How can health services increase access to prevention?

Focus on marginalised populations

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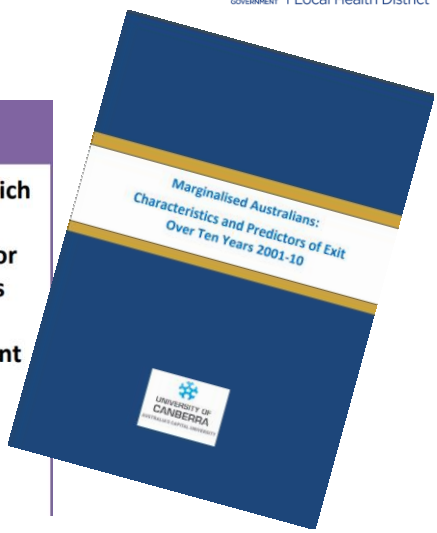
Marginalisation

What is marginalisation?

Marginalisation describes a state in which individuals are living on the fringes of society because of their compromised or severely limited access to the resources and opportunities needed to fully participate in society and to live a decent life. Marginalised people experience a complex, mutually reinforcing mix of economic, social, health and early-life disadvantage, as well as stigma.



Cruwys, T., Berry, H.L., Cassells, R., Duncan, A., O'Brien, L.V., Sage, B. and D'Souza, G. (2013). Marginalised Australians: Characteristics and Predictors of Exit over Ten years 2001-2010. University of Canberra, Australia.

Marginalisation: 13% of Australians

Risk factors	Protective factors/Resilience
Financial hardship	Age
Early life disadvantage	Schooling
Poor health	Parenting figures
Social isolation	Employment
Social stigmatisation	Home ownership
	Good mental health
F>M, Aboriginality	Social/intimate relation ships

Marginalisation in HIV/Sexual health

What do we mean?

- Marginalised generally in society?
- Marginalised from general healthcare system?
- Marginalised from us?
- Marginalised from prevention?
  - Awareness/messages
  - Agency
  - Relevance & appropriateness
  - Priority
  - Access
- Many marginalised groups have strong social structures and supports and may not identify as “marginalised” in all domains.

CRITICAL ENABLERS	
1	**Laws, policies and practices** should be **reviewed** and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations.
2	Countries should work towards implementing and enforcing **antidiscrimination and protective laws**, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations.
3	**Health services** should be made **available, accessible and acceptable** to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health.
4	Programmes should work toward implementing a package of interventions to **enhance community empowerment** among key populations.
5	**Violence** against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

6.3 Key factors to consider when providing services for all key populations

In summary, assuring access, acceptability and affordability requires attention to multiple, specific elements of programme design and delivery. Action on all these elements, appropriate to the specific context, will yield programmes that best serve key populations.

Integrated service provision: People from key populations commonly have multiple co-morbidities and poor social situations. For example, HIV, viral hepatitis, tuberculosis, other infectious diseases and mental health conditions are common in key populations. Integrated services provide the opportunity for patient-centred prevention, care and treatment for the multitude of issues affecting key populations. In addition, integrated services facilitate better communication and care. Thus, wherever feasible, service delivery for key populations should be integrated. When this is not possible, strong links among health services working with key populations should be established and maintained *(43)*.

Service principles: increased access to prevention in marginalised populations

Recognise risks and scope of marginalisation

Multiple social layers impact

How HIV prevention may be one of many priorities

Enablers:

- Laws, rights, reduced stigma
- Health services that meet multiple needs
- Integrated, affordable, accessible, acceptable, equitable
- Decentralised services
- Community and peer involvement, employment

Measurement… how closely do we look?

Accessibility- time and place

ORIGINAL PAPER

The impact of an automatic syringe dispensing machine in inner-city Sydney, Australia: No evidence of a 'honey-pot' effect

Carolyn A. Day ✉, Bethany White, Paul S. Haber

First published: 13 April 2016 Full publication history

DOI: 10.1111/dar.12397 View/save citation

Sexual Health
http://dx.doi.org/10.1071/SH14227

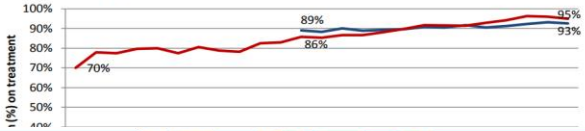
Sexual behaviour and HIV prevention needs of men attending a suburban Sex on Premises Venue

Anthony J. Santella[A,B,G], *Timothy E. Schlub*[C], *Catriona Ooi*[B,D], *Rick Varma*[B], *Martin Holt*[E], *Garrett Prestage*[F] *and Richard J. Hillman*[B,D]

Affordability increases access

Health
South Eastern Sydney
Local Health District

Figure 21: Proportion of HIV positive patients[17] attending publicly funded sexual health and HIV clinics and GBM GP clinics[18] receiving treatment or recorded as on treatment in the previous 12 months by service type and quarter, January 2011 to March 2017



The Deadly Liver Mob goes state-wide

A successful hepatitis C intervention program in Western Sydney will be rolled out across New South Wales thanks to a substantial NHMRC partnership project grant.

The research collaboration, bringing together the Kirby Institute and the Centre for Social Research in Health (CSRH), both based at UNSW, the South Australian Health and Medical Research Institute (SAHMRI), with the NSW Ministry of Health and a number of Local Health Districts (LHD), will implement the proven approach to increasing participation in testing for blood-borne viruses and STIs among Indigenous communities.

Related content

REPORT WA Sex Industry Report 2010

REPORT NSW Sex Industry Report 2012

REPORT NT STI & HIV report 2009 – 2014

Acceptability increases access

Health
South Eastern Sydney
Local Health District

Research paper International Journal of Drug Policy 26 (2015) 992–998

Evaluation of two community-controlled peer support services for assessment and treatment of hepatitis C virus infection in opioid substitution treatment clinics: The ETHOS study, Australia

Carla Treloar[a,*], Jake Rance[a], Nicky Bath[b], Hope Everingham[b], Michelle Micallef[c], Carolyn Day[d,e], Sue Hazelwood[f], Jason Grebely[c], Gregory J. Dore[c]

SHCS Item	Mean (SD) Scores		*p*-value[a]
	Before-Before (n=347)	After-After (n=266)	
I have a good understanding of how HIV is transmitted.	4.3 (0.67)	4.7 (0.51)	<0.001
I have a good understanding of what sexual activities are considered 'safe sex' and 'unsafe sex'.	4.2 (0.71)	4.7 (0.52)	<0.001
I would be able to recognise the symptoms of a sexually transmissible infection (STI).	3.4 (1.00)	4.2 (0.72)	<0.001
I know where to go to get a full sexual health check-up.	4.3 (1.03)	4.7 (0.59)	<0.001
I know how to put a condom on properly.	4.3 (0.80)	4.7 (0.53)	<0.001
I feel confident that I can negotiate the use of condoms with sexual partners.	4.2 (0.81)	4.5 (0.70)	<0.001
Complete scale	**24.7 (4.3)**	**27.4 (2.4)**	**<0.001**

What can clinical services do to increase access to prevention?

- Recognise how marginalisation impacts on access
- Marginalisation is much more than access to healthcare
- Engage with community & signal safety
- The more marginalised, the broader the approach
- Consider access is more than time and location
  - Acceptable, affordable, culturally accessible
- Measure access and develop pragmatic local solutions

Thank you

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