.¹ However, their suggestion that mass treatment programs would be more effective than screening programs is flawed.

They note that screening programs have had some success in reducing the prevalence of STIs, but that an unacceptable prevalence persists. Rather than rejecting screening as an appropriate strategy, it would be more useful to investigate the reasons why screening programs have had limited success. It is likely that the main drawback has been inadequate coverage, and one of the main reasons for this is that there are hard-to-reach groups who are not being included in screening programs. In particular, this would include people with alcohol problems or other addictions, whose lifestyle makes them more at risk for STIs. People in this group, who often live a transient or homeless lifestyle in regional centres, have problems of access to health care and health programs. A mass STI treatment program would not overcome this difficulty and would be just as likely as current screening programs to miss this crucial target group.

What is needed is better support for comprehensive primary health care programs, to allow an extension of current health programs to reach out to these groups. Bowden and Fethers suggest that screening programs are inadequate because of problems with current

levels of staffing and health infrastructure. This is what needs to be addressed. Greater support for community-controlled comprehensive primary health care, to ensure adequate levels of staffing and infrastructure for STI screening (including outreach programs for hard-to-reach populations), would produce better results from STI screening and would also allow better control programs for other health problems. Furthermore, it would help reduce the problem of increasing antibiotic resistance that is likely to result from mass treatment programs.

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1 Bowden FJ, Fethers K. "Let's not talk about sex": reconsidering the public health approach to sexually transmissible infections in remote Indigenous populations in Australia. *Med J Aust* 2008; 188: 182-184. □

Bryan G Walpole

TO THE EDITOR: With their radical population-based approach, Bowden and Fethers¹ bring a refreshing perspective to the management of sexually transmissible infections (STIs) in Indigenous communities — normally a taboo subject with those at risk and their families.

I recently participated in the federal government's Northern Territory Emergency Response, and was told, both centrally and locally, that looking for STIs was off limits, as it might destroy the trust of Aboriginal communities. This meant that I could neither enquire about nor examine children or adolescents below the umbilicus. I noted that most teenage girls had contraceptive implants (a good public health measure), but no STI prophylaxis. I think this is a failure of the Response.

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1 Bowden FJ, Fethers K. "Let's not talk about sex": reconsidering the public health approach to sexually transmissible infections in remote Indigenous populations in Australia. *Med J Aust* 2008; 188: 182-184. □

Francis J Bowden and Katherine Fethers

IN REPLY: Although the title of our article was intentionally provocative, our suggested rethink of current approaches to control of sexually transmissible infections (STIs) in remote communities emphasises the role of individual autonomy and consent, education, health promotion and community involvement. We do not dismiss one-on-one advice,

counselling, follow-up, the need for meaningful relationships with Indigenous people, or the risk of an HIV epidemic.

However, we do suggest that there should be a separation of the strictly medical components of the strategy from the community development components. Furthermore, in the presence of endemic disease, we propose that presumptive treatment should be based on an assessment of risk made at a community level rather than at the individual level, and that removing the otherwise unavoidable delays between screening and treatment may be a more effective first step in reducing the burden of STIs in remote populations.

A "screen, recall, treat and contact trace" approach works to some degree in the mainstream population, in which the prevalence of STIs is much lower than in remote communities, but what is considered "best practice" in suburban Australia does not automatically translate into best practice in the bush. We acknowledge the logistic difficulties of offering any type of broadly based community program in remote areas and we specifically address the problem of treating hard-to-reach groups in communities. We recognise the risk of giving a false sense of security to the target audience, but current approaches provide people in remote areas little protection from STIs. The recent roll-out of the human papilloma virus vaccination in young women could be similarly criticised, but it is possible to implement a biomedical intervention and still continue with education and health promotion.

The question of antibiotic resistance is an important one. The aim of increasing the intensity of treatment over a defined time period is to reduce the total amount of antibiotics prescribed in the longer term. An increase in the level of resistance is the price that is paid for a reduction in the prevalence of disease in any population receiving antibiotics. Nevertheless, we indicated the need for monitoring of resistance patterns in any trials that are undertaken.

The eradication of the eye disease trachoma is dependent on the availability of clean water and better housing, but while this crucial infrastructure is being built we have to continue to treat the condition where it occurs and apply "traditional" public health approaches to population-level control. We think it is reasonable to consider doing the same for STIs.

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