



The Second Western Australian Aboriginal Sexual Health and Blood-borne Virus Strategy and Regional Implementation Plan Template 2010 to 2014

February 2011

ACRONYMS

ACCHS	Aboriginal Community Controlled Health Services
AFAO	Australian Federation of AIDS Organisations
AHCWA	Aboriginal Health Council of WA
AHW	Aboriginal Health Worker
AIDS	Acquired Immunodeficiency Syndrome
AMA	Australian Medical Association
ASHM	Australasian Society for HIV Medicine
ATSI	Aboriginal and Torres Strait Islander
B2 Clinic	Sexual Health Clinic, Fremantle Hospital
BBV	Blood-borne Virus
CDCD	Communicable Disease Control Directorate
DAO	Drug and Alcohol Office
DCD	Department of Community Development
DCS	Department of Corrective Services
DoE	Department of Education
DoHA	Department of Health and Ageing
FH	Fremantle Hospital
FPWA	FPWA Sexual Health Services
GP	General Practitioner
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
II Health Network	Infections and Immunology Health Network
KEMH	King Edward Memorial Hospital for Women
MOU	Memorandum of Understanding
MPHU	Metropolitan Public Health Units
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NDRI	National Drug Research Institute
NGO	Non-government Organisation
NMAHS	North Metropolitan Area Health Service
NPEP	Non-occupational Post-exposure Prophylaxis
NPHP	National Public Health Partnership
NSEP	Needle and Syringe Exchange Program
NSP	Needle and Syringe Program
PEP	Post-exposure Prophylaxis
PHU	Public Health Unit
PLHIV	People living with HIV
PWID	People who Inject Drugs
RACGP	Royal Australian College of General Practitioners
RAHPF	Regional Aboriginal Health Planning Forum
RPH	Royal Perth Hospital
SCGH	Sir Charles Gairdner Hospital
SHBBVP	Sexual Health and Blood-borne Virus Program
SHC	Sexual Health Clinic
SMAHS	South Metropolitan Area Health Service
STI	Sexually Transmitted Infection
UWA	University of Western Australia
WA	Western Australia/Western Australian
WA Health	Department of Health
WAAC	Western Australian AIDS Council Inc.
WACBBVS	Western Australian Committee on Blood-borne Viruses and Sexually Transmitted Infections
WACHAS	Western Australian Committee on HIV and Sexually Transmitted Infections
WACHPR	Western Australian Centre for Health Promotion Research
WACHS	Western Australian Country Health Service
WAGPN	Western Australian General Practice Network
WAHES	WA Health Education Services
WAISHAC	WA Indigenous Sexual Health Advisory Committee
WASUA	Western Australian Substance Users' Association
WHO	World Health Organization

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SECTION 1: INTRODUCTION

The Second (2nd) Western Australian Aboriginal Sexual Health and Blood-borne Virus Strategy (2010-2014) provides direction and a framework for cooperation and support between government and non-government agencies, (including Aboriginal community controlled health services), research organisations and community groups to work together “to reduce the transmission of and morbidity and mortality caused by sexually transmitted infections (STIs) and blood-borne viruses (BBVs) and to minimize the personal and social impact of these infections” (1) among Aboriginal people in Western Australia (WA).

1.1. Background

The Western Australian Aboriginal Sexual Health Strategy 2005-2008, the first of its kind in WA, emphasised the importance of a comprehensive approach to sexual health and outlined a framework for engaging communities and service providers to bring about improvements in sexual health. (2) This strategy recognised the unacceptably high rates of STIs amongst Aboriginal people in WA. It also stressed that the public health importance of STIs in the Aboriginal community warranted a coordinated, comprehensive response sustained over several years. The strategy advocated for a cross-sectoral approach encouraging partnerships between government and non-government agencies involved in health, youth work, education and welfare.

In WA, a range of factors impact on the health of Aboriginal people as they experience social disadvantage such as limited access to education and employment opportunities, low incomes, inadequate housing and overcrowding, and higher rates of incarceration. Other factors that influence the health and well being of Aboriginal People include ongoing marginalisation in society; differing concepts of health and healing between Aboriginal and non-Aboriginal people; a paucity of culturally appropriate sexual health services and health promotion; issues related to trauma and trans-generational grief and loss; co-occurring mental health and alcohol and other drug dependencies; a lack of health infrastructure including the sexual health workforce and difficulties associated with remote service delivery .

A proper understanding and appreciation, by all health professionals, of the multiple determinants of Aboriginal health and wellbeing – physical, psychological, social, cultural and spiritual - is vital for the development and delivery of preventative and restorative health programs. (3)

The Department of Health would like to acknowledge that although the word Aboriginal is used throughout the document, it is referring to both Aboriginal and Torres Strait Islander people and communities in Western Australia.

1.2 Sexual Health

Sexual health is more than freedom from sexually transmissible infections and is regarded as a basic human right. (4) Aboriginal people's aspirations for health and wellbeing in relation to sexual health are reflected in the following principles:

- enjoyment and control of consensual (and potentially) reproductive behaviour in accordance with cultural values, kinship practices and individual ethics

- freedom from shame, guilt, myths about sexual orientation and sexual behavioural choices that do not harm individuals or their sexual partners
- freedom from infectious diseases that are preventable and treatable, and that interfere with sexual life
- freedom from harms that may interfere with the sexual health and emotional well being of individuals. (1)

1.3 Evaluation Findings of the WA Aboriginal Sexual Health Strategy 2005-2008

The Sexual Health and Blood-borne Virus Program (SHBBVP) commissioned the Macfarlane Burnet Institute for Medical Research and Public Health in 2008 to conduct a evaluation of the Western Australian Aboriginal Sexual Health Strategy 2005-2008. Achievements since the implementation of the Western Australian Aboriginal Sexual Health Strategy 2005-2008 include:

- sustained reduction in gonorrhoea notifications since mid 2007
- increase in STI testing rates and staffing for dedicated sexual health positions, particularly in the Kimberley and Pilbara
- increased capacity within primary health services to deliver comprehensive sexual health programs
- continued provision of community education and development of specific culturally appropriate resources.

However, the independent evaluation of the Western Australian Aboriginal Sexual Health Strategy 2005-2008 conducted by the Macfarlane Burnet Institute for Medical Research and Public Health (5) identified the following barriers to implementation:

- difficulties in attracting and maintaining an appropriate and qualified workforce particularly in regional and remote areas, and particularly regarding male Aboriginal personnel
- keeping sexual health and BBVs on the agenda - both politically and at a service delivery level
- lack of Aboriginal 'ownership' in the current response which influences effective implementation and the ability to form effective partnerships with the Aboriginal community controlled health sector
- stigma associated with risk behaviours for BBVs and STIs being a barrier to service access across the board, particularly for Aboriginal people.

The evaluation made the following recommendations that have relevance to future STI/BBV strategic responses for Aboriginal people in WA.

Aboriginal organisations and communities should provide direction and leadership to the SHBBVP in the development of the mainstream and Aboriginal specific response to BBVs and STIs in the Aboriginal population.

Access to mainstream services that are relevant to Aboriginal people should be encouraged by the continued inclusion of Aboriginal people as a priority population in the next iterations of each of the mainstream HIV, hepatitis C and STI policy documents.

A specific strategy aimed toward reducing the burden of BBVs and STIs in Aboriginal people and communities transmitted via unsafe sexual and injecting behaviours should be developed and should include an implementation plan.

The Second Western Australian Aboriginal Sexual Health and Blood Borne Virus Strategy 2010-2014, through its development and implementation, will address these findings.

1.4 Links to other Strategies

In 2010, the Australian Government released a number of national strategies in relation to STIs and BBVs. All identify Aboriginal people as a priority population. These strategic initiatives have informed the development of this document and provide a policy framework in which it can be placed. Priority areas and guiding principles from the national strategies have been considered and included in this strategy.

The national strategies are:

- *Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013*
- *Sixth National HIV Strategy 2010-2013*
- *Second National Sexually Transmissible Infections Strategy 2010-2013*
- *National Hepatitis B Strategy 2010-2013¹*
- *Third National Hepatitis C Virus Strategy 2010-2013.*

1.4.1 Third National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013 (3rd NATSIBBVSTIS).

This strategy notes that the major public health challenges for Aboriginal and Torres Strait Islander communities around BBVs and STIs include: (1)

- sustained and unacceptably high rates of bacterial STIs
- the rate of acquisition of HIV and viral hepatitis through injecting drug use
- the lack of access for many communities to primary health care services that provide culturally appropriate treatment, care and support services

¹ While ATSI people represent only 2% of the Australian population they make up an estimated 16% of those living with chronic hepatitis B.

- significant turnover within the workforce making it difficult to adequately deal with these issues.

New and continuing priority action areas include: (1)

- annual, routine and systematic testing, treatment and follow-up for bacterial STIs of sexually active Aboriginal and Torres Strait Islander young people
- increased access to treatment for Aboriginal and Torres Strait Islander young people who test positive to bacterial STIs
- increase in primary prevention activities that seek to reduce the number of new cases of HIV and viral hepatitis among Aboriginal and Torres Strait Islander people who inject drugs
- competent and accredited workforces consistent across all jurisdictions to address the scope of work outlined in the strategy
- continued health promotion and increased community awareness of STIs, HIV and blood-borne viruses (BBVs)
- continued efforts to prevent transmission of HIV among gay men, men who have sex with men, sistergirls² and transgender people
- continued improvement in the accuracy and completeness of Aboriginal and Torres Strait Islander status in routine STI and BBV surveillance systems across all jurisdictions
- continued research activities that will guide the development and implementation of prevention, treatment and care initiatives in the Aboriginal and Torres Strait Islander community.

1.4.2 Other related National Strategies:

The other National Strategies are equally important in providing direction and context to *The Second Western Australian Aboriginal Sexual Health and Blood-borne Virus Strategy 2010-2014*. They highlight the reality for Aboriginal and Torres Strait Islander communities which have the potential for an acceleration of epidemics. For example, the *Sixth National HIV Strategy* refers to: (6)

- the geographical, cultural and social circumstances of Aboriginal and Torres Strait Islander communities, including high mobility between communities, lower health literacy, and issues such as shame and underlying poor health status
- sustained high prevalence of viral and bacterial STIs in many remote and very remote communities

² In this context the term "sistergirl" refers to an individual with transgender qualities as defined in the *Report of the First National Indigenous Sistergirl Forum 1999 (AFAO)*

- the over-representation of Aboriginal and Torres Strait Islander men and women in prisons and juvenile detention
- limited access to culturally appropriate services, including primary healthcare services for many communities
- higher rates of injecting drug use and sharing of injecting and other equipment.

Priority action areas for these strategies include:

- health promotion, education and prevention targeting priority communities and populations
- vaccination where available (hepatitis B)
- patient and provider-initiated testing and early detection
- clinical management, treatment, and support
- health and wellbeing support
- human rights, legislation and anti-discrimination.

1.4.3 WA Models of Care and Implementation Plans

The WA Health reform process which commenced in 2004 facilitated the development of 'Models of Care' which "aim to describe best practice care and services within the WA health care system for a person or population group prior to and following diagnosis with a particular condition." (7)

STI, HIV and Hepatitis C Models of Care and STI and HIV Model of Care Implementation Plans³ have been developed with the Hepatitis C Model of Care Implementation Plan in final draft. An *Implementation Plan for WA for the National Hepatitis B Strategy 2010-2013* is also in final draft. These documents outline key recommendations which link together with *The Second Western Australian Aboriginal Sexual Health and Blood Borne Virus Strategy 2010-2013* (the Strategy). These models of care and plans identify actions for:

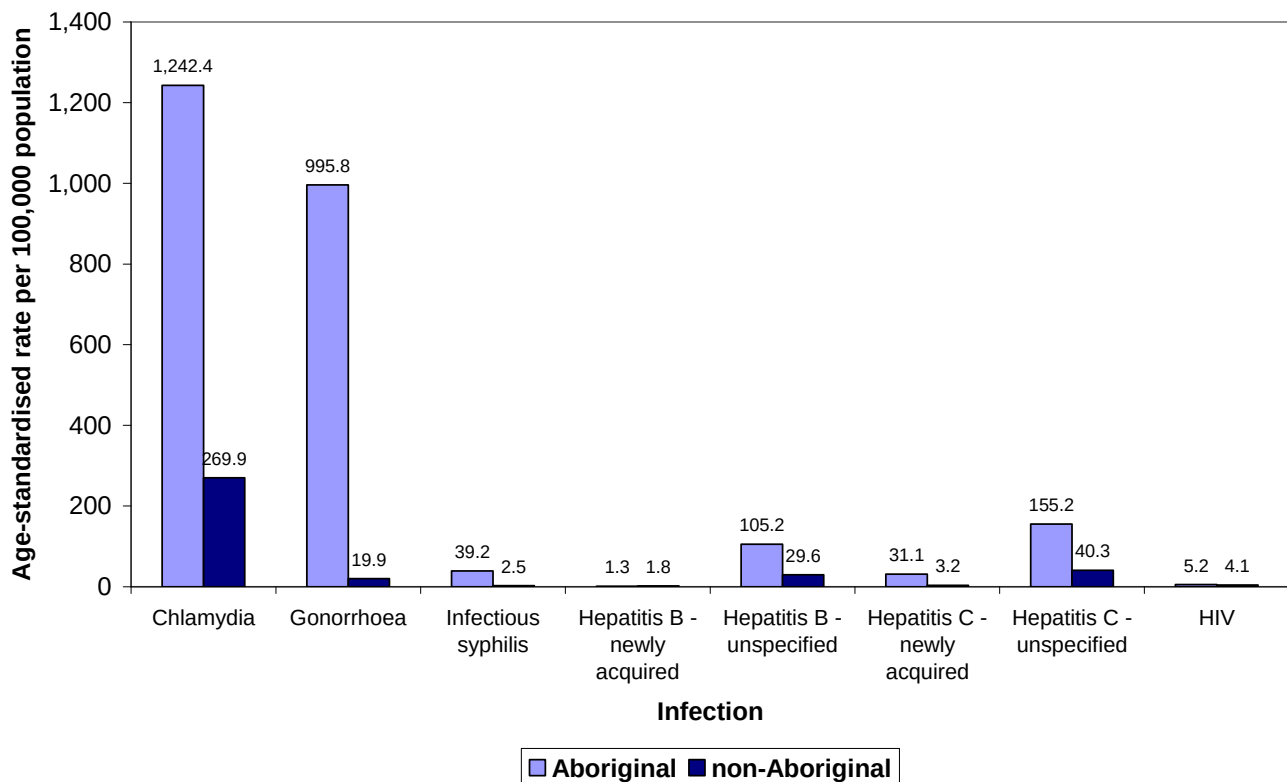
- primary prevention
- secondary prevention and early detection
- disease management and tertiary prevention
- workforce development and training.

³ http://www.public.health.wa.gov.au/3/467/3/policies_and_action_plans.pm <accessed on ,20.02.11>

1.5 Sexually transmitted infections and blood borne viruses among Aboriginal people in Western Australia

In 2009, the rates of STIs and BBVs in WA were between three and 49 times higher among Aboriginal people compared to non-Aboriginal people. The exceptions were newly acquired hepatitis B and HIV, for which the rates were comparable by Aboriginality (Figure 1). For a more detailed description of the epidemiology of STIs and BBVs among Aboriginal people in WA, see Appendix 1.

Figure 1 Age-standardised rate of STI and BBV notifications by Aboriginality, WA, 2009



1.6 Purpose

In line with the Third National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013, the purpose of this Strategy, together with the Regional Implementation Plans, is to provide *direction* and a *framework for cooperation and support* between all key stakeholders “to reduce the transmission of and morbidity and mortality caused by STIs and BBVs and to minimise the personal and social impact of these infections.” (1)

The Strategy aims to reduce the burden of STIs and BBV in Aboriginal communities, and has an implementation plan template designed to encourage local leadership and ownership. There is a need for targeted and culturally appropriate programs which are driven at a regional, local and community level.

The implementation plans are designed to stimulate engagement and collaboration between service providers *at a regional and local level*. This is to encourage a reorientation of services through service mapping, agency networking and local agency commitment to action. Most importantly, it is the mechanism by which the barriers to implementation identified in the Macfarlane Burnet Institute for Medical Research and Public Health Evaluation can be successfully addressed. (5)

1.7 Principles

National approaches to reducing disparities in health and life outcomes experienced by Aboriginal people and communities have, in recent times, stressed the fundamental importance of a rights-based framework for health. (8) This approach allows for consideration and incorporation of individual human rights, citizenship rights and sovereign rights. The 3rd NATSISHBBVS extends this social justice approach with guiding principles that outline the importance of protective behaviours, the Ottawa Charter for Health Promotion, harm reduction, effective partnerships, the valuable role of ACCHS, choice of healthcare provider and a strength-based model of wellbeing that acknowledges the aspirations of Aboriginal peoples.

In line with the above and *The Western Australian Aboriginal Sexual Health Strategy 2005-2008*, this Strategy is underpinned by the following three principles – collaboration and partnerships; primary health care approaches and responsibility.

1.7.1 Collaboration and partnerships

- Comprehensive sexual health and BBV programs rely on effective partnerships to provide a foundation for collaborative planning and comprehensive programming. This includes building effective and meaningful partnerships between mainstream and Aboriginal Community Controlled Health Services (ACCHS) and, through them, improving partnerships with Aboriginal communities across WA.

1.7.2 Primary Health Care Approaches

- Formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights, as this protects those who are vulnerable or marginalised, promotes confidence in the system and secures support for initiatives.
- Harm reduction principles underpin effective measures to prevent transmission of STIs and BBVs.

1.7.3 Responsibility

- Individuals and communities have a mutual responsibility to prevent themselves and others from becoming infected.
- Government will provide leadership in:
 - a. policy formulation through national expert advisory groups and in WA in partnership with WA Aboriginal health services and the WA Aboriginal

community. This includes expert advisory committees on STIs and BBVs which represent a range of key stakeholders, such as the WA Committee on Blood Borne Viruses and Sexually Transmitted Infections (WACBBVS) and the WA Indigenous Sexual Health Advisory Committee (WAISHAC)

- b. funding arrangements with community and professional organisations to ensure effective and comprehensive responses.
- Community-based Aboriginal health services will advocate for the interests of the affected communities in decision making and policy formulation, and work together with government health services to provide sexual health and BBVs primary health services and other programs and services to provide care and support to Aboriginal people affected by STIs and BBVs.

1.8 Indicators of success

Performance indicators will be collected at a state level as a requirement of the range of National and State Strategies and Models of Care relating to HIV, STIs and BBVs which will include, prevalence, notification and testing data, and information about the proportion of the target groups who are receiving testing and treatments. This information will be collected and reported using a range of demographic variables including, where available, Aboriginal status. While this information will provide broad indicators of success, it is important to also evaluate this Strategy through the process and impact of the activity generated in its implementation at a regional and local level. Therefore the indicators of success will include:

- number of regions that have developed plans
- actions implemented
- results of actions implemented.
- achievements/barriers/opportunities and trends in implementing the Strategy.

It is intended that the SHBBVP would facilitate a mid-term process evaluation and provide feed back to the regions. An independent evaluation will be conducted in 2014.

SECTION 2: PRIORITY GROUPS

This strategy covers five main priority Aboriginal population groups in WA.

2.1 Young People aged 15 - 30 years

The population groups with the highest levels of STIs, psychological distress and risk behaviours (including alcohol and drug use, and unprotected sex) are adolescents and young adults (9,10). Adolescence is a time of significant physical and emotional growth and change.

In WA, young Aboriginal people aged 15-30 years carry the highest burden of disease for STIs. Young Aboriginal people may engage in behaviours that put them at greater risk such

as having higher rates of partners and not having the necessary skills, resources or maturity to understand the implications of engaging in unprotected sexual activity, or of how to protect themselves from infection. (2)

Access to health services is a major factor for young Aboriginal people as they may be reluctant, embarrassed, fear insensitive staff and a lack of privacy and confidentiality. The barriers to accessing health services result in lower levels of health education and health literacy than in other community members. (1) Access to culturally relevant information and services is critical for young Aboriginal people.

2.2 People in custodial settings

In WA, Aboriginal people are 20 times more likely to be in prison than non-Aboriginal people, and around one in 15 Aboriginal men in WA will be in prison at any given time. (11)

On 8 October 2009, of the 4,750 prison population, there were 1,909 (40%) Aboriginal people in WA prisons. Of these, 1,732 (91%) were men and 177 (9%) women. The total number of Aboriginal people in prison had more than doubled in seven years, from 800 in mid 2002 to over 1900 in 2009. (11) There are strong links between substance misuse and Indigenous incarceration. While in prison, Aboriginal people are at increased risk of BBV transmission, physical violence, sexual assault and isolation. (12)

Aboriginal offenders often have complex needs through an existing substance misuse, mental health or physical health problem. Separation from family and culture, together with a previous history of an undiagnosed or untreated health condition, places them at great risk while in the correctional system. If left unattended there is the danger of these issues, exacerbating or manifesting other health problems while they are in detention. (12)

In addition, Aboriginal people in prison may engage in behaviours that increase their risk of STI or BBV transmission. While testing for STIs and BBVs can be accessed at any time whilst a person is in prison, there is a need to continue to ensure that there is equitable access to health promotion, and treatment and care services for those in prison settings. (11) Furthermore, anecdotal information is that the transition time from release from prison to returning to family in remote communities is a time of risk for many Aboriginal people, and supportive local strategies are required.

2.3 People who Inject Drugs

Injecting drug use (IDU) is a significant risk factor for the transmission of HIV internationally and the main risk for the transmission of hepatitis C virus. There is limited information on the number of Aboriginal people who inject drugs. (1) Community feedback suggests that in some WA Aboriginal communities there is increasing injecting drug use.

The 3rd NATSIBBVSTI Strategy prioritises the reduction of BBV transmission associated with injecting drug use in response to recent rises in hepatitis C infections within Aboriginal communities. (1) Aboriginal and Torres Strait Islander people who inject drugs have a higher incidence of hepatitis C than other Australians. Aboriginal and Torres Strait Islander people are significantly overrepresented in adult and juvenile custodial settings, which compounds their risk of exposure to hepatitis C. (13)

There is also a need for public health providers to adapt their interventions to the changing patterns of IDU across urban, rural and remote settings. Ongoing initiatives to improve the sexual health of Aboriginal people who inject drugs need to be managed through the development of specific and targeted health promotion initiatives, including community development approaches that promote and strengthen partnerships between people who inject drugs, peer-based organisations, ACCHS and public health providers. (14)

2.4 People Living with HIV and other Blood-Borne Viruses

“In Australia approximately 300 Aboriginal and Torres Strait Islander peoples are diagnosed with HIV, approximately 28,000 with chronic hepatitis B⁴ and approximately 16,000 with chronic hepatitis C”. (1) In Aboriginal communities, fear and ignorance about HIV/AIDS may result in discrimination and marginalisation. This can add additional pressure on those who are infected, and may further distance them from social networks, treatment services and supportive communities, thus increasing the risk of further transmission. Hence, a key issue for Aboriginal people living with HIV, and for their partners, carers, families, friends and children, is the need to maintain privacy and confidentiality around their HIV status. (15) It is important that Aboriginal people living with HIV and viral hepatitis are supported through advocacy and information dissemination.

Aboriginal people living with BBVs have complex needs including the right to confidentiality. In many Aboriginal communities there is fear and misunderstanding about BBVs, often resulting in social discrimination and isolation. In these circumstances, there is the potential for self harm from behaviours such as alcohol and drug use. Co-morbidities such as mental health problems also need to be considered. (1)

2.5 Gay Men and other Men who have Sex with Men

In Australia, about 150,000 men aged 16–59 years identify as gay or bisexual, while a similar number identify as heterosexual but have some history of same-sex sexual contact. (16) Sex between men accounts for over half of all HIV infections in Aboriginal men in Australia. In WA, from 1983 to 2004, 21 per cent of Aboriginal HIV diagnoses were attributed to homosexual transmission. (16)

Aboriginal gay and transgender people can experience shame, discrimination and racism when accessing health services, as well as the added burden of alienation and rejection from family. There are low levels of HIV awareness which include prevention, treatment and care options, in addition to alcohol and drug use. (1)

In addition, “Aboriginal gay men, men who have sex with men, sistergirls and transgender people have consistently reported difficulties accessing both specialist HIV services and ACCHSs”. (1) As in the non-Aboriginal community, Aboriginal men who have sex with men but do not identify as gay, are especially difficult to reach, since they may not access gay-identified agencies, events and resources. (16)

⁴ Aboriginal women with chronic hepatitis B who are pregnant are an important target group as are the children born to these women. Screening and interventions to prevent transmission from mother to child are critical.

SECTION 3: PRIORITY AREAS FOR ACTION

The Western Australian Aboriginal Sexual Health Strategy 2005-2008 described priorities for action utilising a comprehensive sexual health program, the *Eight Way Model*, originally adopted by the Nganampa and then the Ngaanyatjarra Health Services. This model identified the components of a successful sexual health program: planning and management; health promotion and community education; data collection and monitoring; health hardware; clinical services; training; research and evaluation. Linkages between each component contribute to a comprehensive and integrated sexual health program.

The 2008 evaluation found that “the Eight Way model for delivery of comprehensive sexual health care was largely supported by stakeholders”. (5) However, the evaluation also noted that participation and partnerships with Aboriginal communities and organisations were very important and could be improved. As a result of this, partnerships have been included in the Strategy as the first component of the Eight Way model: “*Partnerships, Planning and Management*”.

The implementation plan attached to the Strategy will use the Eight Way Model with the following components.

3.1 Partnerships, planning and management

The need for partnerships to underpin this Strategy has been highlighted by the 2008 evaluation, the 3rd NATSIBBVSTI Strategy, and in other regional approaches to sexual health such as the regional model for delivery of sexual health and BBVs involving the Queensland Aboriginal Islander Health Council. Partnerships between different services enable expertise, knowledge and resources to be shared and can build constructive relationships with traditionally disempowered communities. (17) Engaging the community in the initial planning stage of programs ensures communication is open and transparent and results in community ownership and support which is essential for participation and success. (18)

When tackling STI and BBV issues important factors include coordinated and strategic responses through effective planning and health management, in addition to Aboriginal community ownership and participation and adequate resources. This is important, as regional input helps to identify responsibility and coordinate efforts, in addition to highlighting where roles fit within the scope of STI and BBV issues within the region.

3.2 Health promotion and prevention, community awareness and health literacy

Health promotion and prevention, community awareness and health literacy are essential components of a comprehensive STI and BBV control program (18) playing vital roles in educating people about transmission and minimising the personal and social impact of STIs and BBVs. “Efforts in health promotion and social marketing need to respond to the social, cultural and environmental context in which people live”. (1) Health promotion activities should

be targeted, focus on all elements essential to health and, where possible, be localised and use appropriate language and images.

Community awareness and health literacy can be facilitated not only through health workers but also through members of the community and other professionals such as youth and mental health workers, teachers and alcohol and drug workers. This creates a supportive environment for promoting change.

Vaccination is the most effective means of preventing the transmission of hepatitis B.

3.3 Clinical services (including access to testing, treatment, support and aftercare)

Building the capacity of health care providers to initiate testing, diagnosis, treatment and to engage in culturally appropriate partner notification strategies is critical to reducing the transmission of STIs and BBVs, and the morbidity and mortality and personal and social impacts they cause. Annual routine and systematic testing and follow up treatment programs, such as in Ngaanyatjarra Health in WA where community-wide screening has lowered prevalence, are supported.

Young people aged 15-30 years are screened less often for STIs than older people but are often at greater risk, with those aged 15-19 years who are sexually active and have high rates of STIs at most risk. (1) Specific strategies are required to reach these young people as well as for people in custodial institutions. Regular provider- initiated testing or screening alongside opportunistic testing and follow up must occur concurrently to have an impact on STI prevalence rates. (1) Through increasing opportunistic testing in young people who visit a health clinic or hospital for other reasons, early detection and treatment for asymptomatic infections could be substantially improved. (2)

Clinical services, while needing to provide better access to all Aboriginal people, particularly need to actively engage with Aboriginal males who use health services to a lesser extent than women. When Aboriginal men access health services it is often when they are ill or at a crisis point than at an earlier stage, when the problems are preventable. (19) Another priority population for increasing access to clinical services including testing are Aboriginal people who engage in sex work, particularly street based sex work and people engaging in sex for favours. This group is at increased risk of STI and BBV transmission as they have less opportunity to control the conditions of their sexual encounters. (1)

Increasing access to treatment, care and support for people living with HIV and viral hepatitis needs to be adequately resourced and sufficiently flexible to accommodate changing needs and new treatment options. Access to specialist services to complement primary health care services is necessary and links between mainstream services and ACCHS are vital. (1)

3.4 Health hardware

Health hardware for STI/HIV control includes condoms, sterile needles and other injecting equipment, and single-use sharps equipment. The consistent and correct use of condoms has been shown to be 90 per cent effective in preventing HIV transmission, and condoms are a

proven preventive strategy for those who engage in high-risk behaviours, i.e. people who inject drugs, sex workers and people with STIs. (2)

Health hardware strategies should include:

- unlimited, confidential condom availability, on a 24-hour basis
- access to sterile injecting equipment through a range of confidential and non-judgmental services
- appropriate education about the risks of BBV transmission through ceremonial practices.

3.5 Data collection and monitoring

Regular collection and analysis of data allows for monitoring and evaluating the extent of a problem, ensuring interventions are targeted at the right groups, and evaluating the success of activities. Data need to be collected at state, regional and local levels, and it is important that data have local relevance to health services.

Data can be used to motivate health professionals and community members to work together to reduce STI and BBV rates.

3.6. Workforce development/training

A strong primary health care workforce within the ACCHS and in mainstream health sectors is needed. (1) An adequately resourced sexual health and BBV sector is a prerequisite for effective actions and ultimately better health outcomes for Aboriginal people. It is recognised that, while sexual health impacts on all people, those most at risk are likely to be the more marginalised members of any community.

The number of Aboriginal sexual health and BBV workers should be increased, particularly male personnel. Other health care workers should be provided with opportunities to enhance their knowledge and skills in sexual health prevention, treatment, care and support. (1) In addition, there is the experience of stigma attached to designated sexual health workers in the Northern Territory and WA. This has led to initiatives to develop youth health promotion positions, which deliver sexual health education programs such as Mooditj and PASH within a broader youth health approach (including drug and alcohol, and social and emotional well being program work) and help to link young people with clinics. (2)

Training in cultural respect to enable workers engaging with Aboriginal people to provide culturally appropriate sexual health and blood borne virus services is fundamental to the success of improved health outcomes for Aboriginal people in WA. Accessible and non-judgmental sexual health clinical services which are welcoming and inclusive are essential. Training in clinical skills, including diagnosis, specimen collection, treatment and management are required. In addition, relevant alcohol and other drug training related to harm reduction and prevention strategies are needed.

3.7 Evaluation

Education in evaluation is fundamental for sexual health coordinators and health service providers as evaluation and monitoring of programs are important to ensure the overall effectiveness of sexual health services. Effective sexual service health evaluation should ensure ongoing review and refinement of the operations of STI and BBV programs. (2) Evaluation is an essential element in quality improvement processes.

3.8 Research

Research is important as it provides an evidence base for the development of public policy, programs and service delivery. (5) "Improvements in planning and decision making can be linked to the collection, analysis and appropriate dissemination of accurate and meaningful data. Epidemiological, basic scientific, clinical, social and behavioural research contributes to addressing sexual health and BBVs in the Aboriginal population". (1)

All research involving Aboriginal people should be carried out in line with the National Health and Medical Research Council of Australia's guideline *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. (20)

SECTION 4: IMPLEMENTATION PLAN

The Implementation Plan is a template to provide regions with a framework to assist with localised planning and implementation. It is not intended to be prescriptive and Health Regions may modify and add to the template to suit their specific conditions, priorities and resources. However the Eight (8) Way Model provides the components of a comprehensive sexual health program, therefore the essential linkages between the different elements should be considered when developing local plans.

The Implementation Plan is organised according to the elements of the Eight Way Model. However, the heading *Health Promotion, Community Education and Health Literacy* is further differentiated by priority target group to allow for the specific strategies necessary to meet the needs of these groups.

It is intended that Implementation Plans will be negotiated region by region, through the appropriate regional partnership groups, in particular the Regional Aboriginal Health Planning Forums (RAHPF) and developed locally to meet the specific needs of each region.

Review. The SHBBVP will review the achievements/barriers/opportunities and trends in implementing the Strategy with a mid-term process evaluation. An independent evaluation will be conducted in 2014.

An explanation of the layout of the Implementation Plan.

Responsibilities and commitments by the Communicable Disease Control Directorate (CDCD) and other state-wide agencies (such as the Drug and Alcohol Office, the Departments of Corrective Services and Education, FPWA and other non government agencies with a statewide mandate) are noted in dot points above the table.

The left hand column (*Regional and Local Strategies*) shows a list of evidence-based strategies which should be undertaken at a regional/local level. **Regions should add in their own innovative strategies which enhance and strengthen their local response.**

The next column (*Action*) is designed to capture details of how these strategies can be put into action at a local level, with the other columns providing space for identifying *Responsible agencies*, *Timeframes* and measurable *Results*. Results could be qualitative comments and/or quantitative measures and should provide regions with a mechanism for reflection and tracking of progress.

Some examples of *actions*, *responsibility*, *timeframe* and *results* are provided in the template.

IMPLEMENTATION PLAN TEMPLATE FOR REGIONAL PLANNING.

PRIORITY ACTION AREA 1: PARTNERSHIPS, PLANNING AND MANAGEMENT

Existing partnerships are strengthened and new ones developed. Collaborative planning and management of services and programs are facilitated

Aboriginal and broad stakeholder interest and ownership is developed. Current and emerging STI/BBV risks and problems are identified and prioritised. Interventions are identified, agreed and planned together.

Statewide Agencies responsibilities:

- Provide statewide leadership in partnership development and maintenance
- Provide leadership in areas of specific expertise
- Promote and support regional planning through the Regional Aboriginal Health Planning Forums
- Support Regional Sexual Health Teams and other sexual health staff across the State
- Provide statewide representation on relevant forums and committees
- Support and seek funding for identified regional priority programs where appropriate.

Regional and Local Agencies Action Plan

Regional and Local Strategies (What we can do)	Action (How it can be achieved) (examples)	Responsibility (Who will be involved) (examples)	Timeframe (When)	Results (example)
Develop and maintain local partnerships	<i>Policies and protocols developed between agencies that have local relevance and acceptance</i> <i>Memorandums of understanding developed between agencies</i>	<i>State health service providers, DOHA, DIA, Public Health Units, ACCHS, government and non government schools, Divisions of General Practice, consumer groups (including youth groups), non-government agencies (e.g. FPWA), other health service providers, other relevant sectors, corrective services, police and alcohol and other drug (AOD) agencies.</i>	<i>June 2011</i>	<i>MOU developed and signed by all parties by April 2011</i>
Develop a regional Aboriginal STI/BBV Action Group to plan and manage regionally responsive, coordinated and comprehensive STI/BBV services	<i>Identify key stakeholders and resources and coordinate efforts throughout the local/regional area.</i>			

PRIORITY ACTION AREA 2: HEALTH PROMOTION & PREVENTION, COMMUNITY AWARENESS AND HEALTH LITERACY

Communities are supported through knowledge and skill interventions to adopt safer sexual and /or injecting drug use behaviours. Vaccination programs are provided as the most effective means of prevention of hepatitis B.

Statewide Agencies responsibilities:

- Provide statewide leadership in sexual health and BBV health promotion and community education strategy development
- Fund and support organisations, specific activities and initiatives
- Develop contemporary and relevant school curriculum
- Develop appropriate resources in consultation with Aboriginal stakeholders, including electronic resources
- Develop appropriate social marketing strategies
- Educate statewide agencies about STI/BBV issues and develop partnerships for coordinated program delivery
- Support and drive policy which enables people in custodial settings to have access to the same harm reduction services as people in the community
- Provide culturally appropriate BBV and harm reduction education, training and capacity building support, primarily to ACCHS, but also to a wider range of agencies and workers who may provide services to Aboriginal people who inject drugs
- Develop partnerships for coordinated program delivery.
- Supply hepatitis B vaccine for immunisation of infants, children and at risk adults.

Regional and Local Agencies Action Plan

2.1 PRIORITY POPULATION: YOUNG PEOPLE 15-30 YEARS				
Regional and Local Strategies (What we can do)	Action (How it can be achieved) (Examples)	Responsibility (Who will be involved)	Timeframe (When)	Results
Provide school based sexual and reproductive health and blood awareness education to children through all phases of schooling	<i>Training resources are promoted locally to all schools Local health staff assist with the delivery of sexual health education</i>	<i>Population Health Department of Education Regional Sexual Health Teams ACCCHS FPWA</i>	<i>Ongoing</i>	<i>xx% of schools in region provide sexual health education</i>
Provide targeted sexual and reproductive health/blood awareness programs for Aboriginal teenagers who are disengaged from school.				
Provide appropriate and accessible information resources on STI/BBV	<i>Use new and technologies including SMS text messages and computer based technology such as websites, HITNet etc</i>			
Promote regular events to highlight particular STI/BBV issues				
Educate young people about sexual and reproductive health and blood awareness knowledge, attitudes and practices through a variety of media				

Regional and Local Strategies (What we can do)	Action (How it can be achieved)	Responsibility (Who will be involved)	Timeframe (When)	Results
Educate parents and community elders about sexual health and blood awareness in order to support children's and young people's education				
Provide education about the impact of alcohol and other drug use on STI prevention				
Provide education about Foetal Alcohol Spectrum Disorder through development of culturally appropriate resources and suitably trained workforce to target those most at risk				
Promote and provide hepatitis A & B vaccination to at risk young people				

2.2 PRIORITY POPULATION: PEOPLE IN CUSTODIAL SETTINGS				
Regional and Local Strategies (What we can do)	Action (How it can be achieved) (Examples)	Responsibility (Who will be involved)	Timeframe (When)	Results
Provide targeted STI/BBV programs for Aboriginal people in custodial settings	<i>Train appropriate prison staff and peer leaders to be able to provide information to those at risk within custodial settings</i> <i>Provide and evaluate formal STI/BBV programs for all prisoners on entry to, and prior to release from, prison</i>			
Provide appropriate and accessible information resources on STIs/BBVs for Aboriginal people in custodial settings				
Support the provision of accessible pharmacotherapy and other drug treatment programs in local prisons				
Develop programs and resources to address the risk of BBV transmission from injecting, tattooing and body piercing in custodial settings including vaccination				

2.3 PRIORITY POPULATION: PEOPLE WHO INJECT DRUGS				
Regional and Local Strategies (What we can do)	Action (How it can be achieved) (Examples)	Responsibility (Who will be involved)	Timeframe (When)	Results
Provide targeted BBV programs for Aboriginal people who are at risk of, or who inject drugs	<i>Increase appropriate drug and harm reduction education, and health promotion programs within communities</i>			
Disseminate appropriate health promotion and harm reduction resources to Aboriginal people who inject drugs				
Increase understanding and support for harm reduction strategies including needle and syringe programs as a critical strategy to prevent BBVs				
Increase community awareness of BBV prevention, health outcomes and treatment through a variety of media				
Provide hepatitis A & B vaccinations to Aboriginal people who inject drugs				

2.4 PRIORITY POPULATION: PEOPLE LIVING WITH HIV AND OTHER BLOOD BORNE VIRUSES

Regional and Local Strategies (What we can do)	Action (How it can be achieved)	Responsibility (Who will be involved)	Timeframe (When)	Results
Provide healthy lifestyle education programs to people living with hepatitis C, hepatitis B and HIV				
Continue to actively support programs to reduce HIV-related stigma and discrimination and misconceptions around HIV				
Promote and enhance access to hepatitis A & B vaccination to people living with HIV/AIDS and /or HCV				
Develop appropriate local educational resources for people with HIV and other BBVs				

2.5 PRIORITY POPULATION: GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN				
Regional and Local Strategies (What we can do)	Action (How it can be achieved) (Examples)	Responsibility (Who will be involved)	Timeframe (When)	Results
Facilitate programs which strengthen individual and community capacity to improve knowledge and understanding of STIs/BBVs and modify attitudes and behaviours	<i>Gendered, integrated program development</i> <i>Peer based program development</i> <i>Community development programs</i>			
Provide peer-based education and/or skill building to maintain and improve a safe sex culture as well as regular HIV/BBV and STI testing				
Provide targeted STI/BBV programs for Aboriginal gay men and other men who have sex with men				
Provide appropriate and accessible information resources on STIs/BBVs				
Promote regular events to highlight particular STI/BBV issues				

2.5 PRIORITY POPULATION: GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN				
Educate parents and community elders about STIs/BBVs in order to support the target group				
Use social marketing campaigns to reinforce condom use and STI/BBV testing				
Improve links and interactions between STI and BBV services where required				
Promote and provide access to hepatitis A & B vaccination				

PRIORITY ACTION AREA 3: CLINICAL SERVICES

Provide best practice testing, diagnosis, assessment and treatment in locations that are appropriate and accessible to the target group.

Statewide Agencies responsibilities:

- Ensure that primary health care providers are aware of the need for STI/BBV testing with appropriate pre and post test discussion
- Provide best practice clinical guidelines, policies and training
- Provide audit tools and professional support to improve clinical management including in antenatal care
- Provide aggregated testing and notification data
- Expand existing training and education programs for health professionals

Regional and Local Strategies (What we can do)	Action (How it can be achieved)	Responsibility (Who will be involved)	Timeframe (When)	Results
Deliver early detection and intervention programs	<i>Provide at least annual STI testing to all clinic attendees aged 15-30 years</i>			
	<i>Develop and use systems to track key service level STI management and prevention indicators</i>			
	<i>Provide three month follow up for all confirmed STI cases</i>			
	<i>Provide services in outreach settings such as youth, alcohol and drug and women's health centres.</i>			
	<i>Use innovations in recall systems such as SMS and text buddy</i>			

Regional and Local Strategies (What we can do)	Action (How it can be achieved)	Responsibility (Who will be involved)	Timeframe (When)	Results
Maximise use of standard health checks such as the Adult Health Check/Pap Tests and antenatal checks to extend STI/BBV screening				
Conduct regular audits of STI/BBV treatment and prevention practice, contact tracing in order to improve practice in line with regional quality improvement processes.	<i>Engage/utilise professional expertise to conduct audit and train staff in auditing own services regularly</i> <i>Service plans include regular auditing of services</i>			
Ensure contact tracing is completed on 100% of all HIV and syphilis index cases and attempted on all other STIs				
Improve accessibility of appropriate clinical services (including treatment services) particularly to high risk groups	<i>Provide outreach services in settings where high risk groups are willing to access services</i>			
Increase the clinical management and care planning for people with HBV, as well as HIV and HCV including screening and appropriate intervention in pregnant women				

PRIORITY ACTION AREA 4: HEALTH HARDWARE

Appropriate means are readily available to enable safe sex and reduce harm for people who inject drugs.

Statewide Agencies responsibilities:

- Fund and support for organisations to provide health hardware where appropriate.
- Implement recommendations from the *Needle and Syringe Program Review 2007*, including:
 - o Promotion of needle and syringe programs (NSPs) as core business for health services that provide secondary NSP.
 - o Development of a state-wide NSP policy
 - o Development of additional fixed site needle and syringe exchange programs (NSEPs).
 - o Roll-out of needle and syringe vending machines.
 - o Development of secondary sites as 'enhanced' secondary NSP sites.
 - o Development of strategies to increase the range of injecting equipment available.

Regional and Local Agencies Action Plan

Regional and Local Strategies (What we can do)	Action (How it can be achieved) (examples)	Responsibility (Who will be involved)	Timeframe (When)	Results
Increase availability of and access to condoms and water-based lubricant				
Increase availability and access to injecting drug use equipment				
Ensure safe ceremonial equipment and training is provided where culturally appropriate				

PRIORITY ACTION AREA 5: DATA COLLECTION AND MONITORING

Effective data collection systems are in place and staff are able to use them to measure and evaluate program activity

Statewide Agencies responsibilities:

- Ensure effective data collection and analysis systems are available at the State, regional and service level.
- Provide data on STI/BBV testing to endemic regions to enable monitoring and re-focusing of services to target high-risk groups
- Provide regular (quarterly) epidemiology reports on STI/BBV in Aboriginal populations
- Support services are provided to make the best use of data systems to improve service delivery.

Regional and Local Agencies Action Plan

Regional and Local Strategies (What we can do)	Action (How it can be achieved) (Examples)	Responsibility (Who will be involved)	Timeframe (When)	Results
Use testing data to track trends in areas and groups tested, and identify gaps in service delivery.				
Provide notification data to CDCD including ascertainment of Aboriginality				
Collect, extract and analyse data on testing and treatment to establish effectiveness of service coverage to high-risk groups	<i>Engage/utilise professional expertise to conduct audit and train staff in auditing own services regularly</i> <i>Service plans include regular auditing of services</i>	Services (ACCHS and other clinical providers)		
Provide user-friendly epidemiological data and analysis to Aboriginal communities and all health services.				

PRIORITY ACTION AREA 6: WORKFORCE DEVELOPMENT AND TRAINING

An adequately resourced and trained workforce for effective action in addressing STIs and BBVs in target groups.

Statewide Agencies responsibilities:

- Facilitate and fund professional development including on-line and face-to-face education to relevant workforce groups
- Provide training in contact tracing for doctors, nurses, Aboriginal Health Workers and other health professionals including on-line training
- Provide specific cultural awareness training to improve suitability and accessibility of sexual health and BBV services to Aboriginal people
- Support regional sexual health workforce
- Provide regional STI/BBV updates to local service providers including on-line
- Provide culturally appropriate BBV and harm reduction education and training.
- Support on line communication and networking strategies.

Regional and Local Agencies Action Plan

Regional and Local Strategies (What we can do)	Action (How it can be achieved) (Examples)	Responsibility (Who will be involved)	Timeframe (When)	Results
Promote and support professional development for teachers & school nurses providing sexual health education	<i>Plan and deliver annual in-service training and provide follow up support where necessary</i>	<i>PHU, District Education Office, local schools, health services</i>		
Provide workforce development opportunities for people working with high risk groups	<i>Provide timely orientation to new workforce to the STI/BBV program in endemic regions Provide orientation to provision of NSP for staff working in services that provide NSP (including hospital ED staff)</i>	<i>All health service employers</i>	<i>Within 2 weeks of commencement of employment</i>	
Train doctors, nurses, Aboriginal Health Workers and other health professionals in contact tracing including using on-line training	<i>Organise, promote and support training</i>			

Regional and Local Strategies (What we can do)	Action (How it can be achieved) (Examples)	Responsibility (Who will be involved)	Timeframe (When)	Results
Provide culturally appropriate BBV and harm reduction education, training and capacity building support to agencies providing services to high risk Aboriginal individuals and groups.	<i>Organise, promote and support training</i>	DAO		
Provide specific cultural awareness training to improve suitability and accessibility of sexual health and BBV services for Aboriginal people	<i>Organise, promote and support training</i>			
Increase the number of Aboriginal sexual health and BBV workers particularly focusing on the recruitment and support of male personnel				

PRIORITY ACTION AREA 7: EVALUATION

Sexual health/BBV programs are evaluated as part of local continuous quality enhancement and to ensure overall effectiveness of programs.

Statewide Agencies responsibilities:

- Support the inclusion of evaluation processes and measurement in all sexual health and BBV programs
- Support evaluation as part of quality improvement
- Assist with advice and data to develop evaluation measures as requested.
- Build strategies for demographic data collection into state-wide NSP policy.
- Participate in the National Reference Group for the Australian NSP Survey on an ongoing basis and provide support for services that participate in this survey.
- Support Participatory Action Research involving Aboriginal people and workers at a local level.

Regional and Local Agencies Action Plan

Regional and Local Strategies (What we can do)	Action (How it can be achieved)	Responsibility (Who will be involved)	Timeframe (When)	Results
Support and promote the inclusion of evaluation in all sexual health and BBV programs	<i>Include evaluation measures in all programs</i>			
Support data collection in regional NSP programs so that access by Aboriginal people can be better assessed	<i>Services support and comply with enhanced data collection through local NSPs as required</i>			
Measure acceptability and accessibility of sexual health and BBV services to local Aboriginal people	<i>Service providers to set goals and develop measures to identify trends in service usage in high risks groups</i>			

PRIORITY ACTION AREA 8: RESEARCH

Provide an evidence-base for the development of public policy, programs and service delivery.

Statewide Agencies responsibilities:

- Ensure research is conducted based on culturally appropriate principles.
- Facilitate the accessing of funding for research to inform trends, evidence-based practice and new initiatives in sexual health and BBV services and programs
- Link research findings to policy and program development and improvement
- Support the establishment and ongoing aims of the WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (WA SiREN)
- Facilitate a Research Roundtable and provide input into national research priorities.
- Ensure where appropriate the inclusion of health consumers in the formulation of research priorities and research methodologies

Regional and Local Agencies Action Plan

Regional and Local Strategies (What we can do)	Action (How it can be achieved)	Responsibility (Who will be involved)	Timeframe (When)	Results
Establish base-line data to measure the effectiveness of interventions				
Partner with appropriate research agencies	<i>Participate in research activities which will benefit Aboriginal people in the region</i>			
Direct and inform research agencies regarding priority area for research for the region				

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APPENDIX I

1.1 The epidemiology of STIs and BBVs among Aboriginal people in WA

The surveillance of STIs and BBVs in WA is restricted to infections that are notifiable under the provisions of the *Health Act 1911* and subsequent amendments. These include genital chlamydia infection, gonorrhoea, syphilis, donovanosis, chancroid, HIV/AIDS, hepatitis B and hepatitis C. Since 2004, WA has used the *Australian National Notifiable Diseases Case Definitions* (20). This section focuses on the most commonly notified STIs and BBVs in WA, namely chlamydia, gonorrhoea, infectious syphilis, HIV, hepatitis B and hepatitis C.

1.2 Chlamydia

Genital chlamydia is the most commonly notified disease in WA and Australia (21). In 2009, there were 8,883 chlamydia notifications with 14% (n = 1,227) reported in Aboriginal people, 66% (n = 5,827) in non-Aboriginal people and 21% (n = 1,829) of notifications of unknown Aboriginal status. The proportion of notifications with an unknown Aboriginal status decreased from an average of 38% from 2000 to 2008 to 21% in 2009. A data-linkage study indicated that most STI and BBV notifications of unknown Aboriginal status in WA are actually non-Aboriginal (22).

Among Aboriginal people in 2009, more females were notified with chlamydia infections than males and the male to female ratio was 0.6:1. Most chlamydia notifications among Aboriginal people in 2009 occurred in those aged 15 to 19 years (46%; n = 559) and 20 to 24 years (28%; n = 339).

In 2009, the age-standardised rate (ASR) of chlamydia notifications was 1,242 per 100,000 population among Aboriginal people and 270 per 100,000 population among non-Aboriginal people. However, there has been a decrease in Aboriginal to non-Aboriginal rate ratios since 2003 and the Aboriginal to non-Aboriginal rate ratio in 2009 (4.6:1) was the lowest observed in the previous 10-year period.

The highest chlamydia ASR in both Aboriginal and non-Aboriginal people in 2009 was reported from the Kimberley region (2,201 per 100,000 population and 585 per 100,000 population respectively).

1.3 Infectious syphilis

In 2009, there were 88 infectious syphilis notifications with 39% (n = 34) reported in Aboriginal people and 61% (n = 54) in non-Aboriginal people. Completeness of Aboriginal status has remained high with the Aboriginality of all infectious syphilis notifications being known from 2003 to 2009. An outbreak of infectious syphilis started in May 2008 in the Pilbara region among Aboriginal people and continued into 2009.

Among Aboriginal people in 2009, the male to female ratio of infectious syphilis notifications was 1.0:1. Most gonorrhoea notifications among Aboriginal people in 2009 occurred in those aged 25 to 29 years (29%; n = 10), 15 to 19 years (24%; n = 8) and 20 to 24 years (21%; n = 7).

In 2009, the ASR of infectious syphilis notifications was 39 per 100,000 population among Aboriginal people and 3 per 100,000 population among non-Aboriginal people. Infectious syphilis ASRs among both Aboriginal and non-Aboriginal people fluctuated and the Aboriginal to non-Aboriginal rate ratios from 2006 to 2009 were the lowest observed over the previous 10-year period (Aboriginal to non-Aboriginal rate ratio in 2009 = 15.7:1).

In 2009, the highest infectious syphilis ASR in Aboriginal people and non-Aboriginal people occurred in the Kimberley region (106 per 100,000 population and 33 per 100,000 population respectively).

1.4 Gonorrhoea

Gonorrhoea is the second most commonly notified STI in both Australia and WA (21). In 2009, there were 1,346 gonorrhoea notifications with 68% (n = 916) reported in Aboriginal people and 32% (n = 428) in non-Aboriginal people. Less than 1% (n = 2) of notifications remained unidentified by Aboriginal status.

Among Aboriginal people in 2009, the male to female ratio of gonorrhoea notifications was 1.0:1. Most gonorrhoea notifications among Aboriginal people in 2009 occurred in those aged 15 to 19 years (32%; n = 297) and 20 to 24 years (29%; n = 263).

From 2006 to 2009, the Aboriginal to non-Aboriginal rate ratio decreased to the lowest observed in the previous 10-year period. However, the gonorrhoea ASR in Aboriginal people (996 per 100,000 population) was still far greater than those for non-Aboriginal people (20 per 100,000 population), with the Aboriginal to non-Aboriginal rate ratio = 50.0:1 in 2009.

The highest gonorrhoea ASR in both Aboriginal and non-Aboriginal people in 2009 was reported from the Kimberley region (2,389 per 100,000 population and 90 per 100,000 population respectively).

1.5 HIV

In 2009, there were 89 HIV notifications with 3% (n = 3) reported in Aboriginal people and 97% (n = 86) in non-Aboriginal people. Of the three Aboriginal notifications in 2009, there were two male cases and one female case, and two were from the non-metropolitan region. In the period from 2005 to 2009 the male to female ratio was 1.3:1 for Aboriginal cases compared with 3.3:1 for non-Aboriginal cases.

While the Aboriginal ASR for HIV fluctuated between 2005 and 2009, the non-Aboriginal ASR during this period has steadily increased and was almost at parity with the Aboriginal ASR in 2009 (Aboriginal ASR = 5 per 100,000 population; non-Aboriginal ASR = 4 per 100,000 population).

The three Aboriginal HIV cases notified in 2009 were all heterosexually acquired. In 2009, most non-Aboriginal male cases were MSM (56%; n = 35) followed by heterosexual exposure (41%; n = 26) and most non-Aboriginal female cases had a heterosexual exposure (87%; n = 20).

1.6 Hepatitis B

Newly acquired hepatitis B infections are those where evidence is available that the infection was acquired in the 24 months prior to diagnosis. Unspecified cases are comprised of chronic infections and infections of unknown duration.

1.6.1 *Newly acquired hepatitis B*

In 2009, there were 39 newly acquired hepatitis B notifications with 3% (n = 1) reported in Aboriginal people and 97% (n = 38) reported in non-Aboriginal people. The one Aboriginal person notified with newly acquired hepatitis B in 2009 was a female aged 29.

In 2009, the ASR of newly acquired hepatitis B notifications was 1 per 100,000 population among Aboriginal people and 2 per 100,000 population among non-Aboriginal people. There has been a decrease in Aboriginal to non-Aboriginal rate ratios since 2005 and the Aboriginal to non-Aboriginal rate ratio in 2009 was the second lowest observed over the previous 10-year period (0.7:1).

In 2009, the highest newly acquired hepatitis B ASR in Aboriginal people occurred in the Goldfields region (16 per 100,000 population) and while newly acquired hepatitis B ASRs were low in non-Aboriginal people in all regions, the highest rate was reported in the South Metropolitan region (3 per 100,000 population).

1.6.2 *Unspecified hepatitis B*

In 2009, there were 699 unspecified hepatitis B notifications with 6% (n = 44) reported in Aboriginal people, 89% (n = 623) reported in non-Aboriginal people and 5% (n = 32) of notifications of unknown Aboriginal status.

Among Aboriginal people in 2009, more males were notified with unspecified hepatitis B infections than females and the male to female ratio was 2.7:1. Most unspecified hepatitis B notifications among Aboriginal people in 2009 occurred in those aged 50 and over (34%; n = 15).

In 2009, the ASR of unspecified hepatitis B notifications was 105 per 100,000 population among Aboriginal people and 30 per 100,000 population among non-Aboriginal people. There has been a general decrease in Aboriginal to non-Aboriginal rate ratios since 2005 and the rate ratio in 2009 was one of the second lowest observed over the previous 10-year period (3.6:1).

In 2009, the highest unspecified hepatitis B ASR in Aboriginal people occurred in the Goldfields region (486 per 100,000 population) and the highest unspecified hepatitis B ASR in non-Aboriginal people occurred in the Kimberley region (583 per 100,000 population). However, 79% of the notifications in the Kimberley region in 2009 were among males who were in the Christmas Island Immigration Detention Centre.

Hepatitis C

Newly acquired hepatitis C infections are those where evidence is available that the infection was acquired in the 24 months prior to diagnosis. Unspecified cases are comprised of chronic infections and infections of unknown duration.

1.7.1 Newly acquired hepatitis C

In 2009, there were 93 newly acquired hepatitis C notifications with 28% (n = 26) reported in Aboriginal people and 72% (n = 67) reported in non-Aboriginal people.

Among Aboriginal people in 2009, more males were notified with newly acquired hepatitis C infections than females and the male to female ratio was 4.2:1. Most newly acquired hepatitis C notifications among Aboriginal people in 2009 occurred in those aged 20 to 24 years (38%; n = 10) and 25 to 29 (31%; n = 8).

In 2009, the ASR of newly acquired hepatitis C notifications was 31 per 100,000 population among Aboriginal people and 3 per 100,000 population among non-Aboriginal people. The newly acquired hepatitis C Aboriginal to non-Aboriginal rate ratio increased from 2000 to 2002 before decreasing to 2004 and reaching a peak in 2004. The Aboriginal to non-Aboriginal rate ratio then decreased each year from 2004 to 2007 before increasing to 2008 and 2009 (9.7:1) (Figure 1.6).

In 2009, the highest newly acquired hepatitis C ASR in both Aboriginal people and non-Aboriginal people occurred in the Great Southern region (85 per 100,000 population and 10 per 100,000 population respectively).

1.7.2 Unspecified hepatitis C

In 2009, there were 1,066 unspecified hepatitis C notifications with 11% (n = 114) reported in Aboriginal people, 81% (n = 862) reported in non-Aboriginal people and 8% (n = 90) of notifications of unknown Aboriginal status.

Among Aboriginal people in 2009, more males were notified with unspecified hepatitis C infections than females and the male to female ratio was 1.4:1. Most unspecified hepatitis C notifications among Aboriginal people in 2009 occurred in those aged 25 to 29 years (21%; n = 24), 20 to 24 years and 30 to 34 years (16%; n = 18 respectively).

In 2009, the ASR of unspecified hepatitis C notifications was 155 per 100,000 population among Aboriginal people and 40 per 100,000 population among non-Aboriginal people. The unspecified hepatitis C Aboriginal to non-Aboriginal rate ratio fluctuated from 2000 until reaching a peak in 2006. From 2006 to 2009, the unspecified hepatitis C Aboriginal to non-Aboriginal rate ratio stabilised at around 3.6:1 (Figure 1.7).

In Aboriginal people, the highest unspecified hepatitis C ASR in 2009 was observed in the Great Southern region (365 per 100,000 population) and in non-Aboriginal people, the highest ASR occurred in the Kimberley region (82 per 100,000 population).



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