

Mid-Term Review of the Western Australian:

- **Hepatitis C Action Plan
2006-2008**
- **HIV/AIDS Action Plan
2006-2008**
- **Sexually Transmitted
Infections Action Plan
2006-2008**

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Acronyms

| | |
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| ACCHS | Aboriginal Community Controlled Health Services |
| AHCWA | Aboriginal Health Council of Western Australia |
| AHW | Aboriginal Health Worker |
| AIDS | Acquired Immunodeficiency Syndrome |
| APN | Advanced Practice Nurse |
| ASHM | Australasian Society for HIV Medicine |
| BBV | Blood-borne Virus |
| CAHS | Children and Adolescent Health Services |
| CALD | Culturally and Linguistically Diverse |
| CDCD | Communicable Disease Control Directorate |
| DAO | Drug and Alcohol Office |
| DoET | Department of Education and Training |
| DoCS | Department of Corrective Services |
| DoH | Department of Health, Western Australia |
| DoHA | Department of Health and Ageing |
| FPWA | Family Planning WA Sexual Health Services |
| GP | General Practitioner |
| HCV | Hepatitis C Virus |
| HCWA | Hepatitis Council of Western Australia |
| HIV | Human Immunodeficiency Virus |
| MOC | Model of Care |
| MSM | Men who have sex with men |
| NPEP | Non-Occupational Post-Exposure Prophylaxis |
| NSEP | Needle and Syringe Exchange Program |
| NSP | Needle and Syringe Program |
| OAH | Office of Aboriginal Health |
| OATSIH | Office for Aboriginal and Torres Strait Islander Health |
| PLWHA | People Living with HIV/AIDS |
| RPH | Royal Perth Hospital |
| SHBBVP | Sexual Health and Blood-borne Virus Program, DoH |
| STI | Sexually Transmitted Infection |
| STIGMA | STI testing guidelines for men who have sex with men |
| WA | Western Australia |
| WAAC | Western Australian AIDS Council Inc. |
| WACHAS | Western Australian Advisory Committee on HIV/AIDS and STIs |
| WACHS | Western Australian Country Health Services |
| WAGPN | Western Australian General Practice Network |
| WAISHAC | Western Australian Indigenous Sexual Health Advisory Committee |
| WASUA | Western Australian Substance Users' Association |
| WAVHC | Western Australian Viral Hepatitis Committee |

1. Introduction

On 9 November 2007, a Mid-Term Review Forum of the *Western Australian Hepatitis C Action Plan 2006-2008* (DoH 2006a), the *Western Australian HIV/AIDS Action Plan 2006-2008* (DoH 2006b), and the *Western Australian Sexually Transmitted Infections Action Plan 2006-2008* (DoH 2006c) was held.

The Forum was the second component of the Mid-Term Review, which aimed to determine the achievements of the Action Plans to date, identify priorities which still require action, and focus on what can be achieved in the remaining term of the Action Plans.

Thirty-two stakeholders attended the Mid-Term Review Forum including representatives from government organizations, community-based organizations and the education, medical, health research and scientific sectors in Western Australia (WA). See Appendix 1 for a list of the Forum participants.

The Mid-Term Review Forum was held at the Trinity Conference Centre, Hampden Road, Crawley, from 9am until 12 noon.

Dr Paul Van Buynder, Director of the Communicable Disease Control Directorate, Department of Health WA, officially opened the Mid-Term Review Forum.

This report is a summary of the results of the Mid-Term Review. These results are a supplement to the WA State Action Plans and provide a focus for the remaining term of these Action Plans as determined by the key stakeholders.

2. Purpose of the Mid-Term Review

As stated in the *Western Australian Hepatitis C Action Plan 2006-2008* (DoH 2006a), the *Western Australian HIV/AIDS Action Plan 2006-2008* (DoH 2006b), and the *Western Australian Sexually Transmitted Infections Action Plan 2006-2008* (DoH 2006c), the Sexual Health and Blood-borne Virus Program (SHBBVP) is to conduct a mid-term and final review of the implementation of the Action Plans.

The Action Plans were developed by the SHBBVP in consultation with major stakeholders from government organisations, community-based organisations and the education, medical, health research and scientific sectors throughout WA. The Action Plans were developed to provide WA with a framework under which proposed hepatitis C, HIV/AIDS and sexually transmitted infections (STI) education, prevention, treatment, care and control strategies can be developed and implemented.

In line with a similar process undertaken for the National Hepatitis C, HIV/AIDS and STI Strategies (DoHA 2005a, DoHA 2005b, DoHA 2005c), this review is intended as a 'snapshot' of the progress of the implementation of the Action Plans and not an in-depth recording of all activities undertaken or planned. A full evaluation of the Action Plans will be conducted at the time of their completion in late 2008.

3. Methodology

Initially, a group of key stakeholders was identified. These stakeholders were representatives from community-based, clinical and research organisations, and

representatives from relevant committees including the WA Advisory Committee on HIV/AIDS and STIs, and the WA Viral Hepatitis Committee.

The first component of the Mid-Term Review process commenced in mid-August 2007 and ran until October 2007. A qualitative survey was sent to the key stakeholders investigating how the strategies of the Action Plans had impacted upon the achievements in the fields of hepatitis C, HIV/AIDS and STIs. For a copy of the qualitative survey, please refer to Appendix 2.

Action areas covered in the survey included prevention and education; diagnosis and testing; treatment, care and support; surveillance; research; workforce; priority areas and target groups; partnerships; and emerging challenges and future directions.

Information from key stakeholders was collected and this feedback was compiled into a Summary Paper. This paper was then circulated to all respondents. See Appendix 3 for the Summary Paper.

The second component of the Mid-Term Review process was the Forum held on 9 November 2007. Respondents were invited to the Mid-Term Review Forum where strategies were further discussed and priority actions identified for the remaining term of the Action Plans. This Forum was organised and convened by the SHBBVP.

A number of speakers delivered presentations to the Forum participants. Copies of the slides used in the following presentations are available in Appendix 4:

- Kellie Kwan and Dr Barry Combs - *Trends in Epidemiology*
- Dr Wendy Cheng - *Hepatitis C Model of Care*
- Prof Martyn French - *HIV/AIDS Model of Care*
- Dr Lewis Marshall - *STI Model of Care*

A whole-of-group discussion was held to identify the key priorities relating to each Action Plan. The session was chaired by Ms Lisa Bastian (SHBBVP) and all participants were given the opportunity to contribute. The key points from the discussion were documented on butchers' paper for participants to view during the discussion and detailed minutes were also taken. The minutes are available in Appendix 5.

4. Key Priorities for the Action Plans

The discussion at the Forum elicited a number of key priorities for each of the Action Plans. These priorities are to be pursued in the remaining 12-month period of the Action Plans and are detailed in the tables below.

4.1 Key priorities related to the Western Australian Hepatitis C Action Plan 2006-2008

| Priority Area | Key Priorities | Stakeholders |
|-----------------------------|---|---|
| Prison Population | <ul style="list-style-type: none"> ▪ Ongoing focus on prevention including Needle and Syringe Programs and initiatives targeting violence and tattooing ▪ Increase access to treatment (including support services) | <ul style="list-style-type: none"> ▪ Department of Corrective Services ▪ SHBBVP ▪ Hepatitis Council of WA ▪ Tertiary hospital liver clinics |
| Awareness campaign | <ul style="list-style-type: none"> ▪ Develop a hepatitis C awareness campaign which targets the general community and youth, focuses on prevention and utilises popular web-based mediums | <ul style="list-style-type: none"> ▪ SHBBVP ▪ Hepatitis Council of WA |
| Aboriginal people | <ul style="list-style-type: none"> ▪ Increase focus on hepatitis C ▪ Develop health promotion initiatives which specifically target hepatitis C | <ul style="list-style-type: none"> ▪ Aboriginal Health Council of WA ▪ SHBBVP ▪ Hepatitis Council of WA |
| Rural/Remote Regions | <ul style="list-style-type: none"> ▪ Increase the number of treatment coordinators in regional areas ▪ Continue and enhance initiatives to improved access to treatment in rural/remote regions | <ul style="list-style-type: none"> ▪ WA Country Health Services ▪ WA GP Network ▪ Tertiary hospital liver clinics ▪ Hepatitis Council of WA ▪ SHBBVP |

4.2 Key priorities related to the Western Australian HIV/AIDS Action Plan 2006-2008

| Priority Area | Key Priorities | Stakeholders |
|------------------------------|--|--|
| Treatment | <ul style="list-style-type: none"> ▪ Develop clinical databases | <ul style="list-style-type: none"> ▪ Tertiary health services ▪ SHBBVP ▪ WA AIDS Council ▪ WA GP Network |
| Target Groups | <ul style="list-style-type: none"> ▪ Continue initiatives which focus on refugees, migrants and CALD groups (in addition to the target groups already identified in the Action Plan) | <ul style="list-style-type: none"> ▪ WA AIDS Council ▪ SHBBVP ▪ FPWA/Magenta |
| Education | <ul style="list-style-type: none"> ▪ Reinvigorate community education programs ▪ Target men travelling and/or working overseas ▪ Utilise new mediums popular among young people | <ul style="list-style-type: none"> ▪ WA AIDS Council ▪ SHBBVP |
| Workforce Development | <ul style="list-style-type: none"> ▪ Increase workforce development opportunities for GPs, nurses, health care workers, alcohol and other drug workers and those working in rural/remote areas ▪ Enhance professional development opportunities for health professionals who work with marginalised groups | <ul style="list-style-type: none"> ▪ SHBBVP ▪ WA Country Health Services ▪ WA GP Network ▪ Tertiary health services ▪ WA AIDS Council |

4.3 Key priorities related to the Western Australian Sexually Transmitted Infections Action Plan 2006-2008

| Priority Area | Key Priorities | Stakeholders |
|------------------------------|---|---|
| Primary Prevention | <ul style="list-style-type: none"> Continue focus on primary prevention including high-risk behaviours and high-risk groups | <ul style="list-style-type: none"> SHBBVP FPWA WA AIDS Council WA GP Network |
| Clinical Services | <ul style="list-style-type: none"> Improve screening for STIs (Aboriginal population and metropolitan area) | <ul style="list-style-type: none"> WA GP Network SHBBVP FPWA Aboriginal Health Council of WA |
| Surveillance | <ul style="list-style-type: none"> Enhance surveillance for chlamydia | <ul style="list-style-type: none"> Communicable Disease Control Directorate WA GP Network Contact tracing services |
| Workforce Development | <ul style="list-style-type: none"> Continue training for Practice Nurses Amend Poisons Act to enhance role of nurses in management of STI treatment Work in partnership with WA Country Health Services to improve the retention of the rural/remote workforce Increase access to STI testing in outreach venues Increase promotion/access to resources for teachers | <ul style="list-style-type: none"> WA Country Health Services WA GP Network SHBBVP Department of Education and Training |
| Contact Tracing | <ul style="list-style-type: none"> Create contact tracing positions in the south metropolitan area Increase support from primary medical care for tertiary hospitals and contact tracing services | <ul style="list-style-type: none"> Contact tracing services SHBBVP Tertiary health services WA GP Network |
| STIGMA* Guidelines | <ul style="list-style-type: none"> Sustain the response to the syphilis outbreak in the metropolitan area | <ul style="list-style-type: none"> SHBBVP WA AIDS Council WA GP Network |

In addition to the discussion at the Forum, participants were also given a form to complete which asked them to identify their three key priorities relating to hepatitis C, HIV/AIDS and/or STIs for the remaining time of the Action Plans, the strategies required to implement these, and the people who would be responsible for their implementation. Participants' responses are tabled in Appendix 6.

* Sexually Transmitted Infections Testing Guidelines for Men who have Sex with Men.

5. Conclusion

The Mid-Term Review of the Action Plans provided a valuable opportunity for participants to reflect on the achievements of the Action Plans to-date, and to engage in open discussion around the key priorities relating to Hepatitis C, HIV/AIDS and STIs which require attention and action over the next 12 months.

The key priorities identified from the Mid-Term Review of the Action Plans will be pursued in the remaining 12-month period.

A Final Review of the Plans will be undertaken at the end of 2008 by an independent body to evaluate the implementation of the Plans and measure the achievement of the goals and objectives of the Plans.

6. References

Department of Health 2006a, *Western Australian Hepatitis C Action Plan 2006-2008*, Department of Health, Perth.

Department of Health 2006b, *Western Australian HIV/AIDS Action Plan 2006-2008*, Department of Health, Perth.

Department of Health 2006c, *Western Australian Sexually Transmitted Infections Action Plan 2006-2008*, Department of Health, Perth.

Australian Department of Health and Ageing 2005a, *National Hepatitis C Strategy 2005-2008*, Commonwealth of Australia, Canberra.

Australian Department of Health and Ageing 2005b, *National HIV/AIDS Strategy - Revitalising Australia's Response 2005-2008*, Commonwealth of Australia, Canberra.

Australian Department of Health and Ageing 2005c, *National Sexually Transmissible Infections Strategy 2005-2008*, Commonwealth of Australia, Canberra.

Appendix 1: List of participants at the Mid-Term Review Forum

| Name | Representing |
|--------------------------|---|
| Ms Lisa Bastian | Sexual Health and Blood-borne Virus Program |
| Ms Jude Bevan | Sexual Health and Blood-borne Virus Program |
| Ms Heather Boxall | Silver Chain |
| Dr Susan Carruthers | Curtin University of Technology |
| Dr Wendy Cheng | Royal Perth Hospital |
| Dr Barry Combs | Communicable Disease Control Directorate |
| Mr Michael Doyle | Aboriginal Health Council of WA |
| Dr Christine Dykstra | Royal Perth Hospital |
| Ms Julia Fallon-Ferguson | Department of Health |
| Mr Frank Farmer | Hepatitis Council of WA (HCWA) |
| Dr James Flexman | Royal Perth Hospital |
| Ms Sandra Fox | Western Australian Substance Users' Association |
| Prof. Martyn French | Royal Perth Hospital |
| Ms Naomi Green | Western Australian General Practice Network |
| Dr Bret Hart | North Metro Area Health Service |
| Ms Phillipa Jones | WA Country Health Service |
| Ms Kellie Kwan | Communicable Disease Control Directorate |
| Ms Sue Laing | Sexual Health & Blood-borne Virus Program |
| Ms Georgiana Lilley | Sexual Health & Blood-borne Virus Program |
| Dr Lewis Marshall | Fremantle Hospital |
| Mr Stephen Plecas | Magenta |
| Ms Jill Robinson | Great Southern Population Health Service |
| Ms Sally Rowell | West Australian AIDS Council |
| Mr Kevin Shanks | Western Australian General Practice Network |
| Ms Dace Tomsons | Drug and Alcohol Office |
| Mr John Tunney | Office of Aboriginal and Torres Strait Islander Health WA |
| Dr Paul Van Buynder | Communicable Disease Control Directorate |
| Mr Ken Waddell | Case Management Program |
| Mr Graeme Webb | Department of Education and Training |
| Ms Alexa Wilkins | Sexual Health and Blood-borne Virus Program |
| Ms Barbara Williams | Office of Aboriginal and Torres Strait Islander Health |
| Mr Simon Yam | Western Australian AIDS Council Inc. |

Appendix 2: Mid-Term Review Qualitative Survey

Mid-Term Review of the Western Australian HIV/AIDS, Hepatitis C and Sexually Transmitted Infections Action Plans 2006-2008

PURPOSE

As stated in the *Western Australian Hepatitis C Action Plan 2006-2008*, the *Western Australian HIV/AIDS Action Plan 2006-2008* and the *Western Australian Sexually Transmitted Infections Action Plan 2006-2008*, a mid-term review of the Action Plans is to be conducted by the Sexual Health and Blood-borne Virus Program (SHBBVP). In line with a similar process undertaken for the National Strategies this review is intended as a 'snapshot' of the progress of the implementation of the Action Plans and not an in depth recording of all activities undertaken or planned. A full evaluation of the Action Plans will be conducted at the time of their completion in late 2008.

The Action Plans are available online at:

http://www.public.health.wa.gov.au/3/467/3/policies_and_ac.pm

AIM

The aim of the review is to determine achievements of the Plans to date, priorities which still require action and what can be achieved in the remaining time of the Plans.

PROCESS

The process of the review will include collecting information from key stakeholders and compilation of that feedback which will then be circulated to all respondents. Subsequently, respondents will be invited to a Forum where the issues can be further discussed and priorities identified for the remaining term of the Plans. Following the Forum a report will be circulated to all key stakeholders including the relevant State committees and Health Networks.

The first part of the process is to collect information on the broad action areas of all the Plans for the period of their implementation (2006) to now.

BROAD ACTION AREAS

Stakeholders are asked to consider each of the subheadings and to provide comments on each section relevant to their organisation. The questions are guides and should not limit your responses. If commenting on more than one Action Plan please note the relevant Plan against the comment.

Mid Term Review Template

Name :

Organisation:

1. Prevention and Education

- What strategies are being successfully implemented to raise STI/HIV/HCV awareness in the general population and in high risk groups?
- Has access to information and education improved?
- Are prevention strategies adequately targeting at risk groups?
- Are new strategies being developed to address changing trends? If so what?
- What areas of prevention and education have not progressed satisfactorily and why (barriers etc)?
- Which prevention and education strategies need particular focus in the remaining term of the Plans?

2. Diagnosis and Testing

- Are strategies being implemented to improve availability of best practice diagnosis and testing for people at risk of STI/HIV/HCV? If so what are they and why have they been successful?
- Has there been improved access to diagnosis and testing for high priority groups?
- What barriers exist in the implementation of best practice diagnosis and testing?
- What diagnosis and testing strategies need particular focus in the remaining term of the Plans?

3. Treatment, Care and Support including improving and maintaining the health of those people with HIV/HCV

- What are the greatest successes to date in regards to treatment, care and support?
- Have uptake of treatment and adherence rates increased in the priority populations?
- Are appropriate care and support services available for people living with or affected by HIV/HCV/STIs? If so are they being accessed?
- What are the greatest priorities in treatment, care and support for the remaining term of the Plans?

4. Surveillance

- Are current data collection and dissemination systems providing adequate information to meet the needs of your organisation?

5. Research

- What research is being undertaken in the areas of identified need?
- Are there new priorities for research that can inform policy and practice?
- What are the areas of greatest importance in research in the remaining time of the Plans?

6. Workforce

- What workforce initiatives have been the most effective to date?
- Are education/training/staff development initiatives being developed and are they accessible?
- Is appropriate support being provided in the sector to increase staff recruitment and retention?
- What are the greatest workforce challenges and how can they be addressed in the remaining time of the Plans?

7. Priority areas and target groups

- Are the priority target groups/areas identified in the Plans being adequately targeted with the strategies outlined? What is working well and what is not working so well?
- Are there new priority target groups or areas of need that have arisen since the development of the State Plans? If so please specify.
- What areas or target groups not currently being adequately targeted should be considered the highest priority(s) for the remaining term of the Plans?

8. Partnerships

- What are the positive aspects of the existing partnerships that underpin these Plans?
- Is the partnership approach working as well as it can? If not what barriers exist and how could these be addressed?
- Have new partnerships been developed under the Plans? If so please specify.

9. Emerging challenges and future directions

- What are the new and emerging challenges and how should they be addressed?
- Do you have any suggestions on the future directions of these and subsequent Plans?

10. Other comments

Please make any other comments relating to the implementation of the WA State Action Plans for HIV/AIDS, STIs and HCV.

TIMELINE

It is anticipated that the feedback from this first stage of the process will be available for circulation in October and that the Forum will be held in early November 2007. A report of the Review process will be finalised by the end of 2007.

Please indicate if you or a representative from your agency will attend the Forum in early November (anticipated date 7 November, to be confirmed).

- Yes No

PROVISION OF FEEDBACK

Please provide your completed feedback by 21 September 2007.

If you have any questions regarding this template or your responses, please contact Sue Laing or Jude Bevan directly by email or phone.

Appendix 3: Mid-Term Review Qualitative Survey Summary Paper

Summary Paper to Inform the Mid-Term Review Forum

Friday 9 November 2007

BACKGROUND

The *Western Australian Hepatitis C Action Plan 2006-2008*, the *Western Australian HIV/AIDS Action Plan 2006-2008* and the *Western Australian Sexually Transmitted Infections Action Plan 2006-2008* (the Plans) were developed following extensive consultation with key stakeholders and were published in August 2006. The goals and objectives of the Plans are outlined in Appendix 1.

The implementation of the Plans included a commitment that a mid-term review would be conducted by the Sexual Health and Blood-borne Virus Program (SHBBVP). In line with a similar process undertaken for the National Strategies, the review is intended as a 'snapshot' of the progress of the implementation of the Action Plans and not an in depth recording of all activities undertaken or planned. A more comprehensive assessment of the Plans will be conducted at the time of their completion in late 2008.

AIM

The aim of the review is to determine achievements of the Plans to date, priorities which still require action and what can be achieved in the remaining time of the Plans.

PROCESS

In August 2007, the SHBBVP distributed a template for feedback to key stakeholders throughout WA, requesting details of progress against the broad action areas of all the Plans for the period of their implementation (from mid-2006 to the present time). Stakeholders were also asked to identify priority areas and target groups, and emerging challenges and future directions. The SHBBVP has collated the information received and used the material to develop this summary paper.

Subsequently, respondents will be invited to a Forum on Friday 9 November where the issues can be further discussed and priorities identified for the remaining term of the Plans. This paper aims to inform Forum participants of key issues requiring further discussion and/or progress.

Following the Forum, the SHBBVP will produce a report to be tabled at the WA Advisory Committee on HIV/AIDS and STIs (WACHAS), WA Indigenous Sexual Health Advisory Committee (WAISHAC) and the WA Viral Hepatitis Committee (WAVHC).

Summary of Key Stakeholder Feedback

ACHIEVEMENTS TO DATE

Prevention and Education

- Both government and community based organisations continue to provide leadership in the development and delivery of innovative prevention, education and other health promotion activities, for example, Growing and Developing Healthy Relationships curriculum support materials, safer sex and drug education for school leavers through the KISS (Keep It Safe Summer) project.
- Development of resources for at risk groups.
- Targeted social marketing - Chlamydia campaign, Non-Occupational Post-Exposure Prophylaxis (NPEP) campaign, online information.
- Evidence of delivery of sexual health and blood-borne virus (BBV) education sessions and workshops with a diverse range of target groups. Examples include the rollout of Health in Prison, Health outta Prison (HIP HOP) program for people in metropolitan prisons, and delivery of Mooditj (a culturally appropriate sexual health program for Aboriginal youth) in rural and remote communities.
- Participation in National events, such as World AIDS Day, National Hepatitis C Awareness Week, and community events such as university orientation days where there is opportunity to provide STI and BBV information.
- Review of Needle and Syringe Programs (NSP) in WA to inform future direction.
- Rollout of Needle and Syringe Vending Machines in non-metropolitan locations.

Diagnosis and Testing

- Development of a number of new/updated policies and procedures including STI clinical guidelines, STI/HIV control supplement for endemic regions, antenatal testing policy for STIs and BBVs in line with National testing policy and in collaboration with key stakeholders.
- Some anonymous and free HIV/STI/BBV testing services are available for specific at risk groups in the metropolitan area
- Pilot STI Clinic run by community nurses in Great Southern Region.
- Provision of pre and post-test discussion training for health care workers.
- In the Goldfields (excluding postcodes 0872, 6431 and 6440), combined chlamydia and gonorrhoea tests increased by an average of 8% per quarter from Q1 2004 to Q2 2007, while the corresponding notifications increased by an average of 13% per quarter over the same time period.

Combined chlamydia and gonorrhoea tests in the Pilbara increased by an average of 10% per quarter from Q1 2004 to Q2 2007, while the corresponding notifications increased by an average of 8% per quarter over the same time period.

Treatment, Care and Support

- Hepatitis C treatment nurses in Southwest, Great Southern and Kimberley regions.
- Enhanced partnerships and development of protocols between hospital hepatitis and psychiatric services to address issues that may arise related to treatment.
- For HIV, improved treatment regimes are proving successful and encouraging better uptake and compliance rates.

- Standardisation of STI clinical management forms and clinical protocols in endemic regions.

Surveillance

- The Epidemiology and Surveillance Program, CDCD continues to deliver high quality reporting on WA data, both at National and State level. A recent initiative is the provision of WA data broken down by GP Divisions.
- Ongoing participation by WA services in the Annual Australian NSP Survey.
- Collection of testing data from pathology laboratories in the three endemic regions (Kimberley, Pilbara and Goldfields) as a means of measuring levels and trends in clinical activity.

Research

- Study of the impact of tele-health in uptake of hepatitis C treatment and outcome in rural and remote areas.
- National study of enablers and barriers to needles and syringe programs (NSP) for Aboriginal people who inject drugs.
- Aboriginal BBV Scoping Project to determine how workers and organisations can be better supported to provide BBV harm reduction services to Aboriginal injecting drug users in WA.
- Pharmacy training needs assessment to inform the delivery of training to pharmacists in regard to NSP and BBV prevention.
- Perth Gay Community Periodic survey investigating gay men's sexual behaviours, drug and alcohol use and community connection was conducted 2006. The WA Lesbian and Bisexual Women's Health and Well-Being Survey was conducted in WA for the first time in 2006/2007.
- Participation in the National Prison Entrants BBV Study 2007.
- Consultation on sexual health education experiences and preferences of young people.
- Research was commissioned into the HIV and sexual health knowledge of members of the WA West African community.
- Social research was commissioned on young men's (16-25 years) perceptions, experiences and decision making around the use of condoms and to determine their knowledge and understanding of STI transmission.
- Research on the impact of the teacher professional development in the *Growing and Developing Healthy Relationships* Curriculum Materials is being commissioned.
- Research on the circumstances of overseas acquisition of HIV by WA men is being commissioned.

Workforce

- Workforce development and education in regard to STIs and/or BBVs has been undertaken with a range of key groups including General Practitioners, Practice Nurses, Graduate Nurses, Pharmacists, and Aboriginal Health Workers.
- Workforce development is occurring for other sectors that are likely to have contact with people with, or at risk of, hepatitis C. For example, youth, mental health and alcohol and other drugs sectors. Prison Officer recruits are also receiving training in BBVs and infection control.
- A review of sexual health, HIV/AIDS and hepatitis C workforce training needs was undertaken. It highlighted strengths and gaps in the provision of training

and education to the sexual health and BBV workforce in WA, which have implications for the future development and delivery of training.

- Quarterly Sexual Health Forum provides ongoing education of workers through regular updates on treatment, new trends in infection, and education programs and services.
- Ongoing training has been provided to health care providers on using the STI Flipchart for community education, particularly with Aboriginal people.
- A standard STI/HIV Orientation Package for rural and remote providers is under development.
- Some regions have dedicated STI/BBV officer and Regional NSP Coordinator positions.

Partnerships

- Collaborative partnerships underpin many prevention/education and workforce development initiatives.
- Good partnerships are being developed between GPs and specialist hepatitis C, HIV and STI services.
- Quarterly Sexual Health Forum provides opportunity for informal networking and establishing partnerships.
- Immunology and Infections Health Network and Digestive Health Networks are working in partnership to develop state-wide models of care for hepatitis C, HIV and STIs.

KEY ISSUES

Prevention and Education

- Sensitivities around doing BBV and STI education with upper primary and secondary school students.
- Provision of STI and BBV education to young people not attending school, in particular Aboriginal youth.
- Ongoing need for effective education and prevention strategies in Aboriginal communities for both safer sex and injecting.
- Need to make NSPs (particularly those in rural and regional areas) more than a distribution point for equipment and information (as opposed to education).
- While information is available in prisons, it is difficult to address hepatitis C and BBV prevention in the absence of prison NSPs and safer tattooing strategies.
- “HIV education fatigue” that has developed among some of the gay population which makes them difficult to reach, but gay men and men who have sex with men still remain the most at risk of HIV acquisition and need to remain a priority for education and prevention.
- The message that HIV is now a manageable condition leaves some groups more open to at-risk behaviours.
- Need to develop innovative interventions to address overseas-acquired HIV.
- General community knowledge/awareness of hepatitis C remains low.
- Need for nationally funded Chlamydia campaign.
- The effectiveness of STI/BBV education can be difficult to ascertain and measure.

Diagnosis and Testing

- Lack of bulk billing GPs, and often long waiting times for appointments (particularly in rural and regional areas).

- Lack of GP knowledge and general discomfort around sexual health matters means that opportunistic testing is not carried out.
- Need to increase and develop innovative approaches to opportunistic screening, for example, through alcohol and other drug and mental health sectors; and increase outreach services, for example, at youth venues.
- Lack of sex worker friendly GPs is a barrier to effective diagnosis and testing in this group.
- Perceived lack of confidentiality in rural and remote areas.
- Awareness of the importance of hepatitis C pre and post test discussion and informed consent needs to be increased for GPs.
- Increasing numbers of inmates in prison system creates challenges in providing BBV/STI testing and follow-up.

Treatment, Care and Support

- Despite the removal of liver biopsy as prerequisite for hepatitis C treatment, uptake of treatment remains low - awareness of treatment options and effectiveness needs to be increased. Uptake of treatment for Aboriginal people is particularly low.
- Limited access to hepatitis C treatment in prisons; treatment and follow up for prisoners with STIs can also be problematic.
- Limited resources and capacity of tertiary liver clinics.
- Lack of services in rural and remote areas.
- Need for increased integration of contact tracing services into clinical services.
- Need for more accessible, targeted services for high-risk groups.

Surveillance

Generally, most respondents noted that current surveillance and reporting met the needs of their organizations. Suggestions of where surveillance could be expanded included:

- If overall testing rates were reported, this would allow better interpretation of the changes that occur in disease notifications.
- While a consistently high proportion of STI notifications in remote regions identify Aboriginal status, this needs more attention in some rural areas, and particularly in the metropolitan area.
- Consideration of STI sentinel surveillance at sexual health clinics.
- Consideration of a state-wide syphilis register to enable better management of chronic syphilis.

Research

Areas of research that were identified as requiring attention included:

- Effective ways of encouraging behaviour change (i.e. safer sex/safer injecting) amongst young Aboriginal people.
- Surveying GPs and health care workers about their preferred mode of receiving education.
- Evaluating the effectiveness of the Health in Prison, Health outta Prison (HIP HOP) program.
- Sexual health and condom usage in prisons.
- Assessment of support needs of people living with hepatitis C and/or undergoing treatment.
- Expansion of the Gay Periodic survey to include more STI information.

Workforce

Recruitment and retention was identified as a major concern across the board (e.g. health promotion practitioners, nursing staff, GPs), particularly in rural/remote areas and in the Aboriginal health workforce. Low remuneration in the community and not for profit sectors (compared to government and private sectors) further impacts on recruitment and retention. Other issues related to the workforce included:

- Having workers on short-term contracts creates insecurity and makes connecting to the community difficult.
- Cultural awareness training for all sexual health services needs to be improved.
- National Aboriginal Health Worker competencies have been finalised but need to be implemented.
- Difficulty with reaching more GPs as there is limited interest in BBVs and STIs.
- For rural and remote workers, access to training is limited by access to funds to travel and the need for coverage while participants attend training.
- Staffing issues for teachers can impact on their ability to access professional development such as that which compliments the Growing and Developing Healthy Relationships materials.
- Staff shortages and lack of appropriate housing in remote areas.
- Urgent need to amend the Poisons' Act to enable Advance Sexual Health Nurses to be trained and to practice.
- Investment in sexual health clinical positions to maintain and enhance ongoing workforce capacity.

Partnerships

While many respondents considered that there was strong existing partnerships both within the sector and between sectors, there were areas that were identified that could be strengthened:

- While some inroads are being made, linkages with alcohol and other drugs, mental health and Aboriginal health sectors need to be strengthened.
- Need for increased consumer/peer representation in regional areas in regard to injecting drug use issues.

Priority areas and target groups

The following groups were identified as of priority by many respondents in regards to HIV, hepatitis C and STIs:

- Aboriginal people, particularly youth, street-based sex workers and Aboriginal people in remote communities.
- Young people.
- Prisoners.
- Methamphetamine users.
- Heterosexual people at risk of acquiring HIV overseas.

Emerging challenges and future directions.

A range of emerging challenges and future directions were identified, including:

- Methamphetamine use and impact on unsafe injecting and sexual behaviour.
- Access to injecting equipment in regional areas could potentially be increased through increased numbers of dedicated NSP/NSEP, and by addressing negative attitudes of some NSP service providers.

- Increased access to youth sexual health screening and treatment facilities, especially in rural and remote areas with limited GP services.
- Funding.
- Keeping primary care interested in sexual health.
- Lack of contact tracing services presents a challenge.
- Development of models of care for HIV, STIs and hepatitis C.
- Diversifying HIV epidemic.
- Accessing hard to reach groups, e.g. CALD sex workers.

SUMMARY

As it was put by one respondent in regard to hepatitis C, “Despite the good work being done, a sense of treading water prevails”. This is borne out by responses from key stakeholders in the HIV, STI and hepatitis C areas, which identified a wide range of activity being achieved across the key areas of prevention and education; diagnosis and testing; treatment, care and support; surveillance and workforce development. However, a range of challenges were identified - some on-going and others newly emerging and requiring new and invigorated responses.

Priority target groups largely reflect those identified in the Action Plans - namely Aboriginal people, young people, and people in prison. An emerging priority area is methamphetamine users, who present a challenge both in terms of the potential for unsafe injecting and sexual behaviors.

Issues in regard to access to services in remote and rural areas were identified. This is intensified by workforce recruitment and retention issues - which impact particularly in rural and remote areas but are also acknowledged in metropolitan areas.

That many key stakeholders felt that partnerships were working successfully is encouraging, and the Sexual Health and Blood-borne Virus Program thanks all key stakeholders for their input into this review process.

GOALS AND OBJECTIVES OF THE WA HIV/AIDS, STI AND HEPATITIS C ACTION PLANS

The goals and objectives of the Western Australian HIV/AIDS, STI and Hepatitis C Action Plans are outlined below. Note that these are aligned with the goals and objectives of the corresponding National Strategies.

| | WA HIV/AIDS Action Plan 2006-2008 | WA Sexually Transmitted Infections Action Plan 2006-2008 | WA Hepatitis C Action Plan 2006-2008 |
|-------------------|---|---|--|
| Goal | To reduce HIV transmission and to minimise the personal and social impacts of HIV/AIDS infection in WA. | To reduce the transmission of STIs in WA, with particular reference to STIs other than HIV, through improved awareness and access to appropriate health services. | To reduce transmission and minimise the personal and social impacts of hepatitis C for Western Australians. |
| Objectives | <ul style="list-style-type: none"> • To reduce the number of new HIV/AIDS infections in WA, through health promotion, harm reduction policies, education and improved awareness of transmission and trends in infections. • To improve the overall health and wellbeing of people living with HIV/AIDS (PLWHA) in WA through equitable access to treatments and improved continuum of care in health and human services. • To reduce HIV-related discrimination that impacts upon PLWHA and affected communities in WA. • To develop and strengthen links with other related national and WA strategies and action plans. | <ul style="list-style-type: none"> • To improve awareness of STIs in WA, in particular their economic, social and personal impacts, within the government, medical and community sectors. • To establish a basis for coordinated action on STIs now and in the future in WA. • To increase access to diagnosis, treatment and care of STIs in WA. • To minimise the transmission and morbidity of STIs in identified priority groups in WA. • To improve surveillance and research activities in order to guide the development and implementation of prevention initiatives in WA. • To develop and strengthen links with other related national and WA Strategies and Action Plans. | <ul style="list-style-type: none"> • To reduce transmission of the hepatitis C virus through education, improved awareness of risks and access to harm reduction strategies. • To maximise the health and wellbeing of people with hepatitis C by providing equitable access to appropriate testing, treatments, information and support services. • To improve surveillance within the WA community to provide prevalence and incidence data to better identify and monitor hepatitis C prevention and control strategies. • To reduce the discrimination, isolation and stigma experienced by people with hepatitis C through raising community awareness of hepatitis C and its consequences. • To support virological, clinical and social research which informs evidenced based prevention, treatment and support services. • To develop and strengthen links with other related national and WA strategies. |

Appendix 4: PowerPoint Presentation Slides

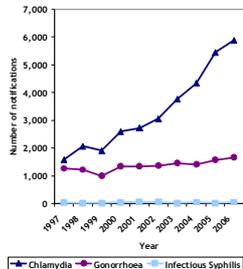
4.a. Trends in Epidemiology: Kellie Kwan and Dr Barry Combs

Mid-Term Review of WA STI/HCV/HIV/AIDS Action Plans 2006-2008:
Trends in Epidemiology

Kellie Kwan & Barry Combs
Epidemiology and Surveillance Program
Department of Health



Overall trends in WA STI notifications, 2006



Change from previous five-year average:

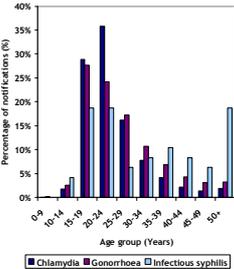
- Chlamydia 52% higher
- Gonorrhoea 16% higher
- Infectious syphilis 24% higher

WA 2006 crude rates in comparison to nation as a whole:

- Chlamydia 1.3 times higher, second highest behind NT
- Gonorrhoea 2 times higher, second highest behind NT
- Syphilis 1.4 times lower



Age trends in WA STI notifications, 2006



STIs mostly affect people under 30:

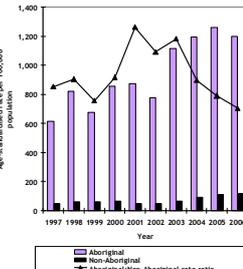
- Chlamydia 83%; peak in 20 to 24 (36%) and 15 to 19 (29%)
- Gonorrhoea 72%; peak in 15 to 19 (28%)

However...

- Infectious syphilis 42%; 44% 35 and older



ASR of chlamydia notifications by Aboriginality, WA, 1997 to 2006



- 40% unknown Aboriginal status in 2006
- Since 2003, rate of increase higher in non-Aboriginal people
- 2006 Aboriginal:non-Aboriginal rate ratio = 10.0:1 (lowest in last 10 years)

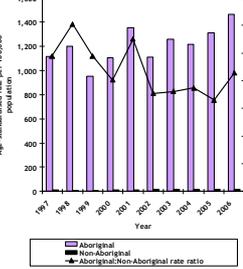


Chlamydia by Aboriginality, Age and Region, WA, 2006

- WA Aboriginal notification rate = 1,199/100,000 pop.
- Highest notification rates in 15 to 19 yr old Aboriginal people in the:
 - Goldfields (10,661/100,000 pop.)
 - Kimberley (9,190/100,000 pop.)
 - South metro (8,622/100,000 pop.)



ASR of gonorrhoea notifications by Aboriginality, WA, 1997 to 2006



- 3% unknown Aboriginal status in 2006
- 2006 Aboriginal:non-Aboriginal rate ratio = 85.5:1
- Rate of increase higher in non-Aboriginal people

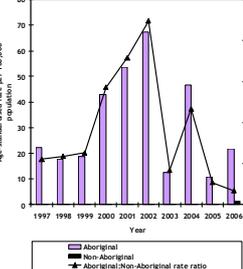


Gonorrhoea by Aboriginality, Age and Region, WA, 2006

- WA Aboriginal notification rate = 1,464/100,000 pop.
- Highest notification rates in Aboriginal people:
 - 20 to 24 yrs in the Pilbara (13,058/100,000 pop.)
 - 15 to 19 yrs in the Kimberley (9,703/100,000 pop.)
 - 20 to 24 yrs in the Goldfields (9,472/100,000 pop.)



ASR of infectious syphilis notifications by Aboriginality, WA, 1997 to 2006



- 0% unknown Aboriginal status in 2006
- Aboriginal ASRs fluctuated over last 10 years
- Increase in non-Aboriginal ASR in 2006
- 2006 Aboriginal:non-Aboriginal rate ratio = 16.8:1 (lowest in last 10 years)

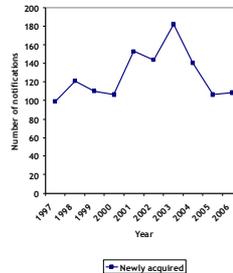


Infectious Syphilis by Aboriginality, Age and Region, WA, 2006

- WA Aboriginal notification rate = 22/100,000 pop.
- Highest notification rates in Aboriginal people:
 - 20 to 24 yrs in the Goldfields (546/100,000 pop.)
 - 30 to 34 yrs in the Kimberley (243/100,000 pop.)
 - 15 to 19 yrs in the Kimberley (228/100,000 pop.)



Number of newly acquired hepatitis C notifications, WA, 1997 to 2006

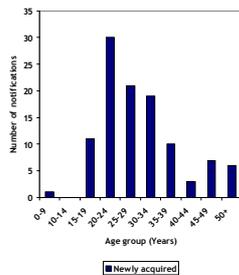


- 106 notifications in 2006 = 26% decrease from previous five-year average of 145.0 notifications per year

- WA 2006 crude rate highest reported in Australia (5.7 vs. 2.2/100,000 pop.)



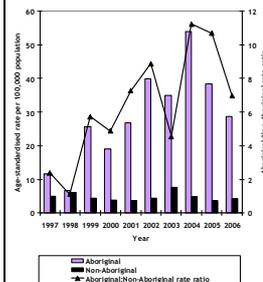
Number of newly acquired hepatitis C notifications by age group, WA, 2006



- Peak age 20 to 34 (65% of notifications)
- 10% of notifications among 15 to 19 yr olds



ASR of newly acquired hepatitis C notifications by Aboriginality, WA, 1997 to 2006



- 6% unknown Aboriginal status in 2006

- Aboriginal ASRs decreasing since 2004
- non-Aboriginal ASRs remaining stable since 2004

- 2006 Aboriginal:non-Aboriginal rate ratio = 7.0:1

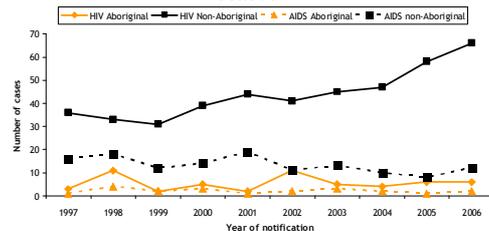


Newly Acquired Hepatitis C by Aboriginality, Region and Sex, WA, 2006

- WA Aboriginal notification rate = 29/100,000 pop.
- Highest notification rates in Aboriginal people in the Great Southern (87/100,000 pop.)
- Among Aboriginal people, more female notifications (male:female ratio = 0.9:1)
- Among non-Aboriginal people, more male notifications (male:female ratio = 1.6:1)

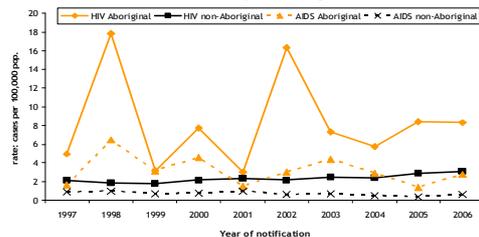


Newly diagnosed HIV/AIDS cases by Aboriginal status



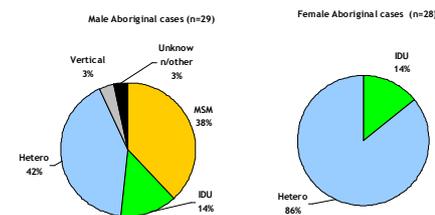
- Increases in HIV notifications mainly in non-Aboriginal pop.
- Recent AIDS notifications/year are stable among Aboriginal and non-Aboriginal cases

HIV/AIDS rates by Aboriginal status

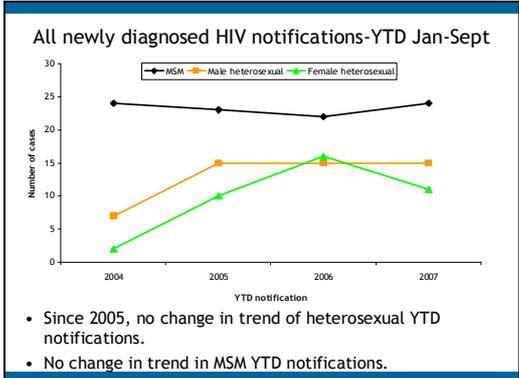
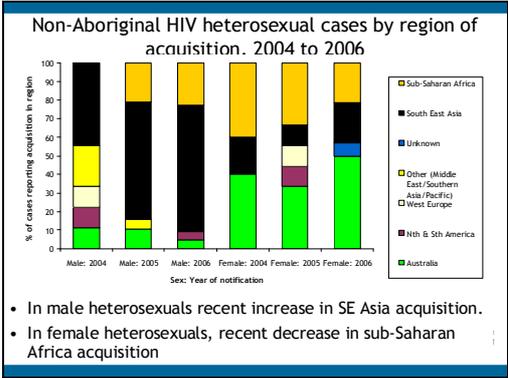
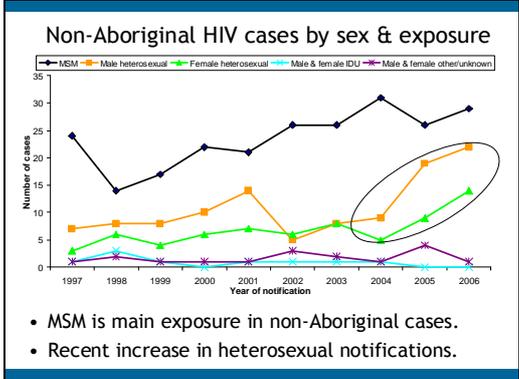
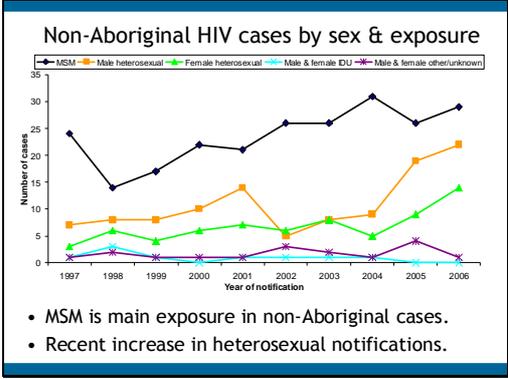


- Aboriginal HIV/AIDS rates more than twice the rate of non-Indigenous

Aboriginal HIV cases by sex & exposure, 1997 to 2006



- Heterosexual is main exposure among Aboriginal cases



HIV summary

- Increase since 1999 mainly due to non-Aboriginal cases.
- Among Aboriginal cases main exposure is heterosexual
- Among non-Aboriginal cases main exposure is MSM but heterosexual cases increasing.
- Male heterosexuals mainly acquiring infection in SE Asia.
- Female heterosexuals acquire infection in Aust and overseas.

4.b. Hepatitis C Model of Care: Dr Wendy Cheng

Hepatitis C Model of Care

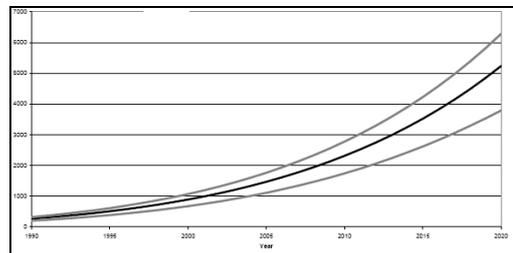
Dr Wendy Cheng
Infections & Immunology and
Digestive Health Networks

Hepatitis C in Australia

- 264,000 persons in Australia affected by HCV
- 5,300 (2%) were living with HCV-related cirrhosis
- During 2005 it was estimated that:
 - 210 developed liver failure
 - 105 developed HCC related to hepatitis C

Treatment of Hepatitis C

- To have an impact on the epidemic the number treated annually needs to increase from 2,000 to 10,000
- Only 1% of the 15,000 patients living with HCV in WA currently have access to treatment
- Optimal model needs to be developed to meet the demand for therapy



Predicted HCV-related mortality 1999-2020 (Hepatitis C Virus Projection Working Group 2002)

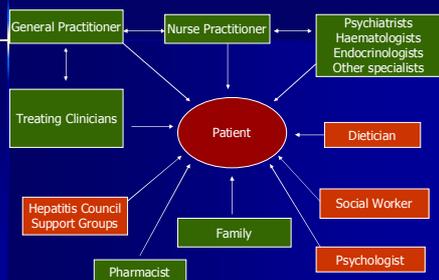
Optimal management of Chronic Hepatitis C

- Prevention
- Establishment of model of care - state-wide co-ordinated Hepatitis C Service (including state-wide database)
- Improvement of access to treatment and provision of equity of care across all sectors
- Management of complications of liver disease
- Hepatocellular carcinoma surveillance program

Current HCV model of care - principles

- Multi-disciplinary team approach
- Established management protocols
- Improvement of access to treatment
- Address co-factors – e.g. alcohol, NASH
- Address extra-hepatic manifestations
- Management of complications of liver disease

Multi-disciplinary approach to Hepatitis C

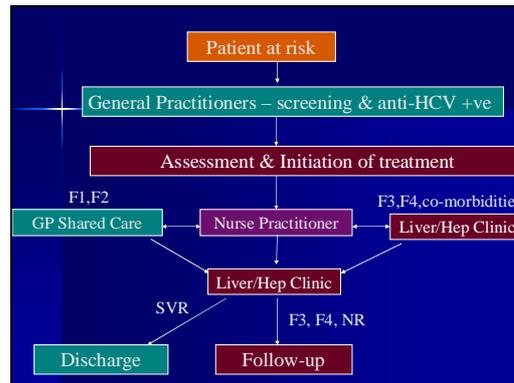


Improving Access to treatment current strategies

- Hepatitis GP Shared care program
- Hepatology Nurse Practitioner
- Increase access to treatment to disadvantaged groups – prisoners, Aborigines, ethnic minorities
- On-site clinics
- Telehealth – recently established for medical and nursing clinics (includes demonstration of self-administering techniques)

General Practitioner HCV Shared Care Program

- Sharing of care of patients initiated on treatment for HCV at tertiary centres
- Particularly effective for patients in remote areas
- Shared care protocol established with specific times for blood tests and instructions
- Nurse Practitioner first person of contact and co-ordinates the program



Nurse Practitioner

- Western Australia leads the nation in having 1st Hepatology Nurse Practitioner in Australia
- Position designated by Director General
- Practises within approved clinical protocols
- Increased scope of practice – prescribing selected drugs, instigating investigations & referral within multi-disciplinary liver group
- 1st contact for GPs and patients

Telehealth HCV Clinics

- The first HCV telehealth service in Australia
- Both medical and nursing clinics
- Established at RPH in May 2006
- WA – area of 2.5 million square kilometers
- Only 1% of the 15,000 patients living with HCV in WA currently have access to treatment, less in rural areas
- PILLAR award to evaluate telehealth service

Objectives of Telehealth Service

- To increase access to treatment for HCV for the patients in rural and remote areas
- To reduce the necessity for patients to travel to Perth
- To improve the capacity of the rural health services
- To provide equity of care for patients in rural and remote areas.

HCV clinics in prisons

- Established in June 2005
- Weekly clinics
- In 21 months
 - No: of patients assessed: 90
 - No: of patient visits: 300
 - No: of patients treated: 25
- Service no longer in existence – lack of funding from Dept of Justice

Model of Care

Models of Care Describe:

The best practice care and services that should be available within a health care system for a person or population group as they progress through the stages of a condition, injury or event.

Hepatitis C Model of Care

- Formation of a Viral Hepatitis Working Group
- Group includes a wide range of representation including NGO
- Development of statewide model of care
- Consolidate the current model of care into a co-ordinated approach

State-wide HCV Model of Care

- HCV identified by two Health Networks (Digestive and Infection & Immunology) as one of the top priorities in health reform process
- Needs a systematic approach encompassing different levels of health care facilities to provide equity of care across the population

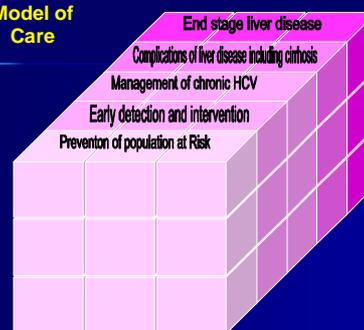
Priorities in Hepatitis C

- State-wide Hepatitis database
- State-wide Hepatitis C service
 - tertiary, secondary hospitals, step-down facilities, inner city clinics, drug rehabilitation centres, prisons
 - Innovative strategies
- Co-ordinated education program for GP and health care workers (metro and rural)
 - Web-based learning

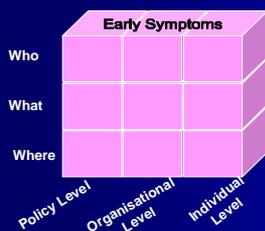
Model of Care - principle

- Uses multi-dimensional matrix with 3 axes
- Stages of liver disease
 - Component of health care system
 - Details of activities and services that should be provided

HCV Model of Care



Model of Care – at each level



Three Key Recommendations

- State-wide HCV data-base
- Telehealth – further development
- Web-based learning

State-wide Hepatitis C database

- Establishment of database subgroup chaired by Dr Mark Watson
- Assess currently available HCV databases – hospitals and commercial
- Approved by SHEF IT Subcommittee
- InfoHealth Representative Kevin Marsh
- Executive Sponsor – Dr Simon Towler

Current status of MOC

- Current draft with Business Support Unit of Health Network
- First draft to be available for circulation shortly
- Final draft needs to be endorsed by I & I and Digestive Health Networks before submitting to Dr Simon Towler

Summary (1)

- Optimal model of care is urgently needed to be able to make an impact on HCV epidemic
- Innovative models incorporating primary care clinicians, nurses and allied health are necessary to increasing screening and treatment

Summary (2)

- HCV model of care should incorporate the following:
 - State-wide HCV model
 - Multi-disciplinary team approach
 - Increase access to treatment in disadvantaged groups – prisoners, minority ethnic groups
 - Utilization of modern technology – database & Telehealth
 - Education - using web-based learning
 - Hepatocellular carcinoma surveillance program

4.c. HIV/AIDS Model of Care: Prof Martyn French

Primary prevention of HIV infection

- Reinvigorate community education programs
 - young people eg. high-schools
 - use new technologies
- Specific prevention interventions
 - MSM (NB. Syphilis 'epidemic')
 - Males living and working overseas
 - Refugees, migrants and students
 - Aboriginal people
- Improve access to testing for BBV/STIs, especially in rural and remote areas

Primary prevention of HIV infection

- Ante-natal screening
- Post-exposure prophylaxis
 - Revised protocols

Training and education

- Improve early detection of HIV cases by medical practitioners (GPs and specialists!)
- Increase the number of GPs to undertake shared-care of people with HIV infection
 - training programs (not short courses)
- Support for, and standardisation of, training programs through ASHM
- Dissemination of best practice guidelines

Revising clinical services

- An aging HIV patient population
 - 61% of patients 40-59 years old
 - 10% of patients >60 years old
 - residual immune dysfunction will compound age-associated immune dysfunction
 - Management of pregnant women with HIV infection
 - Multi-disciplinary Inter-hospital Pregnancy Team
- (Gilles M et al. Perinatal HIV transmission and pregnancy outcomes in indigenous women in Western Australia. *Aust N Z J Obstet Gynaecol.* 2007;47:362-7).

Revising clinical services

- Provision of assisted reproduction technology for 'discordant couples'
- Increased support for rural and remote services
- Support for information technology systems to co-manage people in hospital and the community eg. clinical databases
- Living healthily with a chronic virus infection
 - antiretroviral therapy + ?new immunotherapies
 - avoiding co-morbidities

Revising clinical services

- Future hospital out-patient and in-patient services for people with HIV infection
 - ? inner city 'Communicable Diseases Clinics'
 - move services to other hospitals
 - keep Royal Perth Hospital open!
- Hostel care facilities for people with HIV infection and dementia and/or psychiatric disorders

Community-based support for people with HIV infection

- WAAC
- Enhanced services for people with psychiatric and/or psychological disorders
 - Ruah ('chaotic life-styles')

4.d. STI Model of Care: Dr Lewis Marshall

Model of Care

- Ensuring people get the right care at the right time by the right team and in the right place
- Patient centred
- Equity of services
- Collaborative
- Forward looking
- Responds to existing policy
- Influencing Future Planning

Elements

- Primary Prevention and promotion
 - Govt and non Govt
 - Social marketing, websites, awareness weeks
 - Schools
 - Youth workers
 - Health hardware
- Secondary Prevention
 - Early Detection and Intervention
 - GPs and practice nurses
 - Population screening, A&E, pharmacy
 - Contact tracing

Elements

- Tertiary prevention
 - Disease management
 - More clinical opportunities
 - outreach
 - centre of excellence
 - rural services
 - telehealth
 - Workforce development and training
 - Advanced practice nurses
 - Medical workforce
 - AHW and HPOs

Recommendations

- Primary Prevention
 - Continue and enhance community and targeted social marketing
 - Reinvigorate school-based education/prevention
 - Continue to develop and provide out of school education/prevention programs
 - Invest in existing, new and emerging prevention and education programs
 - Provide appropriate education/prevention strategies for the Aboriginal community
- Secondary Prevention and Early Detection
 - Improve early detection and intervention, particularly for high-risk populations
 - Continue and enhance disease notification and surveillance systems
 - Expand contact tracing services in the metropolitan area and throughout WA

Recommendations

- Disease Management and Tertiary Prevention
 - Enhance metropolitan-based tertiary sexual health clinical services
 - Ensure that clinical services are more accessible and meet the needs of clients
 - Expand rural and remote clinical services
- Workforce
 - Continue to provide opportunities for primary care providers to undertake sexual health/STI training
 - Enhance medical student training
 - Establish the creation of and provide ongoing support for Advanced Sexual Health Nurse positions in WA
 - Enact Poison's Act changes
 - Increase the number of positions and training opportunities for clinicians specialising in sexual health medicine
 - Increase the number of Sexual Health Promotion Officers throughout WA
 - Continue to update and disseminate best practice guidelines for primary health care providers involved with the management of STIs

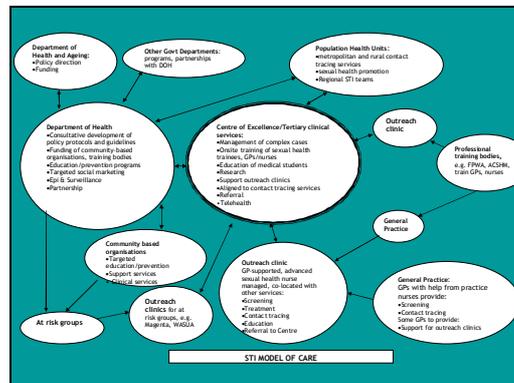


Figure 5: Diagram of the Proposed Three-Tiered Metropolitan Clinical Service Model

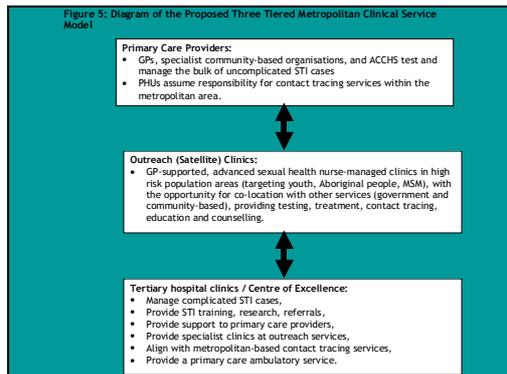
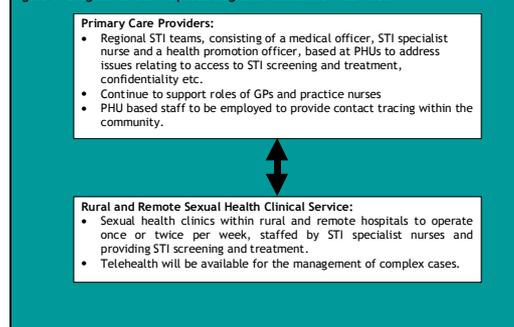


Figure 6: Diagram of the Proposed Regional Clinical Service Model



Appendix 5: Minutes from the Mid-Term Review Forum Discussion

Hepatitis C

The following were identified by one attendee as key priorities to progress over the next 12 months:

- Prevention of transmission - Approaches need to be targeted and be realistic about what is to be achieved. Solid recommendations should be produced on how to prevent transmission with regards to injecting drug use, tattooing and violence in prisons.
- Access to treatment in prisons - It is well recognised that prisons provide an optimal opportunity to access people with hepatitis C and provide important health services because prisoners are in a stable environment and can make considerable improvements to their health. Careful thought is needed about how we are providing services (such as transport for prisoners to treatment services) and ensure that they are of a high standard and are producing positive health outcomes (which will justify that they are required services).

It was reported that the health sections of each prison do not report through the prisons directly. The expectation is that the Department of Corrective Services will pick up this responsibility but realistically this is not going to happen.

Enabling the In-Reach program to be reinstated in prisons was raised as a key issue.

An attendee suggested that we should be addressing why people are actually in prison as the first step and consider how we can reduce the number of Aboriginal people in prisons. This suggestion was supported by another attendee.

A number of attendees agreed on the need for a broad-based media campaign to promote knowledge and prevention of hepatitis C. The strategy for the campaign should include sustainable change outcomes which get followed through. The importance of using media that is popular with young people and introducing this type of promotion and education to younger age groups was also emphasised.

Another attendee who was supportive of the media campaign commented that many students in WA are in the Catholic/private education system and therefore do not receive the government-provided health education, so a public campaign enables these people to be targeted.

One attendee put forward the following three key priority areas:

- Access to treatment especially in rural and remote areas and a regional coordinator for each area
- Statewide HCV Database
- Integration of services/shared care.

The issue of access to treatment for Aboriginal people was discussed. One attendee said that in their experience once Aboriginal people (with hepatitis C) are in hospital they do well and have positive health outcomes. Another attendee commented that progress hinges on whether treatment is a priority for the Aboriginal person. It was suggested that focus could be given to how health

information is being communicated to Aboriginal people and how Aboriginal people are accessing information.

HIV/AIDS

One attendee raised three specific key priority areas relating to HIV/AIDS:

- The need to return to clinical databases that are adequately supported either through hospitals or the Department of Health
- Reinvigorate HIV/STI community education programs with particular focus on overseas-acquired HIV
- Increase funding for rural and remote services provided through Royal Perth Hospital (RPH) and look at different mechanisms for delivering to these groups, (for example increased staffing or an outreach program run from RPH).

The new *Safe Sex No Regrets* media campaign, which has been funded by the Sexual Health and Blood-borne Virus Program (SHBBVP) and developed (from an existing NSW campaign) by the WA AIDS Council (WAAC), was discussed. The campaign, to be launched in December, includes a series of television advertisements, brochures and posters, and it will target a broad cross-section of the community.

The importance of addressing sexual health issues among young people by utilising new popular media (such as Facebook and You Tube) was emphasized as a key mechanism for providing health information. WAAC are progressing ideas to set up a cyberspace/online testing procedure. The City of Bunbury has contacted WAAC about the possibility of running an outreach program and a testing service in Bunbury. This is currently under discussion.

Workforce development in rural and remote areas and heterosexual overseas-acquired transmission of HIV were highlighted as priority issues. Training is needed for community workers and regional staff, as well as outreach programs that target Indigenous people and men who have sex with men (MSM). A whole of sector approach is important (e.g. including mental health and alcohol and other drug services) to ensure the sexual health field does not work in isolation.

It was suggested there is a need to develop a multi-focused plan and methods to encourage general practitioners (GPs) to become involved in shared care for HIV/hepatitis C, and to ensure they are kept up to date with HIV clinical news. It was reported that this has started to occur through the Western Australian General Practice Network (WA GP Network) but due to GPs having other major priorities and busy schedules, sexual health often becomes a low priority. An attendee commented that the Commonwealth structure does not support GP investment in sexual health and a change to this structure would also be an important factor in raising the profile of sexual health among GPs.

It was noted that the WA GP Network, in collaboration with Australasian Society for HIV Medicine (ASHM), are rolling out a project to ascertain GPs' interest in the idea of shared care.

The importance of the prison population and the need for effective BBV prevention in prisons to ensure BBVs do not spread to the broader community when prisoners are released was raised by an attendee.

The need for improved access to culturally appropriate HIV/AIDS (and other health) information for refugee, migrant and culturally and linguistically diverse (CALD) groups was recommended as a key priority.

It was raised that it is important to up-skill and resource the people already living in marginalised communities to provide services (as opposed to recruiting external staff/organisations), and one way to do this would be to approach individual members in the community. It was commented that there are sustainability issues with such a method and that it is more effective to take a broader approach such as including health information in a school curriculum.

Sexually Transmitted Infections

A new project being developed through Fremantle Hospital which aims to improve chlamydia screening in the metropolitan area was discussed and it was suggested this could be funded as a key priority.

A suggestion was made for the provision of a framework to train nurses to increase opportunistic screening of STIs, particularly as young people often do not access GPs.

It was discussed that improving access to services is important but that this cannot be achieved unless there is a trained workforce. This will be better achieved by training nurses, in which case the Poisons Act must be amended to allow nurses to prescribe treatment to patients after screening. This should happen in the next 12 months but will require lobbying the Minister for Health. It is also important that area health services are aware of the need for greater workforce training to ensure that there are training positions available (for doctors and nurses).

Another attendee affirmed the need for more workforce training opportunities and better access to services. It was also noted that for staff in rural and remote areas actually *getting* to training can be difficult as there are not enough staff to backfill positions or there are just not enough staff to recruit into the existing vacant positions. Therefore, the issue of staff recruitment in country areas is also of key importance.

The issue of needing more staff for contact tracing services was raised. One attendee reported that two contact tracing positions have been promised for the south metropolitan area and it is perceived that this is achievable in the next 12 months. The positions would have the capacity to provide contact tracing support for primary care.

It was recommended that a sustained approach needs to be taken to the syphilis outbreak in the metropolitan area in conjunction with following the STIGMA (Sexually Transmitted Infections Testing Guidelines for Men who have sex with Men) guidelines.

A number of items of importance regarding sex workers' health were raised:

- Occupational safety and health guidelines will be implemented with the introduction of the Prostitution Legislation.
- There is a need for increased testing services in establishments and there are issues around how these services would be staffed
- There is a need to provide accurate information to CALD sex workers and better access to all health and non-health services.

Workforce development issues were discussed with focus on the difficulty many teachers experience accessing professional development (PD) opportunities, especially those in regional areas. A flexible structure needs to be developed to offer more PD opportunities to teachers in regional areas and to make it easier for them to attend.

The recommendations which will be produced from the evaluation of the *Growing and Developing Healthy Relationships* curriculum materials will hopefully provide a guide on how to improve workforce development opportunities for teachers. Some early ideas are to better promote the resources that already exist, to work with specific (targeted) districts and to better utilise online resources.

One attendee raised the need to have data on the number of sex workers who are Aboriginal to help inform the development of outreach programs that target this specific group. It was commented that there are significant difficulties in getting this information as sex workers often want to remain anonymous and asking personal questions can be intrusive.

It was suggested that another priority could be enhanced surveillance for chlamydia. This surveillance is automatically generated by the pathology labs and a GP is just required to complete an enhanced surveillance form (not a notification form). This process would also elicit more accurate information on Aboriginal patient health.

Focusing attention on ensuring the public health legislation goes through was recommended as an important area.

The prevalence of risky behaviour highlighted the importance of keeping primary prevention on the agenda. There are opportunities to improve the delivery of prevention programs in the North Metropolitan Area as there are a number of health promotion staff available who can work with schools/nurses.

It was commented that it is important to focus on programs that promote behaviour change in relation to sexual health, not just educating people about the risks.

Feedback provided post-forum recommended that in the next 12 months there could be commitment to:

- distribute information on the new prostitution laws to the industry and to other interested stakeholders
- disseminate the Sex Industry Occupational Safety and Health Code of Conduct to sex workers and sex work establishments.

Appendix 6: Other priorities as identified by key stakeholders

| HCV/HIV/STI Priorities for the Next 12 Months | Strategy to achieve this priority | Who needs to be involved |
|---|--|--|
| Maintain education and testing strategies for clients as core business | Ongoing monitoring to ensure that education and testing is being done | DAO to maintain current activities |
| Workforce development for all staff especially new Aboriginal staff in regional areas | Include HCV/HIV/STI information/education in staff training programs and develop links with local health staff especially in regions | Local health services to link up. |
| Universal HIP HOP for all prisoners (not DAO) | Funding/resources | DCS/DOH |
| Implementation of the K-10 syllabus which provide guidance to teachers about content across each phase of schooling | Maintenance of partnerships between education and health | DOH, DET, communication within district offices. |
| Continued promotion of curriculum support packages such as Growing and Developing Healthy Relationships for teachers of K-10 students | Flexible delivery of professional development as is appropriate within each district context | |
| Continued promotion of availability of professional development for teachers | Linking existing resources to the K-10 syllabus | |
| Urge child and adolescent health services (CAHS) to develop/enhance primary prevention strategies | Universal programs to inform whole population | CAHS ie community health and health promotion |
| CAHS is unique in Australia in having a health promotion workforce and support the work of school nurses. | Targeted programs in high risk suburbs and with disadvantaged groups | Public health links |
| They not only need to increase resilience building programs to reduce the risky behaviour but also target high risk kids | Services to be enhanced to respond to higher levels of screening | Youth sector patient advocates |
| BBVs in the Justice System (NSPs) Outreach screening/testing in rural and remote areas | Advanced Practice Nurse (APN) training particularly in rural and remote areas, workforce training | DET, Nurses Board, GP Networks, FPWA |
| HCV targeted programs for young people early using behaviours | Community development and health promotion to younger cohort and partnership with the DET and youth workers | Criminal Justice and DOH |
| Barriers to access GPs waiting lists, costs of testing for STIs and BBVs | | |

| HCV priorities for the next 12 months | Strategy to achieve this priority | Who needs to be involved |
|---|--|--|
| Finalise Models of Care | Need to engage fund holders in Area Health Services to facilitate implementation of Models of Care. | CDCD |
| Improve educational awareness to care providers and the community for STIs, HIV and HCV | Continue current education programs and look at e-learning as an educational resource eg for prescribing | Infection and Immunology/Digestive Health Networks |
| Telehealth promotion to assist in supporting WACHS. | Need to enhance workforce e.g. APNs to increase capacity of telehealth. | Area Health Services including WACHS. Engage Commonwealth. |
| Increase access to injecting equipment for Aboriginal people | Greater liaison between HCV related services e.g. WASUA and Aboriginal health/community | Relevant community groups and agencies supported by DOH programs |
| Prisoners to have access to injecting equipment | Start dialogue with key stakeholders re injecting equipment in prisons | Industry bodies, prison officers, health professionals and relevant government departments |
| Focus on prevention | Continue expansion of increase access to injecting equipment and peer-based education | Public health broad based campaign informed by good knowledge and understanding |
| State-wide HCV database to facilitate GP HCV shared care program | HCV database working group already formed and chaired by Dr M Watson | Health Networks: Infections and Immunology and Digestive |
| Telehealth to increase access to treatment to remote and rural areas | Ongoing work by Saroj Nazareth, Nurse practitioner at RPH, who is a member of the Telehealth network | DOH, SHBBVP |
| Web-based learning to facilitate understanding and treatment of HCV - for the GP Health Network and public (including school) | Establishment of network to facilitate E learning | Tertiary hospitals |
| Increase access to treatment in rural and remote area, and prisons | New models of care for rural and remote areas eg Telehealth | Tertiary hospitals, GPs, Health Care workers |
| Statewide HCV database | Committee established to take this step up re the appropriate authorities | Government organisations, funding bodies, stakeholders |

| | | |
|---|---|---|
| Recruit and retain staff | Incentives, increased awareness of positions eg universities | tertiary hospitals |
| HCV treatment in prisons needs to continue | More funding | Department of Corrective Services (DoCS), DOH |
| Bring the Aboriginal action plan into the same timeline as others | | SHBBVP, OATSIH, AHCWA, OAH, WAISHAC |
| Broad-based awareness raising campaign focus on youth (10% of new infections) | Media, television | |
| Prisons: prevention and treatment access, unless this is tackled it won't make inroads on epidemic | Advocacy re NSP in prisons. Reinstate/implement in-clinics, inhouse services | DoCS health, liver clinics, DOH |
| Aboriginal prevention | | |
| Prison population prevention: drug treatment, access to HCV treatment in prison | Background information on prisons needed in prevention. Set up workforce, set tasks, prioritise | HCWA, SHBBVP, DAO, HCV treatment services, DoCS health, AHCWA, WA GP Networks |
| HCV education in schools, universities and TAFEs using innovative ways to provide info e.g. web-based | Awareness campaign - set up taskforce | |
| Rural and remote access to treatment/prevention/staff development | | |

| HIV priorities for the next 12 months | Strategy to achieve this priority | Who needs to be involved |
|---|---|---|
| Campaigns to target aboriginal youth IDUs, especially in regional areas and prison | Local and targeted strategies that access these hard to reach groups e.g. sport and social clubs etc | Local staff assisted by Perth programs and staff |
| Improved workforce and training especially in regions and with AHWs. More males | Provide encouragement for regional people to train and then work in their local area. | DOH, TAFE, AHW training etc web-based learning, distance education |
| Refugees and migrants, CALD groups | Culturally and language specific programs through their local ethnic community | Ethnic community groups, migrant health workers, GPs, clinics etc |
| Workforce development of clinical staff and health care workers in rural/remote areas | Greater research into scoping of transmission. More info on who/why/how of men travelling overseas | DOH, GPs, Mental Health, AHCWA, DAO, Prisons, Police |
| Prevention/education/diagnosis/testing for heterosexual transmission of HIV overseas acquired for males and females | Social marketing using MySpace, Facebook, YouTube | Non-govt agencies, DET, mining companies, travel agencies, youth workers, national centre |
| Regional outreach to access indigenous MSM | Education and training particularly in rural/remote areas of GPs, health care workers, community workers | Community feedback/involvement in surveys, focus testing, forums |
| Financial and technical support to establish or maintain HCV and HIV clinical databases | Establish DOH/hospital working groups to identify funding sources etc | HIV specialists from hospitals and IT specialists from hospitals, DOH |
| Reinvigorate community education programs on HIV infection | Establish a working group to consider education programs on HIV/HCV/STI prevention | Staff from CDCD |
| HIV management in primary care/shared care Should this be under HIV? | Advertise training schedules for GPs. Give structure - most important to provide network and ongoing training | ASHM, GP groups, tertiary providers |
| Increase support and funding for rural and remote HIV programs | Increase funding through the Rural Health Service / RPH | Rural Health Service and Medical Specialties Division, RPH |

| STI priorities for the next 12 months | Strategy to achieve this priority | Who needs to be involved |
|--|---|--|
| Poisons Act changed to allow training of staff | Lobbying to get the Act changed | DOH |
| Training positions established. Need to have opportunities for nurses, registrars | Develop training resources. Lobby training organisations to establish positions | Area health services/department network, FPWA |
| Greater access to services especially Aboriginal services and contact tracing | Establish outreach/public health services with increase in contact tracing | Area health services/ACCHS, MOC |
| Improved control of syphilis education with at risk groups and repeated/enhanced screening | Increased education of groups at risk reinforcing need for regular screening e.g. STIGMA guidelines | DOH, WA Guidelines, WAAC education, GP educators, Sexual Health Services |
| Improvements in contact tracing enhancement | Study and implement new methods for those infections which don't get fully contact traced | |
| Education on the need for sexual health testing in young people especially out of school youth | Innovative way to provide information - bus, internet based | SHBBVP, FPWA, youth services |
| Workforce development at all levels especially Advanced Practice Nurses | Funding for stall to provide regular screening at sites | |
| On-site testing for STIs in sex workers | | FPWA, Magenta |

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