Western Australian Aboriginal Sexual Health and Blood-borne Virus Strategy 2019–2023

Message from the Minister for Health

The Western Australia Aboriginal Sexual Health and Blood-borne Viruses Strategy 2019–2023 builds on the strengths and progress from our previous strategies, and is closely aligned to the Fifth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2018-2022. This strategy outlines the guiding principles, goals, targets and priority areas needed for an effective, coordinated and comprehensive state-wide response to the impact of blood-borne viruses and sexually transmissible infections on Aboriginal people in Western Australia (WA).

Aboriginal people are a key priority population for the prevention, early detection and treatment of sexually transmissible infections (STIs) and blood-borne viruses (BBVs). In WA, Aboriginal people are more likely to experience higher rates of STIs and BBVs than their non-Aboriginal counterparts. There are a numbers of factors that contribute to this disparity: important determinants of Aboriginal health inequality in WA include the lack of equal access to primary health care and the lower standard of health infrastructure in Aboriginal communities.

WA Health continues to affirm our commitment to build on crucial invested partnerships with Aboriginal communities and community controlled health services by ensuring our workforce is fully committed to professionalism and sound practice within Aboriginal cultural security. With the infectious syphilis outbreak amongst Aboriginal communities in the Kimberley region in mid-2014, followed by a related cluster in mid-2018 in the Pilbara region, WA Health responded immediately with the establishment of the Syphilis Outbreak Response Group (WA SORG), and the development of a WA Syphilis Outbreak Response Action Plan.
It is imperative that a consistent set of goals and targets are committed to across the nation, with local actions proposed to meet these targets and, ultimately reach the goals. Our focus remains on the significant reduction of the transmission of STIs and BBVs among Aboriginal people, and to close the gap in STIs and BBVs incidence, prevalence, testing and treatment rates between Aboriginal and non-Aboriginal populations. Achieving this will reduce morbidity and mortality related to STIs and BBVs among Aboriginal people. The personal and social impact of STIs and BBVs among Aboriginal people must also be minimised, including the elimination of the negative impact of stigma, racism, discrimination, and legal and human rights issues on Aboriginal people’s sexual health.

As we move forward, it is crucial that we implement this strategy with inspiration from our strong collegial work with health professionals, government departments, community and public health organisations, researchers and members of our local Aboriginal communities. Our key motivation for our work here, nevertheless, must be the optimum health and wellbeing of the Aboriginal community in WA.

I look forward to seeing the positive outcomes of this strategy over the next 4 years and significant in-roads to closing the gap in sexual and BBV health outcomes for Aboriginal communities.

Honourable Roger Cook MLA
Minister for Health

Acknowledgements

The Western Australian Department of Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.
Strategy at a glance

Goals

1. Reduce the transmission of sexually transmissible infections (STIs) and blood-borne viruses (BBVs) among Aboriginal people.
2. Close the gap in STI and BBV incidence, prevalence, testing and treatment rates between Aboriginal and non-Aboriginal populations.
3. Reduce morbidity and mortality associated with STIs and BBVs among Aboriginal people.
4. Minimise the personal and social impact of STIs and BBVs among Aboriginal people.
5. Eliminate the negative impact of stigma, racism, discrimination, and legal and human rights issues on Aboriginal people’s sexual health.

Targets

1. Achieve and maintain hepatitis B childhood vaccination coverage of 95% at 12 and 24 months.
2. Achieve and maintain human papillomavirus (HPV) adolescent vaccination coverage of 80%.
3. Increase STI testing coverage with a focus on areas of highest need.
4. Increase the use of sterile injecting equipment for every injecting episode.
5. Reduce the incidence and prevalence of infectious syphilis with a particular focus on areas of highest disease burden.
7. Reduce the incidence and prevalence of gonorrhoea and chlamydia with a focus on young people.
8. Reduce the number of newly acquired hepatitis C infections by 60%.
9. Maintain the low incidence of human immunodeficiency virus (HIV).
10. Achieve the 95–95–95 HIV diagnosis and treatment targets:
   - increase the proportion of people who are diagnosed to 95%
   - increase the percentage of people diagnosed with HIV on treatment to 95%
   - increase the percentage of people on treatment with an undetectable viral load to 95%
11. Increase the proportion of people living with hepatitis C who are diagnosed to 90% and the cumulative proportion who have initiated direct-acting antiviral (DAA) treatment to 65%.
12. Increase the proportion of people living with hepatitis B who are diagnosed to 80%; receiving care to 50%; and on antiviral treatment to 20%.
13. Reduce hepatitis C attributable mortality by 65%.
14. Reduce hepatitis B attributable mortality by 30%.
15. Reduce the reported experience of stigma among Aboriginal people with BBVs and STIs, and the expression of stigma, in relation to BBV and STI status.
16. Improve knowledge and behaviour regarding safer sex and prevention of BBVs.
17. Maintain low numbers of newly acquired hepatitis B infections across all age groups by 50%.
Key actions

1. Provision of health hardware, vaccination, education, health promotion initiatives and community engagement.

2. Access to and uptake of regular STI and BBV testing in accordance with best practice clinical guidelines for Aboriginal people.

3. Access and adherence to treatment and clinical care, using innovative models and specialist support.

4. Build and support a skilled and responsive workforce, especially Aboriginal staff.

5. Establish supportive and culturally secure environments and involve Aboriginal people in the collaboration and provision of program and service delivery.

6. Conduct meaningful and culturally secure research, surveillance, monitoring and evaluation using best practice models.

Priority populations

- gender and sexually diverse Aboriginal people
- Aboriginal men
- Aboriginal women and girls
- Aboriginal people experiencing homelessness
- Aboriginal people living with HIV
- Aboriginal people living with BBVs
- Aboriginal people in or recently exited custodial settings
- Aboriginal people who inject drugs
- Aboriginal regional and remote communities
- Aboriginal sex workers
- Aboriginal young people.
Other related strategies

- **Aboriginal Health Outcomes Framework: Community-based Health Services**
- **Fifth National Aboriginal and Torres Strait Islander Blood Borne Virus and Sexually Transmissible Infections Strategy 2018–22**
- **National action plan: Enhanced response to addressing sexually transmissible infections (and blood borne viruses) in Indigenous populations**
- **National Drug Strategy 2017–2026**
- **National strategic approach for an enhanced response to the disproportionately high rates of sexually transmissible infections (and blood borne viruses) in Indigenous populations**
- **National Strategic Framework for Aboriginal and Torres Strait Health Plan 2013–2023**
- **Western Australian Aboriginal Health and Wellbeing Framework 2015–30**
- **Western Australian Aboriginal Youth Health Strategy 2018–2030**
- **Western Australian Country Health Service Aboriginal Health Strategy 2018–23** (to be published)
- **Western Australian Health Aboriginal Workforce Strategy 2014–2024**
- **Western Australian Hepatitis B Strategy 2019–2023**
- **Western Australian Hepatitis C Strategy 2019–2023**
- **Western Australian HIV Strategy 2019–2023**
- **Western Australian Immunisation Strategy 2016–2020**
- **Western Australian LGBTI Health Strategy** (to be published)
- **Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025**
- **Western Australian Sexually Transmissible Infections Strategy 2019–2023**
- **Western Australian Syphilis Outbreak Response Action Plan**
## List of acronyms

### Consistent list of terms across the suite of sexually transmissible infections and blood-borne virus strategies 2019–2023

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
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<tr>
<td>ACIR</td>
<td>Australian Childhood Immunisation Register</td>
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<td>AHCWA</td>
<td>Aboriginal Health Council of WA</td>
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<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<td>AHS</td>
<td>Aboriginal Health Service</td>
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<td>AHW</td>
<td>Aboriginal health worker</td>
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<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMR</td>
<td>antimicrobial resistant</td>
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<tr>
<td>ANSPS</td>
<td>Australian Needle and Syringe Program Survey</td>
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<td>APNA</td>
<td>Australian Primary Health Care Nurses Association</td>
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<tr>
<td>ART</td>
<td>antiretroviral treatment</td>
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<tr>
<td>ASHM</td>
<td>Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine</td>
</tr>
<tr>
<td>AOD</td>
<td>alcohol and other drug</td>
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<tr>
<td>BBV</td>
<td>blood-borne virus</td>
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<tr>
<td>BBVSS</td>
<td>Blood-borne Viruses and Sexually Transmissible Infections Standing Committee</td>
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<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CDCD</td>
<td>Communicable Disease Control Directorate</td>
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<tr>
<td>CLAI</td>
<td>condomless anal intercourse</td>
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<tr>
<td>CSRH</td>
<td>Centre for Social Research in Health</td>
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<tr>
<td>DAA</td>
<td>direct-acting antiviral</td>
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<tr>
<td>GDHR</td>
<td>Growing and Developing Health Relationships</td>
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<tr>
<td>GIPA</td>
<td>greater involvement of PLWH</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>HPV</td>
<td>human papillomavirus</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>HTLV1</td>
<td>human T-cell lymphotropic virus type 1</td>
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<tr>
<td>LASH</td>
<td>WA Law and Sex Worker Health</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
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<tr>
<td>MIPA</td>
<td>meaningful involvement of PLWH</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>NCHECR</td>
<td>National Centre in HIV Epidemiology and Clinical Research</td>
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<tr>
<td>NGO</td>
<td>non-government organisation</td>
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<tr>
<td>NHVPR</td>
<td>National Human Papillomavirus Vaccination Program Register</td>
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<tr>
<td>NiPHC</td>
<td>Nursing in Primary Health Care</td>
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<td>NSP</td>
<td>needle and syringe program</td>
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<td>NSEP</td>
<td>needle and syringe exchange program</td>
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<tr>
<td>OTP</td>
<td>opioid treatment programs</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PEP</td>
<td>post exposure prophylaxis</td>
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<td>PGCPS</td>
<td>Perth Gay Community Periodic Survey</td>
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<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
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<td>PIS</td>
<td>Patient Information System</td>
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<td>PLWH</td>
<td>people living with HIV</td>
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<td>POCT</td>
<td>point-of-care testing</td>
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<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
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<td>PWID</td>
<td>people who inject drugs</td>
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<td>RDT</td>
<td>Rapid diagnostic test</td>
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<td>RNA</td>
<td>ribonucleic acid</td>
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<td>RSE</td>
<td>relationships and sexuality education</td>
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<td>RTO</td>
<td>Registered Training Organisation</td>
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<tr>
<td>SASA</td>
<td>Structured Administration and Supply Arrangement</td>
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<tr>
<td>SHBBVP</td>
<td>Sexual Health and Blood-borne Virus Program</td>
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<tr>
<td>SiREN</td>
<td>WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network</td>
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<tr>
<td>SMS</td>
<td>short message service</td>
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<tr>
<td>STI</td>
<td>sexually transmissible infection</td>
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<tr>
<td>s100</td>
<td>section 100</td>
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<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
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<tr>
<td>TasP</td>
<td>treatment as prevention</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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Clarifications

* This strategy uses the terms ‘regional’ and ‘remote’ which applies to all non-metropolitan areas in Western Australia (WA).

* The WA health system uses ‘Aboriginal’ rather than ‘Aboriginal and Torres Strait Islander’ or ‘Indigenous’ in all forms of communication. The use of the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition of the Aboriginal people as the original inhabitants of WA. No disrespect is intended to our Torres Strait Islander colleagues and community. Where referenced documents use the term Aboriginal and Torres Strait Islander, that term is used instead.

* ‘Aboriginal Health Service’ (AHS) refers to all health and medical services targeting Aboriginal people including government-run health services and Aboriginal Community Controlled Health Services (ACCHS).

* ‘Chronic’ refers to diagnosis of infection lasting longer than six months.

* ‘Newly acquired’ refers to evidence of infection having been acquired in the 24 months prior to diagnosis.

* ‘Unspecified’ refers to infections of unknown duration.
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Snapshot of blood-borne viruses and sexually transmissible infections among Aboriginal people in Western Australia

What are blood-borne viruses and sexually transmissible infections?

Blood-borne viruses (BBVs) can be transmitted if blood, semen or vaginal fluids pass from a person who is infected with the virus into the bloodstream of another person via a break in the skin or mucous membrane. In WA, notifiable BBVs include hepatitis B, hepatitis C and HIV.

Sexually transmissible infections (STIs) are infections or diseases that are passed on during unprotected vaginal, anal or oral sex with an infected partner. Some STIs can also be spread through skin-to-skin contact with an infected person. A pregnant mother can also pass an STI to her baby either via the placenta during pregnancy or during birth. STIs can be prevented by having regular STI checks; limiting the number of sex partners; and always using condoms or dental dams and water-based lubricant. All women should be tested for STIs as part of their antenatal care. In WA, notifiable STIs include chancroid, chlamydia, donovanosis, gonorrhoea and syphilis.

What health issues can they cause?

Without treatment, hepatitis B and hepatitis C can cause serious liver diseases, including liver failure and liver cancer. Without treatment, HIV can progress to the point where the immune system becomes fragile, which can lead to serious infections and cancers that can be fatal.

STIs may not result in any obvious symptoms. Untreated STIs can cause a range of mild to severe health complications and also create other health conditions. Some STIs can damage the reproductive system and cause infertility. Others can affect the brain, heart, large blood vessels, spinal cord, skin and bones, leading to possible disability and death. Pregnant women can pass STIs on to their babies causing serious infections and possible death.

How are they managed?

A vaccine for hepatitis B is available. Hepatitis B, hepatitis C and HIV can be managed through antiviral medications that suppress the virus and prevent disease progression. Bacterial STIs such as chlamydia, donovanosis, gonorrhoea and syphilis are treated with antibiotics. Early detection and treatment is important in the management of all STIs.
New diagnoses

**Hepatitis B:** In 2017, the rate of total hepatitis B notifications among Aboriginal people in WA was more than three times higher than the rate among non-Aboriginal people (56 compared to 17 per 100 000 population).

**Hepatitis C:** In 2017, the rate of total hepatitis C notifications among Aboriginal people in WA was more than 10 times higher than the rate among non-Aboriginal people (311 compared to 30 per 100 000 population).

**Human immunodeficiency virus (HIV):** From 2013 to 2017, there were a total of 17 notifications among Aboriginal people in WA, ranging between zero and six cases per year; three cases were notified in 2017.

**Chlamydia:** In 2017, the rate of chlamydia notifications among Aboriginal people in WA was more than three times higher than the rate among non-Aboriginal people (1283 compared to 362 per 100 000 population).

**Gonorrhoea:** In 2017, the rate of gonorrhoea notifications among Aboriginal people in WA was more than 11 times higher than the rate among non-Aboriginal people (958 compared to 83 per 100 000 population).

**Syphilis:** In 2017, the rate of infectious syphilis notifications among Aboriginal people in WA was more than seven times higher than the rate among non-Aboriginal people (69 compared to 9 per 100 000 population). The notification rate among Aboriginal people increased more than six times from 2014 to 2017, reflecting an ongoing outbreak affecting Aboriginal people residing in remote areas of northern and central Australia including northern WA.

**Congenital syphilis:** As of 2017, the last case of congenital syphilis in an Aboriginal child was reported in 2013.

Testing and care

There is no data available on the uptake of hepatitis C or HIV testing and treatment by Aboriginal people in WA.

**Human T-cell Lymphotropic Virus Type 1**

Human T-cell lymphotropic virus type 1 (HTLV-1) is a retrovirus that can be transmitted from mother to child (mostly through breastfeeding), blood transfusions, sexual intercourse and by sharing contaminated needles.¹

This virus can cause lifelong infection and may cause adverse health outcomes in a small percentage of people many years later. Recent research has documented very high prevalence rates of HTLV-1 in certain Aboriginal communities, particularly in central Australia.²
In late 2017, the WA Department of Health initiated the development of a comprehensive **STI & BBV Manual** for WA to provide a guide for the prevention, early detection and treatment of STIs and BBVs, with a focus on regional and remote Aboriginal communities.

The *WA Aboriginal Sexual Health and Blood-borne Virus (BBV) Strategy 2015–2018* advocated for the development of Aboriginal-specific and Aboriginal-inclusive social marketing for STI and BBV prevention messages. The *Look After Your Blood* Campaign was launched in September 2016 and focuses on the prevention, testing and treatment of BBVs. In 2017, the *Stay Safe You Mob* campaign was launched and aims to promote the use of condoms and regular STI testing.

*Yarning Quiet Ways* is a culturally secure resource that was developed to support parents and carers of young Aboriginal people to have discussions about sexual health and BBVs. It is based on the widely used *Talk Soon Talk Often* resource.

A website called *Let’s Yarn* was also developed to provide a portal with resources for health professionals, educators, parents and carers of young Aboriginal people to support conversations about sexual health and BBVs.

The *Birds and the BBVs* is a two-day training course delivered by the Aboriginal Health Council of WA (AHCWA) in partnership with HepatitisWA for Aboriginal health workers (AHWs) and others working with Aboriginal people. From 2016 to 2018, the course was delivered 17 times to more than 130 participants.

The TTANGO2 research project aims to evaluate the long-term uptake, sustainability and impact of STI point-of-care testing (POCT) in regional and remote primary health services. WA has played an important role in the project with 15 services using 17 POCT machines in 2018. A TTANGO2 coordinator is employed by AHCWA to provide support and training for POCT operators.

A comprehensive evidence review on sexual health and BBVs in Aboriginal populations in Australia, Canada and New Zealand was conducted by the WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN) in 2018. The review looked at nearly 600 articles including peer-reviewed and grey literature that addressed all priority areas from the *WA Aboriginal Sexual Health and Blood-borne Virus (BBV) Strategy 2015–2018*.

The infectious syphilis outbreak was identified in the Kimberley region in mid-2014 and a related cluster was identified in mid-2018 in the Pilbara region. The *WA Syphilis Outbreak Response Group (WA SORG)* was formed in response to the syphilis outbreak among Aboriginal people in the Kimberley and Pilbara regions. A face-to-face workshop was held with relevant stakeholders to inform the development of a *WA Syphilis Outbreak Response Action Plan*. 

**Progress under the last strategy**
The Guiding Principles for this strategy reflect those in the *Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018–2022*, adapted for the Western Australian context.

1. **Meaningful involvement of priority populations**

   Aboriginal people should be central to the sexual health and BBV response, and should have meaningful participation in the development, implementation, monitoring and evaluation of effective programs and policies.

2. **Human rights**

   Aboriginal people have the right to live without stigma and discrimination. It is vital to safeguard their human rights so as not to face stigma and discrimination based on their actual or perceived health status, cultural background, socio-economic status, age, sex, sexual or gender orientation or identity. They have the same rights to comprehensive and culturally secure information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.

3. **Access and equity**

   Health and community care in WA should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to gender, sexuality, disease status, drug use, occupation, socio-economic status, migration status, language, religion, culture or geographic location, including in custodial settings. Health and community services should be welcoming, and should work towards increasing access for Aboriginal people.

4. **Health promotion**

   All actions related to the prevention of STIs and BBVs, provision of clinical services and ongoing support and care for Aboriginal people should reflect the Ottawa Charter for Health Promotion.$^3$

5. **Prevention**

   The transmission of STIs and BBVs can be reduced through an appropriate and effective combination of evidence-based biomedical, behavioural and social preventative approaches within an environment that supports and enables healthy behaviours within a supportive and enabling environment. Comprehensive education and prevention programs, together with equitable access to the means of STI and BBV prevention, will be vital going forwards in achieving the targets set within this strategy.
6. **Quality health services**

Supporting and coordinating a multidisciplinary workforce of skilled, motivated and informed healthcare workers, community and peer-based workers and volunteers is essential in delivering culturally-appropriate and quality services for Aboriginal people across WA. Health service delivery should respond to new technologies and best practice in models of care, especially for those living in regional and remote areas.

7. **Harm reduction**

Harm reduction approaches strengthen effective measures to prevent the transmission of STIs and BBVs and minimise the health and social burden in Aboriginal communities. Approaches include condom distribution, needle and syringe programs (NSPs), alcohol and other drug (AOD) treatment programs, counselling and mental health support, and measures to address the social determinants of health.

8. **Shared responsibility**

Individuals and communities have a responsibility to protect themselves and others from the transmission of STIs and BBVs, and are supported and empowered to do so. Government and community organisations also have a shared responsibility to address education and support needs through the provision of resources and supportive environments that facilitate community-led preventative action.

9. **Commitment to evidence-based policy and programs**

The response to sexual health and BBVs in WA has been built on a strong evidence base, informed by high-quality research and surveillance, monitoring and evaluation. With new research findings, it will be essential to refine the evidence base in order to meet new challenges, evaluate current and new interventions, and to develop effective policy and clinical guidelines.

10. **Partnership**

Effective and collaborative partnerships between Aboriginal people, health services, community organisations, the clinical workforce, researchers and government are fundamental to the sexual health and BBV response and achieving the goals and targets set out in this strategy. A partnership approach is characterised by consultation, cooperative effort, clear roles and responsibilities, meaningful contributions, empowerment, respectful dialogue and appropriate resourcing and leadership in order to achieve the goals and targets within this strategy.
Goals and targets

The goals and targets for WA presented in this strategy have been based on the goals and targets detailed within the *Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018–2022*. It is imperative that a consistent set of goals and targets are committed to across the nation, with local actions proposed to meet these targets, and ultimately reach the goals.

**Goals**
1. Reduce the transmission of STIs and BBVs among Aboriginal people.
2. Close the gap in STI and BBV incidence, prevalence, testing and treatment rates between Aboriginal and non-Aboriginal populations.
3. Reduce morbidity and mortality associated with STIs and BBVs among Aboriginal people.
4. Minimise the personal and social impact of STIs and BBVs among Aboriginal people.
5. Eliminate the negative impact of stigma, racism, discrimination, and legal and human rights issues on Aboriginal people’s sexual health.

**Targets – by 2023**
1. Achieve and maintain hepatitis B childhood vaccination coverage of 95% at 12 and 24 months.
2. Achieve and maintain human papillomavirus (HPV) adolescent vaccination coverage of 80%.
3. Increase STI testing coverage with a focus on areas of highest need.
4. Increase the use of sterile injecting equipment for every injecting episode.
5. Reduce the incidence and prevalence of infectious syphilis with a particular focus on areas of highest disease burden.
7. Reduce the incidence and prevalence of gonorrhoea and chlamydia with a focus on young people.
8. Reduce the number of newly acquired hepatitis C infections by 60%.
9. Maintain the low incidence of HIV.

*The goals and targets are specific for the Aboriginal population. Some of these targets will require the development or further development of data sources to monitor progress. This will be progressed through the implementation plan.*

† Compared with 2018.

± No new cases of congenital syphilis nationally notified (as defined by the global surveillance case definition) for two consecutive years.
10. Achieve the 95–95–95 HIV diagnosis and treatment targets:
   - increase the proportion of people with HIV who are diagnosed to 95%
   - increase the percentage of people diagnosed with HIV on treatment to 95%
   - increase the percentage of people on treatment with an undetectable viral load to 95%.

11. Increase the proportion of people living with hepatitis C who are diagnosed to 90% and the cumulative proportion who have initiated direct-acting antiviral (DAA) treatment to 65%.

12. Increase the proportion of people living with hepatitis B who are diagnosed to 80%; receiving care to 50%; and on antiviral treatment to 20%.

13. Reduce hepatitis C attributable mortality by 65%.

14. Reduce hepatitis B attributable mortality by 30%.

15. Reduce the reported experience of stigma among Aboriginal people with BBVs and STIs, and the expression of stigma, in relation to BBV and STI status.

16. Improve knowledge and behaviour regarding safer sex and prevention of BBVs.

17. Maintain low numbers of newly acquired hepatitis B infections across all age groups by 50%.

**Global targets**

The actions within this strategy aim not only to achieve the goals set for WA, but also to contribute towards national and global targets.

There are a number of STI and BBV global targets relevant to Aboriginal people. For details on these targets, please refer to the other *WA Sexual Health and Blood-borne Virus Strategies 2019–2023*:

- *WA Hepatitis B Strategy 2019–2023*
- *WA HIV Strategy 2019–2023*
- *WA Hepatitis C Strategy 2019–2023*
- *WA Sexually Transmissible Infections Strategy 2019–2023*
The burden of STIs and BBVs disproportionately impacts the health and wellbeing of Aboriginal people. This strategy identifies a number of priority populations, and acknowledges that many individuals may identify with or exist across multiple populations, resulting in a diverse and often complex intersection of characteristics, needs and risk factors unique to individuals and populations. 4

**Gender and sexually diverse Aboriginal people**

In comparison to their heterosexual and cisgender counterparts, Aboriginal men who have sex with men (MSM), sistergirls and brotherboys* are more susceptible to STIs and BBVs. Inconsistent condom use, substance use, including people who inject drugs (PWID), and lower testing rates or higher viral loads for HIV are more common among Aboriginal gay and bisexual MSM (both cisgender and transgender) than their non-Aboriginal counterparts. In addition, this priority population also experiences higher levels of discrimination, which can have a negative impact on their health and wellbeing.

**Aboriginal men**

Aboriginal men are a priority population for the prevention and control of STIs and BBVs. Research has shown that men are under-represented across the board in terms of testing, treatment and research. It is imperative that interventions are targeted and specific to the needs of men in order to be effective.

**Aboriginal women and girls**

Aboriginal women are at a higher risk of a variety of health conditions and issues than non-Aboriginal women, including gonorrhoea, chlamydia, pelvic inflammatory disease (PID), other cervical abnormalities, HIV, hepatitis B and hepatitis C. Reproductive health outcomes and care are also variable for this priority population such as rapid-repeat pregnancies or unwanted pregnancies.

**Aboriginal people experiencing homelessness**

There is an over-representation of Aboriginal people who are homeless, which influences their access to appropriate health care. This is coupled with an increased risk of sexual assault and participating in sex work to generate income, which increases their likelihood of acquiring STIs and BBVs.

* Terms used for transgender people within some Aboriginal communities.
Aboriginal people living with HIV

Aboriginal people living with HIV experience a number of barriers to the uptake of and adherence to treatment including a lack of support, clinic structures, geographical distance, low sexual health and BBV literacy, substance use, cultural responsibilities, lack of finances and other work or life commitments. In addition, they are also faced with stigma and are commonly found to experience high rates of mental health issues.

Aboriginal people living with blood-borne viruses

In WA, Aboriginal people are disproportionately affected by BBVs than non-Aboriginal people. In WA in 2017, the hepatitis C notification rate for Aboriginal people compared to non-Aboriginal people was 28 times higher (62.1 compared to 2.2 per 100 000 population) and nine times higher for newly acquired and unspecified hepatitis C (248.7 compared to 27.4 per 100 000 population). In addition, in WA in 2017, the hepatitis B notification rate in the Aboriginal population was more than three times higher compared to non-Aboriginal people.

Aboriginal people in or recently exited custodial settings

Aboriginal people are over-represented in custodial settings. In some populations, incarceration can increase the likelihood of hepatitis C acquisition as a result of unsafe injecting practices.

Aboriginal people who inject drugs

There are significantly higher rates of substance use and injecting drug use among Aboriginal people. This influences a number of factors that create risks including HIV treatment consistency, virological suppression and attendance for STI and BBV testing and treatment. A number of other determinants play a role in this field including unemployment, transience and other systematic issues that negatively affect health outcomes.
Aboriginal people who live in regional and remote communities

People living in regional and remote communities face a multitude of barriers that influence their health outcomes, especially for Aboriginal people. These barriers and challenges include a lack of services or resources, language, culture, stigma and workforce issues. As a result, there is a need for tailored services, a community-wide approach and appropriate upskilling of staff working with Aboriginal people in regional and remote communities.

Aboriginal sex workers

Sex workers are a priority population due to the potential for higher exposure risk related to their occupation. Aboriginal people who are homeless are more likely to seek sex work as a source of income. In addition, sex workers are also at higher risk of being victims of sexual assault.

Young Aboriginal people

Young Aboriginal people are a high priority population and commonly the focus of many prevention and education efforts with numerous established programs existing in WA. This population are at an increased risk of acquiring STIs and BBVs. Factors contributing to this include unsafe sex, shame, low socio-economic status, lack of healthcare access, a sense of invulnerability to STIs and BBVs and a significant lack of knowledge.
Consultation undertaken

The Sexual Health and Blood-borne Virus Program (SHBBVP) undertook consultations between August and November 2018 to inform the development of the WA Sexual Health and Blood-borne Virus Strategies 2019–2023. The consultations were conducted via an online survey and nine face-to-face workshops held in Perth and regional areas of WA.

Various online platforms were used to promote the consultations including social media, websites, e-newsletters and via email.

Online survey

The online survey opened on 1 August 2018 and closed on 31 October 2018. Data was collected through SurveyMonkey with a total of 103 responses received. The majority of participants (85%) identified as health professionals while community members represented 16%. Some respondents selected more than one category. Health professionals who completed the survey were from state government organisations, non-government organisations (NGOs), universities or research-based organisations, local governments, Aboriginal health organisations and private organisations. Most participants were based in metropolitan Perth (62%), followed by regional WA (24%) and remote WA (14%).

Metropolitan consultations

There were two face-to-face consultations held in Perth in early September 2018 facilitated by an external consultant, Tuna Blue. Data was collected through software that allowed for real-time responses from participants as each of the strategies were discussed. The 41 participants attending the consultations represented hospitals, health consumers, prisons, NGOs, Aboriginal health services (AHSs), affected communities, education and research institutes.

Regional consultations

The regional consultations were facilitated by SHBBVP staff in all WA Country Health Service (WACHS) regions including the South West, Goldfields, Wheatbelt, Pilbara, Midwest, Great Southern and the Kimberley. Regional sexual health coordinators and NSP coordinators were contacted to assist with arranging the consultation workshops and existing networks were utilised where possible, such as Aboriginal Health Planning Forum Sexual Health subcommittees. Data was collected by SHBBVP staff and categorised into each of the priority action areas as they were discussed. Over the seven regional workshops, a total of 79 participants attended with representation from state government organisations, NGOs, health networks, family support services, local government, AHSs and research institutes.
Once data collection was completed, the responses were analysed to inform the development of the *WA Sexual Health and Blood-borne Virus Strategies 2019–2023*.

**Consultation findings**

Through these consultations, you told us that:

- There is a distinct need to normalise sexual health and BBVs both in the community and among services working with Aboriginal people. This incorporates normalising conversations, testing and treatment in order to reduce stigma and shame.

- Engaging Aboriginal people and hard to reach groups is integral to the prevention, testing and treatment of STIs and BBVs as a result of higher prevalence and a likelihood to participate in risky behaviours.

- Culturally secure staff and organisations are paramount to increasing engagement with the community to ensure they feel safe and comfortable when utilising sexual health and BBV programs and services.

- Consultation and involvement with Aboriginal people should be at the forefront of all planning, implementation, evaluation and decision making to ensure initiatives are targeted and adequately address the community’s needs.

- There is an identified need for innovation to educate and inform Aboriginal people and the healthcare workforce including utilising new and emerging methods such as outreach programs, social marketing and peer education strategies.

- Effective programs and services rely on the establishment and maintenance of both meaningful and ongoing partnerships that are beneficial to the community.

- The development of indicators and targets to measure progress in Aboriginal health would be beneficial for quality improvement purposes and to facilitate effective monitoring and evaluation.

- An increase in the investment in Aboriginal sexual health and BBVs needs to be addressed with a long-term focus to ensure it remains a priority and receives adequate attention, support and resourcing, especially alongside other health issues.

- Reorienting the workforce is key to ensure they can adequately meet the needs of Aboriginal communities. This includes employing the right people to work alongside the community including friendly, approachable and non-judgemental staff, young people and peer workers.
Evidence to support actions

Prevention and education

- Adherence to vaccine schedules as well as innovative delivery methods and sites are significant priorities for prevention.

- Continuous, opportunistic and strengths-based education models that address families and whole communities can have a significant impact on early detection and treatment.

- Most Aboriginal communities experience relatively low rates of sexual health and BBV knowledge, which impacts ongoing individual and community-wide issues, especially the transmission of STIs and BBVs and treatment uptake.

- The prevalence of STIs and BBVs are vulnerable to a number of important determinants including community members’ inability to afford care, insufficient community knowledge of available services, low English and health literacy, and under-funded or under-resourced health promotion and care services.

- Receptive syringe sharing is more prevalent among Aboriginal people than non-Aboriginal people in WA. In 2018, the prevalence of receptive syringe sharing by Aboriginal people was 37%, whereas by non-Aboriginal people it was 22%. (Iversen J. Personal communication via email, 2019 Feb 21).

Testing and diagnosis

- Testing and diagnosis can be inhibited by a multitude of factors including insufficient culturally-appropriate and gender-specific clinical spaces, services and providers, lack of knowledge of available services, and stigma around sexual health and BBVs.

- There are a number of alternative testing models that services should consider to increase participation in hard to reach communities including community-based, POCT, opt-out, rapid and opportunistic testing.

Disease management and clinical care

- Inconsistency, delays or absence of proper treatment access can lead to disease management and clinical care issues for many communities.

- Unaffordability of both services and treatments can be a significant barrier for people and influence their ability to access services and the uptake of treatment.

- Experiences of treatment can be enhanced through individualised, person-centred care that acknowledges a person’s journey, both geographically and spiritually.
Workforce development

- A variety of factors influence healthcare workers’ capacity to deliver quality sexual health care including lack of time and support; high turnover of staff; lack of sexual health training; lack of male staff for Men’s Business*; community rejection of certain healthcare providers; inconsistent sexual health and BBV guidelines; and exclusion from or conflict with the broader Australian healthcare system.

- AHSs require ongoing support and development opportunities for staff.

- There are a number of benefits that can arise from the inclusion of AHWs and stakeholders in all levels of the healthcare system including improved service provision and attendance; contribution to closing the health gap between Aboriginal and non-Aboriginal people; allowing a service to gain more in-depth knowledge of the community; increased community accountability; and providing community members with an opportunity to become empowered workers within their communities.

Enabling environment

- Feelings of shame are a factor for Aboriginal people that may influence their access to a service for treatment due to stigma.⁷

- Racial discrimination in affected communities is known to have a negative impact on both testing and treatment rates.

- Health outcomes can be dramatically improved through the implementation of both community-based and community-led initiatives to empower communities.

- Cultural competence is integral in healthcare provision, and can be enhanced through:
  > acknowledging the intergenerational trauma experienced by Aboriginal people
  > addressing current issues around discrimination against Aboriginal people
  > training staff on the differing needs of specific communities and the broader Aboriginal population (i.e. kinship systems,† shame and stigma, Men’s and Women’s Business)
  > integrating traditional methods into current healthcare approaches
  > including Aboriginal staff throughout service provision
  > using non-verbal aids and language to communicate wherever possible.

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† Kinship systems refer to how people relate to each other including roles, responsibilities and obligations. (Kinship and skin names [Internet]. Central Land Council; [cited 2019 Apr 8]. Available from: https://www.clc.org.au/index.php/?/articles/info/aboriginal-kinship)
Data collection, research and evaluation

- Aboriginal elders play an important role in research to facilitate better data collection and the implementation of culturally secure methods within the community including negotiation and consultation.
- Regional and remote populations benefit from the appropriate use of technology for data collection.
- Program evaluations that create the most beneficial outcomes for organisations and communities must be robust, regular and well structured.
The key actions for the *Western Australian Aboriginal Sexual Health and Blood-borne Virus Strategy 2019–2023* are condensed into six action areas to align with the *Fifth National Aboriginal Sexual Health and Blood-borne Virus Strategy 2018–2022*. These action areas are not discrete categories but may frequently overlap and exist on a continuum. A successful approach towards reducing the transmission of and the morbidity, mortality and social impact of STIs and BBVs requires a focus on all action areas.

**Prevention and education**

Prevention and education strategies are essential to reduce the transmission of STIs and BBVs through improving knowledge, changing behaviours, increasing uptake of vaccinations and provision of health hardware.

1. Increase access to free or affordable condoms and lubricant by implementing policies and considering a range of distribution methods such as public toilets, hospitals, condom trees, library, hostels, tourism places, Technical and Further Education (TAFE), prisons and schools (where possible).

2. Increase the provision and promotion of NSPs and safe disposal options, especially in local AHSs, to provide access to clean injecting equipment and places to discard used equipment.

3. Implement local and statewide social marketing campaigns that are designed in consultation with Aboriginal people and hard to engage groups that focus on community strengths and resilience to ensure they are relevant and will be effective in increasing knowledge in priority populations.

4. Increase hepatitis B and HPV vaccine schedule adherence by providing diverse delivery methods and sites so as to ensure a range of options are available to meet the needs of Aboriginal people.

5. Develop and utilise locally developed resources that are age appropriate, culturally safe, user-friendly, graphic and are readily available on online platforms to increase reach and utilisation with priority populations.

6. Provide both ongoing and opportunistic education strategies that are engaging, innovative, flexible and culturally secure, and that are delivered by local workers or peer educators in a variety of settings to increase the knowledge and skills of Aboriginal people in relation to sexual health and BBVs.
7. Implement initiatives designed to improve prenatal and antenatal health including access to contraception and antenatal education, with a focus on the importance of regular STI and BBV screening during pregnancy.

8. Develop and implement programs for broader community education and social marketing campaigns to address shame and normalise STI and BBV testing to improve the community’s perceptions of sexual health and BBVs and engagement with programs and services.

Testing and diagnosis

Early detection and intervention can have a significant effect on reducing the transmission of STIs and BBVs by ensuring the community receive the treatment and follow-up that they require.

1. Increase the uptake of testing by reducing costs and providing incentives such as free or subsidised testing options (which may include bulk-billing), vouchers and non-financial enticements.

2. Promote the importance of full STI and BBV screening and encourage testing when managing other conditions such as urinary tract infections (UTIs) to ensure positive cases are identified early and can be treated to reduce the ongoing transmission.

3. Identify strategies to normalise STI and BBV testing and incorporate into routine practice by:
   - having regular conversations about testing with patients and regularly offering the tests
   - integrating testing into other primary health care screening such as adult health checks, Men’s and Women’s checks, cervical cancer screening, contraception consults and antenatal checks
   - promoting the value of self-care and being healthy
   - implementing an opt-out approach.

4. Increase opportunities for testing by providing innovative models and methods to engage priority populations and hard to reach groups such as:
   - self-testing kits (if available)
   - SMS reminders
   - opportunistic testing at community events
   - mobile screening
   - drop-in clinics or outreach to services such as women’s health centres, headspace, employment services, youth services, drug rehabilitation centres, men’s and women’s shelters
   - encouraging online testing via the Could I Have It website
   - mass screening.
5. Continue to implement and support POCT models in clinics to reduce the turnaround time for test results and increase treatment by providing ongoing support and assistance to the clinics and staff that are using POCT technology.

6. Maintain and encourage consistent testing regimens that comply with national, state and regional guidelines, especially in relation to antenatal testing, contact tracing and culturally secure care.

7. Ensure syphilis testing is conducted as part of routine antenatal care in all health services in accordance with clinical guidelines to prevent congenital syphilis cases.

**Disease management and clinical care**

Timely and effective treatment, follow-up and contact tracing play an important role in preventing the transmission of STIs and BBVs as well as reducing the long-term harms and burden of disease.

1. Improve active follow-up for disease management and clinical care using methods such as SMS reminders for treatment and recall systems to ensure those diagnosed with an STI or BBV receive appropriate and timely treatment.

2. Identify initiatives and programs to increase the uptake and adherence of treatment by reducing costs or providing free treatment, especially for hepatitis C.

3. Improve contact tracing processes through better coordination; increased service provider collaboration and confidential client information sharing; establishing good relationships with patients; and implementing innovative and culturally secure methods to provide a private, confidential and comfortable environment.

4. Develop and support the implementation of consistent clinical guidelines that are adhered to and incorporated into routine practice so as to inform and enhance best practice disease management and clinical care.

5. Increase the uptake of hepatitis C treatment for Aboriginal people by increasing awareness and access to reduce the morbidity related to STIs and BBVs.

6. Adopt innovative models of care for disease management and clinical care by implementing nurse-led and other models, mobile treatment clinics and adapt existing models of care to meet the specific needs of Aboriginal people.

7. Increase access to specialist support and services to create easier pathways for general practitioners (GPs) and healthcare workers in regional and remote areas through outreach clinics and telehealth services.
Workforce development

Ensuring that the sexual health and BBV workforce is appropriately trained, supported and renumerated, can have a significant effect on the other priority areas and can facilitate sustainable outcomes for Aboriginal communities.

1. Increase meaningful partnerships and regional networks that collaborate and regularly communicate including organisations such as GPs, AHSs, sexual health services, tertiary services, housing, education, employment, community, NGOs, mental health, drug and alcohol services, disability, clinical services, community services, Registered Training Organisations, tertiary education and emergency departments.

2. Explore the use of peer educators, gendered roles, mentoring programs, service champions and role models to increase engagement with priority populations and therefore maximise the potential reach and outcomes of programs and services.

3. Enable a responsive workforce that is adequately skilled and can be mobilised to address local emerging issues and outbreaks in regional and remote areas.

4. Strengthen and support the Aboriginal healthcare workforce by implementing a number of initiatives such as:
   - providing more Section 50(d)8 positions, Aboriginal Health Practitioners and gendered roles including AHWs in decision making and consultation processes to improve services and increase community participation
   - ensuring there is better utilisation and adequate remuneration of AHWs.

5. Provide innovative and tailored training for the regional and remote workforce by:
   - utilising expertise within the region and ensuring staff have access to training without having to leave the region
   - providing funding for attendance at training
   - customising training for specialities and skills
   - consider training-the-trainer models.

6. Increase and sustain the investment and prioritisation of the SHBBVP by establishing dedicated sexual health and BBV positions and teams (nurses, AHWs, health promotion, doctors) in regional and remote areas, especially in response to emerging local issues such as disease outbreaks.

7. Provide incentives to attract and retain staff in regional and remote areas to reduce the turnover by providing additional leave and better rotations.

8. Ensure the healthcare workforce has access to appropriate resources to enable service and program delivery by developing new resources, promoting existing ones and developing a statewide database.
9. Support and encourage the healthcare workforce to increase STI and BBV testing by:
   ▶ employing dedicated staff for testing
   ▶ providing adequate and appropriate training and resources
   ▶ establishing nurse-led testing models
   ▶ integrating a preventative care focus
   ▶ investigating the feasibility of extending the scope of practice for nurses and AHWs.

Enabling environment

When working with Aboriginal populations, enabling and culturally secure environments can have a significant impact on the engagement with the community and influence the outcomes of services and programs.

1. Establish culturally secure services and a culturally competent healthcare workforce to increase engagement by providing:
   ▶ translation services and resources
   ▶ culturally secure messages
   ▶ a visible commitment to a culturally respectful and non-discriminatory health service
   ▶ adequate training and resources to healthcare workers

2. Provide friendly services with safe spaces and approachable, non-judgemental staff to ensure clients feel comfortable accessing services and discussing sexual health and BBVs.

3. Ensure all programs and services are discreet, respect anonymity and provide privacy, especially within AHSs, to maintain and promote confidentiality for clients and the community.

4. Improve service integration and collaboration with Aboriginal stakeholders to increase the coordination of service delivery and continuity of care to reduce stigma and discrimination.

5. Implement systematic and organisational changes to reduce stigma and discrimination by:
   ▶ developing inclusive work practices
   ▶ building the system’s capability to ensure equity
   ▶ undertaking organisational assessments and cultural audits to identify gaps and inform improvement opportunities
   ▶ improving services through better informed policy, practice and service delivery decisions.

6. Reduce barriers for Aboriginal people accessing services and programs by providing equitable access to testing and treatment, enabling legal environments and considering levels of health literacy in resource development and communication.
7. Increase community engagement in the planning, implementation and evaluation of programs and services through:
   ▶ using different venues and spaces that are comfortable for the target group
   ▶ involving Aboriginal staff
   ▶ taking part in local Aboriginal community events
   ▶ engaging with community, leaders and local services such as the AHS
   ▶ encouraging and supporting community-based and community-led initiatives

8. Explore and implement strategies to normalise sexual health and BBVs through developing rapport with Aboriginal populations and build on this by providing regular and meaningful engagement with the community.

Data collection, research and evaluation

Research, evaluation and surveillance are essential components in the SHBBVP response by providing a strong evidence base, monitoring processes and access to relevant data to inform service and program delivery.

1. Conduct meaningful and ethical research in partnership with relevant organisations and Aboriginal people using culturally secure methods and communicating the findings back to the community to increase community buy-in and ownership.

2. Increase the provision of and routine access to better regional testing data for Aboriginal people that is available in user-friendly formats to improve the surveillance and monitoring of STIs and BBVs.

3. Develop and implement clear indicators and targets that are consistent across agencies, and establish a working group to guide this process to monitor and track progress.

4. Develop or strengthen systems that accurately incorporate STI and BBV clinical items in Patient Information Systems (PISs) in WACHS and AHSs, and encourage staff to correctly record data to facilitate accurate auditing and data extraction.

5. Develop a digital solution that provides real-time access to statewide patient records to improve the early detection and treatment of syphilis.

6. Utilise health promotion planning tools and evaluation frameworks to conduct regular and well-structured culturally secure evaluations that are guided by statewide or regional strategic plans.

7. Implement strategies to increase the identification of Aboriginal people in services in accordance with the National Best Practice Guidelines for Collecting Indigenous Status and recording categories on data collection forms and information systems.
### The monitoring and evaluation framework includes indicators and details data sources to monitor progress against the targets previously mentioned.

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<th>Targets by the end of 2023:</th>
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<td>1. Achieve and maintain hepatitis B childhood vaccination coverage of 95% at 12 and 24 months</td>
<td>Coverage of hepatitis B vaccination at 12 and 24 months among Aboriginal people</td>
<td>ACIR and Rates Calculator</td>
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<tr>
<td></td>
<td>Numerator: Number of Aboriginal children who have dose 3 by 12 (and 24) months of age recorded on the Australian Childhood Immunisation Register (ACIR)</td>
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<td></td>
<td>Denominator: Number of Aboriginal children turning 12 (and 24) months of age in the measurement year on the ACIR</td>
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<tr>
<td>2. Achieve and maintain HPV adolescent vaccination coverage of 80%</td>
<td>Three-dose HPV vaccination coverage for 15-year-old Aboriginal males and females</td>
<td>Indicator to be developed</td>
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<tr>
<td></td>
<td>Numerator: Number of Aboriginal males and females turning 15 years reported to the National Human Papillomavirus Vaccination Register (NHPVR) that comply with the recommended vaccine dosage and administration as per the Australian Immunisation Handbook</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denominator: Number of Aboriginal males and females turning 15 years</td>
<td></td>
</tr>
<tr>
<td>3. Increase STI testing coverage with a focus on areas of highest need</td>
<td>Proportion of Aboriginal people aged 15–24 years receiving a chlamydia and/or a gonorrhoea test in the previous 12 months</td>
<td>Indicator to be developed</td>
</tr>
<tr>
<td></td>
<td>Numerator: Number of Aboriginal people aged 15–24 years tested for chlamydia and/or gonorrhoea at least once in the previous 12 months</td>
<td></td>
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<tr>
<td></td>
<td>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population, Aboriginal, 15–24 year age group</td>
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<td>Targets by the end of 2023:</td>
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<tr>
<td>4. Increase the use of sterile injecting equipment for every injecting episode</td>
<td>Prevalence of receptive syringe sharing by WA participants in the Australian Needle and Syringe Program Survey (ANSPS), by Aboriginal status</td>
<td>ANSPS, The Kirby Institute</td>
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<tr>
<td>5. Reduce the incidence and prevalence of infectious syphilis with a particular focus on areas of highest disease burden</td>
<td>Annual rate of infectious syphilis notifications among Aboriginal people Numerator: Number of infectious syphilis notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages</td>
<td>WA Notifiable Infectious Diseases Database (WANIDD) and Rates Calculator</td>
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<tr>
<td>6. Maintain virtual elimination of congenital syphilis</td>
<td>Number of congenital syphilis notifications among Aboriginal people</td>
<td>WANIDD</td>
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<tr>
<td>7. Reduce the incidence and prevalence of gonorrhoea and chlamydia with a focus on young people</td>
<td>Annual rate of gonorrhoea and chlamydia notifications among Aboriginal people aged 15–24 years Numerator: Number of gonorrhoea and chlamydia notifications among Aboriginal people aged 15–24 years Denominator: ABS Estimated Resident Population, Aboriginal, 15–24 year age group</td>
<td>WANIDD and Rates Calculator</td>
</tr>
<tr>
<td>8. Reduce the number of newly acquired hepatitis C infections by 60%</td>
<td>Annual rate of newly acquired hepatitis C notifications among Aboriginal people Numerator: Number of newly acquired hepatitis C notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages</td>
<td>WANIDD and Rates Calculator</td>
</tr>
<tr>
<td>9. Maintain the low incidence of HIV</td>
<td>Rate of HIV notifications among Aboriginal people Numerator: Number of annual HIV notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages</td>
<td>WA HIV Database and Rates Calculator</td>
</tr>
</tbody>
</table>
## Targets by the end of 2023:

### 10. Achieve the 95–95–95 HIV diagnosis and treatment targets:
- Increase the proportion of people with HIV who are diagnosed to 95%
- Increase the percentage of people diagnosed with HIV on treatment to 95%
- Increase the percentage of people on treatment with an undetectable viral load to 95%

<table>
<thead>
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<th>Indicators</th>
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<td>1. Estimated proportion of Aboriginal people living with HIV who have been diagnosed</td>
<td>Indicator to be developed</td>
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<tr>
<td>2. Estimated proportion of Aboriginal people living with HIV dispensed treatment for HIV infection</td>
<td>HIV specialist clinics in WA</td>
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<tr>
<td>3. Proportion of Aboriginal HIV patients on treatment with an undetectable viral load</td>
<td></td>
</tr>
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</table>

### 11. Increase the proportion of people living with hepatitis C who are diagnosed to 90% and the cumulative proportion who have initiated DAA treatment to 65%

<table>
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<tr>
<th>Indicators</th>
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<tbody>
<tr>
<td>1. Estimated annual proportion of Aboriginal people living with chronic hepatitis C who have been diagnosed</td>
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<tr>
<td>2. Annual rate of unspecified hepatitis C notifications among Aboriginal people</td>
<td>WANIDD and Rates Calculator</td>
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<tr>
<td>3. Proportion of Aboriginal people living with hepatitis C dispensed DAA treatment for hepatitis C infection</td>
<td>Indicator to be developed</td>
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</table>

Numerator: Number of Aboriginal people dispensed DAA treatment for hepatitis C infection
Denominator: Modelled estimate of the number of Aboriginal people living with chronic hepatitis C
<table>
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<th>Targets by the end of 2023:</th>
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<tbody>
<tr>
<td>12. Increase the proportion of people living with hepatitis B who are diagnosed to 80%; receiving care to 50%; and on antiviral treatment to 20%</td>
<td>1. Estimated annual proportion of Aboriginal people living with chronic hepatitis B who have been diagnosed</td>
<td>Indicator to be developed</td>
</tr>
<tr>
<td></td>
<td>2. Annual rate of unspecified hepatitis B notifications among Aboriginal people Numerator: Number of unspecified hepatitis B notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages</td>
<td>WANIDD and Rates Calculator</td>
</tr>
<tr>
<td></td>
<td>3. Proportion of Aboriginal people living with chronic hepatitis B who received monitoring for chronic hepatitis B Numerator: Number of Aboriginal people who received monitoring for chronic hepatitis B Denominator: Modelled estimate of the number of Aboriginal people living with chronic hepatitis B</td>
<td>Indicator to be developed</td>
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<tr>
<td></td>
<td>4. Proportion of Aboriginal people with living chronic hepatitis B dispensed medication for hepatitis B infection Numerator: Number of Aboriginal people dispensed medication for chronic hepatitis B infection Denominator: Modelled estimate of the number of Aboriginal people living with chronic hepatitis B</td>
<td>Indicator to be developed</td>
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<tr>
<td></td>
<td>5. Annual rate of unspecified hepatitis B notifications among Aboriginal people Numerator: Number of unspecified hepatitis B notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages</td>
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<td>6. Proportion of Aboriginal people living with hepatitis B dispensed treatment Numerator: Number of Aboriginal people dispensed treatment for chronic hepatitis B infection Denominator: Modelled estimate of the number of Aboriginal people living with chronic hepatitis B</td>
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<th>Target</th>
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<tbody>
<tr>
<td>13. Reduce hepatitis C attributable mortality by 65%</td>
<td>Estimated number of deaths among Aboriginal people attributable to chronic hepatitis C</td>
<td>Data linkage study</td>
</tr>
<tr>
<td>14. Reduce hepatitis B attributable mortality by 30%</td>
<td>Estimated number of deaths among Aboriginal people attributable to chronic hepatitis B</td>
<td>Data linkage study</td>
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<tr>
<td>15. Reduce the reported experience of stigma among Aboriginal people with BBVs and STIs, and the expression of stigma, in relation to BBV and STI status</td>
<td>Indicator to be developed</td>
<td>Indicator to be developed</td>
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<tr>
<td>16. Improve knowledge and behaviour regarding safer sex and prevention of BBVs</td>
<td>Increased knowledge of STIs and BBVs, Improved harm minimisation behaviours to prevent STIs and BBVs</td>
<td>Secondary schools survey, La Trobe University</td>
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<tr>
<td>17. Maintain low numbers of newly acquired hepatitis B infections across all age groups by 50%</td>
<td>Annual rate of newly acquired hepatitis B notifications among Aboriginal people</td>
<td>WANIDD and Rates Calculator</td>
</tr>
</tbody>
</table>

Numerator: Number of newly acquired hepatitis B notifications among Aboriginal people
Denominator: ABS Estimated Resident Population, Aboriginal, all ages
Governance

The WA Department of Health is committed to a partnership approach between priority populations, government, community-based organisations, health service providers, researchers and policymakers to guide the public health response to STIs and BBVs.

The Department established the WA Sexual Health and Blood-borne Viruses Advisory Committee (WA SHaBBVAC) in accordance with the Public Health Act 2016 (WA) to provide a forum for a multi-agency partnership in the prevention and control of BBVs and STIs. Its purpose is to advise the Chief Health Officer on the development of state policies and programs relating to STIs and BBVs. The Advisory Committee members and other partners work closely with the Department in a joint approach towards the development, implementation and evaluation of the Department’s strategies and implementation plans for HIV, hepatitis B, hepatitis C and STIs, with special consideration for the impact of STIs and BBVs on Aboriginal communities, taking into account matters such as prevention, education, treatment, care, surveillance, research, legal and policy issues, monitoring and evaluation.

The Advisory Committee membership includes agencies that represent the interests of priority populations or are at the forefront of service delivery. Members include health consumers and representatives from the WA Primary Health Alliance, Health Consumers’ Council, WA AIDS Council, Peer Based Harm Reduction WA, Sexual Health Quarters, Magenta, HepatitisWA, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Mental Health Commission, WA Network of Alcohol and Drug Agencies, Youth Affairs Council WA, Aboriginal Health Council of WA, WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN) – Curtin University, Aboriginal Health Directorate (Department of Health), Department of Justice, Australian Department of Health and SECCA. Secretariat services are provided by SHBBVP.
Monitoring and reporting

The Communicable Disease Control Directorate (CDCD) within the Department is responsible for the collation, analysis and reporting on STI and BBV notifications. Consistent with the role of system manager, the CDCD will publish ongoing quarterly and annual epidemiology reports on STI and BBV notifications, testing data and test positivity data. The STI and BBV Quarterly Forum, convened by the Department, will present up-to-date STI and BBV epidemiology reports to the service sector. CDCD will also publish a mid-term and a final report on the progress towards achieving the strategy’s targets, including performance indicators relating to the cascades of care, behavioural surveillance and stigma and discrimination as described in the monitoring and evaluation framework detailed within this strategy.

The Department will provide an activity report on the implementation of the strategy to the Advisory Committee at each meeting to monitor progress towards achieving the targets and to monitor emerging issues.

The Department is also required to report to the Blood-borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS) on the implementation of the public health response in WA and progress towards meeting the national targets set out in the suite of national STI and BBV strategies.
References


5 HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report. Sydney: The Kirby Institute, University of New South Wales (UNSW); 2018.


