Western Australian Sexually Transmissible Infections (STI) Strategy 2019–2023

Message from the Minister for Health

The *Western Australia (WA) Sexually Transmissible Infections Strategy 2019–2023* builds on the strengths and progress from our previous strategies, and is closely aligned to the *Fourth National 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 sexually transmissible infections on vulnerable target populations in WA.

The burden of STIs has always created disproportionate impact on the health and wellbeing of several key priority populations. As such, we must remain vigilant across major outbreaks by ensuring sexual health screening is readily available and promoted to target groups at risk, and contact tracing is activated promptly to prevent further transmission. Young people continue to represent a high proportion of STI notifications, especially chlamydia, while Aboriginal people remain disproportionately impacted by STIs compared to non-Aboriginal people because of several Aboriginal health inequalities in WA. Gay and bisexual men, and other men who have sex with men (MSM), culturally and linguistically diverse communities and sex workers in WA remain priority populations for our strategy.

The *WA Sexually Transmitted Infections Strategy 2015-2018* advocated for a strong partnership approach and collective action between government, non-government, healthcare and research organisations. Via this partnership approach, WA has made progress against its goals to reduce transmission of, and morbidity and mortality caused by STIs, and to minimise the personal and social impact of infections. The focus on using innovative media strategies to enhance STI prevention and education remains at the forefront of our work. It is imperative that we explore effective methods to reach our affected communities in this digital age, and to nuance our messaging and to facilitate fast access to information, testing and treatment of STIs across this diverse population.
A significant step forward was the development of the Structured Administration and Supply Arrangement (SASA) and the Registered Nurse/Aboriginal Health Practitioner STI Treatment Code to enable registered nurses and Aboriginal health practitioners to provide and administer free treatment for chlamydia and/or gonorrhoea to patients as required, improving access and adherence to STI treatment.

The WA Sexually Transmissible Infections Strategy 2019–2023’s goals and targets have been based on those detailed within the Fourth National 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. The actions within this strategy aim to best equip WA to contribute towards the World Health Organization (WHO) Global Health Sector Strategy on STIs 2016-2021, with a global goal to see a radical decline in STIs, and sexual health stigma and discrimination by 2030. I look forward to seeing the positive outcomes for all priority populations over the next 4 years.

Honourable Roger Cook MLA
Minister for Health
Strategy at a glance

Goals
1. Reduce transmission of sexually transmissible infections (STIs) among priority populations in Western Australia.
2. Reduce morbidity and mortality associated with STIs.
3. Minimise the personal and social impact of STIs.
4. Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people’s sexual health.

Targets
1. Achieve and maintain human papillomavirus (HPV) adolescent vaccination coverage of 80% or more.
2. Increase STI testing coverage of priority populations.
3. Reduce the incidence and prevalence of gonorrhoea, chlamydia and infectious syphilis.
5. Eliminate the reported experience and expression of stigma among priority populations affected by STIs.

Key actions
1. Provision of health hardware, vaccination, comprehensive sexuality education, health promotion initiatives and community engagement.
2. Increase access to and uptake of regular STI testing in accordance with best practice clinical guidelines, especially in priority populations.
3. Improve access and adherence to treatment and clinical care, using innovative models and specialist support.
4. Support the capacity of community and peer-based organisations and health services in the collaboration and provision of program and service delivery.
5. Address legal, institutional and regulatory frameworks that act as barriers to health service access and work to minimise stigma and discrimination experienced by priority populations.
6. Conduct meaningful and culturally secure research, surveillance, monitoring and evaluation on STIs and priority populations using best practice models.

Priority populations
- women
- young people
- Aboriginal people
- sexually and gender diverse people
- sex workers
- people in or recently exited custodial settings
- travellers and mobile workers
- people living with a disability
- people with mental health issues
- gay and bisexual men, and men who have sex with men
- people from culturally and linguistically diverse backgrounds.
Other related strategies

- Fourth National Sexually Transmissible Infections Strategy 2018–2022
- Humanitarian Entrant Health Service – policies and information
- 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 2015–2030
- Western Australian Aboriginal Sexual Health and Blood-borne Virus Strategy 2019–2023
- Western Australian Alcohol and Drug Interagency Strategy 2018–2022
- Western Australian Country Health Service Aboriginal Health Strategy 2018–2023 (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 Mental Health, Alcohol and Other Drug Services Plan 2015–2025
- Western Australian Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy (to be published)
- Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018–2025 (to be published)
- Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018–2025
- Western Australian Methamphetamine Action Plan
- Western Australian Sexually Transmitted Infections (STI) Strategy 2015–2018
- Western Australian STI Strategy 2015–2018 Monitoring and Evaluation Framework
- Western Australian Women’s Health Strategy 2013–2017
- Western Australian Youth Health Policy 2018–2023
- World Health Organization (WHO) Global Health Sector Strategy on Viral Hepatitis 2016–2021
List of acronyms

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

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<th>Acronym</th>
<th>Description</th>
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<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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<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>
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<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 Protection</td>
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<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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<td>DAA</td>
<td>direct-acting antiviral</td>
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<td>GDHR</td>
<td>Growing and Developing Health Relationships</td>
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<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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<tr>
<td>HPV</td>
<td>human papillomavirus</td>
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<tr>
<td>Abbreviation</td>
<td>Description</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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<td>NHVPR</td>
<td>National Human Papillomavirus Vaccination Program Register</td>
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<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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<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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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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Western Australian Sexually Transmissible Infections (STI) Strategy 2019–2023

UNSW University of New South Wales
UTI urinary tract infection
U=U Undetectable = Untransmissable
VL viral load
WA Western Australia
WACHS WA Country Health Service
WA health system The WA health system consists of the Department of Health, Child and Adolescent Health Service, North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service and WA Country Health Service, and Health Support Services.
WANIDD WA Notifiable Infectious Diseases Database
WHO World Health Organization
WA SHaBBVAC WA Sexual Health and Blood-borne Viruses Advisory Committee
WA SORG WA Syphilis Outbreak Response Group

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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Western Australian Sexually Transmissible Infections (STI) Strategy 2019–2023

Why is this strategy needed?

Snapshot of sexually transmissible infections in Western Australia

What are sexually transmissible infections?

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, the primary notifiable STIs for this strategy include chancroid, chlamydia, donovanosis, gonorrhoea and syphilis.

What health issues do they cause?

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?

Bacterial STIs such as chlamydia, donovanosis, gonorrhoea and syphilis are treated with antibiotics. Early detection and treatment is important in the management of all STI.

Chlamydia

The number of chlamydia notifications in WA in 2017 (n = 11 557) was comparable to the 2012 to 2016 five-year average of 11 640 notifications per year. Notification and testing rates were highest in people aged 15 to 24 years and the notification rate was four times higher among Aboriginal people compared to non-Aboriginal people.

Gonorrhoea

The number of gonorrhoea notifications in WA in 2017 (n = 3360) was 27% higher than the 2012 to 2016 five-year average of 2650 notifications per year. Notification and testing rates were highest in people aged 15 to 24 years and the notification rate was 12 times higher among Aboriginal people compared to non-Aboriginal people.
In 2017, 17% of completed gonorrhoea enhanced surveillance forms had an exposure category identified as ‘men who have sex with men’ (MSM). Both Aboriginal and non-Aboriginal people reported similar specimen sites for gonorrhoea testing but there were marked differences in terms of clinical settings, treatment and sexual exposure.

**Syphilis**

The number of syphilis notifications in WA in 2017 (n = 483) was the highest reported in the previous 10 years. The notification rate was almost seven times higher among Aboriginal people compared to non-Aboriginal people. There were no congenital syphilis cases in 2017. In 2017, 61% of completed infectious syphilis enhanced surveillance forms had an exposure category identified as MSM. There were marked differences between Aboriginal and non-Aboriginal people in terms of reason for presentation, sex and type of partner and mode of transmission of infectious syphilis. As of 2017, the last case of congenital syphilis in an Aboriginal child was reported in 2013.
Progress under the last strategy

The WA Sexually Transmitted Infections (STI) Strategy 2015–2018 advocated for a strong partnership approach and collective action between government, non-government, healthcare services and research organisations. Using this partnership approach, WA has made progress against its goals to reduce transmission of and morbidity and mortality caused by STIs, and to minimise the personal and social impact of infections.

Several innovative media strategies have been developed to enhance STI prevention and education. These campaigns targeted young people and Aboriginal communities in WA, directing them to access free testing for chlamydia and gonorrhoea via the Could I Have It and Get the Facts campaign websites. Intensive and targeted marketing strategies by the WA health system across four STI and blood-borne virus (BBV) related campaigns have reaped positive rewards, with digital impressions exceeding 6.5 million over a recent four-month period.* Click-through rates across these campaigns are also within the Google Ads benchmark of 3.17% for search and 0.46% for display, averaging 0.4%. These campaigns have also reached regional and remote WA via highly invested broadcast and print advertising.

Large-scale updates and improvements to relationships and sexuality education (RSE) resources have been conducted. These include the comprehensive Growing and Developing Healthy Relationships (GDHR), an online RSE resource for teachers; and Talk Soon Talk Often, an RSE resource for parents. Information for students, parents, teachers and schools regarding the human papillomavirus (HPV) vaccination program was updated and linked to GDHR to improve knowledge and completion of the HPV vaccination series.

A Structured Administration and Supply Arrangement (SASA) and a Registered Nurse/Aboriginal Health Practitioner STI Treatment Code enabled Registered Nurses and Aboriginal Health Practitioners to provide and administer free treatment for chlamydia and gonorrhoea to patients as required, improving access and adherence to STI treatment.

On the research front, Curtin University delivered the Western Australian Law and Sex Worker Health (LASH) Study: A Summary Report, which assessed the sexual health and welfare of sex workers in WA. Research was also conducted in genomic epidemiology and population structure of Neisseria gonorrhoeae from remote highly endemic WA populations; and understanding risk factors for gonorrhoea in young heterosexual people in Perth. Information from these reports informed provision of education programs, clinical guidelines and best practice management of gonorrhoea infections.

* Digital impression is a term that refers to the point in which an advert is viewed once by a visitor, or displayed once on a web page, potentially reaching an audience.
The infectious syphilis outbreak in the Kimberley region in mid-2014 and a related cluster in mid-2018 in the Pilbara region saw the active call to action across government and community organisations in the formation of the WA Syphilis Outbreak Response Group (WA SORG). A WA Syphilis Outbreak Response Action was developed with a framework to combat the outbreak, and to help prevent its spread into neighbouring regions. The Kimberley, Pilbara and Goldfields regions have also established regional Syphilis Outbreak Response Teams to guide local activity in line with the WA SORG and national syphilis outbreak response.
The Guiding Principles for this strategy reflect those in the *Fourth National Sexually Transmissible Infections Strategy 2018–2022*, adapted for the Western Australian context.

1. **Meaningful involvement of priority populations**
   
   Priority populations should be central to the public health response to STIs and should have meaningful participation in the development, implementation, monitoring and evaluation of effective programs and policies.

2. **Human rights**
   
   People living with an STI or those at risk of STIs have the right to live without stigma and discrimination. It is vital to safeguard the human rights of priority populations 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 appropriate 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 priority populations.

4. **Health promotion**
   
   All actions related to the prevention of STI transmission, treatment and management of STIs, provision of clinical services and ongoing support and care for priority populations should reflect the Ottawa Charter for Health Promotion.¹

5. **Prevention**
   
   The transmission of STIs can be reduced through an appropriate and effective combination of evidence-based biomedical, behavioural and social approaches within a supportive and enabling environment. Education and prevention programs, together with access to the means of prevention, including HPV vaccination, will be vital for achieving the targets set within this strategy.
6. **Quality health services**

Supporting and coordinating a multidisciplinary workforce of motivated, trained and informed health professionals, community and peer-based workers and volunteers is essential in delivering culturally secure and high-quality services for priority populations across WA. Health service delivery should respond to new technologies and best practice models of care for those living with or at risk of STIs.

7. **Harm reduction**

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

8. **Shared responsibility**

Individuals and communities are empowered when can prevent themselves and others from acquiring STIs. 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 priority population led preventative action.

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

The response to STIs in WA has been built on a strong evidence base, informed by high-quality research and surveillance, monitoring and evaluation. With new research findings, the evidence base may be refined in order to meet new challenges, evaluate current and new interventions, and to develop effective social policy and clinical guidelines.

10. **Partnership**

Effective and collaborative partnerships between priority populations, health services, community organisations, the clinical workforce, researchers and government are fundamental to the response to STIs and to achieve 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.
The goals and targets presented in this strategy have been based on the goals and targets detailed within the *Fourth National 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 transmission of STIs among priority populations in WA.
2. Reduce the morbidity and mortality associated with STIs.
3. Minimise the personal and social impact of STIs.
4. Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people’s sexual health.

**Targets – by 2023**

1. Achieve and maintain HPV adolescent vaccination coverage of 80% or more.
2. Increase STI testing coverage of priority populations.*
3. Reduce the incidence and prevalence of gonorrhoea, chlamydia and infectious syphilis.†
4. Maintain virtual elimination of congenital syphilis.‡
5. Eliminate the reported experience and expression of stigma among priority populations affected by STIs.
6. Improve knowledge and behaviour regarding safer sex and prevention of BBVs.

* Compared with 2017
† Compared with 2017. Targets specific to Aboriginal people included in *WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2019–2023*.
‡ No new cases of congenital syphilis nationally notified (as defined by the global surveillance case definition) for two consecutive years.
World Health Organization Global health sector strategy on sexually transmitted infections 2016–2021

The actions within this strategy also aim to best equip WA to contribute towards national and global testing, treatment and elimination targets.

**Global goal**

By 2030
- End STI epidemics as public health concerns.

**Global targets**

By 2030
- 90% reduction in syphilis incidence globally
- 90% reduction in gonorrhoea incidence globally
- Sustain 90% national coverage and at least 80% in every district (or equivalent) in countries with the HPV vaccine in their national immunisation program.
Priority populations

The burden of STIs disproportionately impacts the health and wellbeing of several key priority populations. This strategy identifies the 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.

Women

Historically, women have not been listed as a distinct priority population but have been recognised as existing across most priority populations. In recognition of the increase in STI notifications and issues including intimate partner violence, unplanned pregnancy and sexual assault, women must be considered a priority population. This includes both cisgender and transgender women. Women may be at a heightened risk of acquiring STIs due to their reproductive anatomy, and tend to disproportionately bear the long-term consequences of STIs on their reproductive health and fertility.²

Key subpopulations of women include those who are:

- who are affected by STIs and associated syndromes, such as pelvic inflammatory disease (PID)
- pregnant, who must be a key focus for STI prevention, testing and treatment due to the potential for mother-to-child transmission
- migrant or from culturally and linguistically diverse (CALD) backgrounds
- Aboriginal
- living with human immunodeficiency virus (HIV)
- sex workers
- transgender.

Young people

Young people continue to represent a high proportion of STI notifications, especially chlamydia. The range of risk factors for young people include lack of STI knowledge and awareness, lack of access to prevention (condoms) and testing, underestimating the seriousness or risk of STIs, financial costs of health care, lack of access to Medicare and social barriers such as fear of stigmatisation.³ Comprehensive and inclusive sexual health education and targeted STI prevention and health promotion initiatives are essential for reducing STIs in this population.

Key subpopulations of young people include those who are:

- sexually and gender diverse
- Aboriginal
from CALD backgrounds

in juvenile custodial settings, out-of-home care facilities or other transitional housing.

Aboriginal people

Aboriginal people continue to be disproportionately impacted by STIs compared to non-Aboriginal people, requiring a targeted focus on enhancing health services, programs and policies to close the sexual health gap. Aboriginal people may be more likely to experience intersecting risk factors and barriers to health access and equity. This includes living in remote geographical locations; lacking access to culturally secure education, testing and treatment services; experiencing stigma and discrimination; and having a disproportionate representation in custodial settings and prison. Partnership with Aboriginal community services, Aboriginal elders and members of the Aboriginal community is vital to identify, address and remedy the barriers to good sexual health experienced by Aboriginal people.

Sexually and gender diverse people

Sexually and gender diverse people have specific sexual health care needs and risks, and may experience barriers to accessing appropriate prevention and education, treatment and care. This may include stigma and discrimination or difficulty finding a healthcare provider who is competent in sexually and gender diverse care. Legal frameworks and policies may create barriers to equitable access of health services for transgender and gender diverse people and need to be addressed alongside the provision of more inclusive education and appropriately skilled health services.

Key subpopulations sexually and gender diverse people include those who are:

- young
- living with HIV
- Aboriginal, including brotherboys and sistergirls*
- undergoing hormonal or medical treatment or procedures to assist with gender affirmation.

Sex workers

Historically, sex workers in WA have had good adherence to condom use, and have lower rates of STIs than the general population. However, recent evidence suggests there has been a decrease in condom use among sex worker populations, potentially placing these individuals at high risk of STI transmission. Stigma and discrimination may impact access to health services, as can regulatory and legal issues such as the criminalisation of certain forms of sex work via the 

* Terms used for transgender people within some Aboriginal communities.
Key subpopulations of sex workers include those who are:
- sexually and gender diverse
- migrants or from CALD backgrounds
- based in rural and regional areas
- Aboriginal
- affected by STIs
- living with HIV
- living with a disability.

People in or recently exited custodial settings
Custodial settings, including prison, juvenile detention facilities and out-of-home care facilities may be high-risk environments for STI transmission. There is often limited access to STI prevention and education, both within and outside the custodial settings. Further research and targeted strategies are required to determine the burden of STI in this population and effectively prevent, treat and manage STIs for those imprisoned, on remand, awaiting sentencing and exiting custodial settings.

Travellers and mobile workers
The increasing mobility of populations provides an opportunity for the spread of STIs, including drug resistant strains. Travellers, fly-in fly-out workers, seasonal workers and the communities they have contact with may be at heightened risk of acquiring STIs. Evidence demonstrates that it is not uncommon for people to behave differently when they travel, including engaging in high-risk or unsafe sexual practices, and this may occur in countries with high STI prevalence. Access to services for travellers who are ineligible for Medicare is also an important consideration.

People living with a disability
People living with a disability, including those in care facilities, may experience increased vulnerability to sexual violence, STI risk and other sexual and reproductive health issues. People living with a disability may have difficulty accessing sexual and reproductive health services, may be dependent on guardians, family members or carers for education and information, or may often have their needs for sexual education and health care overlooked. Access to appropriate sexual health and STI prevention, education and healthcare services for people living with a disability and their carers and families is essential.
People with mental health issues

People with mental health issues may experience greater isolation, stigma and discrimination than the general population, and may experience unique risk factors relating to their sexual health, including a higher likelihood of AOD use, which may lead to high-risk sexual behaviours. Research also suggests that several priority populations, including sexually and gender diverse people, may experience mental health issues such as depression and anxiety at higher rates than the general population, indicating an important intersection. There are also many factors that affect the extent to which a person who has experienced mental health issues is able to recover and live a satisfying life. Access to the right mix of primary health services, private and community-based health, agency and community sector supports is required. As people with mental health issues may already be engaged with the health system for ongoing care, this provides a good opportunity for sexual health education and opportunistic STI testing.

Gay and bisexual men, and men who have sex with men

Gay and bisexual men, and MSM are disproportionately affected by all STIs and have a higher prevalence and risk of acquiring STIs and BBVs such as syphilis and HIV when compared to the general population. The transmission of other viruses during sexual contact via the faecal-oral route, such as hepatitis A and shigellosis, is also an emerging issue among MSM. Gay and bisexual men, and MSM may have specific sexual health needs, though they may also experience stigma or discrimination related to their sexual identity or disease status. Appropriate prevention education and healthcare services should emphasise the importance of safer sex practices and condom use, alongside regular testing and early treatment. This is particularly important in the context of the use of pre-exposure prophylaxis (PrEP) for HIV prevention.

Key subpopulations of gay and bisexual men, and MSM include those who are:
- living with HIV
- engaging in chem-sex
- migrants or from CALD backgrounds.

Culturally and linguistically diverse people

Some research has indicated that CALD people may have lower knowledge about STIs and a higher prevalence of some STIs than the non-CALD population, indicating a need to improve sexual health literacy and access to appropriate and culturally secure health services for this population. It is important to acknowledge that CALD populations include a diverse range of people from different countries, cultural identities and lived experiences, and that many of these groups may face stigma or misunderstanding. Tailored approaches, resources and services are needed to address the specific cultural, language and gender issues that exist alongside the response to STIs.

Key sub-populations of CALD people include:
- those born in countries with high STI and BBV prevalence
- refugees and humanitarian entrants
- those who are ineligible for subsidised health care, including international students.
Evidence to support the action areas

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:

- Young people need comprehensive and sex-positive sexual health education, with a focus on developing healthy relationships, understanding consent and preventing STIs.
- Community and peer involvement must be emphasised at every point, including the co-design of programs and policies, support for utilising peer and community-based health workers in the implementation of local initiatives, and community input into the qualitative evaluation of programs and initiatives.
- Novel testing and treatment approaches such as community opportunistic screening programs and point-of-care testing (POCT) need to be utilised more.
- Research and health service evaluation are needed to determine how sexually and gender diverse people experience accessing sexual health care and looking after their sexual health.
- Greater collaboration between government departments is needed to enhance responses to sexual health for priority populations.
- Health workers should be sensitive to issues regarding partner notification where there is or may be a background of family or intimate partner violence.
- Increased opportunities for attitudes and values training for health workers could contribute to a more resilient and capable workforce, and reduce the likelihood of community members experiencing stigma or discrimination when they access health services.
- More support for training and retaining Aboriginal health workers (AHWs) and practitioners in primary health and community services needs to be given, particularly in response to the syphilis outbreak in some of WA’s regional and remote areas.
- Nurse practitioners and nurse-led models of care should be utilised in community organisations, custodial settings and Aboriginal communities to increase uptake of STI testing and treatment.
- Good education and health care are about building safe, healthy and resilient communities.
Evidence to support actions

Prevention and education

- Knowledge about STIs, including chlamydia, remains poor among secondary school students, reinforcing the need to provide students with comprehensive sexual health education including information on STIs and how to prevent them.19

- Approximately 8% of young men and 4% of young women reported same-sex only attraction and 5% of young men and 14% of young women were attracted to people of both sexes, representing a total of 31% of young people having some form of same-sex attraction according to the Fifth National Survey of Australian Secondary Students and Sexual Health. These statistics point to a considerable need to provide sexuality education and information that is inclusive and addresses specific sexual health concerns that same-sex attracted young people may have.19

- Trends in declining condom use, particularly among gay and bisexual men and sex workers, emphasise the need for ongoing targeted health promotion initiatives in this area.6,7

- Initiatives such as the provision of free condoms at sporting clubs and general practitioners (GP) clinics and placing condom machines in public toilets are effective ways to ensure and normalise equitable access to condoms for young people.20

Testing and diagnosis

- Adherence to clinical guidelines regarding frequency of antenatal syphilis testing is essential for preventing adverse maternal, fetal and perinatal outcomes, particularly in outbreak or endemic areas.21

- Novel interventions for increasing uptake of STI testing such as testing in community or non-clinical health settings and using digital or SMS reminders may be effective at increasing testing rates and normalising testing in young people and Aboriginal people.22

- Barriers to testing and diagnosis include insufficient culturally-appropriate and gender-specific clinical spaces, services and providers, lack of knowledge of available services, and stigma around sexual health and STIs.23

Disease management and clinical care

- Women with chlamydia infection may have a 41% greater risk of subsequent ectopic pregnancy than women without chlamydia, and gonorrhoea may result in a similar risk of ectopic pregnancy and infertility, requiring a continued emphasis on timely diagnosis and treatment to prevent long-term adverse outcomes.24

- Three cases of extensively antimicrobial resistant (AMR) gonorrhoea were reported in 2018, with two of those infections occurring in Australia. An effective response to this threat requires a strong focus on increased testing and diagnosis and appropriate disease management and clinical care.25

Workforce development

- Nurse-led clinics can enable vital access to health services and treatment, particularly in remote areas or where there are health workforce shortages. Evidence suggests that nurse-led clinics are acceptable, feasible and safe, and clients accessing nurse-led clinics felt they were given more time and were informed about their health and choices.26 Training and administrative support for nurses and ongoing nurse-led clinics should therefore be emphasised.27
Peer-based services play a significant role in enabling access to otherwise hard to reach priority populations and enhance community-appropriate delivery of education and services. Peer workers understand their communities and may be able to overcome sociocultural barriers that otherwise prevent people from accessing prevention, education and health services. Research has found that the use of peer-based services and peer-education programs lead to improvements in sexual health knowledge and attitudes.\(^{28,29}\)

Partnerships and collaboration across a range of organisations can facilitate collective action to address community health and capacity building of the sector. Translating expertise into coordinated action requires strong leadership from key organisations and government.\(^{30}\)

Enabling environment

The anticipation, perception or experience of stigma and discrimination can have harmful effects on an individual’s quality of life and healthcare utilisation.\(^{31}\)

Social determinants, such as poverty, sociocultural context, gender inequities, social disadvantage and geographical isolation have been found to impact on Aboriginal adolescents’ sexual behaviours and risk. There is a need for the development, delivery and maintenance of community-led programs including the use of peer education to address these issues and ensure the cultural appropriateness and relevance of sexual health education and services.\(^{32}\)

There is a strong need to address the legal, regulatory and institutional frameworks that are known to create barriers to good sexual health and service access for priority populations such as sex workers and transgender people. Legal contexts have been found to affect the level of health service access and isolation experienced by a community.\(^{33}\) For example, the criminalisation of some forms of sex work under the Prostitution Act 2000 (WA) has been found to increase the risk of STI transmission and issues such as stigma, discrimination and isolation when compared to models of decriminalisation.\(^{6}\) Changes to legal and regulatory frameworks should be based on evidence-informed national and international best practice.

Data collection, research and evaluation

Developing strong policies and programs requires an understanding of the complex determinants of sexual health risk. Meaningful research around the transmission of STIs and sexual health outcomes for priority populations must go beyond surveillance-type data to include the complex social and behavioural aspects of sexual activity, including investigating knowledge, attitudes and values.\(^{32}\)

Strengthened research and monitoring of AMR strains of STI such as AMR gonorrhoea is needed to identify best practice for prevention, testing and diagnosis, and treatment and clinical care. This should include enhanced surveillance such as population-based surveillance and surveillance of treatment failures and antimicrobial use.\(^{34}\)
The key actions for the *Western Australian Sexually Transmissible Infections (STI) Strategy 2019–2023* are broken down into six primary areas to align with the *Fourth National Sexually Transmissible Infections 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 requires a focus on all action areas.

## Prevention and education

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

1. **Increase the capacity of schools, including Education Support Centres, to deliver comprehensive RSE in a safe, non-judgemental and supportive environment by using a whole school approach.** Comprehensive RSE includes:
   - development of skills, clarification of values and acquisition of knowledge to empower students to make informed, safe and healthy decisions
   - a positive, sexually and gender diverse inclusive view of relationships and sexuality
   - delivery by the classroom teacher or appropriate RSE provider supported by health professionals
   - delivery across all years of schooling
   - use of evidence-informed resources such as GDHR\(^{35}\) and the International Technical Guidance on Sexuality Education.\(^{36}\)

2. **Support further increases in the number of adolescents including Aboriginal adolescents completing the HPV vaccination series as per the *National Immunisation Strategy* and the *Western Australian Immunisation Strategy 2016–2020*.**

3. **Increase use of and access to peer-based and outreach STI prevention and education services for priority populations by increasing opportunities for people to undertake peer training and enhancing service linkage with peer-based services or programs.**

4. **Promote consistent and effective use of safe sex hardware including condoms and other barrier methods by increasing discreet access to free or affordable condoms and increasing acceptability of condom use among priority populations.** This may include:
   - providing culturally secure education on safe and effective condom and other barrier use
   - increasing availability of condom vending machines
   - increasing health promotion efforts on social media.
5. Implement targeted age appropriate and culturally secure STI prevention education initiatives and resources for priority populations via a range of channels including digital platforms and social media to enhance accessibility of STI prevention messages.

6. Ensure STI prevention education, access to condoms and recommended regular STI testing is promoted alongside PrEP for HIV prevention to minimise the risk of increased STI transmission in those using PrEP, and to ensure timely treatment of STIs.

**Testing and diagnosis**

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

1. Ensure antenatal syphilis testing is conducted as a priority in all public and private sector health services in metropolitan, regional and rural WA. This includes ensuring the testing and diagnosis of all STIs including syphilis is conducted as part of routine antenatal care to minimise the risk of mother-to-child transmission and adverse health outcomes for infants.

2. Use novel approaches to increase acceptability, accessibility and uptake of STI testing in priority populations, with a focus on regional and remote areas. This may include:
   - use of community and peer-led initiatives
   - onsite STI testing facilities at sporting or music events
   - free online STI testing programs
   - use of STI self-testing kits
   - SMS reminders
   - STI testing on entry and exit of custodial settings
   - outreach testing services
   - drop in clinics at women’s health centres, Headspace, employment services, youth services, AOD rehabilitation facilities and men’s and women’s housing shelters
   - POCT testing technologies
   - integration of STI testing with other routine health services such as adult health checks.

3. Promote and maintain the use of regularly updated evidence-based clinical guidelines and resources for accurate STI testing and diagnosis.

4. 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 healthcare 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.
5. Enhance evidence-based guidance and stewardship on AMR and utilise best practice testing procedures to enable appropriate antibiotic prescribing.

6. Develop the capacity of health infrastructure in regional and remote areas to increase testing and diagnosis during STI outbreaks and epidemics.

**Disease management and clinical care**

Timely and effective treatment, clinical care and contact tracing using innovative models and specialist support play an important role in preventing the transmission of STIs and reducing the long-term harm and burden of disease.

1. Identify and implement evidence-informed approaches for improving partner notification systems and contact tracing activities and efforts, particularly in regional and remote areas, to enhance the diagnosis and treatment of people who may not otherwise realise they have been exposed to an STI and reduce the rates of onward transmission and reinfection with STIs.

2. Promote and maintain the use of regularly updated evidence-based clinical guidelines and resources for STI treatment and management to ensure high quality, appropriate and consistent disease management and clinical care.

3. Utilise innovative models of care for disease management and clinical care such as nurse-led models of care and outreach clinics.

4. Develop the capacity of health infrastructure in regional and remote areas to enhance the delivery of disease management and clinical care during STI outbreaks and epidemics.

5. 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 receive appropriate and timely treatment.

6. Ensure best practice and timely treatment of STIs to reduce likelihood of complications and adverse outcomes, especially in pregnant women and their infants.

**Workforce development**

The facilitation of appropriate and successful prevention, testing and treatment initiatives will continue to rely on a highly skilled and adequately trained healthcare workforce. Support and education for staff and volunteers working with people at risk of or affected by STIs, in a variety of settings, is central to the response to STIs in WA.

1. Increase accessibility of training and professional development opportunities for healthcare staff in rural and regional areas by using digital platforms for local organisations to leverage.
2. Encourage collaboration and capacity building between health services, community organisations and the government sector, including between different government departments, in relation to and for the purpose of improving prevention and education programs in schools and in the community health service delivery, and in relation to policies that impact priority populations.

3. Ensure healthcare professionals, including GPs, are well informed and are aware of and have access to appropriate and current guidelines on testing and treatment so as to provide optimal information and support to patients.

4. Support the capacity and role of community and peer-based organisations to provide appropriate prevention, education, advocacy and other care services to priority populations so as to enhance service access and equity for priority populations.

5. Explore multidisciplinary models for STI prevention, testing and treatment by:
   - utilising the skills of appropriately trained health professionals including AHWs and practitioners
   - facilitating the provision of nurse-led services
   - enhancing opportunities for education, professional development and specialisation for health professionals.

6. Improve the recruitment and retention of staff, particularly in regional and remote areas, to ensure a high level of expertise and workforce capacity exists across all areas by providing incentives.

Enabling environment

To ensure health and community care in WA is accessible to all, supportive and enabling environments that are culturally secure must be provided to anyone living with or at risk of STIs. This will include participation of priority populations in service design and implementation, addressing stigma and discrimination within the healthcare workforce, upholding client rights and responsibilities, and addressing regulatory health and systemic barriers to service access.

1. Enhance STI education, prevention, testing and treatment initiatives to ensure they support efforts to reduce STI-related stigma.

2. Implement systematic changes at the organisational and policy level to reduce stigma and discrimination by developing inclusive work practices, building system capability to ensure equity and undertaking routine organisational assessment to identify gaps and inform opportunities for improvement.

3. Review and address legal, institutional and regulatory frameworks and system policies that may perpetuate discrimination or serve to create barriers to health access and equity for priority populations, and work to ameliorate legal and regulatory barriers to an appropriate and evidence-based response.

* This may include collaboration between the WA Department of Health and WA Department of Justice in relation to legislation impacting the health of sex workers and STI testing programs for people entering and exiting custodial settings, and between the WA Department of Health and WA Department of Education in relation to enhancing comprehensive RSE in schools.
4. Support the healthcare workforce in providing non-discriminatory and non-stigmatising care so as to improve the quality of interactions with clients and encourage health service access by providing attitudes and values training to all specialists, primary healthcare workers and community-based service providers interacting with clients or consumers.

5. Collaborate across community organisations, health services and government departments to establish a dialogue and address social determinants that may hinder positive health behaviours and access to services, including stigma, discrimination, isolation, low socio-economic status, STI status and incarceration history.

6. Implement education and health promotion initiatives using a range of platforms, including social media messaging, to address STI-related stigma and discrimination expressed in community and healthcare settings.

7. Address the political, administrative and community context in which sexual health education and promotion in schools is situated, including issues such as stigma and misunderstanding, to enhance support for comprehensive and inclusive schools-based RSE.

Data collection, research and evaluation

To fully understand the burden of STIs among priority populations and guide further action, collection of enhanced behavioural data and relevant research and evaluation, including on the impact of stigma and discrimination, is essential.

1. Increase research efforts, utilising peer researchers where appropriate, in relation to STI prevalence and sexual health outcomes of priority populations for which there is a paucity of data, including transgender people and people who are currently in or have recently exited custodial settings, so as to inform and enhance programs and policies affecting these populations.

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

3. Investigate and monitor trends in the knowledge, attitudes, behaviours and experiences of priority populations in relation to their sexual health, including stigma and discrimination, and identify opportunities to expand this data and strengthen collaborative efforts so as to inform and improve the development and delivery of programs, policies and services.

4. Enhance statewide capacity to respond to current and emerging trends in STIs by:
   - improving the quality, completeness, timeliness and standardisation of demographic and disease data and enhanced surveillance
   - implementing strategies to increase the identification of Aboriginal people in services in accordance with the National Best Practice Guidelines for Collecting Indigenous Status in Health Data Sets.
5. Strengthen initiatives for monitoring, identifying and collaboratively addressing new and emerging issues in STIs, including AMR, Mycoplasma genitalium and the implications of STIs in PID and other associated morbidities, so as to inform and enhance best practice testing, diagnosis, disease management and clinical care.

6. Build on the existing evidence base and address data gaps to ensure the maintenance of a current and evolving body of research by identifying new opportunities for meaningful research and supporting research across disciplines.
### Surveillance, monitoring and evaluation framework

The monitoring and evaluation framework includes indicators and details data sources to monitor progress against the targets previously mentioned.

<table>
<thead>
<tr>
<th>Targets by the end of 2023</th>
<th>Indicators</th>
<th>Sources</th>
</tr>
</thead>
</table>
| 1. Achieve and maintain HPV adolescent vaccination coverage of 80% or more | HPV three-dose vaccination coverage for 15-year-old males and females  
Numerator: Number of males and females turning 15 years reported to the National Human Papillomavirus Vaccination Program Register (NHVPR) that comply with the recommended vaccine dosage and administration as per the Australian Immunisation Handbook  
Denominator: Number of males and females turning 15 years | NHVPR and Rates Calculator |
| 2. Increase STI testing coverage of priority populations | Proportion of 15–24 year olds receiving a chlamydia or gonorrhoea test in the previous 12 months  
Numerator: Number of individuals aged 15–24 years tested at least once in the previous 12 months  
| 3. Reduce the incidence and prevalence of gonorrhoea, chlamydia and infectious syphilis | Annual rate of gonorrhoea, chlamydia and infectious syphilis notifications  
Numerator: Number of gonorrhoea, chlamydia and infectious syphilis notifications by sex  
Denominator: ABS Estimated Resident Population, Aboriginal and non-Aboriginal, by sex | WA Notifiable Infectious Diseases Database (WANIDD) and Rates Calculator |
| 4. Maintain virtual elimination of congenital syphilis | Number of congenital syphilis notifications | WANIDD |
### Targets by the end of 2023

<table>
<thead>
<tr>
<th>5. Eliminate the reported experience and expression of stigma among priority populations affected by STIs</th>
<th>Indicators</th>
<th>Sources</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Proportion of people who report experiencing stigma and discrimination in respect to STI status</td>
<td>Centre for Social Research in Health, University of New South Wales (UNSW)</td>
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<tr>
<td></td>
<td>Proportion of the general public who report feelings of stigma and discrimination towards people with an STI</td>
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<tr>
<td></td>
<td>Proportion of health professionals who report feelings of stigma and discrimination towards people with an STI</td>
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<tr>
<td>6. Improve knowledge and behaviour regarding safer sex and prevention of BBVs</td>
<td>Increased knowledge of STIs and BBVs</td>
<td>Secondary Schools Survey, La Trobe University</td>
</tr>
<tr>
<td></td>
<td>Improved harm minimisation behaviours to prevent STIs and BBVs</td>
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</tbody>
</table>
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


