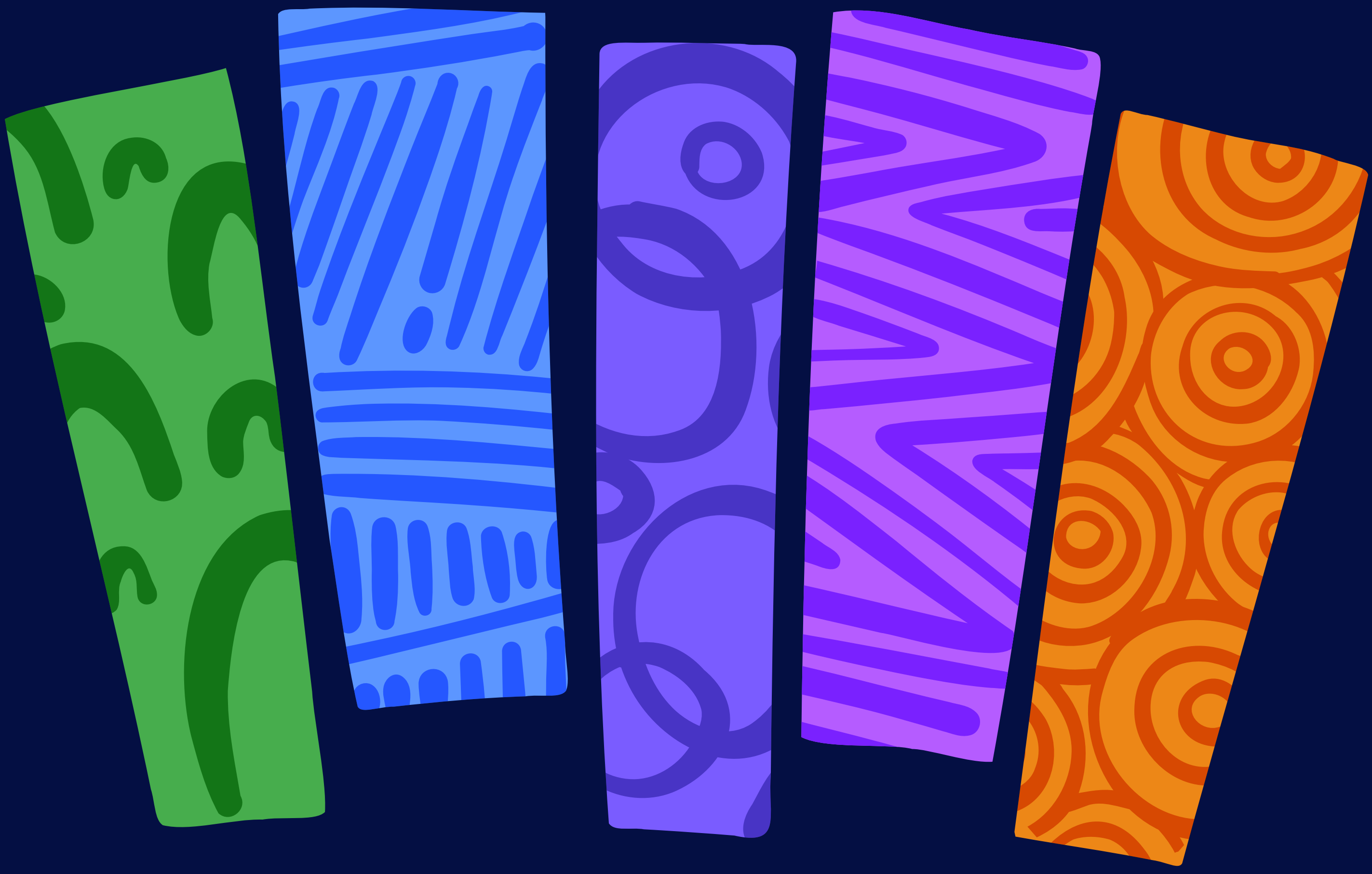
Government of **Western Australia**
Department of **Health**

Western Australian Sexual Health and Blood-borne Virus Action Plan 2024–2030



Acknowledgement of Country

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

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Visualising our Action Areas

Enabling Environment

Symbols of people representing the population's access to services across the state. Ensuring we create a safe environment and support wellbeing.

Prevention and Education

Symbolising strength, building knowledge, and educating communities across WA.

Integrated Care

Overlapping circles represent collaboration and the idea of intersections and integrated services.

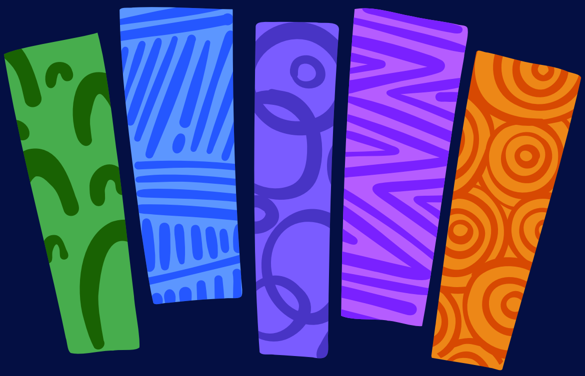
Workforce Development

Learning and building on previous knowledge, in a move towards better ways of working with a person-centred approach, underscoring the pivotal role of our workforce in our strategy.

Data, Evaluation and Research

Yarning circles symbolise knowledge. The circles overlap and feed into each other, sharing research and understanding.

The **yarning circle** combines all five Action Areas to represent the Action Plan as a whole. The river design extends and directs the journey of implementing the Action Plan.



PART 1

Background and overview

A

Building on a successful response

The Sexual Health and Blood-borne Virus Strategy 2024-2030 (the Strategy) and this Action Plan build on significant achievements and learnings that have been planned and delivered through collaborative, committed, and effective partnerships across Western Australia (WA). Some major achievements include:

Significant ongoing investment in statewide multimedia sexual health and blood-borne virus **campaigns**.

Ongoing investment into **national and local research** to track trends over time.

Sustained planning and coordination of the **public health response to prevent and control STIs and BBVs** through WA strategies.

Establishment of regional sexual health teams.

Sustained review and **maintenance of clinical guidelines** and resources for clinicians.

Sustained and expanded **investment into doctor, Aboriginal health worker, and nurse training** in SH and BBV.

Low STI rates amongst sex workers.

Preservation of **free access to antiretrovirals** without a co-payment.

Over 20 years of **investment into schools-based relationships** and **sexuality education resources** with associated teacher training.

Sustained key stakeholder engagement through advisory committees and working groups for developing clinical guidelines, policy, programs and resources.

Epidemiology and surveillance data regularly provided at sector meetings and forums to update stakeholders and to monitor effectiveness of programs.

Other recent achievements include:

2016

First jurisdiction in Australia to release a government policy on PrEP for HIV.

Between March 2016 and October 2023, **hepatitis C treatment was received by 9,762 individuals in WA.**

2018

Activation of the WA Syphilis Outbreak Response (WA SORG) – a partnership approach to address the syphilis outbreak.

2019

Ensuring that scientific evidence related to U=U is **recognised in regulations under the Public Health Act 2016.**

2020

Establishment of point-of-care testing.

2021

Development of a **WA Department of Health BBV stigma and discrimination training module** for health workers.

2022

Prevention of an Mpox outbreak in WA.

At the end of 2022, an estimated **98 per cent of people** in WA diagnosed with HIV and on treatment had an **undetectable viral load.**

2023

Statewide needle and syringe program: by 2023 there were
20 primary outlets (needle and syringe exchange sites),
109 secondary outlets (services that provide needle and syringe programs),
576 pharmacies that sell needles and syringes, and
7 needle and syringe dispensing machines.

2024

As of March 2024, there were **29 HIV and 57 hepatitis B s100 prescribers** in primary care settings.

B

Overview of the Action Plan

Taking on board the achievements and learnings to date, the Strategy sets out a refreshed vision, supported by new targets and ways of working with priority populations and in priority settings. This Action Plan provides the further details on what is needed to achieve the goals and targets, through a practical roadmap for the sexual health (SH) and blood-borne virus (BBV), and sexually transmissible infection (STI) sector (the sector).

Information provided in this Action Plan has been developed using findings from codesign workshops that were facilitated in regional and metropolitan areas across WA. The localised workforce that attended, and who brought their extensive experience in the provision of SH, BBV and STI (BVSTI) services, were invaluable in informing this Action Plan. Guidance from the codesign process has been further developed alongside best practice literature, policy, and evidence to support the workshop findings. Through this process, an Action Plan that is practical and relevant for WA communities has been created and is organised into the following three key parts:

Part 1: Overview

This part provides an overview about the Action Plan, how to use it, and the context for priority areas which group priority actions and their associated activities.

Part 2: Planning Framework 1

Planning Framework 1 provides a holistic and overarching approach for the SH and BVSTI sector, with priority actions and activities structured at a broad level, so that they provide a basis for developing tailored programs at the relevant organisation/agency level.

Key considerations and ideas for implementation are included, so in this format a range of organisations/agencies can develop their own programs and initiatives by using the framework as a planning guide. The framework has been developed in this way, appreciating that actions will vary depending on the organisation, group, or agency delivering health or social services which engage with priority populations or priority settings.

Part 3: Planning Framework 2

Planning Framework 2 is committed to improving SH and BVSTI outcomes for Aboriginal people. During the codesign process, the Aboriginal Health Council of WA (AHCWA) recommended the provision of nuanced information to support the design, delivery, monitoring, and evaluation of health initiatives for Aboriginal people.

Planning Framework 2 is a complimentary to Planning Framework 1 and the Strategy, which embodies the key principle that the health and wellbeing of Aboriginal people is everybody's business. Services and organisations are encouraged to utilise this Action Plan in its entirety, drawing from all the information provided across Planning Frameworks 1 and 2, especially in terms of the priority actions and activities.

C Implementing the Action Plan

As outlined in the Strategy, the Western Australian (WA) Blood-borne Virus and Sexually Transmissible Infections Advisory Committee (WA BVSTIAC) will provide a forum for multi-agency advice regarding the prevention and control of BVSTIs, along with oversight for the implementation of the Strategy and Action Plan as they relate to progress towards targets.

Priority actions and activities in this Action Plan will also inform the development of future projects and funding initiatives led by the Sexual Health and Blood-borne Virus Program, within the Communicable Disease Control Directorate, WA Department of Health.

The WA Department of Health recognises that the sector includes a diverse range of stakeholders, from government agencies to community organisations, primary health providers, and peer-led networks. In this context, each stakeholder will need to consider the ways in which the Strategy and Action Plan can enhance their planning and delivery of SH and BVSTI initiatives.

Some key planning and delivery considerations for stakeholders in using both the Strategy and Action Plan include:

REFLECT on which areas of the Strategy and Action Plan are relevant to the current work, mission, or strategic priorities of your agency/organisation, identifying where there are any synergies/gaps.

REFLECT on how successes and challenges experienced by your agency/organisation can inform the future implementation of the strategy and priority actions and activities. Consider how these insights can be effectively shared, such as through the WA BVSTIAC.

REVIEW how your agency/organisation's planning cycle aligns with the Strategy and Action Plan, with deliberation on how priority actions and activities might be implemented within current/future planning cycle/s.

ASSESS which priority actions and activities your agency/organisation is already contributing to, delivering, or planning to deliver.

PRIORITISE actions and activities your agency/organisation can contribute to and/or effectively lead in, within current resourcing.

ASSESS which priority actions your agency/organisation could contribute to through new partnerships or collaborations, then identify relevant stakeholders for possible joint initiatives, funding, or resource sharing opportunities.

CONSIDER how your agency/organisation measures current program/initiative progress towards strategy targets, with the lens on assessing what future indicators/metrics/processes/systems might be needed to enhance existing monitoring and evaluation.

ASSESS how your agency/organisation currently is, or is planning to, respond to changing community needs and/or the evolving BVSTI epidemics.

D Action areas

Priority actions and activities within this Action Plan are organised across five action areas outlined below, with a corresponding contextual summary which sets the scene for the listed activities in the two planning frameworks.

Action Area 1: Enabling Environment (EE)

Health and social services for SH and BVSTI care in WA must be accessible to everyone. Outlined in the Strategy are WA's 12 ways of working, which are fundamental to ensuring an enabling environment is fostered and sustained. Intersectional approaches, the meaningful involvement of priority populations, human rights, multisectoral partnerships, Aboriginal empowerment, and shared responsibility are ways of working which safeguard an enabling environment, and which support the health and wellbeing of all Western Australians.

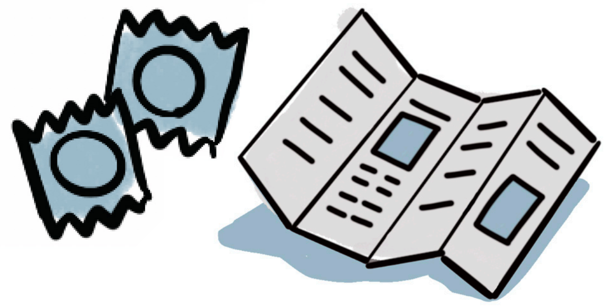
The importance of adopting intersectional approaches to shift the ways in which we work will be critical to ameliorate experiences of stigma and discrimination, especially when seeking support. A survey of populations and their experiences of negative treatment from healthcare workers suggests there is still significant work required in this space, with 35 per cent of sex workers and 20 per cent of people who inject drugs reporting negative treatment often/always.[1] A study of LGBTIQ Australians also reported that only 43.4 per cent felt accepted accessing health or support services, and 85.1 per cent of respondents reported that it was important that the health service/s they use were LGBTIQ inclusive.[2]

For Aboriginal people, services and programs which provide safe, welcoming, and culturally appropriate spaces and settings that are both discreet and non-judgemental are essential for client engagement.[3,4] Staff working across the sector should undertake appropriate training to ensure they provide interactions with clients that are free from experiences of stigma, discrimination, and racism,[5] with an ongoing commitment by stakeholders to address these issues through consistent efforts which are framed positively and delivered in engaging ways.

Deliberate and authentic community engagement are the foundation for fostering enabling environments. For Aboriginal people, shared decision-making means ensuring that there is Aboriginal representation in all components of services and programs, from planning through to evaluation, and that partnerships with Aboriginal services are equal, ongoing, and sustainable. Embedding this shared accountability to improve SH and BVSTI outcomes will ensure that the needs of communities are met, and that driving change is the focus over attributing blame.[6]

Advocating for, and driving systemic improvements to create enabling environments, will also require the monitoring of legal, institutional, and regulatory systems. Especially those that have the potential to impact the achievement of priority actions and targets in the Strategy, or which affect priority populations and settings.

Action Area 2: Prevention and Education (PE)



Prevention and education strategies are fundamental to reduce the transmission of BVSTIs. Strength-based education requires more than raising awareness and knowledge. It relies on developing attitudes, values, and skills that allow people to make informed decisions about their health, to achieve positive behavioural change and reduce risk behaviours. Codesign workshops across the state highlighted the need for initiatives to be tailored to unique regions and communities across WA, with the meaningful involvement of priority populations in the planning, delivery, and evaluation of prevention and education initiatives.

Feedback during the codesign process, supported by evidence, highlighted that effective prevention and education initiatives in Aboriginal communities utilise strengths-based approaches and cultural education methods, such as intergenerational teaching, two-way learning, and the power of storytelling.[7,8,9] These approaches are enriched when delivered in relevant place-based settings and on Country. Consideration should be given to modes of delivery, such as whole of community health promotion, with a focus on using healing, resilience, and strength of community and culture. Across communities, strong kinship and family connection creates strong relationships that can be essential for culturally safe education and support.[10] Such support might vary from advice, through to provision of condoms and injecting equipment to help keep community safe.[11] Similarly, pride and strength in community and identity can empower Aboriginal people to advocate for appropriate healthcare, and negotiate risk reduction strategies at a personal level.[12]

Improvements to the state school health curriculum, through mandating relationships and sexuality education (RSE), means quality training to equip teachers with the confidence and skills is more important than ever.[13] Although parents and schools play a key role, opportunistic education through GPs, community leaders, counsellors, and peer educators, help to fill in the gaps to ensure a comprehensive approach is achieved. Topics like consent, communication, and respectful relationships are generally wanted by young people, and when included, rather than just disease specific education, can improve overall engagement. Holistic approaches to SH and BBV education should also consider that building safe spaces and cultures for these conversations may also unintentionally impact participants with experiences of sexual abuse. Programs and initiatives should therefore build in appropriate strategies to support victims and survivors.[14]

Condoms still offer the most effective method of prevention against STIs. Whilst some evidence shows positive attitudes towards condom use amongst young people, only 34.3 per cent of young people reported always using a condom, and less than half reported using a condom at most recent sexual activity.[8] Amongst gay and bisexual men who have sex with men (GBMSM), consistent condom use with casual partners has been declining over the past five years, which may be related to increased access to pre-exposure prophylaxis (PrEP) for HIV. Amongst sex workers in WA, self-reported inconsistent condoms use was high with demand for condomless sex from clients often driving this.[15] While the continued provision of free and low-cost condom access remains a key prevention activity, health promotion initiatives need to emphasise the importance of regular BVSTI testing to facilitate early treatment, particularly for those having condomless sex with casual partners.

The progress of biomedical prevention methods has played a central role to the prevention of some BVSTIs. The hepatitis B virus (HBV) and human papilloma virus (HPV) have vaccinations which are delivered as part of the childhood and adolescent program, consequently reducing rates of infection and disease, though education on their importance remains essential for ongoing uptake. PrEP for HIV, postexposure prophylaxis (PEP) and antiretroviral treatment (ART) have been a game-changer for HIV prevention, particularly in recent times with advancements in long-acting injectable ART. Education initiatives should encompass contemporary science related to undetectable viral loads for HIV as a prevention method, and as part of a holistic approach to improving SH, reducing stigma, and creating a new base line understanding of HIV as a manageable condition.

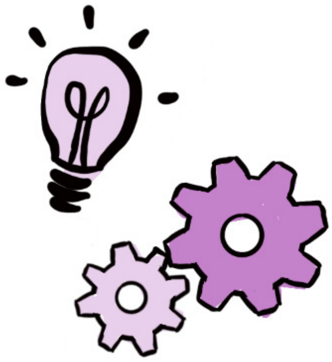
Action Area 3: Integrated Care (IC)

Strengthening care for SH and BVSTIs will require integrated and person-centred approaches, based on effective coordination across different services for the testing, treatment, management, and support of patients, along with their partners/families. Improved collaboration between specialist services, primary care, Aboriginal Community Controlled Health Services (ACCHS), allied health, and community services to develop the capacity across the sector to deliver a seamless, connected health journey, which meets the individual needs of each person, will create a future where there is 'no wrong door'.

For Aboriginal communities across WA, an understanding of culture must be at the heart of service provision. This means recognising for many Aboriginal people that their ability to engage in their own health care may be related to the involvement of, or impact on their family. Relatedly, the preference to be cared for in or close to their community and on Country.[6] An understanding of health across the life course, and intersectional factors impacting health, is important in person-centred care as it provides a lens for providers to better understand how to improve continuity in care for both individuals and communities across the state.

The accessibility of services, and whether they are accessed, can be dependent on a range of factors. This is particularly the case in regional and remote areas of WA, where there may be limited clinical capacity, or patient/client concerns around confidentiality due to smaller community settings. Easing some of these concerns can be aided through the provision of choices such as: condoms and sterile injecting equipment which allow for easy and discreet access; providing patients options which consider their privacy and allow them to indicate they want BVSTI testing; normalising BVSTI conversations and including testing as part of routine health checks; providing self and point-of-care testing technologies to encourage testing among priority populations; workforce diversity to allow for cultural or gendered healthcare provision.[16,17,18] Overall, good intergrated care services tend to be reliant on establishing rapport and investing time into building relationships and trust within communities for improved contact tracing, treatment adherence, and regular testing.[5]

Action Area 4: Workforce Development (WD)



A strong multidisciplinary workforce of motivated and informed health, education, and peer-based workers is vital to allow for the provision of best-practice person-centred care across WA.

Challenges in workforce development opportunities exist across the state due to vast distances between locations with travel often required. To ensure equitable access and opportunities for all areas of WA, innovative training opportunities, that are evidence-based and utilise the latest technologies in digital health are needed. Responsive and accessible clinical guidelines, supported by web-based resources, mobile applications, and hybrid approaches for training delivery, can strengthen workforce education and learning, further enhanced where practical with face-to-face opportunities.

Building a strong Aboriginal health workforce is critical to achieving a sustainable and culturally responsive SH and BVSTI sector. Aboriginal health staff provide cultural perspectives that benefit the communities they care for by enhancing the health services they represent. This advantage needs to be balanced with the understanding that the Aboriginal health workforce can also be burdened with taking on additional cultural load, through providing a cultural lens and guidance outside of their job description.[19,20] Non-Aboriginal health workers that understand and respect how cultural identity can shape Aboriginal people's SH and BVSTI health experiences remain paramount to improving health outcomes consistently across all services.

Issues in relation to the recruitment and retention of health workers needs to be addressed particularly in regional and remote areas, to ensure the required expertise, capability, and capacity exists in all areas. Innovative models adapted to local contexts warrants further exploration to address such challenges, which may include nurse-led, task sharing or incentivised initiatives.[21] Epidemiological trends and emerging issues should also guide where support and investment is needed.

Action Area 5: Data, evaluation, and research (DR)

Evidence-based policy and decision-making should be the starting point for all action areas to drive progress towards the achievement of the goals and targets in the Strategy.[22,23,24] Comprehensive, timely data, and rigorous, relevant research provide a factual and objective basis for decision-making and monitoring progress; identifying priority areas and gaps in knowledge or understanding; allowing for resource allocation where it is most needed.
The epidemiology of BVSTIs in WA is changing, underscoring the importance of enhanced behavioural and demographic data, triangulated with qualitative research where appropriate, to understand trends. Some challenges remain in undertaking research and enhanced surveillance without placing unnecessary burdens on frontline services or compromising patient privacy and confidentiality. Community organisations working with priority populations and ACCHS are often requested to participate in research and to provide data. While research and data are required to drive service and program planning, better outcomes can be achieved when these organisations are engaged in the codesign of research projects early on.

Early engagement, consultation, and codesign works towards empowering communities and creating community ownership in responses. For Aboriginal people, the recognition of principles related to data sovereignty is critical for meaningful engagement, and the reporting of data should take a strength-based approach that protects and respects Aboriginal people and communities by reporting information that is relevant, contextual, and disaggregated, with opportunities for truth telling facilitated through ongoing collaboration. Where there are opportunities to improve the granularity of data to better identify trends, awareness of these above approaches should drive action, with consideration given to how digital and data innovations can strike the right balance.

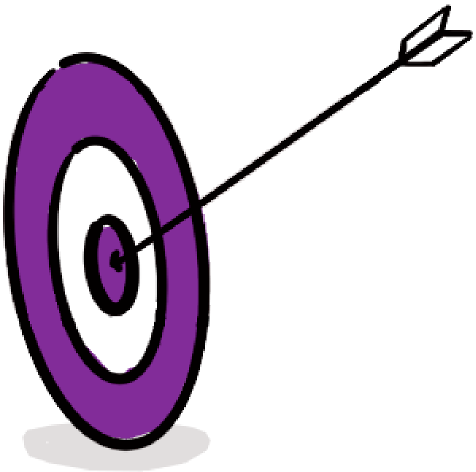
Efficiencies in notification systems, from completeness of data through to expediency in reporting, can be valuable during a change in epidemiological trends or during an outbreak. Integrated digital patient management systems which protect privacy but also assist in modelling gaps in the care cascade, can strengthen ways in which person-centred care is delivered. Similarly, increasing options in which patients can engage in their own care and provide feedback enable patient agency and engagement with their provider, along with strengthening overall service delivery.

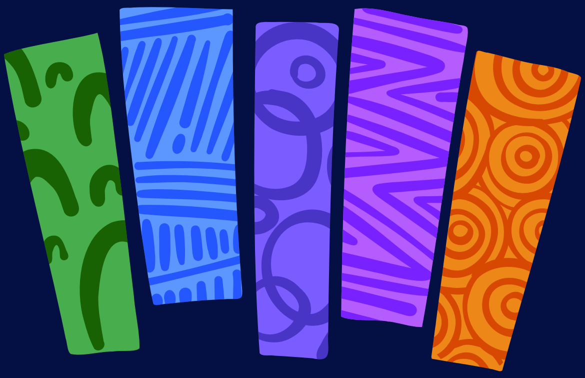
Data and research activities should be grounded in strong governance, security, and privacy protocols, along with ethical, human rights and data sovereignty principles. Ongoing and meaningful collaboration with priority populations, community and peer-based organisations, community leaders and advocates, research institutes, policy makers and health providers will ensure that the implementation of this strategy and plan is supported by a strong, contemporary evidence base.

Across the five Action Areas, activities within the two planning frameworks are generally listed once or in one action area. It is important to note that whilst an activity might be listed in one area, many of the activities are interlinked and relevant across one or more areas. Therefore, all five priority areas should be considered alongside the Strategy for a comprehensive and holistic approach towards progress in achieving the targets. Table 1 below provides an example of how priority actions listed in Planning Framework 1 relate to the targets in the Strategy.

Table 1: Alignment of Strategy Targets with Priority Actions

Strategy targets	Priority actions for progress towards targets
Childhood Vaccination; Prevention of mother-to-child transmission; Prevention; Harm Reduction	EE1; EE2; EE4; EE5; PE1; PE2; PE3; PE4; WD1; WD2; WD3; WD4; WD5; DR1; DR2; DR3; DR4; DR5
Testing; Incidence Reduction	EE1; EE2; EE4; EE5; PE1; PE2; PE3; PE4; IC1; IC2; IC3; IC4; WD1; WD2; WD3; WD4; WD5; DR1; DR2; DR3; DR4; DR5
Proportion Diagnosed; Proportion in Care; Proportion Receiving Treatment; Proportion Cured; Attributable Mortality	EE1; EE3; EE4; EE5; IC1; IC2; IC3; IC4; IC5; IC6; WD1; WD2; WD3; WD4; WD5; DR1; DR2; DR3; DR4; DR5
Stigma Reduction; Quality of Life; Legal and Human Rights	EE1; EE3; EE4; EE5; PE1; PE2; PE3; WD1; WD2; WD3; WD4; WD5; DR1; DR2; DR3; DR4; DR5





PART 2

Planning framework 1:

A holistic and overarching approach for improving sexual health and blood-borne virus outcomes.

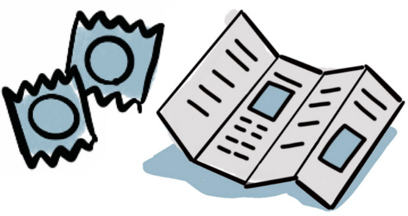
Action Area 1: Enabling Environment (EE)

Priority action	Priority activities	Monitoring progress
EE1 **Approaches to intersectionality**	**1.1** Embed ongoing programs and initiatives that **educate on and address intersectionality, especially for the health workforce** by: • learning and assessing how intersectionality may shape internal operations and service delivery within an agency/organisation/group • provide education and training on intersectionality to foster awareness and an understanding on how intersectionality shapes interactions with clients and services • facilitate an environment that embraces equity, diversity, and inclusion through implementing policies, processes, and programs that use an intersectional understanding, from workforce recruitment through to service delivery and public communications • develop a culture of leadership and commitment to addressing intersectionality by ensuring that leaders at all levels advocate for equity, diversity, and inclusion • create opportunities for feedback from staff and clients/ patients to better understand challenges and to identify opportunities for improvement. **1.2** Monitor and **review legislation and regulatory or system policies/frameworks** that: • create barriers to accessing health or social support and/or • perpetuate stigma and discrimination.	• Actions by agencies/ organisations/groups on activities to educate or address intersectionality • Training events in WA on intersectionality • Reported policies, processes, and programs to address intersectionality • Client/patient feedback • SH and BBV representation on reference groups, advisory groups and in codesign processes • Reported changes to legislation/policies/ systems • Audit and review of application of accessibility standards • Stigma indicator reports
	1.3 Monitor stigma and discrimination **in the community** that impacts on health-seeking behaviour of priority populations and their access to testing and treatment services.	
	1.4 Ensure programs and initiatives cater for and meet **minimum standards for accessibility**.[25]	

Priority action	Priority activities	Monitoring progress
EE2 **Meaningful involvement**	**2.1** Work in **partnership with priority populations** to promote prevention, improve treatment linkage and care coordination, and improve our intersectional approach by: • identifying gaps in priority population engagement with care • partnering with new community organisations linked to priority populations • engaging with priority populations to identify issues related to stigma and discrimination, co-designing strategies to address these issues.	• Audit of collaborations and potential new collaborations • Consumer feedback • Priority population engagement in codesign process • Stigma and discrimination indicators • Consumer feedback • Community engagement in codesign processes • Statements and implementation of GIPA/MIPA
	2.2 Educate and understand the practical implementation of the **greater involvement of people living with HIV (GIPA)/meaningful involvement of people living with HIV (MIPA)** principles, extending these to all priority populations, ensuring these are included across the provision of prevention, education, support, and advocacy.	
	2.3 Embed **community engagement** in the planning, implementation and evaluation of programs and services. This may include: • identifying relevant community stakeholders • engaging with community, leaders, and local services at all stages of program and service delivery.	
EE3 **Human rights/ sexual rights**	**3.1** Provide patients and consumers with information about their **rights and responsibilities** to SH and BBV.	• Analytics of resources accessed and disseminated • Consumer feedback
EE4 **Partnerships**	**4.1** Foster **collaborations** between different agencies, organisations and groups by: • monitoring and supporting projects across sectors to improve efficiencies and to address gaps • broadening reach of resources and training to out-of-sector stakeholders • connecting with alcohol and other drug (AOD), homelessness, housing, disability, and mental health services • promoting the use of up-to-date evidence (epidemiological/research/scientific/programmatic best practice) to other sectors.	• Representation from SH and BVSTI sector in reference groups, advisory groups and consultations • Reported/acknowledged collaborations
	4.2 Strengthen partnerships between **specialist SH and BBV** services with **other primary care services** to embed SH and BBV services in person-centred care.	
	4.3 Contribute to **reference and advisory groups** on broader public policies that impact the SH and BBV health of priority populations (e.g. sexual assault prevention, reproductive health, immigration).	

Priority action	Priority activities	Monitoring progress
EE5 **Cultural responsiveness**	**5.1** Establish **culturally competent** workforces and services through adhering to best practice standards[26,27,28] and: • ensuring there is an organisational approach and commitment to cultural awareness and safety • ensuring there is appropriate workforce development and training on respecting and understanding Aboriginal culture and people • ensuring governance structures, policies and practices enshrine principles of quality care and cultural safety • establishing mechanisms to recognise, address, and prevent racism at the individual and organisational levels • providing open opportunities to clients/patients to provide feedback and report on experiences.	• Consumer feedback • Staff reported incidents • Audit number of community-controlled services engaged in BVSTI initiatives
	5.2 Enhance collaboration with **Aboriginal Community Controlled Health Services.** This may include: • exploring opportunities to transition services or share funding with relevant community controlled organisations.[29]	

Action area 2: Prevention and education (PE)



Priority action	Priority activities	Monitoring progress
PE1 **Health Promotion**	**1.1 Deliver** codesigned statewide BVSTI prevention **campaigns** which: • are culturally safe, responsive and evidence-based, addressing/raising awareness on epidemiological BVSTI trends • provide information on behavioural and biomedical prevention options • link to other state and national campaigns • have a whole-of-population and priority population prevention focus at different transition points over the life course • are in contemporary and engaging formats • focus on educating in positive ways to reduce stigma and discrimination.	• Campaign/social media metrics • Evaluation (process or impact) • Consumer feedback • Information from key agencies/organisations delivering initiatives/services • Changes in testing, notification, treatment uptake, reduced time to treatment and contact tracing. • Audit of health promotion materials • Website analytics • Number of outreach events delivered and attended
	1.2 Update and codesign strength-based, locally relevant **resources** across a range of media formats for all priority populations including: • plain language resources • translated resources • online and hardcopy resources • website strategy considerations for access options[30] and promotion • utilise social media and other communication channels based on engagement metrics and trends in technology.	
PE2 **Education**	**2.1** Increase the capacity of **schools** to deliver **comprehensive relationships and sexuality education** (RSE) in a safe, non-judgmental, and supportive environment by using a whole school approach including: • Developing undergraduate and in-service teacher training minimum standards • evidence informed resources for schools in line with WA curriculum and *International Technical Guidance for Sexuality Education* • strategies to reach youth disengaged from the school system • consideration of a range of school settings - Education Support Centres, alternate education settings, juvenile justice settings • development of minimum SH and BBV health literacy for school leavers.	• Information from key agencies/organisations delivering initiatives/services • Audit of programs, priority populations, gaps • Evaluations of programs delivered (e.g. improvement in knowledge, skills, attitude) • Consumer feedback

Priority action	Priority activities	Monitoring progress
	2.2 Deliver culturally appropriate **community education programs** in formal and non-formal settings for people of all ages to encourage positive health behaviours. This may include: • programs in priority settings (as per the Strategy) • programs in community settings (e.g. entertainment venues, sports programs, festivals, health expos, online events, and social media) • opportunistic education when providing health hardware • the use of peers and local workers to support two-way learning • collaborations between other services, particularly with the ACCHS sector.	
	2.3 Implement sustainable **peer-led models** to address gaps in existing services and programs. This may include: • models of support and training • collaborations with other services and sectors • considering payment for services.	
PE3 **Health Hardware**	**3.1** Increase **access and acceptability of condoms** by providing free or affordable condoms and lubricant by: • targeting areas where access is limited • developing innovative distribution methods which expand existing programs • distributing to support campaigns and other health promotion initiatives • development of policies that enable access.	• Number of condom dispensers and locations • Number of condoms distributed • Priority population surveys • Priority population research • Information from key agencies/organisations delivering initiatives/ services • Kirby Institute *Needle Syringe Program Minimum Data Collection* • Number of new sites and mode of distributing • Distribution report -capture distribution per capita • *ACE App* or other media analytics
	3.2 Increase access to and distribution of **sterile injecting equipment** and **safe disposal options** among people who inject drugs. This may include: • a range of distribution methods (face-to-face, outreach, dispensing machines) • increasing the number and range of services and settings providing needle and syringe programs (NSP) • assessing metropolitan, regional, and remote areas for service need • programs to improve health literacy • advocacy for legislative policy that removes barriers for engagement with services • ensuring equitable access for all geographical areas • collaborations with service providers connected to priority populations and settings • stigma and discrimination reduction strategies.	
	3.3 Increase **promotion of NSPs**, safer injecting education, and safe disposal options including: • partnering with local government and services • using a range of media platforms to promote NSP locations • increasing community awareness of the public health benefits of NSP.	

Priority action	Priority activities	Monitoring progress
PE4 **Biomedical Prevention**	**4.1** Increase access and uptake of relevant **PrEP** and **PEP** among at-risk communities by: • identifying and implementing new options for access where possible (advocating for options in primary care and assessing options for provision in regional and remote areas) • identifying gaps in knowledge and awareness among healthcare workers/providers and tailoring education initiatives to address gaps • improving community education.	• Number of people accessing HIV PrEP through PBS • Number of people accessing PEP through PBS • Number of prescribers • Number HPV vaccinations • Data from vaccination surveillance and reporting system (*Australian Immunisation Record*) • *National Immunisation Strategy and the Western Australian Immunisation Strategy 2024-2028.* • WA participation in trials • Number of people with Medicare ineligibility
	4.2 Increase **vaccine** coverage for vaccine preventable infections (HPV, HBV, with consideration for availability of new vaccines in line with TGA approval and ATAGI guidance) by: • developing culturally appropriate, safe and responsive education for parents and children • improving regional and remote access to vaccinations. • ensuring diverse vaccine delivery methods across a range of sites.	
	4.3 Monitor trends and **support trials** of innovative biomedical prevention and treatment methods.	

Action Area 3: Integrated Care (IC)

Priority action	Priority activities	Monitoring progress
IC1 **Point-of-Care Testing** **(PoCT)**	**1.1** Expand **PoCT** testing in primary health care settings by: • exploring mobile and outreach testing options • continuing training diverse workforce (e.g. peers) • advocating for inclusion within Medicare Benefit Schedule (MBS) • monitoring emerging PoCT technology • supporting research into the PoCT cascade, including rapid treatment protocols and antimicrobial surveillance for resistance • prioritising services that serve higher risk populations • prioritising services that care for Aboriginal people (e.g. ACCHS).	• Number and distribution of PoCT services • Incidence of BVSTI via PoCT testing • Linkage and time to treatment
IC2 **Patient-led testing and incentives**	**2.1** Increase **innovative testing** options by: • continuing online testing options • reviewing novel online testing options (e.g. postal test kits, downloadable pathology) with consideration to improving testing options for people in regional and remote areas. • increasing home testing options.	• Number of tests ordered (by type) • Number of tests completed (test positivity) • Number and type of incentives • Number of tests and treatments resulting from incentives • Number of bulk-billed visits offered and utilised
	2.2 Develop **resources to empower patients** to initiate conversations with healthcare professionals.	
	2.3 Consider **incentives** (monetary and non-monetary) for higher risk population groups to test, treat, and provide contacts.	
	2.4 Increase the accessibility of low cost or **free** testing and treatment.	
IC3 **Opportunistic testing and treatment**	**3.1** Implement strategies to **normalise testing** and incorporate into **routine practice** by: • embedding testing into existing health checks (e.g. 715 adult health checks, men's and women's checks, cervical screening, contraception consults, antenatal checks, when managing other conditions such as urinary tract infections) • upskilling healthcare workers to promote regular testing • considering community-wide screening programs • increasing clinicians' incentives to test (e.g. MBS item numbers for undertaking annual testing) • promoting opt-out testing models of health care • provide re-treatment for recurrent infections, if required.	• Number of unique BVSTI notifying services • Guidelines for opt-out testing models • Number of prescribers • Number of tests, notifications, and treatments.
	3.2 Explore **partnerships** that increase services' ability to provide testing and treatment (e.g. emergency departments, custodial settings).	

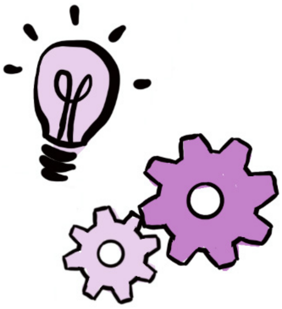
Priority action	Priority activities	Monitoring progress
IC4 **Preventing onwards transmission**	**4.1** Improve **contact tracing activities** and efforts by: • increasing service provider collaboration and coordination • improving systems for confidential client information sharing • implementing innovative and culturally appropriate methods to provide a private, confidential, and safe environment with appropriate staff (e.g. trained peers, Aboriginal Health Workers (AHWs) and Aboriginal Liaison Officers (ALOs) • providing training on collecting accurate information in a sensitive way • prioritising rapport and relationships with patients and communities.	• Number of people treated from contact tracing • Number of people lost to follow up • Number of PDPT administered • Number of people trained in contact tracing
	4.2 Strengthen **partner notification** approaches, particularly in GP settings through: • use of social media • utilising peers, AHWs and ALOs • implementation of guidelines for partner notification.	
	4.3 Explore opportunities to embed use of **patient delivered partner therapy** (PDPT) (e.g. chlamydia treatment).	
	4.4 Ensure that **patients and partners/contacts understand and can access:** • relevant biomedical prevention options (PEP, PrEP, U=U, viral load) • relevant behavioural prevention options (sexual risk reduction practices, safer injecting etc.) • appropriate testing • counselling and support.	

Priority action	Priority activities	Monitoring progress
IC5 **Models of care**	**5.1** Expand **nurse-led models** of care. This may include: • utilising Nurse Practitioners and Practice Nurses for testing and treatment assessment, both in specialist and primary/community settings • streamlining stable longer term BBV patients into nurse-led follow up processes • ensuring that ongoing training is provided, particularly for BBV testing and management.	• Number of nurse-led clinics • Audit of services operating hours • Time to linkage into specialist care • Number of healthcare workers trained • Number of organisations/ entities offering comprehensive SH and BBV services • Consumer feedback • Audits and evaluations of patient handover processes • Number of referrals to/ from specialist services • Number of patients with health profiles requiring management plans that have a management plan • Number of collaborations with new general health care services • Evidence of policies or governance processes which enshrine community/patient participation • Proportion of people who are successfully treated • Number of people retained in care • Number of people maintaining viral suppression due to outreach services • Number and location of mobile and home services • Consumer feedback • Evaluation of onsite testing initiatives • Antenatal syphilis testing guideline adherence • Monitoring antenatal testing targets in the strategy • Evaluation of partner initiatives • Number of partners tested and treated
	5.2 Integrate SH and BBV health into **person-centred care**[31] across the sector and in priority settings. This may include: • developing new and existing collaborations/partnerships • improving service linkages and patient referral processes (such as through the use of patient management plans, especially for patients with multi morbidities) • workforce training in person-centred care • support for generalist services from referring specialist services (to ensure patient management is in line with best practice clinical guidelines) • the use of visiting specialists to mentor staff in regional and remote areas to develop capacity • enhancing patient handover processes. • providing patient/community options for feedback.	
	5.3 Upskill and utilise **peer workers** in community organisations to improve testing, treatment, contact tracing and linkage care.	
	5.4 Increase **access to services** by: • offering out of hours options • increasing drop-in service provision • exploring community-based options for specialist review/consultation where possible • expanding – Highly Specialised Drug Program (section 100 [s100]) prescribers (and supporting existing s100 prescribers to maintain accreditation and case loads) • exploring options for outer metropolitan areas and regional hubs.	

Priority action	Priority activities	Monitoring progress
	5.5 Expand the **reach of services** by: • establishing new collaborations with primary and community health services to embed testing, treatment, and management into routine care • increasing outreach/mobile testing at community events (e.g. sporting clubs, education settings, TAFEs, festivals) • delivering regular education and training for community and primary care services • using peer led models of service where appropriate.	
	5.6 Strengthen **treatment and care** through additional options including: • home visits options for patients at higher risk • increasing telehealth options for patient follow up • active follow-up in patient management and treatment by using recall systems (e.g. SMS reminders) • community pharmacy dispensing, ensuring that co-payments or other costs are not incurred by the patient to reduce barriers to adherence or treatment completion • investigating treatment adherence apps, tools/reminders, or protocols for check ins, for those patients with adherence issues or that are experiencing treatment side effects that consent to the additional support • subsidised psychosocial support (counselling, linkages to social activity groups) • consideration and support for National Disability Insurance Scheme (NDIS) options for patients with multi morbidities.	• Number of partners tested and treated.
	5.7 Improve **testing and treatment** of BVSTIs in **pregnant people** and their infants by: • delivering workforce development for culturally appropriate engagement • ensuring integration into quality standards and considering indicators for reporting • implementing initiatives to increase testing and treatment of non-pregnant partners.	

Priority action	Priority activities	Monitoring progress
IC6 **Quality standards**[32,33,34]	**6.1** Promote and ensure ease of access to **clinical guidelines** and resources for testing, treatment, and clinical management. This includes: • implementing systems to ensure use of most current guidelines • ensuring alerts and updates are accessed and included in operations • regular staff training.	• Audit of data and reporting systems • Reports of breaches • Number of AMR cases
	6.2 Monitor **quality standards** to ensure patient rights, privacy and confidentiality are upheld.	• Number of health care workers trained
	6.3 Reduce the spread of **antimicrobial resistance (AMR)**[35] by: • improving awareness of AMR in STIs (especially for resistant Neisseria gonorrhoeae) through the education of clinicians on epidemiological trends, infection prevention and controls, and relevant regulatory measures • educating patients on completing courses of treatment to prevent resistance • monitoring trends through AMR surveillance, including cases from regional/remote areas and those detected through PoCT • localised workforce development as AMR cases emerge.	

Action Area 4: Workforce Development (WD)



Priority action	Priority activities	Monitoring progress
WD1 **Quality standards in education and training**	**1.1** Increase staff awareness and knowledge through **regular education and training opportunities.** These opportunities need to: • be delivered in a variety of formats (e.g. online learning, videoconference, information sharing platforms, face-to-face) • be in accessible locations • address gaps in knowledge/awareness for focus topics • be delivered in collaboration with key stakeholders, priority populations and content experts • include opportunities to train diverse workforces (e.g. whole of staff training, multidisciplinary training) • consider training needs in the development of workplace policy and procedures.	• Number of training / education activities delivered • Training evaluations • Audit of workplace policies and procedures • Improvements to practice as result of training • Feedback from consumers
	1.2 Expand tertiary and further professional development capacity to deliver SH and BBV education e.g. for **medical students, nursing and midwife students, and teaching students.** This may include: • SH accreditation with minimum standards for doctors, nurses, pharmacists, midwifes and teachers of RSE in schools • promote nurse practitioner scholarships.	
	1.3 Develop supportive and **comprehensive induction processes** by: • creating a training package that sets a minimum standard for SH and BVSTI practice based on established guidelines • including SH and BVSTI training for multidisciplinary services and specialty services • supporting and training locum staff, overseas trained healthcare workers, and non-specialist healthcare workers • adapting processes and training to meet needs of regional and remote locations • involving local community leaders or peer educators in the orientation of new staff.	

Priority action	Priority activities	Monitoring progress
WD2 **Workforce Capacity**	**2.1** Utilise recruitment processes that promote **long term retention of staff** particularly in regional and remote areas by: • identifying and addressing areas with staff shortages • exploring staff planning models that allow for long term positions • exploring innovative contract models • considering incentives such as additional leave, flexible rotations, etc • implementing mentorship programs, workforce wellbeing and support programs.	• Evaluation of initiatives to improve staff retention • Audits of staff turnover rates • Exit interviews and employee feedback
	2.2 Increase capacity for **research roles** or research opportunities within the workplace.	• Research projects and data
	2.3 Identify and support **SH and BVSTI champions** within health services and other settings.	• Collaborations with champions in other services
WD3 **Multidisciplinary models of care**	**3.1** Educate all staff in **person-centred care**, embedding SH and BVSTI health into primary health care.	• Number of staff trained • Feedback from consumers
	3.2 Explore and implement innovative methods of **engagement with GPs** including: • use of multimedia tools • continuing professional development credits • disseminating data and evidence to support need for holistic care.	• Number of accredited prescribers • Number of GPs completing SH and BVSTI trainings
	3.3 Increase the number of primary care practitioners with **s100 community prescriber accreditation** for HIV, and HBV, along with general primary care provider training for HCV.	• Number of accredited HIV and HBV s100 prescribers.
	3.4 Expand **scope of practice** for relevant professions and roles to be able to undertake testing and treatment of BVSTIs. This may include: • advocating for changes to policy and legislation required for increase scope of practice (e.g. Health Insurance Act, Medicare reform) • expanding scope of practice for registered nurses, Aboriginal Health Practitioners (AHPs) and AHWs • expanding scope of practice for peer workers to offer PoC.	• Number of new services providing testing/ treatment under scope expansion • Health Insurance Act amendments
	3.5 Promote and implement **guidelines** to upskill diverse workforce to build BVSTI testing and treatment into non-SH and BVSTI specialist healthcare (e.g. GPs, primary care, emergency departments, AHPs and midwifery workforces) by: • reviewing and updating WA BVSTI management guidelines (Silver Book) • exploring digital innovations to improve user experience of online guidelines for clinicians and consumers.	• Analytics of websites and distribution of guidelines • Audit of organisational processes to ensure up to date guidelines being used

Priority action	Priority activities	Monitoring progress
WD4 **Equitable access**	**4.1** Provide tailored and **culturally appropriate training for the regional and remote** workforce by: • utilising expertise within the region • providing training within region (online and face-to-face) • funding travel or providing bursaries/scholarships for training out of region • considering training-the-trainer models • considering advocacy for expansion of scope of practice for some professions.	• Number of training/course attendances by regional staff • Number of local training opportunities available • Number of health care workers trained with assistance of bursaries and scholarships
WD5 **Culturally safe and responsive practice**	**5.1** Ensure **workforce diversity** recruitment and visibility (e.g. Aboriginal people, gender diverse people, gender balance across a range of health roles) This may include: • purposeful and selective recruitment to roles and in role advertising • including community and peers in recruitment processing and planning • ensuing adequate remuneration. **5.2** Support **AHPs** to complete SH and BVSTI training. **5.3** Develop **pathways** for **young Aboriginal people** to enter the SH and BVSTI workforce by: • exploring peer worker opportunities during broader health study • providing flexible study opportunities (e.g. ability to undertake study on Country) • exploring options for secondary and tertiary training in health care. **5.4** Ensure involvement and employment of **peers and people with lived experience.**	• Audit of workplace diversity • Number of AHPs completing training from funded services • Number of Aboriginal people undertaking relevant training and study • Number of Aboriginal people employed in SH and BVSTI services • Number of peers and people with lived experience employed/ involved in SH and BVSTI services

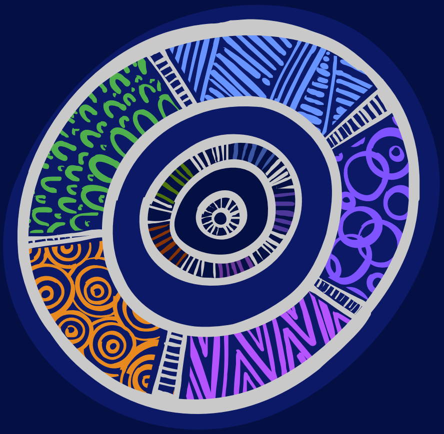
Action Area 5:
Data, evaluation, and research (DR)

Priority Action	Priority Activities	Monitoring Progress
DR1 **Planning**	**1.1 Plan and develop** BVSTI data/research initiatives which are evidence based and: • assess the coverage and quality of current information/evidence • considers the current BVSTI information landscape in WA and Australia (current and planned data systems/sets, surveys, research, emerging data sets and monitoring systems) • clearly demonstrates purpose and how the initiative will address an existing need to meet the goals and targets of this strategy • clearly demonstrates how the initiative will add value to current BVSTI analyses, develop capacity across the sector, and support decision making • accounts for operational and resourcing requirements with identification of key partnerships and linkages across the sector • what qualitative/quantitative measures need to be collected and how they contribute to targets; mode and format for data collection (e.g. face-to-face surveys conducted by peer workers, online forms, interviews) • timeliness of reporting results to inform responses.	**DR1 to DR3** • Number of proposals developed and progressed • Number of new projects/ initiatives commenced • Number of projects informing progress of goals and targets in the strategy • Number of data and research partnerships • Number of data sharing agreements/ memorandums of understanding that relate to reporting on strategy goals and targets • Interim reviews of projects/initiatives or progress reporting/point in time updates towards achievement of strategy goals and targets • Demonstrated improvements across the care cascade from diagnosis to linkage to care • Improvements in notification data • Consumer engagement/ feedback with services/ digital health initiatives

Priority Action	Priority Activities	Monitoring Progress
DR2 **Stakeholder engagement and governance**	**2.1** BVSTI data/research initiatives should **collaborate and engage** by: • establishing partnerships with relevant priority populations, organisations/agencies, ACCHS, and services to ensure ongoing and meaningful engagement from planning through to dissemination of findings • ensuring partnerships and collaborations are open, inclusive, collaborative, respectful and meaningful, honouring the ways of working within this strategy, adhering to relevant best practice guidelines[36,37] • ensuring mechanisms are established for feedback and escalation of issues • establishing a clear delineation of roles and responsibilities to ensure accountability is understood • ensuring appropriate access, such as through data-sharing agreements, and memorandums of understanding, including principles of equity and data sovereignty • ensuring appropriate privacy,[38] such as through confidentiality protocols and digital protection measures, and checking on client/patient permissions if new sharing arrangements occur • describing the sustainability and return on investment of the project/initiative.	
DR3 **Data/information processes and systems**	**3.1** Systems and processes for the general **collection, storage, and analysis of data/information** should factor in: • a review of existing platforms for data collection/storage and analysis, considering updates where feasible to improve analysis and reporting, with future reviews part of business operations • ‘soft launching’ new collection and storage tools/processes/systems to allow for refinement • initial and ongoing training for staff involved in collection and analysis • options such as in-person/face-to-face collection and self-reported notification to encourage granularity and completeness of data • utilising digital advancements to assist with data collection and recording e.g. online or autogenerated streamlined forms • ongoing potential for integration/linkages with other data systems or data sets (usage/availability of national/jurisdictional data sets along with active and passive surveillance systems across the cascade of care) • technological limitations • triangulation/comparability of data with other analyses (understanding trends over time) • processes/protocols for: - ensuring data quality, validation, and audits - quality assurance - exchanging data/information (e.g. deidentified data) • cybersecurity measures • ongoing storage and preservation.	

Priority Action	Priority Activities	Monitoring Progress
DR3 **Data/information processes and systems**	**3.2** Systems and processes for **improving notification data, diagnosis, and subsequent linkage to care** for BVSTIs should create efficiencies by: • educating priority populations and patients on why data is being collected, how it will be used, and how their privacy will be managed • explore and develop innovative solutions to assist in contacting and locating individuals who are mobile or transient for contact tracing and support (if required) • exploring mechanisms to link information across the BVSTI cascade, with goal of identification of loss to follow up • developing digitising processes and protocols to improve access and efficiency, with tracking from diagnosis to treatment • the promotion and utilisation of *My Health Record*, with informed consent (noting that some people may not support this or have opted out) • identifying missed opportunities for prevention and education • prioritising areas for quality improvement in current systems • identifying data sets to inform surveillance of comorbidities and attribute mortality for people with BVSTI related disease • exploring data capture options for - Aboriginal status, gender diversity, sexual identity, risk behaviours, quality of life, experiences of stigma and discrimination, re-infection and re-treatment rates for HCV.	
	3.3 Provide **education to priority populations and patients** on why data is being collected, how it will be used, and how their privacy will be managed. This may include: • considering where innovative peer-led models of data collection can be used • providing opportunities for feedback and engagement.	
DR4 **Reporting on data to inform action**	**4.1** Ensure that **data is easily accessible** to inform future planning and delivery of projects. This may include: • creating live and openly accessible dashboards • considering point in time analysis versus ongoing analyses to review trends in disease incidence, risk behaviours and exposures. • communication updates through key collaborations.	• Laboratory, notification and clinic data is utilised to inform the achievement of targets within this strategy. • Site-based data (e.g ACCESS) • Study cohort data

Priority Action	Priority Activities	Monitoring Progress
DR4 **Reporting on data to inform action**	**4.2** Consider ways in which data systems can report on **the retention of patients/clients** in treatment programs across the care cascade. This may include: • surveillance of HCV testing • surveillance of HBV testing • surveillance of HIV CD4 and HIV viral load data • data linkage to enable surveillance of co-morbidities and attributable mortality within people living with BVSTI-related diseases • timely follow up of those lost to treatment.	
	4.3 Monitor **treatment resistance trends** in BVSTIs.	
	4.4 Develop/expand/advocate for the use of **electronic health record (EHR) systems.** This may include: • exploring current issues with people using *My Health Record* who go by aliases and address confidentiality concerns that underpin these issues • considering how *My Health Record* can be used as a more reliable and consistently used data source • decreasing fragmentation of health records across multiple databases and technologies.	
DR5 **Research and evaluation to inform action**	**5.1** Identify opportunities where **service delivery or engagement in services can be strengthened** by research/evaluation, with the objective of developing specific recommendations for improvement. This may include: • undertaking peer-led research to identify gaps in knowledge/information on topics such as risk reduction practices or service gaps/issues • reviews on novel service delivery models to meet changing testing/treatment options • research on engagement with SH and BBVs, with the follow through to testing (such as effectiveness of social media campaigns/messages from influencers through to uptake of testing) • evaluations with a focus on cost effectiveness and affordability of current and future BVSTI initiatives.	• Research/project dependent • Platforms/initiatives for sharing findings • Promotion and uptake of planning tools and frameworks • Acknowledgement by services/organisations of uptake/use of Action Plan
	5.2 Implement ways t**o share research and information from successful programs** to enable replication and implementation in local areas. This may include: • establishment of a platform to share success stories and challenges of research and program • research translation • implementation methods to disseminate knowledge.	
	5.3 Promote and utilise **health promotion planning tools and evaluation frameworks** to conduct regular and evidence-based evaluations.	



PART 3

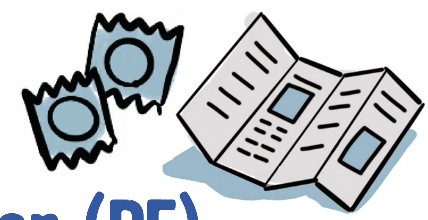
Planning framework 2:

A holistic approach for improving sexual health and blood-borne virus outcomes for Aboriginal People.

Action Area 1: Enabling Environment (EE)

Priority action	Priority activities	Monitoring progress
EE1 **Policy and Advocacy**	**1.1** Implement **systematic and organisational changes** to **reduce stigma** and discrimination by: • developing inclusive work practices • enhancing services capability to ensure equity • undertaking organisational assessments and cultural audits to identify gaps and inform improvement opportunities • eliminating institutional racism in health services through better informed policy, practice and service delivery decisions.	• Client/patient feedback • Service process and policy audits • SH and BVSTI representation on reference groups, advisory groups and in codesign processes • Audit and review of application of accessibility standards
EE2 **Meaningful Involvement**	**2.1** Embed **community engagement** in the planning, implementation and evaluation of programs and services to embed shared decision-making. • using spaces that are comfortable and safe for Aboriginal people • involving Aboriginal staff • taking part in local Aboriginal community events • engaging with community, leaders and local services such as the ACCHS • encouraging and supporting community-based and community-led initiatives.	• Consumer feedback • Evidence of community engagement and codesign processes • Tailored services for priority populations within Aboriginal communities.
	2.2 Prioritise engagement with **priority populations** within **Aboriginal communities** when undertaking codesign of services and programs to ensure they meet the needs of the diversity that exists within Aboriginal communities.	
EE3 **Partnerships**	**3.1** **Foster collaboration** between different organisations that enable coordinated service delivery and continuity of care for Aboriginal people by: • considering the **various health services** that Aboriginal people use across WA • respecting the expertise that **Aboriginal Community Controlled Health Services/Organisations (ACCHS/ACCHOs)** provide to Aboriginal health • connecting **social and emotional wellbeing (SEWB) services** and program in with SH and BBV services.	• Representation of Aboriginal people and Aboriginal organisations in reference groups, advisory groups and consultations • Reported/acknowledged collaborations
	3.2 Strengthen partnerships between government, service providers and community that create efficiencies and improvements for service and program delivery. Partnerships may achieve this by: • expanding service delivery by creating **place-based partnerships** • **supporting services through shared goals** • enabling **codesigned programs**.	

Priority action	Priority activities	Monitoring progress
EE4 **Cultural responsiveness**	**4.1** Establish **culturally responsive workforce and services** by: • ensuring there is an organisational commitment to culture awareness and safety • providing translation of services and resources • demonstrating a visible commitment to a culturally respectful and non-discriminatory service provision • providing appropriate training and workforce development on respecting and understanding Aboriginal culture and people • establishing mechanisms to recognise, address, and prevent racism at the individual and organisational levels.	• Consumer feedback • Number of training events and resources • Learning management system/training audits • Investment into ACCHS for SH and BVSTI healthcare • Audit number of community-controlled services engaged in BVSTI initiatives
	4.2 Support a community-controlled response by supporting ACCHS. This may include: • exploring opportunities to transition government sexual and BBV health services to community-controlled organisations • increasing investment in SH and BBV initiatives within ACCHS	
EE5 **Normalising SH and BVSTIs**	**5.1** Increase understanding of experiences such 'shame'[16, 17] as it relates to SH and BVSTIs (understanding these will vary between communities and individuals) and engage with local Aboriginal communities to implement strategies that **normalise SH and BVSTIs**.	• Study cohort data (e.g. GOANNA Study) • Consumer feedback • Number of BVSTI tests requested
	5.2 Create services that are **safe spaces** that have **approachable, non-judgemental** staff, that encourage clients to feel comfortable accessing services and discussing SH and BVSTIs.	
	5.3 Ensure all programs and services are **discreet**, respect **anonymity** and provide **privacy**, to maintain and promote confidentiality for clients and the community.	



Action area 2: Prevention and education (PE)

Priority action	Priority activities	Monitoring progress
PE1 **Health Promotion**	**1.1 Deliver statewide BVSTI** prevention **campaigns** that are developed in **collaboration and focus tested** with Aboriginal people and communities that: • are responsive, evidence based and address epidemiological trends • focus on communities' strengths and resilience • are in relevant and engaging formats • utilise contemporary mediums that are used by Aboriginal people.	• Reporting from key agencies and/or non-government organisations • Campaign/social media metrics • Evaluation (process or impact) • Consumer feedback • Changes in testing, notification, treatment uptake, reduced time to treatment and contact tracing • Audit of health promotion materials • Website analytics (for web-based resources) • Number and type of resources developed
	1.2 Develop and **utilise locally developed resources** that are: • age appropriate • **culturally responsive** • user friendly • accessible to people of all literacy levels • readily available on online platforms.	
PE2 **Education**	**2.1** Deliver **ongoing and opportunistic education sessions** that: • are engaging, innovative, flexible and culturally responsive • provide space for two-way learning between community and educator • **are delivered by local workers** (where possible) • are delivered in a variety of settings • increase knowledge, attitudes, and skills.	• Information from key agencies/organisations delivering initiatives/services including number of sessions, target group, participation numbers, content covered etc. • Evaluations of education sessions delivered (e.g. improvement in knowledge, skills, attitude) • Proportion of education sessions delivered by peer educators and/or local workers • Consumer feedback • Number of congenital syphilis cases • Antenatal testing data
	2.2 Deliver **education sessions delivered by peer educators and influential community members (such as Elders or community leaders/influencers where appropriate)** that: • are engaging, innovative, flexible and culturally responsive • provide space for healing and resilience through strengths-based approaches • are delivered in a variety of settings • increase the knowledge, attitudes, and skills.	
	2.3 Implement **education initiatives for pregnant and post-partum women** with a focus on the importance of regular BVSTI screening during pregnancy, as well as the use of condoms.	

Priority action	Priority activities	Monitoring progress
PE3 **Health Hardware**	**3.1** Provide access to **free** or **affordable condoms** and lubricant in a range of settings such as public toilets, hospitals, condom trees, libraries, hostels, tourist venues, TAFEs and other educational settings.	• Number of condom dispensers and locations including number of ACCHS distributing condoms • Number of condoms distributed • Information from key agencies/organisations delivering initiatives services • Number of ACCHS distributing needles and syringes • Kirby Institute *Needle Syringe Program Minimum Data Collection* • Needle and syringe distribution data
	3.2 Provide access to and distribution of **sterile injecting drug equipment** and **safe disposal options** among PWID by: • increasing number of needle and syringe programs (NSPs) • increasing provision in remote based services.	
	3.3 Increase the **promotion of NSPs, safer injecting education** and **safe disposal options**, including at ACCHS.	
PE4 **Biomedical Prevention**	**4.1** Increase access and uptake of **PrEP** and **PEP** among at-risk populations within Aboriginal community by: • increasing awareness of biomedical options • ensuring that messaging is relevant for Aboriginal communities.	• Number of people accessing PEP and PrEP through PBS closing the gap co-payment program • Data from vaccination surveillance and reporting system (Australian Immunisation Record)
	4.2 Increase vaccine coverage for **vaccine** preventable infections (HPV, HBV) by: • providing a range of vaccine provider settings that are culturally responsive.	
PE5 **Community and culture**	**5.1** Ensure **community control, self-determination, whole of community approach**, and **connection to culture** are built into health promotion and prevention initiatives.	• Evidence of services and programs that include community control, self-determination, whole of community approach, and connection to culture

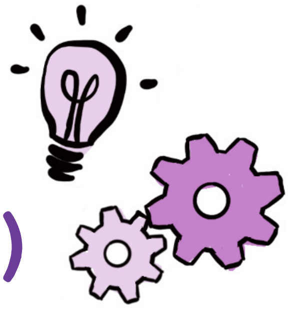
Action Area 3: Integrated Care (IC)

Priority action	Priority activities	Monitoring progress
IC1 **Point-of-Care Testing (PoCT)**	**1.1** Expand **PoCT** in services that provide care for Aboriginal people. Priority should be considered for ACCHS and other services that see subpopulations of Aboriginal community who are highly transient across regions in WA.	• Number and distribution of PoCT services • Notifications of BVSTI via PoCT • Linkage and time to treatment
IC2 **Patient-led testing and incentives**	**2.1** Increase **innovative testing** options by: • continuing online testing options • reviewing novel online testing options (e.g. postal test kits, downloadable pathology) with consideration to improving testing options for people in regional and remote areas. • increasing home testing options.	• Number of BVSTI tests requested (by type) • Number of notifications (by type) • Test positivity rate (number of notifications / total number of tests) • Number and type of incentives • Number of tests and treatments resulting from incentives • Number of bulk-billed visits offered and utilise
	2.2 Consider **incentives** (monetary and non-monetary) for higher risk population groups to test, treat and provide contacts. This may include: • free or subsidised testing options (which may include bulk billing) • vouchers and other novel enticements (e.g. childcare, phone credit, merchandise, entry into a competition).	
IC3 **Opportunistic testing and treatment**	**3.1** Implement strategies to **normalise testing** and incorporate **into routine practice** by: • embedding testing into existing health checks (e.g. 715 adult health checks, men's and women's checks, cervical screening, contraception consults, antenatal checks, when managing other conditions such as urinary tract infections). • promoting opt-out testing models of health care. • having regular conversations about testing with patients and regularly offering the tests • promoting full BVSTI screenings • implementing community-wide screening programs • collaborating with ACCHS boards and Elders to increase support for SH and BBV healthcare. • Explore partnerships that increase services' ability to provide testing and treatment (e.g. emergency departments, custodial settings).	• Number of unique BVSTI notifying services • Guidelines for opt-out testing models • Number of tests, notifications, and treatments. • Treatment rate (people diagnosed that are treated / people diagnosed)
	3.2 Explore **partnerships** that increase services' ability to provide testing and treatment (e.g. emergency departments, custodial settings).	
	3.3 Increase testing and treatment of **Aboriginal men** through **targeted interventions** such as: • men's clinics • men's camps and testing on Country.	

Priority action	Priority activities	Monitoring progress
IC3 **Opportunistic testing and treatment**	**3.4** Improve **care continuity** for Aboriginal people who temporarily relocate to Perth Metropolitan area by: • promoting relevant metropolitan services • improving **patient management and handover** between Metropolitan based services and regional services.	
IC4 **Preventing onward transmission**	**4.1** Improve **contact tracing activities** by: • increasing **service provider collaboration** and coordination • improving systems for **confidential client information sharing** • prioritising **rapport** and **relationship building** with local community • implementing innovative methods to provide a private, confidential and comfortable environment for contact tracing to occur (e.g. use of online partner notification or social media) • providing phone credit or phones • providing case management of people with complex psycho-social needs.	• Number of people treated from contact tracing • Proportion of people diagnosed who do not receive treatment • Median/ mean time from diagnosis to treatment • Number of people trained in contact tracing
	4.2 Decrease **time-to-treatment** by: • improving **active follow-up** for disease management and clinical care by using recall systems (e.g. SMS reminders) • increasing **service provider collaboration** for patient management • ensuring effective treatments are available across the state with priority given to directly observed therapies.	
	4.3 Aboriginal health workforce are engaged in **patient recall** for treatment and contact tracing.	

Priority action	Priority activities	Monitoring progress
IC5 **Models of care**	**5.1** Increase **outreach models of care** by increasing: • **mobile testing and treatment services** • **place-based testing and treatment services** at community events and services • **home visits** for testing and treatment.	• Treatment rate (people diagnosed that are treated / people diagnosed) • Number of 715 health check claims made per year • Number of people maintaining viral suppression due to outreach services • Number and location of mobile and home services • Evaluation of onsite testing initiatives • Antenatal BVSTI testing in accordance with guidelines. • Number of partners tested and treated • Number of people who get re-infected • Number of services offering gender specific services • Audit of services operating hours • Time to linkage into specialist care • Audits and evaluations of patient handover processes • Number of patients with health profiles requiring management plans that have a management plan
	5.2 Adopt and adapt **innovative in-reach models of care** to meet the specific SH and BBV needs of Aboriginal people by considering: • nurse-led models of care • Community Controlled co-coordinated models of care e.g. ACCHS providing service delivery for Aboriginal people in justice settings. • the use of visiting specialists • walk-in clinics • gender specific clinics/ clinic times • after hour clinic times.	
	5.3 Increase access for Aboriginal people to **specialist SH and BBV support** and services within their region of residence through outreach clinics and telehealth services.	
	5.4 Increase BVSTI testing of pregnant people to prevent mother to child transmission by implementing initiatives that increase testing and treatment of **Aboriginal men** whose **partners are pregnant** or who are **fathers-to-be**.	
IC6 **Quality standards**	**6.1** Develop and maintain **consistent clinical guidelines** that are adhered to and incorporated into routine practice, ensuring best practice disease management and clinical care.	• Audit of patient management systems and alignment with guidelines • Number of AMR cases • Number of gonorrhoea samples sent for AMR detection • Analytics for clinical guideline documents
	6.2 Implement strategies and procedures to ensure **adequate monitoring** of **antimicrobial resistance** amongst Aboriginal communities. This may include: • monitoring quality of antimicrobial resistance surveillance to ensure consistency irrespective of remoteness • ensuring surveillance of antimicrobial resistance for cases of gonorrhoea diagnosed through PoC testing.	

Action Area 4: Workforce Development (WD)



Priority action	Priority activities	Monitoring progress
WD1 **Quality standards in education and training**	**1.1 Expand registered training organisations** (RTOs) capacity to deliver SH and BBV units as part of training in Certificate III and IV for Aboriginal and Torres Strait Islander Primary Health Care.	• RTOs in WA offering a unit in SH and BVSTI health.
WD2 **Workforce Capacity**	**2.1** Increase **dedicated FTE** in services to provide SH and BBV services and programs, including: • outreach/ Community Engagement/ Liaison Officers • Health Promotion Officers • clinical staff (nurses, medical practitioners, AHWs and AHPs • SH program coordinators.	• Evaluation of initiatives to improve staff retention • Audits of staff turnover rates • Exit interviews and employee feedback • Number of dedicated gendered roles within the sector • Proportion of Aboriginal communities that have access to male and female health workers • Proportion of positions that are 50(d)
	2.2 Improve the **gender balance** of the health workforce by having male and female workers across a range of health roles including: • clinical workers (AHWs, AHPs, GPs, nurses) • SEWB (Social Workers, Community Liaison Officers) • prevention and education (Health Promotion Officers).	
	2.3 Increase and sustain the **investment** of the **SH and BBV healthcare workforce** in regional and remote areas, especially in response to emerging local issues such as disease outbreaks.	
	2.4 Explore opportunities for **longer term health worker contracts** (min. two years) to be implemented to enable greater support for staff and to allow for building of rapport within community.	
	2.5 Increase the **Aboriginal healthcare workforce** by implementing initiatives, such as: • providing more Section 50(d) *(Equal Opportunity Act 1984)* positions • including staff in decision making and consultation processes to improve services and increase community engagement • ensuring there is better utilisation of staff and adequate remuneration.	

Priority action	Priority activities	Monitoring progress
WD2 **Workforce Capacity**	**2.6** Develop pathways for young Aboriginal people to enter the health workforce, this may include: • peer worker opportunities while studying health worker qualifications • the ability to undertake some study on Country • training for year 11's and 12's (Certificate II in Aboriginal health).	
	2.7 Provide **incentives** to **attract and retain staff** in regional and remote areas to reduce the turnover by providing additional leave and better rotations.	
	2.8 Identify and support **SH and BVSTI champions** within health services to assist services to maintain SH and BBV services.	
	2.9 Implement strategies for the Aboriginal health workforce to **decrease the risk of burn out** resulting from an expectation to take on **additional cultural load**.	
	2.10 Enable a responsive workforce that is adequately skilled and can be mobilised to **address local emerging issues** and outbreaks in regional and remote areas.	
WD3 **Multidisciplinary models of care**	**3.1** Advocate for **increased scope of practice** for the Aboriginal health workforce. In addition, consider expanding scope of peer workers to undertake PoCT as a screening tool.	• Number of staff trained in PoCT • Feedback from consumers • Number of new services providing testing/ treatment under scope expansion • Health Insurance Act amendments
WD4 **Equitable access**	**4.1** Health workforce has **access** to **resources** that improve and support service and program delivery.	• Number of training/ course attendances by regional staff • Number of local training opportunities available • Number of health care workers trained with assistance of bursaries and scholarships
	4.2 Explore opportunities for **resources** to be **tailored for individual regions** and needs.	
	4.3 Develop and maintain a **statewide resource database**.	
	4.4 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 • considering train-the-trainer models.	

Priority action	Priority activities	Monitoring progress
WD5 **Culturally safe and responsive practice**	**5.1** Support the **Aboriginal health workforce** to complete clinical SH and BBV training. **5.2** Increase knowledge and confidence of health workers to provide **culturally responsive** SH and BBV healthcare. This can be achieved through access to specialised SH and BBV trainings that address cultural responsive practice. **5.3** Enhance **staff induction** for SH and BBVs, with a **focus on locum staff**, by ensuring **consistent key information**, **with localised guidance** included. **5.4** **Involve** local community **leaders** in the **orientation of new staff** to increase familiarisation with local community priorities, cultural practices and to develop relationships. **5.5** Improve **community engagement** and **building of trust** within community by: • building engagement into work responsibilities • supporting staff to invest time in community engagement.	• Number of Aboriginal health staff completing training • Number of Aboriginal people undertaking training and study • Number of Aboriginal people employed in SH and BVSTI services • Number of peers and people with lived experience employed/ involved in SH and BVSTI services
WD6 **Partnerships and collaboration**	**6.1** Create **meaningful partnerships** and **professional networks** that provide support to each other and opportunity for knowledge sharing. Networks should aim to: • communicate regularly • connect staff who may not have SH and BBV staff within their own service • connect staff who may be working in remote settings • foster sharing of successful programs and interventions to facilitate program expansion to other communities.	• Evidence of meaningful partnerships • Number and location of regional networks

Action Area 5: Data, evaluation, and research (DR)

Priority action	Priority activities	Monitoring progress
DR1 **Data/information processes and systems**	**1.1** Develop or strengthen systems that accurately incorporate **BVSTI clinical items** in Patient Information Systems (PISs) in health care settings and encourage staff to correctly record data to facilitate accurate auditing and data extraction.	• Audit of patient management systems within services • Number of regions using syphilis management system • Number of ACCHS accessing syphilis management system
	1.2 Develop autogenerated pathology requests within PIS and ensure they are kept current and aligned to clinical guidelines.	
	1.3 Develop a **digital solution** that provides real-time access to relevant state-wide patient records that improve patient management, particularly the management of syphilis. Solutions need to be accessible for staff within ACCHS.	
DR2 **Reporting on data to inform action**	**2.1** Data **reporting utilises a strengths-based approach**. Reports should provide contextual and disaggregated data that is relevant, protects and respects Aboriginal people and communities.	• Laboratory, notification and clinic data • Site-based data (e.g ACCESS, ATLAS) • Study cohort data (eg. GOANNA Study)
	2.2 Increase accessibility to relevant **notification and testing data** for Aboriginal people that is available at a regional level and in user-friendly formats. This may include: • creating live and accessible dashboards • embedding BVSTI data within datasets and platforms already being utilised.	

Priority action	Priority activities	Monitoring progress
DR3 **Research and evaluation to inform action**	**3.1** Conduct **codesigned** and ethical research **in partnership** with relevant organisations and Aboriginal people using culturally responsive methodology.	• Number of Western Australian Aboriginal Health Ethics Committee approvals granted for SH and BVSTI research projects • Platforms/initiatives for sharing findings • Promotion and uptake of planning tools and frameworks • Acknowledgement by services/organisations of uptake/use of Action Plan
	3.2 Support interested **ACCHS** to participate in **SH and BBV health research**.	
	3.3 Ensure Aboriginal communities in WA have **data sovereignty** by supporting data ownership and provision of data that is of value to the community.	
	3.4 Utilise **health promotion planning tools** and **evaluation frameworks** to conduct regular and well-structured evaluations that address cultural responsiveness and are guided by state-wide or regional strategic plans.	
	3.5 Foster community buy-in and ownership by **communicating the findings** back to the involved communities and people.	
DR4 **Identification of Aboriginal people**	**4.1** Implement strategies to increase the accurate **identification of Aboriginal people** in services using the *National best practice guidelines for collecting Indigenous status in health data sets* collection forms and information systems.	• Proportion of BVSTI notifications that have Indigenous status field completed • Site-based data (e.g. ACCESS, ATLAS)

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