Government of **Western Australia**
Department of **Health**

Western Australian Sexual Health and Blood-borne Virus Strategies

Implementation report 2020

2019–2023

Contents

1. Introduction

In July 2019, the Western Australian (WA) Sexual Health and Blood-borne Virus Advisory Committee (WA SHaBBVAC) endorsed the five *WA Sexual Health and Blood-borne Virus Strategies 2019-2023* (*WA Strategies*). The development of the *WA Strategies* was led by the WA Department of Health with significant contribution from state government and non-government clinical, community and workforce organisations.

The *WA Strategies* provide an agreed framework for a high quality and coordinated response to prevention and control of blood-borne viruses (BBVs) and sexually transmissible infections (STIs) in WA. They include the:

- *WA Sexually Transmissible Infections Strategy*
- *WA Human Immunodeficiency Virus (HIV) Strategy*
- *WA Hepatitis B Strategy*
- *WA Hepatitis C Strategy*
- *WA Aboriginal Sexual Health and Blood-borne Virus Strategy*

Each of the five strategies sets out a range of *Key actions* to address gaps in WA’s current response, and complement other jurisdictional, national and international policy documents that contribute to the response to BBVs and STIs. They also build on previous actions and investments from the *Western Australian Sexual Health and Blood-borne Virus Strategies 2015-2018.*

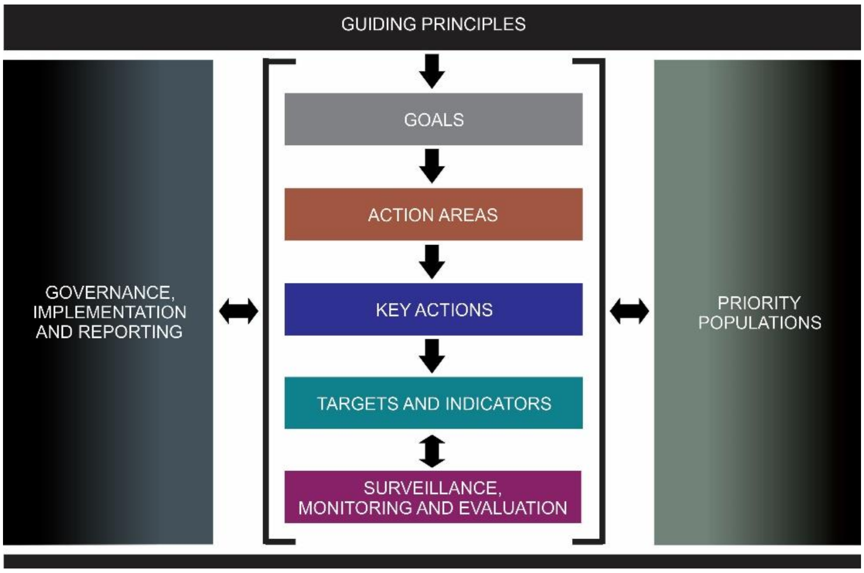
2. Overview of the *WA Strategies*

The ***Guiding principles*** support high-quality, evidence based and equitable responses to BBVs and STIs and are drawn from efforts over time to respond to the challenges and impacts of HIV, hepatitis B, hepatitis C and STIs. These guide the activities under the *WA Strategies* but are not specifically measured. The ten *Guiding principles* are consistent across the five *WA Strategies* and *The National Blood Borne Viruses and Sexually Transmissible Infections Strategies 2018-2022 (National Strategies)* with adaptations for the WA context.

Each *Strategy* outlines ***Goals*** and ***Targets*** which are aligned with the *National Strategies.* ***Goals*** provide a shared and strategic direction across all levels of government, community and workforce partners. The ***Targets*** aim to best equip WA to contribute towards national and global testing, treatment and elimination targets. 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.

Each *Strategy* has six ***Action areas*** that set out a range of ***Key actions*** to address gaps in WA's current response and support the achievement of the *Goals* and *Targets*. The *Action areas* are not discrete categories, they frequently overlap and may exist on a continuum.

The ***Surveillance, monitoring and evaluation framework*** includes indicators and details sources to monitor progress against the *Targets*.



3. Purpose and scope of the *Implementation Report*

This *Implementation Report* will guide activities against the *Key actions* across the life of the *WA Strategies* and will enable annual reporting to the WA Sexual Health and Blood-borne Virus Advisory Committee (SHaBBVAC) and the Blood-borne Virus and Sexually Transmissible Infections Standing Committee (BBVSS).

The report will:

- review current STI and BBV activities and identify areas that need additional action
- assist government to prioritise future investment
- align current activities with one or more *Key actions* and through that linkage, enable reporting against *Action areas*.
- identify linkages between strategy targets and *Action areas*
- provide the annual reporting framework.

4. Methodology

The following steps were taken in the development of *The Implementation Report:*

- intent to develop implementation plans/reports was tabled at the WA SHaBBVAC meeting in June 2019
- mapping tables were developed to identify the coverage of the *Key actions* for each priority population within the *Action areas* for each of the *WA Strategies*
- mapping tables were provided to key stakeholders across the sector to consider service contributions to *Action areas* and *Key actions*
- gap analysis was facilitated and recorded in a table using a ‘traffic light’ coding system to identify areas that require further action
- recommendations were made to address ‘red’ and ‘orange’ coded areas
- development of the processes for activity reporting
- reporting templates were populated in consultation with organisations.

5. Monitoring and reporting framework

Reporting of progress against the *WA Strategies* is delivered across two separate but complementary frameworks:

- annual progress against the *Action Areas* and *Key actions*
- annual progress towards *Targets* via the *Surveillance, monitoring and evaluation framework.*

This combined approach enables measurement of action and guidance of future investment within each *Strategy*, and across all the *WA Strategies*, as well as measure the effectiveness of action via surveillance and monitoring.

Additionally, WA SHaBBVAC consumer representatives, with the support and collaboration of the Health Consumers Council, will facilitate an annual consumer satisfaction survey of all SHBBVP funded organisations. Funded organisations will be asked to provide a response to consumers addressing any areas of concern and actions to be taken. The Health Consumers’ Council will assist in disseminating the results and responses back to consumers. Findings will be reported to WA SHaBBVAC. Findings will be reported to the WA ShaBBVAC.

6. *WA STI Strategy* Implementation report

6.1 *WA STI Strategy* - At a glance

Surveillance, monitoring and evaluation

Guiding principles

- Meaningful involvement of priority populations
- Human rights
- Access and equity
- Health promotion
- Prevention
- Quality health services
- Harm reduction
- Shared responsiblity
- Commitment to evidence-based policy and programs
- Partnership

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

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.

Targets are measured by indicators

Action areas

Prevention and education	Testing and diagnosis	Disease managment and clinical care	Workforce development	Enabling environment	Data collection, research and evaluation
6 key actions	6 key actions	6 key actions	6 key actions	6 key actions	6 key actions

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 MSM |CaLD

6.2 *WA STI Strategy* - Gap analysis and recommendations

Mapping tables were provided to organisations across the sector to identify the coverage of the *Key actions* for each priority population within the *Action areas* for each of the *WA Strategies.* These mapping tables were used to conduct this gap analysis.

Key: 🟩 Significant coverage 🟨 Some room for improvement 🟥 Significant room for improvement

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.		
Key actions		**Recommendations**
1. Increase the capacity of schools, including Education Support Centres, to deliver comprehensive Relationships and Sexuality Education (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 *Growing and Developing Healthy Relationships* (GDHR) and the *International Technical Guidance on Sexuality Education*.	🟨	Continue capacity building teachers and schools through the pre-service and in-service teacher training. Continue consumer engagement and workforce capacity building with current practising teachers on the Panel of Writers. Continue to progress the action plan from the GDHR Impact Evaluation. Continue to implement GDHR improvements recommended from lesson plan trials by the Panel of Reviewers/Writers. Continue to use the data from the *WA Survey of Secondary Students and Sexual Health* (WA SSSASH) to inform improvements to the GDHR website. Map the GDHR website to the *International Technical Guidance of Sexuality Education* and conduct a gaps analysis. Continue maintaining strong sector relationships (e.g. Department of Education (DoE), School Drug Education and Road Aware (SDERA)) Continue systematic review of GDHR content to ensure content is current, accurate and comprehensive (i.e. offers education in real life contexts that include such things as alcohol and other drug use and the associated risks). Explore professional development collaborations with SDERA to establish better links between RSE and drug education.

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.	🟨	Work with Immunisation, Surveillance and Disease Control (ISDC) team to plan strategies to increase uptake of vaccines. Continue to support ISDC with the development of the school-based vaccination education program. Identify areas with low vaccination rates for targeted intervention.
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.	🟥	Explore opportunities to engage peers in STI projects and support community organisations to respond to needs of priority populations.
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.	🟩	Emphasis of role in condom in reducing STIs. Address misconceptions among young people around condoms and other contraceptives (e.g. that condoms are not needed if on the Pill).
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.	🟥	Increase commitment to ensuring that campaigns and STI prevention education is inclusive of minority priority groups to expand and enhance the acceptance of key sexual health messages. Map prevention and education initiatives and resources for priority populations that are currently funded and provided and complete a gap analysis to guide future interventions.
6. Ensure STI prevention education, access to condoms and recommended regular STI testing is promoted alongside Pre-exposure prophylaxis (PrEP) for HIV prevention to minimise the risk of increased STI transmission in those using PrEP, and to ensure timely treatment of STIs.	🟨	Continue to support workforce development in prescribers of PrEP to ensure best practice STI prevention education, testing and disease management occurs for consumers of PrEP.

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.

Key actions		**Recommendations**
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.	🟨	Continue to raise awareness of syphilis antenatal testing in health professionals and the community through multifaceted channels including social marketing, provision of clinical guidelines and workforce development.
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, Alcohol and other drugs (AOD) rehabilitation facilities and men's and women's housing shelters • Point of care testing (POC) testing technologies • integration of STI testing with other routine health services such as adult health checks.	🟨	Encourage sharing of information between regional and remote areas, community services, and government organisations to ensure that innovative programs can be adapted to reach multiple priority populations. Explore options for SMS results notifications.
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.	🟨	Provide guidance to primary health care professionals on how to incorporate opportunistic STI and BBV testing into service delivery.
5. Enhance evidence-based guidance and stewardship on antimicrobial resistance (AMR) and utilise best practice testing procedures to enable appropriate antibiotic prescribing.	🟩	AMR education to be included in education of priority populations.
6. Develop the capacity of health infrastructure in regional and remote areas to increase testing and diagnosis during STI outbreaks and epidemics.	🟨	Continue to support the enhancement of the regional and remote services to be mobilised and responsive to outbreaks and epidemics through networking and capacity building.

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.

Key actions		**Recommendations**
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.	🟨	Expand current data collection tools to ensure that systems allow evaluation of how effectively contact tracing is occurring in health services and appropriately monitor time to testing and time to treatment of known contacts. Explore options to implement SMS partner notification systems.
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.	🟥	Encourage sharing of information between regional and remote areas, community services, and government organisations to ensure that innovative programs can be adapted to reach multiple priority populations. Explore telehealth options for rural, regional and remote patients to increase access.

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.	🟧	Continue to support the enhancement of the regional and remote services to be mobilised and responsive to outbreaks and epidemics through networking and capacity building.
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.	🟧	Continue to explore and implement strategies, such as point-care-testing, that remove barriers for follow up to 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.	🟧	Maintain and expand on access to up-to-date clinical guidance for healthcare workers particularly for those who work closely with sub-populations that are particularly vulnerable or at risk such as 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.

Key actions		**Recommendations**
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.	🟧	Continue to explore digital solutions for training such as online training modules, videos, video conferencing and recordings.
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.	🟥	Continue to create spaces that bring community health workers, primary health workers and government agencies together to encourage collaboration to reach priority populations.
3. Ensure healthcare professionals, including General Practitioners (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.	🟧	Conduct an audit and gap analysis of current peer-based programs to ensure coverage to priority populations.

5. Explore multidisciplinary models for STI prevention, testing and treatment by: • utilising the skills of appropriately trained health professionals including Aboriginal health workers (AHWs) and practitioners • facilitating the provision of nurse-led services • enhancing opportunities for education, professional development and specialisation for health professionals.	🟥	Support and promote information sharing amongst services with successful and innovative models through networks, capacity building and case studies. Conduct a systematic review of evidence for multidisciplinary models for STI prevention, testing and treatment.
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.	🟥	Support service providers to develop and implement strategies to attract and retain staff working in sexual health and BBVs.

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.

Key actions		**Recommendations**
1. Enhance STI education, prevention, testing and treatment initiatives to ensure they support efforts to reduce STI-related stigma.	🟧	Share best practice initiatives throughout the sector (e.g. at Quarterly forums). SiREN to share and disseminate best practice initiatives through its website, social media handles and e-news.
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.	🟧	Review current national and state policies, guidelines and resources. Update state policies, guidelines and resources to include information and guidance on stigma and discrimination. Periodically assess levels of workforce stigma. Share best practice from sector.
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.	🟥	Encourage and support production of documents and initiatives that advocate or support the health of priority populations and remove social, legal or institutional barriers that prevent priority groups from accessing health services and appropriate healthcare. Support the generation of research evidence (e.g. Law and Sex worker Health study).

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.	🟧	Advocate and support improvements of non-discriminatory and non-stigmatising care for trans people and sex workers.
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	🟧	Continue to monitor reach and effectiveness of social marketing campaigns and support organisations to implement social marketing into service delivery.
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.	🟥	Continue to strengthen relationships with Department of Education. Continue to monitor and review national and international developments in this space. Collaborate with key stakeholders to strengthen advocacy. Continue to update resources and tools for schools on the GDHR website to strengthen advocacy in this space. Utilise current data and research to support advocacy.

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.

Key actions		**Recommendations**
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.	🟧	Liaise with universities to collaborate with relevant PhD and Masters students to fill potential gaps in current research. Liaise with other sectors to investigate opportunities for collaborative research projects.
2. Develop a digital solution that provides real-time access to statewide patient records to improve the early detection and treatment of syphilis.	🟥	Continue to scope the development of a syphilis register. Source options based on scoping.

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.	🟨	Continue to support research efforts that examine the sexual health of priority populations and ensure findings are disseminated to relevant organisations.
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*.	🟥	Identify resources that promotes the identification of Aboriginal people and importance of correct data collection on forms and in information systems.
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 Pelvic Inflammatory Disease (PID) and other associated morbidities, so as to inform and enhance best practice testing, diagnosis, disease management and clinical care.	🟨	Continue to support spaces that allow sharing of information particularly spaces that share research on upcoming sexual health trends and concerns to ensure WA remains responsive to emerging issues. As emerging sexual health issues arise ensure that literature reviews occur to enable a critical view of the risk, from a WA context, those health issues pose to the health of the Western Australian community.
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.	🟨	Continue to support research efforts that examine the sexual health of priority populations and ensure findings are disseminated to relevant organisations.

6.3 *WA STI Strategy* - Annual *Action area* report

The development of this report is based on reporting from Sexual Health and Blood-borne Virus Program (SHBBVP) funded organisations and service providers, SHBBVP programs and campaigns and WA surveillance data. This report highlights significant activities and has been populated in consultation with relevant service providers. It does not attempt to be a full inventory of activities conducted by stakeholders within the WA sexual health, BBV and STI sector and complementary sectors (e.g. Department of Justice) that contribute to the multi-faceted approach to meeting the goals and targets.

January 2019 – December 2019	Key actions
Prevention and education	
SHQ engagement with general public The SHQ sexual health helpline had 2,964 exchanges with the general public and the SHQ website had over 110,000 visits. Social media campaigns had 100,000s of interactions with the vulva cupcake post achieving 15,000+ reach and Men's Health Week 12,000+ reach.	PE3, PE4, PE5, PE6, TD2, EE1, EE2, EE6.
Youth Education Peers (YEP) education The Technosexual Summit, looking at the role of technology, online and digital media spaces on youth sexual health, had over 100 attendees and YEP have been using innovative youth engagement tools (e.g. Tik Tok) to cater for the everchanging social media landscape. The YEP Crew also contributed greatly to the Falls Festival Testing by providing peer education and support.	PE3, PE4, PE5, PE6, WD2, WD4, EE1, EE4, EE5, EE6, EE7.
Talk soon. Talk often Talk soon. Talk often (TSTO) is a book designed to support parents talking to their children about sex and relationships. The resource was updated with new content and a new graphic design using images of local WA people and the new edition was released in November 2019 with over 11,000 distributed to date. Work has progressed on the development of TSTO webpage.	PE1, PE5, PE6, EE1, EE5, EE6
School-based Relationships and Sexuality Education (RSE) Continual update and improvement of the Growing and Developing Healthy Relationships (GDHR) website – a resource to support schools to deliver comprehensive RSE. There were 12,433 WA users in the 2018-2019 financial year, an increase of 156 users from the last financial year. Commenced implementation of the improvements in line with feedback received from the GDHR panel of reviewers/writers lesson plan trails (conducted across 2018-2019) which included: assessment task drafted; improvements to site navigation; new lesson plans to accompany the *Get the Facts* youth videos on sexing, sex and the media, condom use, pornography and puberty.	PE1, PE4. PE5, PE6

Access to condoms In 2019 there was a significant increase in the number of condom dispensers and vending machines that were distributed to sites in WA. A total of 50 condom dispensers were distributed to 14 different locations in the 19-20 financial year to date. In addition, the ‘Find Free Condom’ feature was added to the *Get the Facts* website to increase access to condoms. SHQ distributed 19,030 condoms at health promotion events and as part of National Condom Day activities and a new diversity condom pack was developed.	PE4
STI Video In 2019 a significant amount of work was undertaken with Zac Creative to develop a video to provide an overview of STIs for Aboriginal populations. The development of the video was informed by a working group that consisted of stakeholders working in the sector with experience in working with Aboriginal populations. The key messages of the video included the symptoms, transmission, prevention, testing and treatment of STIs. The video is to be launched in early 2020.	PE4, PE5, PE6
Testing and diagnosis	
Onsite festival STI testing The SHBBVP at the DoH, ran a novel sexual health promotion activity which included the implementation of an onsite STI testing facility at Falls Downtown, a two-day music festival in Fremantle, in January 2019. The STI testing facility was the first of its kind implemented in WA. The initiative saw 458 tested with 96% being a part of the target group. There were 14 people diagnosed with chlamydia. This initiative offered an opportunity to normalise testing in the target group, increase access to safer sex hardware through the distribution of 2,500 condoms and through peer educators offered safer sex education.	PE3, PE4, PE5, TD2, TD4, DMCC3
Syphilis point of care testing program 11 Aboriginal Community Controlled Health Services (ACCHS) received funding from Commonwealth government to implement point-of-care testing (PoCT) into service delivery. The Commonwealth funded project only allowed ACCHS to enrol in the program. To decrease gaps in service the business case for the state specific point of care testing program was approved which secured funding to support 80 sites and 24 health services to implement point of care testing into service delivery across WA. The state program is able to enrol organisations that were previously unable to receive PoCT through Commonwealth funding. Services include prisons, WA Country Health Services, Royal Flying Doctor, and an expansion for ACCHS.	TD1, TD2, TD3, TD6, DMCC2, DMCC3, DMCC4, DMCC6l, WD4
Disease management and clinical care	
SASA In 2019 a Structured Administration and Supply Arrangement (SASA) was put in place to allow registered nurses working in a public health program to administer antibiotics as treatment for syphilis. This includes public health programs operated or managed by a Health Service Provider of the WA Health system, or contracted entity, or a health service.	DMCC2, DMCC3, DMCC5, DMCC6
Silver Book The *Silver Book* website was upgraded in 2019 in response to feedback that the site was not user friendly. The Silver Book was also continually updated throughout the year to ensure that medical professionals had access to information relating to the diagnosis and management of STIs particularly around syphilis at a time when guidelines for testing and priority populations were changing along with epidemiology trends.	TD3, DMCC2, WD3,

Syphilis Quick Guide To ensure that healthcare professionals are supported, particularly those located in regional and remote areas, a syphilis quick guide resource began development. To increase the capacity of the workforce the syphilis quick guide aims to give clinical guidance on testing recommendations, treatment recommendations, and contact tracing for priority populations.	TD3, DMCC2, WD3,
GP Medication Access Program The GP Medication Access Program provides free treatment for people who have a positive STI test. It was initially developed and implemented in the Goldfields region and has since been rolled out to other WACHS regions. The program has resulted in an increase in access to treatment as well as increased relationships with general practices.	DMCC3 &DMCC6
Workforce development	
Nursing course The two-day sexual health nursing course was delivered in Perth on the 7-8th of June 2019 and attended by 26 nurses, 23% of them were from regional locations. **Nursing update** A Sexual Health update on gonorrhoea and syphilis was attended by 24 health professionals (5 GPs and 19 nurses), 21% were from regional location. Another session on syphilis was delivered to 27 rural and regional GPs who attended the annual Rural Health West conference and 20 participants attended a session on antenatal syphilis at RHW Aboriginal Health Conference.	WD3, WD4, WD5
Curtin's The Relationships and Sexuality Education (RSE) Project In response to a request for support and training from the community health nurse, The Curtin RSE Project was funded to run an additional regional training session at Roebourne District High School. A whole school workshop trained 32 primary and secondary school staff members including school principal and two deputy principals. The RSE Project is part-way through a project examining whole-school implementation of RSE via a case study approach. Three school sites (Maida Vale PS, Safety Bay SHS and Roebourne DHS) are being provided with technical expertise to improve their delivery of RSE via a focus on (1) teaching and learning, (2) whole-school environment and ethos and (3) collaboration with families and other key stakeholders. Each site is developing and implementing their own strategies. The project will conclude at the end of 2020.	WD2, PE1, PE4, PE5, PE6, EE1, EE5
ASHM conferences WA hosted the 2019 ASHM HIV and Sexual Health Conferences for the first time in 10 years. The Sexual Health and Blood-borne Virus Program sponsored the conferences and had significant involvement in the conference with the coordination of a syphilis symposium, HIV symposium, GP education event and booth. Staff from the program also had one oral presentation and four poster presentations at the conference as well as staff being involved in chairing some sessions.	WD2
GP STI module Planning with ASHM commenced in 2019 to develop an online GP STI module to provide workforce development that can be completed at a time that is convenient to the doctor. A steering group of practitioners was been established to determine the module content.	WD1
SHQ training A new LGBTI+ reference group was formed comprising of seven members of the community members to provide guidance and feedback on the continuous development of LGBTI+ inclusive practice at SHQ. A LGBTI+ Diversity workshop was developed and delivered in November receiving really positive feedback. SHQ also developed a new sexual health course for Aboriginal people and others who work with Aboriginal people. This involved some community consultation and assessment of priorities. The resulting course, STARS (Start Talking About Relationships and Sexual health), was delivered for the first time at SHQ in November for 16 participants with excellent feedback.	WD1, WD2, WD3, WD4, WD5, EE2, EE3, EE4, EE5, EE6, EE7.

Enabling environment	
WA SORG The WA syphilis outbreak response group (SORG) was initiated in 2018 and continued to grow and gain traction in 2019. This group has representatives from all the outbreak regions plus the at-risk region of Midwest. The SORG has five working groups each attached to a key action area. These working groups were responsible for implementing actions stipulated by the SORG. Actions include advocating for designated sexual health roles in the regions, implementing monitoring tools, contributing to testing and contract tracing guidelines and increasing regional workforce development.	TD1, TD3, DMCC1, DMCC2, DMCC6, WD1, WD2, WD3, WD4, WD5, WD6, DCRE4
Magenta interpreter facilitated clinical sessions In 2019, Magenta increased its capacity and access to contracted interpreters. In the second half of 2019, 60.38% of Magenta's clinic sessions were facilitated by an interpreter. Use of phone interpreters is potentially "unsafe" and use of regular interpreters enables clients to build supportive relationships with their interpreters reducing barriers to returning for regular testing.	TD2, TD4, DMCC3, EE2, EE4
Roebourne whole school teacher training In response to a request for support and training from the community health nurse, The Curtin RSE Project was funded to run an additional regional training session at Roebourne District High School. A whole school workshop trained 32 primary and secondary school staff members including school principal and two deputy principals.	EE1, EE4, EE 5, EE6, EE7, PE1, PE4, PE5, PE6
SECCA 'Sexuality, Relationships and My Rights' resource SECCA created a resource in 2019 discussing sexual health, relationships and the rights of people living with a disability and is available via hard copy and electronic version. The resource has been created in simple English and relies heavily on images to ensure it is accessible for their consumers and aims to educate people living with a disability on their rights relating to sexuality in a sex positive manner that ensures that information isn't being filtered based on what people may believe is useful information.	PE1, PE5, EE1, EE4, EE5
Data collection, research and evaluation	
SHQ Introduction of an intimate partner violence screening tool which has seen a significant increase in referrals from the clinic to the counselling services and strengthened and formalised referral pathways.	EE1, EE2, EE3, EE4, EE5, DCRE1, DCRE3, DCRE4.
WA secondary schools report A state specific report was commissioned from LaTrobe's National Survey of Australian Secondary Students and Sexual Health. This has been used to update school and parent resources, guide future projects and provides a data source for measuring some of the WA STI Strategy targets.	DCRE1, DCRE3, DCRE4, DCRE6
Evaluation of festival testing An evaluation of the 'Get the All Clear': Falls Festival Onsite STI Testing was conducted in 2019. Findings from the evaluation demonstrated that the onsite STI testing facility provided a convenient opportunity for STI testing for young people and appeared to have a positive impact on those who participated. There was also a positive indication that the presence of the facility gave a green light to festival goers to talk more comfortably about STI testing. Abstracts on the festival initiative were submitted for the ASHM Sexual Health Conference, Communicable Disease Control Conference and the Youth Health Conference.	DCRE3

Syphilis Communiques The WA Syphilis Outbreak Response Group began the development and publication of regular communiques. Three communiques were published in 2019 to provide up to date information for all relevant stakeholders including epidemiology data, WA SORG governance updates and activity for all five priority areas.	DCRE4
Syphilis Register In 2019 a project commenced that aims to assist in the response to the syphilis outbreak. Funding was secured to enable a scoping activity that will examine what the reporting requirements are in relation to syphilis and how this data can be collected to ensure that appropriate and timely contact tracing can occur and identification of current or previous cases of syphilis can be ascertained. The syphilis register project will submit recommendations by the end of the 19-20 financial year.	DCRE2
Gonorrhoea qualitative interviews Paper submitted reporting the findings of a public health investigation to examine *Risk perceptions, misperceptions and sexual behaviours among young heterosexual people with gonorrhoea in Perth, Western Australia*. 18 qualitative interviews conducted with young people recently diagnosed with gonorrhoea. Key findings were improving access to accurate information about STI prevention - STIs can be asymptomatic, not all are treatable, promoting condom use, and gonorrhoea can be transmitted through oral sex.	DCRE1, DCRE3, DCRE5, DCRE6,

6.4 WA STI Strategy – Progress towards targets

SHBBVP report on annual progress against targets, developed through national and state surveillance data.

Key: 🟩 Target met 🟨 Tracking to meet target by 2023 🟧 Progress made towards target 🟥 Target not met/not tracking to meet target by 2023

Targets by the end of 2023:	Indicators	Sources	Progress	
1. Achieve and maintain HPV adolescent vaccination coverage of 80 per cent	HPV three-dose vaccination coverage for 15-year-old males and females	National Human Papillomavirus Vaccination Program Register (NHVPR) and Rates Calculator	Males 65.65%	Females 76.52%
	Numerator: Number of males and females turning 15 years of age reported to the 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 of age			
2. Increase STI testing coverage in priority populations	Proportion of 15-24 year olds receiving a chlamydia or gonorrhoea test in the previous 12 months	Testing data and Rates Calculator	32% 15-24 year olds tested – increase of 3% from 2013-2017 average	
	Numerator: Number of individuals aged 15–24 years tested at least once in the previous 12 months			
	Denominator: ABS Estimated Resident Population, Aboriginal and non-Aboriginal, 15–24 year age group			
3. Reduce the prevalence of gonorrhoea, chlamydia and infectious syphilis	Annual rate of gonorrhoea, chlamydia and infectious syphilis notifications	WA Notifiable Diseases Database (NIDD) and Rates Calculator	123.6 notifications per 100,000 population. Increase by 24% from 2013-2017 average	
	Numerator: Number of gonorrhoea, chlamydia and infectious syphilis notifications by sex			
	Denominator: ABS Estimated Resident Population, Aboriginal and non-Aboriginal, by sex			
4. Sustain no notifications of congenital syphilis	Number of congenital syphilis notifications	WANIDD	1 notification per 100,000 population. Increased from 2013-2017 average.	

5. Reduce the reported experience and expression of stigma in relation to STI	Proportion of people who report experiencing stigma and discrimination in respect to STI status	Centre for Social Research, UNSW	64% of the general public who report feelings of stigma and discrimination towards people with an STI. No previous data for comparison.
	Proportion of the general public who report feelings of stigma and discrimination towards people with an a STI		
	Proportion of health professionals who report feelings of stigma and discrimination towards people with a STI		
6. Improve knowledge and behaviour regarding safer sex and prevention of blood-borne viruses	Increased knowledge of STIs and BBVs	Secondary schools survey, La Trobe University	Average percentage of correct responses across all questions for: HIV – 80.5% STIs – 51.8% STI symptoms – 73.7% Viral hepatitis – 36.9% HPV – 43.0% No previous WA data for comparison.
	Improved harm minimisation behaviours to prevent STIs and/or BBVs		

Government of **Western Australia**
Department of **Health**

WA Sexual health and blood-borne virus strategies 2019–2023

STIs

2019–2023 baseline report

The big picture in 2018

- The rate of chlamydia and congenital syphilis notifications remained stable, and gonorrhoea and infectious syphilis increased.

Notification rate per 100,000 population	2013 to 2017 Average	2018	Mid-term review**	
Chlamydia	**436.2**	**423.0**		**Stable**
Gonorrhoea	**99.6**	**123.6**		**↑ 24%**
Infectious syphilis	**7.5**	**15.4**		**↑ 105%**
Number of congenital syphilis notifications	**0.4**	**1.0**		

Prevention and education

- The HPV vaccination rate among adolescents was below the 2023 target of 80%.
- Sexual health knowledge among secondary school students was high but consistent condom use was low.

	2013 to 2017 Average	2018	Mid-term review**	
HPV three-dose vaccination coverage for 15-year-olds **Males**	**65.6%**			
Females	**76.6%**			
Proportion of knowledge questions correctly answered by secondary school students	*	**62.5%**		
Proportion of sexually active students reporting always or often using condoms in the past year	*	**45.8%**		

Testing

- The proportion of 15 to 24-year-olds receiving a chlamydia or gonorrhoea test in the previous 12 months remained stable.

	2013 to 2017 Average	2018	Mid-term review**	
Proportion of 15 to 24-year-olds receiving a chlamydia or gonorrhoea test in the previous 12 months	**29%**	**32%**		**Stable**

Stigma and discrimination

- Feelings of stigma and discrimination towards people with an STI were high.

	2013 to 2017 Average	2018	Mid-term review**	
Proportion of the general public who report feelings of stigma and discrimination towards people with an STI	*	**64%**		

**No data available. For further information see the Implementation Report: Progress towards targets.*

** Data to be collected around 2021

7. *WA HIV strategy* Implementation Report

7.1 *WA HIV Strategy* - At a glance

Surveillance, monitoring and evaluation

Guiding principles

- Meaningful involvement of priority populations
- Human rights
- Access and equity
- Health promotion
- Prevention
- Quality health services
- Harm reduction
- Shared responsiblity
- Commitment to evidence-based policy and programs
- Partnership

Goals

1. Virtually eliminate HIV transmission in Australia within the life of this strategy.
2. Maintain the virtual elimination of HIV transmission among PWID, sex workers and from mother to child.
3. Reduce mortality and morbidity related to HIV.
4. Minimise the personal and social impact of HIV.
5. Eliminate HIV-related stigma, discrimination, and legal and human rights issues on people's health.

Targets

1. Increase the proportion of people with HIV (in all priority populations) who know their HIV status to 95%.
2. Increase the proportion of people diagnosed with HIV on treatment to 95% within six weeks of diagnosis for those newly diagnosed, reducing this timeframe further over the life of the strategy.
3. Increase the proportion of people on treatment with an undetectable viral load to 95%.
4. Reduce the incidence of HIV transmission in men who have sex with men (MSM).
5. Reduce the incidence of HIV transmission in other priority populations other than MSM - people living with HIV; Aboriginal people; culturally and linguistically diverse (CALD) people from high HIV prevalence countries; people who travel to high prevalence countries; sex workers; PWID; people in custodial settings; and sexually and gender diverse people.
6. Maintain the virtual elimination of HIV among sex workers, PWID and from mother to child through the maintenance of effective prevention programs.
7. Ensure all people attending public sexual health services and general practices are assessed for pre-exposure prophylaxis (PrEP) eligibility.
8. Ensure at least 75% of people living with HIV report good quality of life.
9. Reduce the reported experience of stigma among people living with HIV, and the expression of stigma, in respect to HIV status.

Targets are measured by indicators

Action areas

Prevention and education	6 key actions
Testing and diagnosis	5 key actions
Disease managment and clinical care	7 key actions
Workforce development	7 key actions
Enabling environment	5 key actions
Data collection, research and evaluation	5 key actions

Priority populations

People living with HIV |Gay and bisexual men, and men who have sex with men |Aboriginal people

Culturally and linguistically diverse people from high prevalence countries |People who travel to high prevalence countries

Sex workers |People who inject drugs |People in custodial settings |Sexually and gender diverse people

7.2 WA HIV Strategy - Gap analysis and recommendations

Mapping tables were provided to organisations across the sector to identify the coverage of the *Key actions* for each priority population within the *Action areas* for each of the *WA Strategies.* These mapping tables were used to conduct this gap analysis.

Key: 🟩 Significant coverage 🟧 Some room for improvement 🟥 Significant room for improvement

Prevention and education

Approaches to HIV prevention and education should combine community mobilisation, behavioural strategies, biomedical interventions and harm reduction initiatives in an organised effort to reduce the transmission of HIV. Further, a strong enabling environment can support the access and reach of combination HIV prevention initiatives. Biomedical approaches to HIV prevention such as pre-exposure prophylaxis (PrEP), treatment as prevention (TasP) and achieving an undetectable VL have revolutionised the HIV prevention toolbox. These biomedical interventions have also instigated a movement that aims to eradicate HIV-related stigma and discrimination through providing accurate and meaningful information based on a solid foundation of scientific evidence.

Key actions		**Recommendations**
1. Review and revitalise generalised (wider community) and targeted (priority population) health promotion initiatives for HIV, ensuring that contemporary evidence is embedded within relevant, clear and consistent messaging, communicated through innovative mixed media channels.	🟧	In consultation with key stakeholders, review existing messaging and assess whether dissemination initiatives are addressing gaps. Develop a plan for the renewal and dissemination of appropriate targeted messaging.
2. Sustain effective HIV programs that encompass community-led and peer-based approaches for engaging with priority populations on strategies for safer sex, STI and HIV testing, and harm reduction.	🟧	Continue to evaluate and support programs which are community-led and peer-based, ensuring that programs are effective in reaching priority populations.
3. Provide contemporary HIV prevention and education programs in a range of settings, including community health services, schools and organisations or services that interact with priority populations.	🟧	Identify settings where programs are not being provided and develop strategies to address this.
4. Improve access to PrEP and post exposure prophylaxis (PEP) by identifying gaps where knowledge among priority populations is low, or where healthcare provider options for PrEP and PEP is limited, and by introducing initiatives to mitigate these gaps.	🟧	Identify where gaps exist in knowledge among priority populations and access; and develop strategies to increased access (e.g. GP training, outreach clinics, Telehealth for rural and remote settings).

5. Seek to improve the health outcomes for people living with HIV (PLWH) by increasing awareness on: • the benefits of rapid antiretroviral treatment (ART) initiation • achieving and sustaining an undetectable viral load (VL) • TasP • supporting mental health • diet and nutrition • comorbidity risk factors • engaging with primary healthcare providers for non-HIV related conditions.	🟩	
6. Ensure the wide distribution and availability of sterile injecting equipment, safer injecting education and other drug harm reduction education among people who inject drugs (PWID), including a focus on people living in regional, rural and remote areas.	🟧	Explore options to improve availability of sterile injecting equipment out of hours, in regional areas and in prison settings. Identify and implement ways to reduce stigma experienced by some PWID from hospital based health workforce.
Testing and diagnosis		
HIV testing is the gateway to HIV prevention, treatment, care and other support services. Testing that is conducted based on risk and in accordance with principles of informed consent, confidentiality, counselling and connection to appropriate services enables people to know their HIV status and adopt safer behaviours. Efforts to increase access to testing should be underpinned by community education and linkages to clinical services, particularly for home-based and point-of-care testing (POCT). Effectively directed HIV testing can support early diagnosis and in combination with rapid linkage into specialist care can ensure the newly diagnosed person receives relevant support and guidance on initiating ART and managing their health.		
Key actions		**Recommendations**
1. Expand the use and accessibility of a range of HIV and STI testing options, that incorporate new testing technologies (such as home-based and point of care testing (POCT) with proven modalities for facilitating testing (such as peer-based and community-based initiatives) to improve rates of early diagnosis, and to reduce the structural, social and community barriers to testing faced by priority populations.	🟧	Using an evidence base and co-design methodologies, develop strategies to expand options for HIV and STI testing that incorporate new testing technologies.
2. Improve the capacity of GPs, primary and community healthcare professionals to diagnose HIV by supporting essential knowledge on: • conducting discussions covering sexual health and regular STI testing • identifying and assessing known and unknown HIV and BBV risk factors • indications for opportunistic testing at different stages of HIV infection • contemporary HIV prevention including PEP, PrEP and TasP • best practice for conveying a positive or negative HIV diagnosis.	🟧	Continue to support and promote workforce development opportunities provided by ASHM and other relevant providers which strengthen WA's GPs, primary and community healthcare professionals to diagnose HIV at earlier stages and to communicate best practice information to patients.

3. Ensure that all people diagnosed with HIV are linked to specialist care and offered referrals to relevant support services as soon as possible following diagnosis.	🟧	Conduct a gap analysis to identify areas/or priority populations where there are no relevant support services available.
4. Continue to promote the use of evidence based clinical guidelines and resources in both training and clinical service delivery settings.	🟩	

5. Continue to identify efficiencies in the HIV cascade of care that will improve individual and public health outcomes.	🟧	Recognising that the HIV cascade of care involves multiple providers, key agencies/organisations need to ensure strong communication protocols exist so that the patient pathway through the health system and system of social support is facilitated at points of need. Advocate for and support the inclusion of Aboriginal Liaison Officers, PLWH and other individuals from priority populations to assist in helping patients to navigate health systems.

Disease management and clinical care

The lifelong management of PLWH requires a multidisciplinary approach to supporting disease management and clinical care in order to meet the varying needs of the individual. The ongoing clinical management for PLWH needs to factor in the management of HIV along with supported pathways for referral to manage any other health issues, encompassing models of shared care with GPs and communication protocols with other clinical specialists. Approaches to onwards referral for PLWH should consider any geographical, social, cultural and gender barriers with regards to accessing other services. As HIV treatment options evolve and newer simplified regimens become available, clinical monitoring of both the patient and emerging evidence on newer treatments should be integral to decision making. PLWH have a unique knowledge of their own treatment and management and need to be actively engaged as equal participants in the planning and delivery of their own care.

Key actions		**Recommendations**
1. As a priority, ensure that people newly diagnosed with HIV receive evidence-informed counselling and support on living with HIV, the benefits of rapid ART commencement and preventing onwards transmission.	🟩	
2. Improve the health care provided to PLWH across WA, including regional and remote locations, by strengthening and coordinating linkages between: • GPs • community health services • sexual health physicians • psychosocial support services • community pharmacies • specialists • aged-care services	🟩	
3. Strengthen models of care to holistically meet the needs of PLWH who have more complex psychosocial needs by facilitating supported linkages to relevant services for: • mental health	🟧	Conduct a gap analysis to determine if the needs of PLWH from smaller populations (e.g. heterosexual men and women, CALD PLWH) have access to the supports they need.

• alcohol and other drugs (AOD) • housing • employment • disability • social welfare • legal support	🟧	
4. Monitor and evaluate the quality standards within models of aged care, ensuring that they are inclusive, respectful and meet the needs of PLWH.	🟥	Building on the work and evidence base developed within WA and nationally, there is a need for coordinated advocacy to push the agenda for quality aged care which meets the need of the ageing population of PLWH.
5. Increase options to facilitate access to HIV treatment and care in those health services providing culturally relevant care to Aboriginal people and culturally and linguistically diverse (CALD) populations.	🟧	In consultation with AHCWA and agencies working with Aboriginal people, consider developing targeted workforce development initiatives.
6. Ensure that PLWH receive the necessary support for developing health literacy on understanding life with HIV and sustained ART adherence, with support options that include community-based and peer-led approaches.	🟧	Continue to support agencies and programs providing support to PLWH.
7. Facilitate options for PLWH that aim to improve mental health, resilience and social connectedness.	🟧	Continue to support agencies and programs providing support to PLWH.

Workforce development

The delivery of high-quality services that understand and respond to the needs of priority populations requires a multidisciplinary workforce of trained healthcare professionals and peer-based workers established in community and public health, aged care, sexual health clinics, general practices, Aboriginal Health Services (AHSs), AOD and mental health services. The development and promotion of up-to-date evidence-based clinical guidelines and training modules should be accessible to WA's healthcare workforce to support the delivery of best practice health care. Education on current scientific evidence on the prevention and management of HIV, and methods to address HIV or priority population related stigma and discrimination should be included in all STI and BBV training programs for community service providers and primary healthcare and specialist services.

Key actions		**Recommendations**
1. Facilitate innovative workforce development initiatives that include multiple options for education and training, which include online learning, videoconference/ teleconference, information sharing platforms and face-to-face learning opportunities.	🟩	
2. Develop the awareness of the mainstream healthcare workforce on identifying stigma and discrimination related to HIV or priority populations, alongside methods for addressing these identified forms of stigma and discrimination.	🟧	Support the development of appropriate training, which may include online training to increase awareness of, and address, stigma and discrimination.

3. Target training for identified healthcare workforce sectors engaging with priority populations to ensure that high-quality professional development and support is provided for: • conducting culturally and non-binary discussions on sexual health • identifying and assessing HIV risk across different priority populations • indications for opportunistic testing at different stages of HIV infection • testing options and new testing technologies • testing policy and protocols • contemporary HIV prevention including PEP, PrEP and TasP • harm reduction education • partner/contact notification • HIV treatment and ongoing management of PLWH • identifying and managing HIV or priority population related stigma.	🟨	In consultation with relevant stakeholders, consider developing targeted workforce development initiatives. Conduct a gap analysis to determine if workforce training is addressing the needs of specific groups less likely to be associated with HIV (e.g. women).
4. Continue to regularly update and strategically promote accessible evidence-based clinical guidelines and tools covering the HIV cascade of care to enable the professional development of healthcare workforce sectors, particularly general practices, delivering services to priority populations.	🟨	Review existing guidelines and update as relevant to WA and disseminate as required.
5. Continue to explore and share experiences of innovative multidisciplinary models of care for HIV prevention and management, particularly models such as telehealth for rural and remote areas.	🟩	
6. Continue to support and promote s100 prescriber training and accreditation, particularly in areas of need, alongside the promotion of HIV shared care protocols.	🟩	
7. Support the capacity and role of community organisations to implement greater involvement of PLWH (GIPA)/meaningful involvement of PLWH (MIPA) principles in the provision of education, prevention, support and advocacy services to priority populations.	🟨	In consultation with relevant stakeholders and with PLWH, increase awareness and implementation of MIPA principles.

Enabling environment

The foundation supporting the HIV response is the framework of principles, protocols, policies and laws that seek to create an enabling environment for public health and social change. It is however widely recognised that stigma and discrimination related to HIV and directed at priority populations remains as one of the most significant barriers to the HIV response. Increased efforts are needed to address stigma and discrimination, and also to ensure the meaningful involvement of PLWH and priority populations in all aspects of the HIV response. This strategy has a focus on the health and community sector; however, it acknowledges that issues such as "criminalisation impact on priority populations by perpetuating isolation and marginalisation and limiting their ability to seek information, support and health care."

Key actions		**Recommendations**
1. For HIV health promotion and educational initiatives, prioritise consistent evidence-based messaging that dispels myths around HIV transmission and living with HIV, ensuring that all content produced counteracts stigma and discrimination related to HIV or directed at priority populations.	🟩	
2. Provide initiatives to assist PLWH to challenge and address incidences of stigma and discrimination.	🟥	Ensure options exist to address incidences of stigma and discrimination (from support, interventions and linkages to legal advice where necessary), are promoted and known among PLWH.
3. Make sure that health services are transparent in their approach to quality standards, including standards that uphold patient rights and address privacy and patient confidentiality.	🟧	Advocate for accessible and clear standards which safeguard quality patient care, patient rights, privacy and confidentiality.
4. Using an evidence base, review and address institutional, regulatory and system policies that create barriers within the HIV cascade of care, impact on health-seeking behaviour or perpetuate stigma and discrimination.	🟥	Working with priority populations and PLWH, identify critical institutional, regulatory and system policies that create barriers within the HIV cascade of care and advocate for these barriers to be addressed.
5. Engage in dialogue with other government sectors to promote the use of up-to-date HIV-related science to improve policies affecting PLWH, and to discuss the impacts of wider public policy decisions on the health of priority populations.	🟥	Working with key agencies and organisations within the HIV response, ensure that up-to-date HIV-related science is used across policies and upcoming policy decisions which affect, or has the potential to affect PLWH and priority populations.

Data collection, research and evaluation

The Australian HIV response has been successful to date due to the active partnership between PLWH and the community sector, researchers, clinicians and government. Identifying gaps and areas for improvement in mechanisms that collect and store data is critical in developing a clear picture of HIV in WA, and how the epidemic may be changing. While gaps in surveillance data exist across priority populations, the role of social, behavioural and clinical research continues to assist in providing information that bridges these gaps. The maintenance of a strong research agenda and evidence-based informing action should be balanced by avoiding unnecessary burden on service providers. Importantly, the principles enshrined within this strategy should inform all research, evaluation and surveillance activities.

Key actions		**Recommendations**
1. Contribute towards and continue to support national research and evaluation projects on HIV and priority populations.	🟧	Continue existing support and consider if additional projects can be supported.
2. With a focus on the HIV cascade of care, identify areas where data collection and storage can be improved or where data linkage projects can be developed to better monitor trends in priority populations.	🟧	Analysis of cascade of care to identify areas where data gaps exist and where existing data collection may be enhanced.
3. Ensure that relevant research, evaluation and surveillance data is disseminated to services and organisations involved in the HIV response to inform future planning and delivery of projects.	🟧	Continue existing strategies for disseminating data (e.g. quarterly forums; regular epidemiology, testing, and treatment uptake reports on-line; provision of specific data on request; SiREN and develop additional strategies.
4. Build the capacity of services and organisations involved in the HIV response to appropriately evaluate the effectiveness of current projects so that areas for improvement can be identified and incorporated into future planning.	🟧	Continue ensuring that support options are provided for organisations working within the HIV response to increase evaluation capacity.
5. Investigate reported incidences of stigma or discrimination encountered by PLWH and using appropriate research frameworks, monitor actual and perceived drivers, facilitators and power structures causing HIV-related stigma and discrimination.	🟧	Ensure that PLWH can report incidences of stigma and discrimination, and that these incidences are appropriately monitored and documented, to create a clearer picture in WA of the frequency, range and drivers of occasions of stigma/discrimination related to HIV. Identify gaps in evidence for priority populations (e.g. heterosexual people travelling to high prevalence countries), support research to address evidence gaps and disseminate key findings.

7.3 *WA HIV Strategy* - Annual Action area report

The development of this report is based on reporting from Sexual Health and Blood-borne Virus Program (SHBBVP) funded organisations and service providers, SHBBVP programs and campaigns and WA surveillance data. This report highlights significant activities and has been populated in consultation with relevant service providers. It does not attempt to be a full inventory of activities conducted by stakeholders within the WA sexual health, BBV and STI sector and complementary sectors (e.g. Department of Justice) that contribute to the multi-faceted approach to meeting the goals and targets.

January 2019 – December 2019	Key actions
Prevention and education	
WA PrEP Implementation Trial The WA PrEP Implementation Trial (PrEPIT WA) closed on 30 April 2019. A total of 901 study participants were enrolled across four trial sites after 10.5 months of enrolment.	PE4
HIV and STIs campaign An overseas acquired HIV and STIs campaign was launched along with a travel health consumer webpage on HealthyWA updated to cover information on overseas acquired HIV and STIs. Social media and online advertising launched on 1 December 2019.	PE1
PrEP resource In consultation with Magenta, the Sexual Health and Blood-borne Virus Program produced a PrEP resource specifically for sex workers in an effort to respond to a gap in tailored information for sex workers in relation to PrEP.	PE2
Testing and diagnosis	
HIV and STIs campaign AS part of the above HIV and STI campaign, GPs across the state were contacted by mail to highlight the need for opportunistic testing in overseas returned travellers from high risk countries.	TD2
PrEPIT Due to PrEPIT WA, the M Clinic saw significant rises in HIV and STI testing over 2019. Uptake of rapid testing remains low, mostly due to the fast turnaround of serological results in WA.	TD1
Disease management and clinical care	
Case management Case management services provided by SHAPE Program (WAAC) in Perth Metropolitan area to up to 35 clients living with HIV who have complex psychosocial needs, and to 23 clients in the Goldfields by Goldfields Public Health Unit - HIV case management program.	DMCC2, DMCC3

Guidelines for Managing HIV Transmission Risk Behaviours in Western Australia Extensive consultation was completed to update the *Guidelines for Managing HIV Transmission Risk Behaviours in Western Australia.* The updated WA guidelines will align with the national guidelines.	EE5, DM3
Workforce development	
PrEP training A total of 236 health professionals including 2 specialists, 77 GPs and 115 nurses attended PrEP training sessions delivered by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) in Perth and regional WA. A list of trained PrEP prescribers was published online. https://ww2.health.wa.gov.au/Articles/N_R/PrEP-Prescribers	WD3
HIV s100 GP Prescribers As of the start of December 2019 there were 18 HIV s100 GP Prescribers in WA.	WD6, DMCC2
HIV symposium HIV symposium: HIV Testing - Four ways, held during the 2019 Australasian Sexual Health and HIV&AIDS Conference with speakers: Ben Whilcock (AFAO), Dr Moira Wilson (FSH), Dr David Speers (QEII), Dr Jason Ong (Alfred Health). There were approximately 70 attendees at the session.	WD1, TD1
Enabling environment	
'Reasonable Precautions' Factsheet A new factsheet explaining what constitutes 'reasonable precautions' in relation to STIs and BBV transmission was developed and published on the WA Health website. The factsheet incorporates information which includes 'having an undetectable HIV viral load (less than 200 copies/mL), usually resulting from being on effective treatment' is a sufficient standalone reasonable precaution for preventing the onwards transmission of HIV (supporting the 'undetectable equals untransmissible' campaign). https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Sexual%20Health/PDF/Notifiable-infectious-diseases-fact-sheet.pdf	EE4, PE5
Meaningful Involvement of People Living with HIV/AIDS (MIPA) principles The Western Australian AIDS Council integrated the Meaningful Involvement of People Living with HIV/AIDS (MIPA) principles across the organisation with an associated action plan.	EE2
Forums for people living with HIV The Western Australian AIDS Council held a number of forums for people living with HIV in WA, including a 'legal and migration forum' along with 'have your say', treatment forum.	EE2, DMCC6
Data collection, research and evaluation	
PrEPIT WA service provider evaluation The Sexual Health and Blood-borne Virus Program funded SiREN to conduct a PrEPIT WA service provider evaluation on experiences on providing PrEP. The evaluation report was finalised in 2019.	DCRE4

PrEPIT WA trial outcomes The final report and outcomes from the PrEPIT WA trial were presented by the Kirby Institute at the 2019 Australasian Sexual Health and HIV&AIDS Conference. Results from the report by Kirby were also used in a presentation by the Communicable Disease Control Directorate which analysed HIV epidemic trends in WA and the influence of treatment as prevention interventions and policy decisions.	DCRE4
National Survey Participation National surveys including the Gay Community Periodic Survey and the Australian Needle Syringe Program Fingerpick Survey were conducted during 2019 in WA.	DCRE1

7.4 WA HIV Strategy – Progress towards targets

SHBBVP report on annual progress against targets, developed through national and state surveillance data.

Key: 🟩 Target met 🟨 Tracking to meet target by 2023 🟧 Progress made towards target 🟥 Target not met/not tracking to meet target by 2023

Targets by the end of 2023:	Indicators	Sources	Progress
Achieve the 95–95–95 HIV diagnosis and treatment targets:			
1. Increase the proportion of people living with HIV (in all priority populations) who know their HIV status to 95%	Estimated proportion of people living with HIV who have been diagnosed	Indicator to be developed	This reporting indicator is yet to be developed.
	HIV testing rates in WA:	Laboratory data and Rates Calculator	The HIV notification testing rate in 2018 was 53/100,000, which was stable compared to the previous five year period (53/100,000)
	Numerator: Number of annual HIV tests conducted in WA		
	Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population, Aboriginal and non-Aboriginal, all ages		
2. Increase the proportion of people diagnosed with HIV on treatment to 95% within six weeks of diagnosis for those newly diagnosed, reducing this timeframe further over the life of the strategy	**Estimated proportion of people living with HIV dispensed treatment for HIV infection:**	PBS treatment data and WA HIV Database	93% of people diagnosed with HIV on treatment in 2018.
	Numerator: Number of people dispensed treatment for HIV infection		
	Denominator: Estimated number of people diagnosed with HIV living in WA		
3. Increase the proportion of people on treatment with an undetectable VL to 95%	**Proportion of HIV patients on treatment with an undetectable VL:**	HIV specialist clinics in WA	95% of cases diagnosed in 2017 have reached undetectable viral load within 12 months of diagnosis.
	Numerator: Number of people diagnosed with HIV on treatment with an undetectable VL		
	Denominator: Number of people diagnosed with HIV on treatment		
4. Reduce the incidence of HIV transmission in MSM	Number of annual HIV notifications reported in MSM	WA HIV Database	The number of HIV notifications decreased in MSM by almost 47% compared to the 2013-2017 average.

5. Reduce the incidence of HIV transmission in other priority populations other than MSM - people living with HIV; Aboriginal people; CALD people from high HIV prevalence countries; people who travel to high prevalence countries; sex workers; PWID; people in custodial settings; and sexually and gender diverse people.	Number of annual HIV notifications reported in Aboriginal people, people from high HIV prevalence countries, people travelling to high HIV prevalence countries, people in custodial settings and gender diverse people.	WA HIV Database	Notifications among Aboriginal people remained stable with 2 notifications per 100,000 population in 2018 compared to 3.4 average in 2013 -2017.
			Notifications among people born in high HIV prevalence countries remained stable with 10 cases reported, compared to 10.4 average cases per year in the 2013-2017 period.
			In 2018, there was a slight increase in HIV notifications in people travelling to high HIV prevalence countries (n=11), compared to the 2013-2017 average (n=9)
			In 2018 the number of HIV cases reported in people custodial settings remained low.
			The number of HIV cases reported in transgender person remained low in 2018
6. Maintain the virtual elimination of HIV among sex workers, PWID and from mother to child through the maintenance of effective prevention programs.	Number of annual HIV notifications in sex workers and cases reporting injecting drug use and vertical acquisition	WA HIV Database	The number of HIV cases reported in sex workers and cases reporting vertical acquisition remained low in 2018.
			Number of HIV notifications in PWID remains stable with 2 notifications per 100,000 population compared with 1.6 average in 2013-2018
			Vertical acquisition
7. Ensure all people attending public sexual health services and high priority population caseload general practices are assessed for PrEP eligibility	Number of individual dispensed HIV drug regimens for PrEP	PBS data	From April to December 2018, 625 people in WA had access PrEP through the Pharmaceutical Benefits Scheme. 4.5% (n=26) of non-HIV positive PGCPS respondents had accessed PrEP in the previous 6 months.
	Proportion of eligible people on PrEP	PGCPS Survey	

8. Ensure at least 75% of people with HIV report good quality of life	Proportion of HIV Futures Study participants who report their general health status and their general wellbeing to be excellent or good	HIV Futures Study	WA specific data not available for 2018.
9. Reduce the reported experience of stigma among people living with HIV, and the expression of stigma, in respect to HIV status	Proportion of people living with HIV who report experiencing stigma and discrimination in respect to their HIV status	Centre for Social Research in Health, University of New South Wales	WA specific data not available for 2018.
	Proportion of the general public who report feelings of stigma and discrimination towards people living with HIV		
	Proportion of health professionals who report feelings of stigma and discrimination towards people living with HIV		

Government of **Western Australia**
Department of **Health**

WA Sexual health and blood-borne virus strategies 2019–2023

HIV

2019–2023 baseline report

The big picture in 2018

- The rate of HIV notifications decreased in WA. The number of HIV notifications decreased in both men who have sex with men (MSM) and heterosexual people, with the largest decrease reported in MSM which declined almost 50% compared to the 2013–2017 average.
- The number of HIV notifications remained low and stable among Aboriginal people and people who inject drugs.

	2013 to 2017 Average	2018	Mid-term review**	
HIV notification rate per 100,000 population	**3.6**	**2.0**		**↓ 44%**
Number of HIV notifications in men who have sex with men (MSM)	**56.4**	**30**		**↓ 47%**
Number of HIV notifications in heterosexual people	**34.2**	**21**		**↓ 39%**
Number of HIV notifications in people who inject drugs	**1.6**	**2**		**Stable**
Number of HIV notifications in Aboriginal people	**3.4**	**2**		**Stable**

Testing

	2013 to 2017 Average	2018	Mid-term review**	
Number of HIV tests per 1,000 people	**53.0**	**53.0**		**Stable**

Treatment as prevention

- With an estimated 93% of people diagnosed with HIV on treatment in 2018, WA is on track to achieving the 95% treatment coverage target by 2023. When a HIV-positive person is on treatment and their viral load is suppressed, the chance of onward transmission is negligible.
- Pre-exposure prophylaxis (PrEP) is a once-daily pill used by HIV-negative people as a prevention method that was listed on the Pharmaceutical Benefits Scheme (PBS) on 1 April 2018.

	2013 to 2017 Average	2018	Mid-term review**	
Time to treatment *Proportion of people diagnosed with HIV who started treatment within one month of diagnosis*	*	**93%**		**Target 95%**
Treatment coverage *Estimated proportion of people living with HIV who are on treatment*	*	**90%**		**Target 95%**
Viral suppression *Proportion of people diagnosed with HIV who reached an undetectable viral load within 12 months of diagnosis* # Cases diagnosed in 2017	*	**95%#**		**Target 95%**
Number of WA residents who recieved PrEP susidised by the PBS 1 April to 31 December 2018	*	**625** ^		

*No data available. For further information see the *Implementation Report: Progress towards targets.*

** Data to be collected around 2021

8. *WA Hepatitis B Strategy* Implementation report

8.1 *WA Hepatitis B Strategy* – At a glance

Surveillance, monitoring and reporting

Guiding principles

- Meaningful involvement of priority populations
- Human rights
- Access and equity
- Health promotion
- Prevention
- Quality health services
- Harm reduction
- Shared responsiblity
- Commitment to evidence-based policy and programs
- Partnership

Goals

1. Make significant progress towards eliminating hepatitis B as a public health threat.
2. Reduce transmission of and the mortality and morbidity caused by hepatitis B.
3. Minimise the personal and social impact of hepatitis B.
4. Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on the health of people living with hepatitis B.

Targets

1. Achieve and maintain hepatitis B childhood vaccination coverage of 95% at 12 and 24 months.
2. Reduce the number of newly acquired hepatitis B infections across all age groups by 50%, with a focus on priority populations.
3. Increase the proportion of people living with chronic hepatitis B who are diagnosed to 80%.
4. Increase the proportion of people living with chronic hepatitis B receiving care to 50%.
5. Increase the proportion of people living with chronic hepatitis B who are receiving antiviral treatment to 20%.
6. Reduce hepatitis B attributable mortality by 30%.
7. Reduce the reported experience of stigma among people living with hepatitis B, and the expressions of stigma, in respect to hepatitis B status.

Targets are measured by indicators

Action areas

Prevention and education	Testing and diagnosis	Disease managment and clinical care	Workforce development	Enabling environment	Data collection, research and evaluation
3 key actions	2 key actions	2 key actions	3 key actions	3 key actions	4 key actions

Priority populations

People living with hepatitis B |People from culturally and linguistically diverse backgrounds | Aboriginal people

Children born to pregnant women living with hepatitis B |Other unvaccinated adults at higher risk of infection

8.2 *WA Hepatitis B Strategy* - Gap analysis and recommendations

Mapping tables were provided to organisations across the sector to identify the coverage of the *Key actions* for each priority population within the *Action areas* for each of the *WA Strategies.* These mapping tables were used to conduct this gap analysis.

Key: 🟩 Significant coverage 🟨 Some room for improvement 🟥 Significant room for improvement

Prevention and education

The following actions aim to improve hepatitis B related knowledge among the priority populations and to improve access to hepatitis B prevention initiatives, thus contributing towards achieving the goals and targets set out in this strategy.

Key actions		**Recommendations**
1. Improve hepatitis B related health literacy among priority populations in relation to the: • risk factors and preventative factors • availability of hepatitis B vaccinations and testing • availability of treatment • need for regular monitoring.	🟨	Migrant Blood Borne Virus and Sexual Health Survey research at Curtin University will determine knowledge gaps to inform prevention and education efforts in CALD. Information from survey to be disseminate and implement strategies to address gaps.
2. Increase access to: • hepatitis B vaccination for all priority populations including free vaccination for infants, adolescents, pregnant women and unvaccinated adults at higher risk of infections • other preventative measures such as condoms, sterile needles and syringes, and safer sex education.	🟩	
3. Develop partnerships to improve service coordination through the sharing of information and resources among: • CALD communities and organisations • service providers already engaging with priority populations • research institutes working in the viral hepatitis area.	🟨	Investigate evidence and/or programs used in other jurisdictions. Track progress in the Eliminate Hepatitis C Working Group.

Testing and diagnosis

It is estimated that in Australia nearly 38% of people living with hepatitis B are undiagnosed, making regular testing essential for early diagnosis to allow for better access to treatment, ongoing care and better health outcomes for the priority populations. The following actions aim to decrease the number of undiagnosed cases among people in WA living with hepatitis B.

Key actions		Recommendations
1. Increase access to routine and opportunistic testing by: • increasing awareness among healthcare workers and priority populations of the need for targeted testing of those at risk of hepatitis B infection • increasing testing options available in primary health and community-based settings such as through outreach initiatives while maintaining appropriate standards of care • conducting contact tracing for people who have tested positive for the hepatitis B surface antigen.	🟨	Narrow cast social marketing targeting at-risk populations and general practitioners to increase testing and contact tracing.
2. Employ evidence and peer-based approaches that promote testing among priority populations.	🟥	Complete a grey and peer-reviewed literature review on peer-based models across priority populations.

Disease management and clinical care

These actions aim to increase the number of people living with hepatitis B who are on treatment and engaged in care. To effectively achieve this, the following actions are recommended.

Key actions		Recommendations
1. Increase the number of people living with chronic hepatitis B on treatment and engaged in care by: • informing priority populations about the need to monitor and manage their hepatitis B infection and the treatment options available • increasing the number of accredited hepatitis B prescribers • monitoring the number of health services providing hepatitis B care and treatment to priority populations.	🟥	Currently 5.8% treatment uptake. Efforts needed to increase treatment uptake to 20%. Increased general practitioners training and community s100 prescribers required.

2. Improve the management and treatment of hepatitis B by: • identifying opportunities to improve patient management systems • improving access to and coordination of hepatitis B services by strengthening links between service providers already engaging with the priority populations including the use of telehealth where required in regional and remote areas • enhancing GP management of patients with hepatitis B including developing pathways for GP to GP and GP to specialist referrals • continuing to explore and share experiences of innovative models of care for hepatitis B prevention and management, particularly models for rural and remote areas such as nurse-led models and models utilising Aboriginal health practitioners • ensuring the provision of culturally secure services to priority populations.	🟥	Investigate options to enhance care options, such as, GP training, health pathways (through WAPHA). Liaise with Telehealth to investigate support options for rural and remote settings.

Workforce development

The following actions aim to develop a healthcare workforce that is highly skilled and adequately trained in the treatment and management of hepatitis B. To effectively achieve this, the following actions are recommended.

Key actions		**Recommendations**
1. Improve awareness, knowledge and skills of the healthcare workforce in relation to early detection, monitoring and treatment of hepatitis B by increasing: • the number of professional development opportunities available to the healthcare workforce including in regional and remote areas • access to training opportunities through the use of digital and online platforms such as videoconferencing, webinars and recorded presentations in addition to face-to-face training • the awareness of available educational resources to assist in the management of hepatitis B.	🟨	Map the workforce development opportunities currently funded and provided and complete a gap analysis. Develop resources in conjunction with priority populations.
2. Increase hepatitis B treatment prescriber course access, promotion and participation of non-accredited GPs working with priority populations, including those in regional and remote areas.	🟥	Investigate options to improve access to Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) training for rural and remote based general practitioners.
3. Develop shared care models to better support new prescribers through linkages with experienced prescribers including the use of telehealth where required in regional and remote areas.	🟥	Investigate shared care models in other jurisdictions to assess the effectiveness of peer support models.

Enabling environment

People living with hepatitis B are likely to experience discrimination and stigma. This can have a significant impact on their health outcomes and may prevent them from seeking support. To effectively address stigma and discrimination, the following actions are recommended.

Key actions		**Recommendations**
1. Provide patients and consumers with information about their rights and responsibilities in relation to hepatitis B prevention, testing, treatment and care.	🟥	Develop on-line and hard-copy health consumer resource.
2. Monitor stigma and discrimination in the community that impacts on health-seeking behaviour of priority populations and their access to testing and treatment services.	🟧	Liaise with Centre for Social and Health Research on stigma and discrimination indicators for WA.
3. Review and address institutional, regulatory and system policies that create barriers to equality of prevention (including access to vaccination), testing, treatment, care and support for priority populations, including people living with hepatitis B.	🟧	Literature review and environmental scan on barriers to testing, treatment and care.

Data collection, research and evaluation

There are a number of gaps in the research and surveillance related to hepatitis B. To fully understand the burden of disease caused by hepatitis B in WA, the following actions are recommended.

Key actions		**Recommendations**
1. Identify opportunities to improve the timeliness, completeness and consistency of data collections.	🟧	
2. Explore the prevalence and nature of stigma and discrimination experienced by people living with hepatitis B in WA.	🟧	Liaise with Centre for Social and Health Research on stigma and discrimination indicators for WA.
3. Identify gaps in knowledge among healthcare workforce and priority populations relating to hepatitis B prevention, testing, treatment and care.	🟥	Complete a needs analysis among healthcare workers to identify gaps.
4. Identify and address barriers in accessing hepatitis B vaccination, testing, treatment and care among priority population groups, including people from countries with an intermediate or high prevalence of hepatitis B.	🟥	SHaBBVAC to review the gap workforce needs analysis and review literature review and environmental scan on barriers to testing, treatment and care. Support qualitative research with priority populations to understand barriers.

8.3 *WA Hepatitis B Strategy* - Annual *Action area* report

The development of this report is based on reporting from Sexual Health and Blood-borne Virus Program (SHBBVP) funded organisations and service providers, SHBBVP programs and campaigns and WA surveillance data. This report highlights significant activities and has been populated in consultation with relevant service providers. It does not attempt to be a full inventory of activities conducted by stakeholders within the WA sexual health, BBV and STI sector and complementary sectors (e.g. Department of Justice) that contribute to the multi-faceted approach to meeting the goals and targets.

January 2019 – December 2019	Key actions
Prevention and education	
Free hepatitis B vaccinations funded by WA Department of Health for: • men who have sex with men • people who inject drugs • sex industry workers • people living with HIV, chronic hepatitis B or C infection or chronic liver disease • people newly notified with hepatitis B (newly acquired or chronic/unspecified) from 1 January 2019.	PE2
Hepatitis B Community Engagement Hepatitis WA's Hepatitis B Community Engagement program works with multicultural communities providing accurate and easy to understand information about hepatitis B and aiming to destigmatize the topic within culturally and linguistically diverse communities.	PE1
Pilbara Needle and Syringe Exchange Program A new NSEP was established at the Karratha Health Campus in South Hedland. Prior to this, there were no enhanced needle and syringe services in the Pilbara region.	PE2
Testing and diagnosis	
Hepatitis B Multicultural Peer Education The Multicultural Peer Education Project educates and supports community members with skills and resources in order for them to promote hepatitis B through peer interactions and workshops. In 2019, 26 sessions were delivered to 289 people	PE3

Golden Tickets - World Hepatitis Day In collaboration with North Metro TAFE AMEP, CaLD people from high prevalence countries received education on hepatitis B including informed consent. Seventy-five Golden tickets were distributed after the education sessions to offer testing to priority populations who had attended the session, but had not been previously tested or vaccinated. Participants could present the ticket for a hepatitis B blood test and were expected to come back a week later for the results and vaccination if required. Ticket holders required a Medicare card in order to participate.	TD1, PE1, PE2
Disease management and clinical care	
Hepatitis B s100 prescribers WA had 36 accredited hepatitis B prescribers by end of August 2019, 8 practice in regional location.	DMCC1, WD2
Liver Healthy Life workshops HepatitisWA delivered six 'Liver Healthy Life' workshops and 55 pictorial education sessions in 2019. The workshops are interactive, using juicing and salads to introduce liver health and education about hepatitis B. Education sessions use picture and model based to accommodate people who speak English as a second language. Educational content includes the importance of knowing hepatitis B status, transmission, prevention, testing, vaccination, treatment, monitoring and how to maintain liver health.	DMCC1, PE1, PE3, TD2, EE2
National Hepatitis B Educators Network HepatitisWA are part of the National Hepatitis B Educators Network. The network provides rare opportunity for hepatitis B community educators to come together to share their experiences, skills and knowledge.	DMCC2, WD1
Workforce development	
Hepatitis B s100 Prescriber Course Hepatitis B s100 Prescriber Course delivered in Perth attended by 5 GPs, 4 Medical Officers and 1 GP Registrar. WA had 36 accredited hepatitis B prescribers by end of August 2019, with 8 practicing in regional location.	WD2, DMCC1
Support for prescribers All prescribers are offered individualised support through access to: • their nominated linking specialist • a WA-HBV dedicated ASHM project officer • ASHM in-house clinical advisors. ASHM provided individualised support to 12 prescribers to assist them in accessing HBV CPD activities and maintain their accreditation, with one prescriber also reporting accessing individualised support from their linking specialist.	WD3
Case discussion update for prescribers Hepatitis B case discussion update was held for prescribers to join in person or online via webinar. Twelve prescribers attended in person and three participated online. Access to Hepatitis B Online Modules and Hepatitis B Video Module provided by ASHM to all prescribers. All prescribers have access to ASHM's Vimeo library which contains over 100 videos relevant to hepatitis B.	WD1

Enabling environment	
Reasonable precautions factsheet A new factsheet explaining what constitutes ‘reasonable precautions’ for a person who is at risk of contracting a notifiable infectious disease and for a person who has a notifiable infectious disease to prevent spread of STIs and BBV transmission was developed and published on the WA Health website. https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Sexual%20Health/PDF/Notifiable-infectious-diseases-fact-sheet.pdf	EE1
Vaccination Guidelines Guidelines for the *Provision of Hepatitis A and B Vaccine to Adults in Western Australia at Risk of Acquiring these Infections by Sexual Transmission and Injecting Drug Use* updated,	EE3
Hepatitis B Multicultural Networks HepatitisWA engaged with various multicultural networks across Perth, providing ongoing opportunities to work with a number of multicultural agencies. This had led to workforce development education on hepatitis B to service provides including: South East Metro Cultural Network, East Metro Multicultural Network, North Metro Multicultural Network, North Metro Multicultural Network, Combined CaLD Network Forum, Humanitarian Entrants Interagency Network (HEIN), Diversity Café	EE1, DMCC1, DMCC2, PE1, PE2, PE3, TD1 TD2
Data collection, research and evaluation	
Pharmaceutical Benefits Scheme (PBS) data analysis and report Analysis and reporting of PBS data to assess the number of WA residents who were dispensed treatment for chronic hepatitis B virus (HBV) from 2015 to 2017. *Hepatitis B Treatment Uptake in WA - Initiations of Treatment for Chronic Hepatitis B, 2015 to 2017* report published online in 2019 – available at https://ww2.health.wa.gov.au/Articles/A_E/Epidemiology-of-STIs-and-BBVs-in-Western-Australia .	EE4
Migrant Blood Borne Virus and Sexual Health Survey (MiBSS) research The MiBSS research at Curtin University is underway and will determine knowledge gaps to inform prevention and education efforts in CALD.	DCRE4, EE3

8.4 WA Hepatitis B Strategy – Progress towards targets

SHBBVP report on annual progress against targets, developed through national and state surveillance data.

Key: 🟩 Target met 🟨 Tracking to meet target by 2023 🟧 Progress made towards target 🟥 Target not met/not tracking to meet target by 2023

Targets by the end of 2023:	Indicators	Sources	Progress
1. Achieve and maintain hepatitis B virus (HBV) childhood vaccination coverage of 95 per cent at 12 and 24 months	Coverage of HBV vaccination at 12 months and 24 months	Australian Childhood Immunisation Register (ACIR) and Rates Calculator	🟨 93.43% coverage of hep B vaccination at 12 months in 2018
	Numerator: Number of children in the relevant cohort who have dose 3 by 12 (and 24) months of age recorded on the ACIR		🟧 89.63% coverage of hep B vaccination at 24 months in 2018
	Denominator: Number of children turning 12 (and 24) months of age in the measurement year on the ACIR		
2. Reduce the number of newly acquired HBV infections across all age groups by 50 per cent, with a focus on priority populations	Annual rate of newly acquired HBV notifications	WA Notifiable Infectious Diseases Database (WANIDD) and Rates Calculator	🟧 Newly acquired hep B notification rate of 0.9 per 100,000 population in 2018 compared to 1.0 average in 2013-2017
	Numerator: Number of newly acquired HBV notifications		
	Denominator: ABS Estimated Resident Population, Aboriginal and non-Aboriginal, all ages		
3. Increase the proportion of people living with chronic HBV who are diagnosed to 80 per cent	1. Estimated annual proportion of people living with chronic HBV who have been diagnosed	Indicator to be developed	🟥 Indicator yet to be developed
	2. Annual rate of unspecified HBV notifications	WANIDD and Rates Calculator	Unspecified hep B notification rate of 17.5 per 100,000 population in 2018 compared to 21.1 average in 2013-2017
	Numerator: Number of unspecified HBV notifications		
	Denominator: ABS Estimated Resident Population, Aboriginal and non-Aboriginal, all ages		

4. Increase the total proportion of people living with chronic HBV receiving care to 50 per cent	Proportion of people living with chronic HBV who received monitoring for chronic HBV	Data linkage study	Data not available at time of report
	Numerator: Number of people who received monitoring for chronic HBV		
	Denominator: Modelled estimate of the number of people living with chronic HBV		
5. For people living with chronic HBV, increase the proportion receiving antiviral treatment to 20 per cent	Proportion of people with living chronic HBV dispensed drugs for HBV infection	PBS treatment data	5.8% of people living with chronic hep B were dispensed drugs for hep B infection in 2018. This is up 49% from the average of 3.9% in 2013-2017.
	Numerator: Number of people dispensed drugs for chronic HBV infection		
	Denominator: Modelled estimate of the number of people living with chronic HBV		
6. Reduce HBV attributable mortality by 30 per cent	Estimated number of deaths attributable to chronic HBV	Data linkage study	Data not available at time of report
7. Reduce the reported experience of stigma among people living with HBV, and the expression of stigma, in respect to HBV status	Proportion of people living with chronic HBV who report experiencing stigma and discrimination in respect to HBV status	Centre for Social Research in Health, UNSW	Data not available at time of report
	Proportion of the general public who report feelings of stigma and discrimination towards people living with chronic hepatitis B		59% of general public report feelings of stigma and discrimination towards people living with hep B in 2018. No previous data for comparison
	Proportion of health professionals who report feelings of stigma and discrimination towards people living with chronic hepatitis B		10% of health professionals report feelings of stigma and discrimination towards people with chronic hep B in 2018. No previous data for comparison.

Government of **Western Australia**
Department of **Health**

WA Sexual health and blood-borne virus strategies 2019–2023

Hepatitis B

2019–2023 baseline report

The big picture in 2018

- The rate of newly acquired hepatitis B notifications remained stable and unspecified hepatitis B decreased.

Prevention through immunisation

- Childhood vaccination at 12 months was approaching the 2023 target of 95%.

Treatment

- The proportion of people living with chronic hepatitis B who were dispensed drugs for hepatitis B infection increased but remained below the 2023 target of 20%.

Stigma and discrimination

- Feelings of stigma and discrimination towards people living with chronic hepatitis B were high among the general public.

	2013 to 2017 Average	2018	Mid-term review**	
Newly acquired hepatitis B *notification rate per 100,000 population*	1.0	0.9		Stable
Unspecified hepatitis B *notification rate per 100,000 population*	21.1	17.5		↓ 17%
Coverage of hepatitis B vaccination *At 12 months*	91.8%	93.4%		Stable
At 24 months	89.5%	89.6%		Stable
Proportion of people living with chronic hepatitis B dispensed drugs for hepatitis B infection	3.9%	5.8%		↑ 49%
Proportion of the general public who report feelings of stigma and discrimination towards people living with chronic hepatitis B	*	59%		
Proportion of health professionals who report feelings of stigma and discrimination towards people living with chronic hepatitis B	*	10%		

*No data available. For further information see the *Implementation Report: Progress towards targets.*

** Data to be collected around 2021

9. *WA Hepatitis C Strategy* implementation report

9.1 *WA Hepatitis C Strategy* - At a glance

Surveillance, monitoring and reporting

Guiding principles

- Meaningful involvement of priority populations
- Human rights
- Access and equity
- Health promotion
- Prevention
- Quality health services
- Harm reduction
- Shared responsiblity
- Commitment to evidence-based policy and programs
- Partnership

Goals

1. Make significant progress towards eliminating hepatitis C as a public health threat.
2. Reduce transmission of and morbidity and mortality caused by hepatitis C.
3. Minimise the personal and social impact of hepatitis C.
4. Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on the health of people living with hepatitis C.

Targets

1. Reduce the number of newly acquired hepatitis C infections by 60%, with a focus on priority populations.
2. Increase the proportion of people living with hepatitis C who are diagnosed to 90%.
3. Increase the cumulative proportion of people living with chronic hepatitis C who have initiated direct-acting antiviral (DAA) treatment to 65%.
4. Reduce hepatitis C attributable mortality by 65%.
5. Reduce the reported experience of stigma among people living with hepatitis C, and the expression of stigma, in respect to hepatitis C status.
6. Increase the use of sterile injecting equipment for every injecting episode.

Indicators

Action areas

Prevention and education	Testing and diagnosis	Disease managment and clinical care	Workforce development	Enabling environment	Data collection, research and evaluation
5 key actions	5 key actions	6 key actions	5 key actions	4 key actions	7 key actions

Priority Populations

People living with hepatitis C | People who inject drugs | People in or recently exited custodial settings | Aboriginal people | People from culturally and linguistically diverse backgrounds

9.2 WA Hepatitis C Strategy - Gap analysis and recommendations

Mapping tables were provided to organisations across the sector to identify the coverage of the *Key actions* for each priority population within the *Action areas* for each of the *WA Strategies.* These mapping tables were used to conduct this gap analysis.

Key: 🟩 Significant coverage 🟧 Some room for improvement 🟥 Significant room for improvement

Prevention and education

The facilitation of appropriate education, targeted towards both priority populations and the general public, as well as implementation of evidence-based harm reduction initiatives can aid in preventing the transmission of hepatitis C and in informing people of the testing and treatment options for hepatitis C.

Key actions		**Recommendations**
1. Implement innovative hepatitis C public education initiatives with a focus on transmission risk and harm reduction strategies and to raise awareness of DAA treatments.	🟩	
2. Increase the availability, range and distribution of sterile injecting equipment among PWID, especially in regional and remote areas and for Aboriginal PWID.	🟩	
3. Increase access to health, safer injecting and safe disposal information for PWID, including the utilisation of peer-based initiatives and education tailored to priority populations.	🟩	
4. Facilitate a coordinated partnership approach towards prevention and education initiatives, and share the successes of these approaches with service providers.	🟧	Eliminate Hepatitis C Working Group to consider this.
5. Support the continued provision of and equitable access to evidence-based OTP for priority populations.	🟩	

Testing and diagnosis

Increasing the diagnosis rate of those living with hepatitis C will be a key target to achieve by the end of this strategy, and into the future. Accurately assessing the true prevalence rate of hepatitis C within WA, and measuring the success of this strategy, will depend on the delivery of non-discriminatory, innovative and complete testing processes.

Key actions		Recommendations
1. Increase awareness of the importance of testing among priority populations including engagement in all stages of the testing process (antibody testing, confirmatory hepatitis C RNA and monitoring of liver condition).	🟩	
2. Increase routine and opportunistic testing, through primary health care, community-based services, allied health services and within custodial services.	🟨	Continue to support community based and other services that provide testing and consider how testing opportunities may be increased through other services.
3. Investigate the use of emerging technologies including rapid diagnostic testing (RDT) and POCT to increase testing rates.	🟥	POCT research trials are currently being undertaken at some services and will inform the future use of these technologies.
4. Develop and maintain peer-based strategies that include utilising the skills and experience of people living with hepatitis C and PWID to encourage people to test and progress into treatment and ongoing management of their condition as required.	🟨	A peer-based hepatitis C education project regarding testing and treatment has been rolled out and will contribute to the development of further strategies.
5. Identify opportunities to improve the application of recommended testing procedures for hepatitis C by clinicians, including patient follow-up post antibody test and application of confirmatory hepatitis C RNA testing.	🟥	Recommended testing procedures to be highlighted in all workforce development initiates and clinical resources.

Disease management and clinical care

Since the inclusion of DAA treatment for hepatitis C on the Pharmaceutical Benefits Scheme (PBS)in March 2016, Australia has been leading the way globally as a nation where elimination of hepatitis C is a realistic prospect. Enhancing awareness of these revolutionary treatments, increasing rates of treatment for those affected by hepatitis C and providing timely and relevant referral to treatment services and ongoing care will be vital within WA to ensure treatment remains a priority and people are engaged throughout the hepatitis C cascade of care.

Key actions		Recommendations
1. Increase public awareness of the availability of and the effectiveness of DAA treatment for hepatitis C.	🟨	Continue and enhance strategies to increase public awareness.
2. Provide support and information to GPs and practice nurses to increase the number of DAA prescribers treating through general practice.	🟨	Continue to follow up GPs who notify hepatitis C cases (through HepatitisWA GP project), and strengthen other workforce development initiatives and resources.
3. Establish new community service led treatment clinics and enhance current clinics operating within community-based services to target priority populations.	🟨	Identify potential new sites and opportunities for community service led treatment clinics.

4. Maintain and improve partnerships between primary healthcare workers, specialists, allied health services, community-based services (including alcohol and other drug (AOD) services), AHS and custodial services to ensure appropriate pathways into treatment and management or care is available for those diagnosed with chronic hepatitis C.	🟧	Eliminate Hepatitis C Working Group to consider this.
5. Enhance current treatment projects and introduce innovative strategies to increase access to DAA treatment for hepatitis C for those within custodial settings or those recently exited the custodial setting.	🟩	
6. Support the healthcare workforce to identify and engage people living with hepatitis C in treatment and ongoing care, including improving patient management systems, conducting patient recall and ongoing monitoring for patients with pre-existing liver disease issues.	🟥	Investigate successful models of patient engagement and monitoring, and provide support to replicate or adapt these as relevant.

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 living with hepatitis C, in a variety of settings, will be central to the response to hepatitis C in WA.

Key actions		**Recommendations**
1. Provide ongoing support and information to GPs, nurse practitioners and the wider healthcare workforce on prevention, accurate testing processes and the pathway to treatment for patients living with hepatitis C.	🟧	Continue to support provision of health workforce education by ASHM and other providers.
2. Facilitate innovative workforce education and training initiatives to build a highly skilled healthcare workforce, including increasing use of online learning, videoconference and teleconference, information sharing platforms and face-to-face learning opportunities.	🟧	Investigate and implement contemporary model of delivery for health workforce education.
3. Provide innovative and tailored education for the Aboriginal healthcare workforce on hepatitis C transmission risk and prevention methods and the ability to appropriately conduct or refer patients for hepatitis C testing and treatment.	🟥	Continue to support the Aboriginal Health Council of WA (AHCWA) to deliver the Birds and the BBVs training (BBV/STI training), and explore other options to provide tailored education for the Aboriginal healthcare workforce.
4. Support community-based organisations, custodial settings, NSP sites and relevant peer networks to increase their engagement with priority populations in order to improve health literacy and their connection to diagnostic services, treatment and ongoing care.	🟧	Support targeted workforce development initiatives for these sectors.
5. Promote relevant clinical guidelines on testing, treatment, care and support for people living with hepatitis C.	🟩	

Enabling environment

In relation to the Guiding Principles of Human Rights, _referring to safeguarding the human rights of priority populations, and to access and equity in ensuring health and community care in WA is accessible to all, supportive and enabling environments must be provided to anyone living with or at risk of hepatitis C. This will include participation of priority populations in service design and implementation, addressing stigma and discrimination within the healthcare workforce and upholding client rights and responsibilities as well as addressing regulatory health and systemic barriers to service access._

Key actions		**Recommendations**
1. Engage with priority populations to identify the greatest barriers to accessing appropriate and timely health care, and involve priority populations in devising strategies to address these issues.	🟩	
2. Educate the healthcare workforce on the stigma and discrimination issues faced by PWID and other priority populations, the appropriate language to use and strategies to engage people who are living with hepatitis C or who are at risk of hepatitis C transmission.	🟨	Incorporate stigma and discrimination issues into all workforce development initiatives regarding hepatitis C, and develop tailored training to address this issue.
3. Ensure clients and patients have access to information about their rights and responsibilities when accessing health care.	🟩	
4. Review and address institutional, regulatory and system policies that create barriers to equality of prevention, testing, treatment, care and support for people living with hepatitis C and at-risk priority populations.	🟥	Working with priority populations, identify critical institutional, regulatory and system policies that create barriers within the HIV cascade of care and advocate for these barriers to be addressed.

Data collection, research and evaluation

Improvement in consistent collection of relevant data and responsible use of data is required to orient health services and drive actions within this strategy and beyond. Gaps in surveillance data exist across the priority populations, with the true prevalence of hepatitis C and burden of disease within the community still unknown. Collection of enhanced behavioural data and relevant research will be vital in moving forwards, including continual monitoring of risk factors, treatment uptake and evidence and impact of stigma and discrimination on people at risk of or living with hepatitis C. The use of relevant evaluation methods must also be built into the program design and implemented accordingly.

Key actions		**Recommendations**
1. Improve the consistency of data collection and increase the completeness of priority population specific data, including PWID, Aboriginal people, people from CALD backgrounds and those currently in or recently exited custodial settings.	🟥	Follow up with Immunisation, Surveillance and Disease Control Program regarding increasing the completeness of data.
2. Contribute towards, and continue to support national research and evaluation projects.	🟩	

3. Increase surveillance on behavioural trends and risks for hepatitis C including injecting drug use and receptive needle sharing, as well as maintaining data on treatment commencement and adherence.	🟧	Continue to participate in the Needle Syringe Program National Minimum Data Collection (NSPNMDC) and the Australian Needle and Syringe Program Survey (ANSPS) (both of which are annual national data collection projects undertaken by the Kirby Institute, UNSW), and consider options for data collection in non-metropolitan regions. Support participation in other research and surveillance activities as relevant.
4. Investigate and monitor stigma and discrimination, as well as related issues that impact on the decisions people at risk of hepatitis C or those living with hepatitis C may face.	🟥	Continue to liaise with Centre for Social Research in Health on stigma and discrimination indicators for WA.
5. Build competence within the sector to appropriately evaluate current and future projects to ensure alignment with relevant action areas within this strategy.	🟩	
6. Investigate opportunities to participate in and conduct data linkage projects utilising relevant state and national datasets to further explore prevalence, incidence, reinfection and treatment rates.	🟧	Literature review environmental scan on data linkage project undertaken in other jurisdictions that may be able to be replicated in WA, and development of innovative data linkage projects.
7. Share relevant research, evaluation and surveillance data with the sector to inform future planning and projects.	🟩	

9.3 WA Hepatitis C Strategy - Annual *Action area* report

The development of this report is based on reporting from Sexual Health and Blood-borne Virus Program (SHBBVP) funded organisations and service providers, SHBBVP programs and campaigns and WA surveillance data. This report highlights significant activities and has been populated in consultation with relevant service providers. It does not attempt to be a full inventory of activities conducted by stakeholders within the WA sexual health, BBV and STI sector and complementary sectors (e.g. Department of Justice) that contribute to the multi-faceted approach to meeting the goals and targets.

January 2019 – December 2019	Key actions
Prevention and education	
Expansion of Needle and Syringe Exchange Program services As part of the response to the Methamphetamine Action Plan (MAP) Taskforce report, additional funding was provided to expand Peer Based Harm Reduction WA's NSEP services in the Southwest. This will enable better access and availability of NSEPs in the Southwest region.	PE2, PE3
Great Southern Needle and Syringe Exchange Program (NSEP) A new NSEP was established at the Great Southern Population Health Unit in Albany. Funding was provided in response to the MAP Taskforce report's recommendations of improving access and availability of NSEPs in regional areas. While needle and syringe programs have been provided in the Great Southern region in the past through health services and pharmacies, this is the first dedicated NSEP to be established in this region, increasing access to preventative health services for people who drugs.	PE2, PE3
Pilbara Needle and Syringe Exchange Program (NSEP) A new NSEP was established at the Karratha Health Campus in South Hedland. While needle and syringe programs have been provided in the Pilbara region in the past through health services and pharmacies, this is the first dedicated NSEP to be established in this region, increasing access to preventative health services for people who drugs.	PE2, PE3
Testing and diagnosis	
Peer worker phlebotomy training Peer Based Harm Reduction WA have a peer worker in both the South West and Perth who have trained and achieved accreditation in phlebotomy.	TD1, TD4
Outreach testing and treatment Nurse Practitioner and a NSEP peer worker from Peer Based Harm Reduction WA have been providing monthly testing and treatment clinic at a drop-in centre for street present people in Bunbury. These and other innovations in the South West have led to a substantial increase in testing in that region.	TD1, TD4, DMC3

World Hepatitis Day World Hepatitis Day observed on 28th July 2019. Organisations across the state promoted testing and treatment through various mediums including social media, advertising campaigns and interviews.	TD1, PE1
Disease management and clinical care	
Hepatitis C Peer Harm Reduction Education Project (PHRE) Peer Based Harm Reduction WA have undertaken a project to recruit and train people who inject drugs, who have completed, or are undergoing, hepatitis C treatment to inform their peers about testing and treatment. This project has also development of peer-based resources on treatment to encourage consumers to undertake treatment.	DMC3, TD1, TD4
South West Health Clinic Peer Based Harm Reduction WA have commenced a health clinic at their Bunbury site, which provides hepatitis testing and treatment, and outreach services.	DMC3, TD2
Test Cure Live Campaign (TCL) TCL is a national hepatitis C awareness campaign that aims to identify people living with hepatitis C and encourage them to speak to their GPs about testing and/or cure. HepatitisWA successfully engaged with the community through newspaper and radio advertisements, social media, interviews, digital marketing, and window decals. Flyers and mouse mats were also distributed to GPs, health services and healthcare professionals.	DMC1, DMC2, TD1, PE1
Workforce development	
Eliminate Hepatitis C Australia project The Eliminate Hepatitis C Australia project provided workforce development grants to AHCWA, HepatitisWA, Peer Based Harm Reduction WA, and WANADA to increase HCV treatment rates over the next two years.	WD1, WD2, WD3, WD4, WD5
General Practitioner (GP) Liaison Project - HepatitisWA Historically GPs and Nurse Practitioners (NPs) refer patients who are diagnosed with hepatitis C for specialist treatment. This project provides support to GPs, NPs and other clinical and practice staff that report hepatitis C notifications to increase their knowledge and confidence in prescribing hepatitis C treatments.	WD1 WD2 EE2 DMC2
Curing hepatitis C in primary care A treatment update for primary care providers was held in Perth on 7 May 2019. 26 WA-based participants attended: 11 GPs/Medical Practitioners and 15 Nurses. 2 participants were from Derbarl Yerrigan Health Service.	WD 1, WD3, WD5
Enabling environment	
NSP client card This business card aims to provide clients with more confidence in accessing needle and syringe program services. While the card does not offer any protection, it informs any concerned parties that the client is utilising needle and syringe programs and provides a list of organisations that support the safe disposal of needles and syringes including the WA Police.	EE1
Peer based community education Peer Based Harm Reduction WA PBHRWA undertake a range of community education activities which aim to provide service information and harm reduction education and to reduce the level of stigma and discrimination towards people who inject drugs. This	EE1

can involve peer-based education and insights to change the perceptions of the wider community and supporting other agencies to work more effectively with drug users.	

The Missing Millions Campaign The campaign was launched by HepatitisWA to remove the stigma surrounding hepatitis C. HepatitisWA wanted to show that anyone exposed to risk factors could have hepatitis C and should consider getting tested. The campaign encouraged people to talk to their doctor about testing. Coffee cups were produced with the Paper Cup Project and disseminated throughout cafes around the Perth Metropolitan area. The goal of the coffee cup campaign was to encourage people to get tested for hepatitis C and to talk about hepatitis C and the cure with their GP.	EE1, EE2, TD1, PE1
Data collection, research and evaluation	
Australian Needle and Syringe Program Survey 2019 This national study is coordinated by the Kirby Institute (UNSW). Conducted over a one week period in October and), all clients attending NSPs at Peer Based Harm Reduction WA, WA AIDS Council and HepatitisWA were invited to complete a brief, anonymous questionnaire and to provide a capillary blood sample for HIV and HCV testing.	DC2, DC7
Needle Syringe Program National Minimum Data Collection (NSP NMDC) 2019 This national study is coordinated by the Kirby Institute (UNSW)a and provides information on Australian NSP service provision to enable reporting against key NSP indicators as outlined in the National Surveillance and Monitoring Plan. On a specified day, all clients attending NSPs at Peer Based Harm Reduction WA, WA AIDS Council and HepatitisWA were invited to complete a brief, anonymous questionnaire, and information about the services provide (e.g. referral, education) are also collected for each occasion of service.	DC2, DC7
TEMPO partnership project Peer Based Harm Reduction WA have been approached by the Kirby Institute to be involved in the expansion of the ‘Enhancing hepatitis C testing and treatment among people who inject drugs attending needle and syringe programs: the TEMPO Study’. This study includes point of care testing, and it is anticipated that involvement in this study will further enhance the uptake testing and treatment for hepatitis C treatment.	DC2, TD3

9.4 *WA Hepatitis C Strategy* – Progress towards targets

SHBBVP report on annual progress against targets, developed through national and state surveillance data.

Key: 🟩 Target met 🟨 Tracking to meet target by 2023 🟧 Progress made towards target 🟥 Target not met/not tracking to meet target by 2023

Targets by the end of 2023:	Indicators	Sources	Progress
1. Reduce the number of newly acquired HCV infections, with a focus on priority populations, by 60 per cent	Annual rate of newly acquired HCV notifications	WA Notifiable Infectious Diseases Database (WANIDD) and Rates Calculator	Notification rates of newly acquired hep C in 2018 were 4.4 which is down 17% compared to 5.3 average in 2013-2017.
	Numerator: Number of newly acquired HCV notifications		
	Denominator: ABS Estimated Resident Population, Aboriginal and non-Aboriginal, all ages		
2. Increase the proportion of people living with HCV who are diagnosed to 90 per cent	Estimated annual proportion of people living with chronic HCV who have been diagnosed	Indicator to be developed	Indicator yet to be developed
	Annual rate of unspecified HCV notifications	WANIDD and Rates Calculator	Unspecified hep C notification rate of 31.2 per 100,000 population in 2018 compared to 37.2 average in 2013-2017
	Numerator: Number of unspecified HCV notifications		
	Denominator: ABS Estimated Resident Population, Aboriginal and non-Aboriginal, all ages		
3. Increase the cumulative proportion of people living with chronic HCV who have initiated direct-acting antiviral treatment to 65 per cent	Proportion of people living with HCV dispensed DAA treatment for HCV infection	PBS treatment data	March 2016 – Mar 2019 30.5% of people living with hep C were dispensed DAA treatment. This is up 243% since Mar 2016-Sept 2016.
	Numerator: Number of people dispensed DAA treatment for chronic HCV infection		
	Denominator: Modelled estimate of the number of people living with chronic HCV		
4. Reduce HCV attributable mortality overall by 65 per cent	Estimated number of deaths attributable to chronic HCV	Data linkage study	Project is pending commencement. Ethics approval granted.

5. Reduce the reported experience of stigma among people living with HCV, and the expression of stigma, in respect to HCV status	Proportion of people living with HCV who report experiencing stigma and discrimination in respect to HCV status	Centre for Social Research, UNSW	56% of people living with hep C report experiencing stigma and discrimination. No previous data for comparison.
	Proportion of the general public who report feelings of stigma and discrimination towards people living with hepatitis C		58% of the general public report feelings of stigma and discrimination towards people with hep C. No previous data for comparison.
	Proportion of health professionals who report feelings of stigma and discrimination towards people living with hepatitis C		12 % of health professionals report feelings of stigma and discrimination towards people with hep C. No previous data for comparison.
6. Increase the use of sterile injecting equipment for every injecting episode	Prevalence of receptive syringe sharing by WA participants in the Australian Needle and Syringe Program Survey (ANSPS)	Australian Needle and Syringe Program Survey (ANSPS), The Kirby Institute	🟥 Prevalence of receptive syringe sharing in 2018 was 30% which is a 30% increase from 23% average in 2013-2017.

Government of **Western Australia**
Department of **Health**

WA Sexual health and blood-borne virus strategies 2019–2023

Hepatitis C

2019–2023 baseline report

The big picture in 2018

- The rate of hepatitis C notifications decreased.

	2013 to 2017 Average	2018	Mid-term review**	
Newly acquired hepatitis C *Notification rate per 100,000 population*	5.3	4.4		↓ 17%
Unspecified hepatitis C *Notification rate per 100,000 population*	37.2%	31.2%		↓ 16%

Risk and transmission

- Receptive syringe sharing increased.

	2013 to 2017 Average	2018	Mid-term review**	
Prevalence of receptive syringe sharing by WA participants in the Australian Needle and Syringe Program Survey (ANSPS)	23%	30%		↑ 30%

Treatment

- Proportion of people living with hepatitis C dispensed direct-acting antiviral (DAA) treatment for hepatitis C infection increased but remained below the 2023 target of 65%.

	2013 to 2017 Average	2018	Mid-term review**	
Proportion of people living with hepatitis C dispensed DAA treatment for hepatitis C infection	**Mar 2016 to Sept 2016** 8.9%	**Mar 2016 to Mar 2019** 30.5%		↑ 243%

Stigma and discrimination

- Feelings of stigma and discrimination towards people living with chronic hepatitis C were high among the general public.

	2013 to 2017 Average	2018	Mid-term review**	
Proportion of people living with hepatitis C who report experiencing stigma and discrimination in respect to hepatitis C status	*	56%		
Proportion of the general public who report feelings of stigma and discrimination towards people living with hepatitis C	*	58%		
Proportion of health professionals who report feelings of stigma and discrimination towards people living with hepatitis C	*	12%		

**No data available. For further information see the Implementation Report: Progress towards targets.*

** Data to be collected around 2021

SHP-013694 MAR' 20

10. WA Aboriginal Sexual Health and Blood-borne Virus Strategy Implementation Report

10.1 *WA Aboriginal Sexual Health and BBV Strategy* – At a glance

Surveillance, monitoring and reporting

Guiding principles

- Meaningful involvement of priority populations
- Human rights
- Access and equity
- Health promotion
- Prevention
- Quality health services
- Harm reduction
- Shared responsiblity
- Commitment to evidence-based policy and programs
- Partnership

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

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.
6. Maintain virtual elimination of congenital syphilis.
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.
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%.

Indicators

Action areas

Prevention and education	Testing and diagnosis	Disease managment and clinical care	Workforce development	Enabling environment	Data collection, research and evaluation
8 key actions	7 key actions	7 key actions	9 key actions	8 key actions	7 key actions

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

10.2 *WA Aboriginal Sexual Health and BBV Strategy* - Gap analysis and recommendations

Mapping tables were provided to organisations across the sector to identify the coverage of the *Key actions* for each priority population within the *Action areas* for each of the *WA Strategies.* These mapping tables were used to conduct this gap analysis.

Key: 🟩 Significant coverage 🟧 Some room for improvement 🟥 Significant room for improvement

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.

Key actions		**Recommendations**
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).	🟧	Identify areas with low access to condoms and conduct targeted promotion.
2. Increase the provision and promotion of needle and syringe programs (NSPs) and safe disposal options, especially in local Aboriginal Health Services (AHSs), to provide access to clean injecting equipment and places to discard used equipment.	🟥	Promote NSPs to AHS through CEO meetings and Clinical Advisory Group Provide support and links to capacity building and community needs assessments if required.
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 human papillomavirus (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.	🟧	Work with Immunisation, Surveillance and Disease Control team to plan strategies to increase uptake of vaccines. Identify areas with low vaccination rates.
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.	🟨	Continue to support the implementation of peer education programs such as the Young Leaders Program. Continue to support the development and implementation of educational resources and programs which is supported by capacity building of educators.
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.	🟨	Support RSHT to provide education to midwives and obstetricians on the importance of prenatal and antenatal screening Develop an education package for antenatal groups Promotion of Young Deadly Syphilis Free videos that relate to 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.	🟨	Continue to promote training and link participants with regional sexual health coordinators to provide ongoing support for community based education Consider a digital campaign to address shame and normalise

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.

Key actions		**Recommendations**
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.	🟥	Through the syphilis response, engage services to provide localised incentive programs to increase the uptake of testing such as the Her Rules Her Games shirts
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.	🟨	Ensure this is incorporated into the training sessions provided to clinicians (especially ED and GP doctors) and the Silver Book.
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.	🟨	Provide training/case studies on how to incorporate STI/BBV testing into routine primary health care.

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.	🟧	Support and promote information sharing amongst services with successful and innovative models through networks, capacity building and case studies.
5. Continue to implement and support point of care testing (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.	🟥	Provide workforce training on how to integrate testing into antenatal care.

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.

Key actions		**Recommendations**
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.	🟥	Evaluate the recall outcomes from use of SMS reminders.
2. Identify initiatives and programs to increase the uptake and adherence of treatment by reducing costs or providing free treatment, especially for hepatitis C.	🟥	Conduct research into successful programs for increasing the uptake and adherence of treatment and share findings with the sector.

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.	🟨	Develop and/or promote resources and guidelines on contact tracing to support health professionals. Support and promote information sharing amongst services with successful contact tracing methods through networks, capacity building and case studies.
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.	🟥	Conduct research into successful programs for increasing hepatitis C treatment and share findings with the sector.
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.	🟥	Support and promote information sharing amongst services with successful and innovative models through networks, capacity building and case studies.
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.	🟥	Promote access to specialist support and link regional and remote services with specialists to provide ongoing support and advice

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.

Key actions		**Recommendations**
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, non-government organisations (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.	🟨	Provide targeted training for the workforce especially on outbreak responses.
4. Strengthen and support the Aboriginal healthcare workforce by implementing a number of initiatives such as: • providing more Section 50(d) positions, Aboriginal Health Practitioners and gendered roles • including Aboriginal Health Workers (AHWs) in decision making and consultation processes to improve services and increase community participation • ensuring there is better utilisation and adequate remuneration of AHWs.	🟥	Ensure AHW and other Aboriginal Health staff are included in consultations on resources and involved in working groups where possible.
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 sexual health and BBVs 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.	🟥	Support service providers to increase the prioritisation of sexual health and BBVs through advocacy.
7. Provide incentives to attract and retain staff in regional and remote areas to reduce the turnover by providing additional leave and better rotations.	🟥	Support service providers to develop and implement strategies to attract and retain staff working in sexual health and BBVs.
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.	🟨	Ensure all resources are available online and information regarding ordering is widely available. Continue to promote the orientation package which includes a comprehensive overview of relevant resources.

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.	🟨	Support service providers to prioritise testing amongst their workforce and services.
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.		
Key actions		**Recommendations**
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.	🟨	Continue to build and review the Let's Yarn website which provides resources that facilitate culturally appropriate care and education by health professionals
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.	🟩	Support service providers to implement strategies that can evaluate whether patients feel services are safe, non-judgemental, discreet and culturally appropriate (e.g. Health Consumer Council survey).
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.	🟩	Support service providers to implement strategies that can evaluate whether patients feel services are safe, non-judgemental, discreet and culturally appropriate (e.g. Health Consumer Council survey).
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.	🟨	Promote and support the establishment of regional sexual health and BBV networks to increase service integration and collaboration.

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.	🟨	Promote LGBTI+ training, the LGBTI strategy and the rainbow tick accreditation program.
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.	🟨	Provide workforce training and resources on community engagement using case studies and/or success stories.
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.	🟨	Conduct a literature review into barriers and enablers for normalising testing amongst young people. This will then inform the development of guidelines for health service providers using the findings.

Data collection, research and evaluation

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

Key actions		**Recommendations**
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.	🟨	Ensure there is representation from Aboriginal people on steering groups for research projects. Provide links between services and the WA Aboriginal Health Ethics Committee and considering workforce training in this area.

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.	🟥	Conduct needs assessment to identify the gaps and barriers in accessing regional testing data. Work with the regions to implement the findings/recommendations.
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.	🟥	Working group has been established and is investigating systems and opportunities to integrate indicators
4. Develop or strengthen systems that accurately incorporate STI and BBV clinical items in Patient Information Systems (PISs) in WA Country Health Services (WACHS) and AHSs, and encourage staff to correctly record data to facilitate accurate auditing and data extraction.	🟨	Work with CHIS and Communicare to ensure systems can accurately capture STI and BBV information. Consider developing a fact sheet (if one doesn't already exist) about the importance of correctly recording data.
5. Develop a digital solution that provides real-time access to statewide patient records to improve the early detection and treatment of syphilis.	🟥	Continue to scope the development of a syphilis register. Source options based on scoping.
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.	🟨	Promote the use of the SiREN Planning and Evaluation Toolkit. Promote Health Promotion short course to the sector when they become available. Investigate guidelines or resources relating to culturally secure evaluations and promote. Use findings from research project *Increasing Aboriginal peoples' use of services that reduce harms from illicit drugs* to inform future practice and projects.
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.	🟥	Identify resources that promotes the identification of Aboriginal people and importance of correct data collection on forms and in information systems.

10.3 *WA Aboriginal Sexual Health and BBV Strategy* - Annual *Action area* report

The development of this report is based on reporting from Sexual Health and Blood-borne Virus Program (SHBBVP) funded organisations and service providers, SHBBVP programs and campaigns and WA surveillance data. This report highlights significant activities and has been populated in consultation with relevant service providers. It does not attempt to be a full inventory of activities conducted by stakeholders within the WA sexual health, BBV and STI sector and complementary sectors (e.g. Department of Justice) that contribute to the multi-faceted approach to meeting the goals and targets.

January 2019 – December 2019	Key actions
Prevention and education	
Young Leaders The Aboriginal Health Council of WA (AHCWA) delivers the Young Leaders Program which provides training and support for peer educators to provide local initiatives that address a range of health issues including sexual health, blood-borne viruses, mental health, relationships, and drugs and alcohol. The program has been implemented in Geraldton, Newman and the Perth Metropolitan area. There were eight training sessions delivered in 2019 with a total of 29 peer educators recruited in the program thus far. Those peer educators delivered nine health promotion events and education sessions in their communities in 2019.	PE6, PE8, WD2
Deadly Sista Girlz Program The Deadly Sista Girlz Program is delivered by the Wirrpanda Foundation and is partly funded by the Department of Health. The program provides culturally appropriate health education (including sexual health) and mentoring to young Aboriginal girls in Western Australia. In 2019, 674 participants attended 1,000 sessions across nine regional and metropolitan schools.	PE6, PE8, WD2
Testing and diagnosis	
TTANGO2 In 2019 there were 14 sites in WA conducting point of care testing (POCT) through the TTANGO2 program. The TTANGO2 provides POCT for chlamydia and gonorrhoea in regional and remote Aboriginal health services. Trichomonas testing was introduced into the program in 2019.	TD4, TD5
Her Rules Her Game The Kimberley Aboriginal Medical Service and the West Kimberley Women's Football League work in partnership to coordinate the Her Rules Her Game initiative. One component of the initiative is the provision of Her Rules Her Game shirts as incentives for Aboriginal people to get their 715 adult health checks. A total of 300 shirts were given out in the first half of 2019 and there has been a reported 20% increase in STI testing over past 12 months at the Aboriginal Community Controlled Health Organisations in the Kimberley.	TD1, TD3

Disease management and clinical care	
SASA In 2019 a Structured Administration and Supply Arrangement (SASA) was put in place that authorises Aboriginal Health Practitioners working in a public health program to administer antibiotics, for the treatment of syphilis. This includes public health programs operated or managed by a Health Service Provider of the WA Health system, or contracted entity, or a health service that is a member of AHCWA.	DMCC6, WD4
Workforce development	
Birds and the BBVs Birds and the BBVs is a two-day short course for staff working in Aboriginal Community Controlled Health Services. It is coordinated by the AHCWA in partnership with HepatitisWA. There were 10 trainings delivered in 2019 with a total of 119 participants. Due to the program's success, other jurisdictions have expressed in interest in delivering a similar course based on the Birds and the BBVs model.	WD5, WD9
Online Syphilis Training The Sexual Health and Blood-borne Virus Program (SHBBVP) commissioned ASHM to develop and host an online syphilis training package in response to the syphilis outbreak. The content was developed in consultation with all four jurisdictions that are impacted by the outbreak. The training was launched at the 2019 Australasian Sexual Health and HIV Conference in September, 2019. As of 31 January, 2020 a total of 242 people had completed the training and 60.5% (n=144) were from WA.	WD3, WD5
TTANGO Aboriginal Reference Group As part of the TTANGO2 program an Aboriginal Reference Group was established to include and recognise program champions. The group had a number of face-to-face meetings in 2019 and was chaired by the AHCWA TTANGO Coordinator.	WD1, WD2, WD4
Enabling environment	
Deadly Sista Girlz Dancing The Deadly Sista Girlz program provides opportunities for young Aboriginal girls to connect with and learn about their culture. In November 2019, a group of participants from Yule Brook College performed a number of dances at the official opening ceremony of the new Wirrpanda Foundation Lathlain Facility. The event was attended by the Federal, State and Local Governments as well as a number of key stakeholders and Board Members.	EE1, EE7
Regional Syphilis Funding Community-led initiatives are essential for community ownership and engagement in the delivery of services and programs. In 2019 the SHBBVP provided $20,000 to the Kimberley, Pilbara and Goldfields to develop and implement local projects in response to the syphilis outbreak. The regions have commenced working on a number of initiatives including an orientation videos for health professionals in the region, resources produced in local language, training delivered within the regions and an incentive based program to increase antenatal care.	EE7, EE8, PE5

Data collection, research and evaluation	
SiREN Evidence Review With funding from the Department of Health, SiREN developed and published *An evidence review from Australia, Aotearoa/New Zealand and Canada for the WA Aboriginal Sexual Health and Blood-borne Virus Strategy.* A total of 591 articles were analysed in the review. A suite of supporting assets were also developed.	DCRE1
Young Leaders Evaluation AHCWA conducted an evaluation of the Young Leaders Program which provided some encouraging results. 67% of recruited peer educators are female and majority are high school students. The evaluation demonstrated an increase in knowledge of the peer educators, especially in relation to sexual health. It also showed an increase in confidence and reduction in stigma. The report showed that the program had received a lot of great feedback. When asked about being a young leader, one of the participants reported: "I felt very proud of myself and not only did I feel proud but also my family and community acknowledged me. It also boosted my leadership skills and made me more confident to talk to people my age about certain things involved within today's society of children & young adults."	DCRE6
Midwest STI Clinic Data The Midwest STI Clinic regularly records data relating to their occasions of service to monitor utilisation of the clinic and client trends. There were 340 occasions of service provided by the Clinical Nurse Specialist in the clinic in 2019. Occasions of service reflect how the Walk-in STI clinic is well accepted among target group 15-25 years of age where they are aware that they will receive discrete, confidential and non-judgemental service. The Midwest Public Health Unit also obtain client feedback on the clinic occasionally for the purpose of continuous quality improvement.	DCRE2, DCRE4, DCRE6
Increasing Aboriginal peoples' use of services that reduce harms from illicit drugs A research project is underway conducted by Curtin University (funded by Healthway). Qualitative interviews with Aboriginal PWID, NSP staff and key informants are being conducted to understand barriers and enablers to accessing services to develop intervention(s) to increase access to NSPs and BBV testing and treatment.	DCRE1, DCRE2, DCRE7

10.4 *WA Aboriginal Sexual Health and BBV Strategy* – Targets and indicators

SHBBVP report on annual progress against targets, developed through national and state surveillance data.

Key: 🟩 Target met 🟨 Tracking to meet target by 2023 🟧 Progress made towards target 🟥 Target not met/not tracking to meet target by 2023

Targets by the end of 2023:	Indicators	Sources	Progress
1. Achieve and maintain HBV childhood vaccination coverage of 95 per cent at 12 and 24 months	Coverage of hepatitis B (HBV) vaccination at 12 months and 24 months among Aboriginal people	Australian Childhood Immunisation Register (ACIR) and Rates Calculator	🟧 88.71% coverage of hep B vaccination at 12 months in 2018 is a 5% increase from 84.78% average in 2013-2017.
	Numerator: Number of Aboriginal children who have dose 3 by 12 (and 24) months of age recorded on the ACIR		🟥 81.61% coverage of hep B vaccination at 24 months is a 5% decrease from 85.81% average in 2013-2017.
	Denominator: Number of Aboriginal children turning 12 (and 24) months of age in the measurement year on the ACIR		
2. Achieve and maintain HPV adolescent vaccination coverage of 80 per cent	HPV three-dose vaccination coverage for 15-year-old Aboriginal males and females	Indicator to be developed	🟥 Indicator not yet developed
	Numerator: Number of Aboriginal males and females turning 15 years of age reported to the National HPV Vaccination Program Register (NHVPR) that comply with the recommended vaccine dosage and administration as per the Australian Immunisation Handbook		
	Denominator: Number of Aboriginal males and females turning 15 years of age		

3. Increase STI testing coverage with a focus on areas of highest need	Proportion of Aboriginal people aged 15-24 year receiving a chlamydia and/or gonorrhoea test in the previous 12 months	Indicator to be developed	Indicator not yet developed. Current testing data does not include Aboriginality.
	Numerator: Number of Aboriginal people aged 15–24 years tested for chlamydia and/or gonorrhoea at least once in the previous 12 months		
	Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population, Aboriginal, 15–24 year age group		
4. Increase the use of sterile injecting equipment for every injecting episode	Prevalence of receptive syringe sharing by WA participants in the Australian Needle and Syringe Program Survey (ANSPS), by Aboriginal status	Australian Needle and Syringe Program Survey (ANSPS), The Kirby Institute	In 2018, 30% of all respondents reported receptive syringe sharing, compared to 23% average in 2013-2017
5. Reduce the incidence and prevalence of infectious syphilis with a particular focus on areas of highest disease burden	Annual rate of infectious syphilis notifications among Aboriginal people	WA Notifiable Infectious Diseases Database (WANIDD) and Rates Calculator	86.2 notifications per 100,000 population in 2018 is a 136% increase from 36.5% average in 2013-2017.
	Numerator: Number of infectious syphilis notifications among Aboriginal people		
	Denominator: ABS Estimated Resident Population, Aboriginal, all ages		
6. Sustain no notifications of congenital syphilis	Number of congenital syphilis notifications among Aboriginal people	WANIDD	0 notifications of congenital syphilis in 2018.
7. Reduce the incidence and prevalence of gonorrhoea and chlamydia with a focus on young people	Annual rate of gonorrhoea and chlamydia notifications among Aboriginal people aged 15-24 years	WANIDD and Rates Calculator	5,214 chlamydia notifications of per 100,000 population in 2018 is a 7% decrease from 5,582 in 2013-2017.
	Numerator: Number of gonorrhoea and chlamydia notifications among Aboriginal people aged 15-24 years		2,696 gonorrhoea notifications per 100,000 population is a 15% decrease from 3,168 average in 2013-2017.
	Denominator: ABS Estimated Resident Population, Aboriginal, 15–24 year age group		

8. Reduce the number of newly acquired HCV infections by 60 per cent	Annual rate of newly acquired hepatitis C (HCV) notifications among Aboriginal people	WANIDD and Rates Calculator	56.7 notifications per 100,000 population in 2018 is a 6% decrease from 60.6 average in 2013-2017.
	Numerator: Number of newly acquired HCV notifications among Aboriginal people		
	Denominator: ABS Estimated Resident Population, Aboriginal, all ages		
9. Sustain the low incidence of HIV	Rate of HIV notifications among Aboriginal people	WA HIV Database and Rates Calculator	1.7 notifications per 100,000 population in 2018, which is a 56% decrease from 3.9 average in 2013-2017.
	Numerator: Number of annual HIV notifications among Aboriginal people		
	Denominator: ABS Estimated Resident Population, Aboriginal, all ages		
10. Achieve the 95–95–95 HIV diagnosis and treatment targets: Increase to 95 per cent the proportion of people with HIV who are diagnosed Increase to 95 per cent the percentage of people diagnosed with HIV on treatment Increase to 95 per cent the percentage of those on treatment with an undetectable viral load	1. Estimated proportion of Aboriginal people living with HIV who have been diagnosed	Indicator to be developed	Indicator not yet developed
	2. Estimated proportion of Aboriginal people living with HIV dispensed treatment for HIV infection Numerator: Number of Aboriginal people dispensed treatment for HIV infection Denominator: Estimated number of Aboriginal people diagnosed with HIV living in WA	Indicator to be developed	Indicator not yet developed
	3. Proportion of Aboriginal HIV patients on treatment with an undetectable viral load Numerator: Number of Aboriginal people diagnosed with HIV on treatment with an undetectable viral load Denominator: Number of Aboriginal people diagnosed with HIV on treatment	HIV Specialist Clinics in WA	Data not yet available
11. Increase the proportion of people living with HCV who are diagnosed to 90 per cent and the cumulative proportion who have initiated direct acting antiviral treatment to 65 per cent	1. Estimated annual proportion of Aboriginal people living with chronic HCV who have been diagnosed	Indicator to be developed	Indicator not yet developed
	2. Annual rate of unspecified HCV notifications among Aboriginal people Numerator: Number of unspecified HCV notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages	WANIDD and Rates Calculator	211.2 notifications of unspecified hep C per 100,000 population in 2018 is a 6% increase from 199.0 average in 2013-2017.

	3. Proportion of Aboriginal people living with HCV dispensed DAA treatment for HCV infection Numerator: Number of Aboriginal people dispensed DAA treatment for chronic HCV infection Denominator: Modelled estimate of the number of Aboriginal people living with chronic HCV	Indicator to be developed	Indicator not yet developed
12. Increase the proportion of people living with HBV who are diagnosed to 80 per cent; receiving care to 50 per cent; and on antiviral treatment to 20 per cent	1. Estimated annual proportion of Aboriginal people living with chronic HBV who have been diagnosed	Indicator to be developed	Indicator not yet developed
	2. Annual rate of unspecified HBV notifications among Aboriginal people Numerator: Number of unspecified HBV notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages	WANIDD and Rates Calculator	27.9 notifications per 100,000 population in 2018 is a 29% decrease from 39.3 average in 2013-2017.
	3. Proportion of Aboriginal people living with chronic HBV who received monitoring for chronic HBV Numerator: Number of Aboriginal people who received monitoring for chronic HBV Denominator: Modelled estimate of the number of Aboriginal people living with chronic HBV	Indicator to be developed	Indicator not yet developed
	4. Proportion of Aboriginal people with living chronic HBV dispensed drugs for HBV infection Numerator: Number of Aboriginal people dispensed drugs for chronic HBV infection Denominator: Modelled estimate of the number of Aboriginal people living with chronic HBV	Indicator to be developed	Indicator not yet developed. Current data does not include Aboriginality.
	5. Annual rate of unspecified HBV notifications among Aboriginal people Numerator: Number of unspecified HBV notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages	WANIDD and Rates Calculator	Unspecified hep B notification rate among Aboriginal people of 27.9 per 100,000 population in 2018 compared to 39.3 average in 2013-2017

	6. Proportion of Aboriginal people living with HBV dispensed treatment Numerator: Number of Aboriginal people dispensed treatment for chronic HBV infection Denominator: Modelled estimate of the number of Aboriginal people living with chronic HBV	Indicator to be developed	Indicator yet to be developed
13. Reduce HCV attributable mortality overall by 65 per cent	Estimated number of deaths among Aboriginal people attributable to chronic HCV	Data linkage study	Data not available at time of report
14. Reduce HBV attributable mortality overall by 30 per cent	Estimated number of deaths among Aboriginal people attributable to chronic HBV	Data linkage study	Data not available at time of report
15. Reduce the reported experience of stigma among Aboriginal people with BBV and STI, and the expression of stigma, in relation to BBV and STI status	Indicator to be developed	Indicator to be developed	Indicator yet to be developed.
16. Improve knowledge and behaviour regarding safer sex and prevention of blood-borne viruses	Increased knowledge of STIs and BBVs Improved harm minimisation behaviours to prevent STIs and/or BBVs	Secondary schools survey, La Trobe University	Average percentage of correct responses across all questions for: HIV – 80.5% STIs – 51.8% STI symptoms – 73.7% Viral hepatitis – 36.9% HPV – 43.0% (NB: This data is not Aboriginal specific) No previous WA data for comparison.
17. Maintain low numbers of newly acquired HBV infections across all age groups by 50 per cent	Annual rate of newly acquired HBV notifications among Aboriginal people Numerator: Number of newly acquired HBV notifications among Aboriginal people Denominator: ABS Estimated Resident Population, Aboriginal, all ages	WANIDD and Rates Calculator	2.7 notifications of newly acquired HBV per 100,000 population is a 59% increase from 1.7 average in 2013-2017.

Government of **Western Australia**
Department of **Health**

WA Sexual health and blood-borne virus strategies 2019–2023

Aboriginal sexual health and BBV strategy

2019–2023 baseline report

STIs

- Sexually transmissable infections (STIs) among Aboriginal people in Western Australian showed some progress. However, this was tempered by persistent challenges. The notification rate for gonorrhoea and chlamydia was lower than the 2013–2017 baseline, but infectious syphilis significantly increased.

BBVs

Notification rates among Aboriginal people.

- Among blood-borne viruses, there was a decrease in unspecified hepatitis B and newly acquired hepatitis B increased, though the overall numbers were low.

Prevention through immunisation

- The target for childhood vaccination rates for 2023 is 95%.

Notification rates among Aboriginal people per 100,000 population	2013 to 2017 Average	2018	Mid-term review**	
Chlamydia *(15–24 years)*	**5,582**	**5,214**		↓ **7%**
Gonorrhoea *(15–24 years)*	**3,168**	**2,696**		↓ **15%**
Infectious syphilis	**36.5**	**86.2**		↑ **136%**
Number of congenital syphilis notifications	**0.2**	**0**		**Stable**
Newly acquired hepatitis B	**1.7**	**2.7**		↑ **59%**
Unspecified hepatitis B	**39.3**	**27.9**		↓ **29%**
Newly acquired hepatitis C	**60.6**	**56.7**		↓ **6%**
Unspecified hepatitis C	**199.0**	**211.2**		↑ **6%**
Coverage of hepatitis B vaccination at 12 months among Aboriginal people	**84.7%** 	**88.7%** 		↑ **5%**
Coverage of hepatitis B vaccination at 24 months among Aboriginal people	**85.8%** 	**81.6%** 		↓ **5%**

** Data to be collected around 2021

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