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MANAGEMENT CONSULTANTS



ABORIGINAL AND TORRES STRAIT
ISLANDER BLOODBORNE VIRUS AND
SEXUALLY TRANSMISSIBLE
INFECTION PROGRAMS EVALUATION
REPORT 2021-2025.
SUMMARY REPORT



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ACKNOWLEDGEMENT

IPS Management Consultants acknowledges the Traditional Owners and Custodians of Country throughout Australia, and their continuing connection to land, waters and community. We pay our respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

We acknowledge the contributions of Aboriginal and Torres Strait Islander people, organisations and services who participated in consultations and informed this evaluation through their perspectives and experiences.

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About this evaluation

Aboriginal and Torres Strait Islander communities and health services are leading local approaches to preventing and responding to bloodborne viruses (BBVs) and sexually transmissible infections (STIs). IPS Management Consultants was engaged by the Australian Centre for Disease Control (Australian CDC) to evaluate three Programs. The evaluation looked at the impact of the Programs, what is working well, what is affecting delivery, and what could strengthen future delivery.



The Programs have different histories, purposes, funding arrangements and participating services. Together, they contribute to the broader Aboriginal and Torres Strait Islander BBV and STI response.



This evaluation did not directly engage Aboriginal and Torres Strait Islander people accessing services.

Findings are based on available data and the perspectives of stakeholders involved in designing, funding and delivery of sexual health, BBV and STI services.

How the evaluation was undertaken

The evaluation used multiple lines of evidence to build a comprehensive picture.



Consultations

Discussions with ACCHOs, Program partners and government stakeholders.



Published research and previous evaluations

Review of relevant published implementation evidence and previous evaluation material.



Program monitoring and administrative data

Analysis of available Program activity, performance and administrative data.



Epidemiological modelling

Epidemiological modelling undertaken by the Kirby Institute in partnership with NACCHO and verified by FTI Consulting to examine the potential longer-term effects of ongoing program implementation with a gradual increase in testing.



Visits on country

Visits to participating services to understand local context, service delivery and implementation.



The evaluation reviewed evidence from different sources and distinguished observed implementation findings from population-level outcomes projected through epidemiological modelling.

BBVSTI program

BUILDING LOCALLY DETERMINED BBV AND STI RESPONSES

ABOUT THE PROGRAM



The BBVSTI Program began in 2021 and supports ACCHOs to strengthen workforce capacity and capability and deliver locally decided BBV and STI activities.

The Program provides flexibility for ACCHOs to decide workforce arrangements and activities according to local priorities, workforce availability and community needs.

WHAT THE EVALUATION FOUND



Workforce investment

The Program has enabled ACCHOs to invest in workforce capacity and capability. Training and professional development support workforce skills and confidence. NACCHO's Sexual Health and BBV Community of Practice also supports development of knowledge sharing.

Local flexibility and adaptation

ACCHOs use the Program's flexibility to tailor activities to local priorities, workforce availability and community needs.

Prevention and community engagement

ACCHOs deliver locally determined prevention, health promotion and community engagement activities designed to strengthen awareness, reduce stigma and support access to sexual health services.

Data capability

In 2024, the Program introduced additional investment in data and continuous quality improvement. Building strong systems and trusted ways to share data will take time.

Testing activity

Available data show increased signals in testing activity. However, not all participating ACCHOs were represented in the available dataset, and some services also receive support through ESR and/or PoCT Program. Changes therefore cannot be attributed to the BBVSTI Program alone.

WHAT NEEDS CONTINUED ATTENTION

Workforce sustainability



Recruitment, retention, and workforce continuity remain important to sustaining progress.

Funding continuity

Short-term funding arrangements and uncertainty about future investment can affect recruitment, retention and longer-term service planning.

ESR Program

A community-controlled response that has evolved over time

KEY FINDINGS

Flexible funding



Flexible funding enables participating ACCHOs to respond to local needs and adapt prevention, testing, treatment, follow-up and community engagement activities to local circumstances.

Workforce capacity and capability



Dedicated Aboriginal Health Workers, Aboriginal Health Practitioners, nurses, sexual health coordinators and local champions support prevention, outreach, testing, treatment, community engagement and follow-up.

Community engagement



Trusted local workers, outreach and culturally responsive approaches create opportunities to engage people who may not otherwise access clinic-based sexual health services.

Governance and quality systems



NACCHO's role supports coordination across training, syphilis PoCT quality management, supply and workforce support while maintaining connection with participating ACCHOs.

Community of practices



NACCHO's Sexual Health and BBV Community of Practice provides opportunities for onboarding, problem solving, peer learning, workforce support and sharing resources across services.

Opportunities for the ESR program



Workforce shortages, staff turnover, recruitment challenges, housing pressures and short-term funding continue to affect some places. Access to timely jurisdictional testing and treatment data is a challenge, limiting visibility of activity and outcomes across the broader response.

ESR contributes to the broader STI and BBV response.

Even though syphilis is the focus, the evaluation found broader contributions through workforce development, knowledge sharing, NACCHO's Sexual Health and BBV Community of Practice and locally determined sexual health activities.

These activities strengthen ACCHO capability and support broader STI and BBV responses alongside the infectious syphilis response.

PoCT Program

BRINGING TESTING CLOSER TO WHERE PEOPLE GET CARE

Program findings



Overview of the Program

Molecular PoCT, embedded within strong systems delivers faster results, supports better care and builds stronger health outcomes for Aboriginal and Torres Strait Islander people.



Timely treatment

The strongest direct evidence of Program effectiveness was improved treatment timeliness, reducing the time between testing and treatment compared with conventional laboratory pathways.



The technology alone is not enough

Effective delivery depends on trained staff, quality management, clinical governance, connectivity, logistics, ongoing site support and integration into clinical pathways



Workforce training

The Program supports competency-based training and ongoing workforce development across participating services.



Broader diagnostic infrastructure

Infrastructure and workforce capability developed through the PoCT Program have also supported respiratory testing and other infectious disease applications.



Value for money

Economic modelling found community-led molecular STI PoCT to be good value for money in remote Australian communities compared with standard laboratory testing.



MBS funding

Evidence from the Program helped the introduction of Medicare Benefits Schedule rebates for eligible STI molecular PoCT in remote and very remote services



Workforce sustainability

Workforce turnover creates an ongoing need for training and onboarding. Sustaining a sufficient group of trained operators is important for continuity of testing.



Continued opportunities

There are also limits to the outcomes that can be monitored through Program data alone. Measures such as treatment, re-testing and re-infection may require access to other clinical and jurisdictional datasets.

What did we learn across the Programs?

Our evaluation found that effective delivery is supported by local knowledge, trusted relationships and the ability to adapt. Delivery looks different in every context, and that is a strength of the Programs.

Local flexibility supports better delivery



There is no single model that works across every ACCHO, service or community

Evidence

Geography, workforce availability, community priorities, cultural context and existing service infrastructure all shape program delivery

The evaluation found that allowing services to adapt workforce arrangements and activities to local circumstances is an important strength of the Programs.

Frontline innovation matters



Frontline workers are not simply delivering set activities

Evidence

Examples of frontline innovation include community events, health promotion campaigns, sporting activities, incentives and locally tailored engagement strategies.

Local knowledge, trusted relationships and feedback from communities help workers figure out what is likely to work best in their context.

Communities of Practice and workforce networks provide opportunities to share ideas, learn from one another and adapt successful approaches.

Not all of this work is shown in routine reporting.

Relationships are part of the work



Trusted relationships are important for effective delivery

Evidence

Trusted relationships influence whether people feel comfortable discussing sexual health accessing testing and returning for care.

Outreach, informal conversations, repeated engagement, maintaining contact with people who move between communities and creating culturally safe opportunities to talk about sexual health are important but difficult to measure.

Strong services are built around people, relationships and local knowledge

A cross-cutting finding

Across all three Programs, workforce capacity and capability emerged consistently as critical enablers of successful implementation.



Workforce Capacity means having enough people, positions and time to do the work.



Workforce Capability means having the skills, knowledge, confidence, leadership and systems needed to do it well.



Enough people in the right roles



Skills, training and clinical competence.



Established positions with clear time allocation



Cultural knowledge, community understanding and confidence.



Sufficient time and workload to deliver services.



Leadership, mentorship and supportive supervision.



Tools, systems and ways of working that enable quality care.

Aboriginal Health Workers, Aboriginal Health Practitioners, nurses, sexual health workers, coordinators and other frontline staff translate Program investment into care that works locally.



Build relationships

Build trust and ongoing relationships



Undertake outreach

Take services and conversations beyond the clinic.



Create opportunities to talk

Create culturally safe opportunities to discuss sexual health.



Support testing and treatment

Support access to testing and timely treatment.



Follow people up

Support follow-up and continuity of care.



Adapt services to community

Adapt delivery to local priorities and circumstances.

The challenge remains

Workforce shortages, turnover and recruitment challenges, particularly in regional and remote settings, continue to constrain implementation across the Programs.

What could ongoing implementation mean over

the longer term?

Epidemiological modelling was used to project what could occur over time under the assumptions of the model.

PROJECTED OVER 10 YEARS

These are projections – outcomes that could be achieved.

The modelling examined annual testing, treatment rates and timeliness, re-testing following diagnosis and antenatal screening over 10 years.

The modelling estimates what could occur over time under its assumption of ongoing delivery and a gradual increase in testing (relative to a 'No programs' scenario). It does not isolate individual Program effects, and should be read alongside observed evaluation findings.

48% reduction in STI prevalence

82% reduction in trichomoniasis

65% reduction in infectious syphilis

57% reduction in chlamydia

32% reduction in gonorrhoea

72% relative reduction in reproductive morbidities

57% reduction in preterm births when combined with enhanced antenatal screening

89% reduction in congenital syphilis, including associated stillbirths and neonatal deaths, when combined with enhanced antenatal screening

Re-testing after diagnosis had a bigger **effect on STI rates** than **increasing** annual testing uptake.

This shows the importance of looking beyond testing alone and considering the full pathway from testing to treatment and re-testing.

What should happen next?

BBVSTI Program



- Continue investment in workforce capacity and capability
- Recognise and support frontline innovation
- Strengthen opportunities for services to share what works
- Improve data capability without creating unnecessary reporting burden

ESR Program



- Preserve the flexibility that enables locally determined responses
- Sustain workforce investment
- Make the Program's contribution to both infectious syphilis and the broader STI and BBV response clearer in future monitoring and reporting

PoCT Program



- Maintain the training, quality management, clinical governance, connectivity and delivery support that make the technology work in practice
- Sustain a trained workforce
- Continue to embed testing within routine models of care

Across the broader service system



- Stronger workforce continuity
- Greater funding certainty
- Better use of existing data
- Continued Aboriginal community-controlled leadership
- Shared learning across services
- Sustained investment in the relationships and local capabilities that underpin effective delivery

Conditions for sustainability

Sustained impact depends on the conditions that enable ACCHOs to plan, deliver and improve services over the long term.



Continuity



Workforce

Stable funding supports continuity

- Evidence shows funding certainty and contracting arrangements are important influences on workforce stability and continuity.
- Short-term funding, rising delivery costs, limited indexation and contract timing create challenges for recruitment, retention, service planning and continuity of locally delivered activities.
- Workforce expertise, community relationships and local knowledge take time to develop and cannot necessarily be quickly replaced.
- Greater continuity of investment supports retaining staff, planning ahead and sustaining locally developed approaches.

Better data should support services – not simply create more reporting



Data for learning



Reporting burden



Aboriginal and Torres Strait Islander data sovereignty

- The evaluation found opportunities to strengthen how data are used for learning, planning and continuous quality improvement.
- Some important information is already collected through Program reporting; other outcomes require access to clinical, jurisdiction or surveillance data outside the Programs.
- Improving the evidence base does not simply mean asking ACCHOs to report more.
- Future work should consider how existing data can be better accessed, shared, linked and interpreted while respecting Aboriginal and Torres Strait Islander data sovereignty and avoiding unnecessary reporting burden.

Strong Aboriginal and Torres Strait Islander BBV and STI responses depend on strong services, strong workforces, community-controlled leadership, locally responsive delivery and the systems and investment needed to sustain them.



The work is not limited to individual tests, activities or funding agreements.

The Programs invest in people, workforce capacity and capability, prevention, community engagement, testing, treatment, governance, service systems and locally responsive ways of working.



For the BBVSTI and ESR Programs, Aboriginal community-control enables ACCHOs to choose how activities are delivered in response to their communities and local circumstances.



The PoCT Program adds rapid diagnostic capability across participating ACCHOs and government health services, supported by training, quality management and clinical systems.



Workforce shortages and turnover, short-term funding arrangements, rising delivery costs and data access limitations make it harder to maintain continuity and show the full impact of the work.



The evidence points to continued investment rather than short-term intervention. Workforce expertise, trusted relationships, local knowledge and effective service models develop over time.



The modelling shows that many potential population health benefits could be seen over a longer period if prevention, testing, treatment, re-testing and antenatal screening strategies are sustained.

Acknowledging the limits of the evaluation

All evaluations have limits. It is important to be clear about what this evaluation can and cannot tell us.

- The evaluation did not directly engage Aboriginal and Torres Strait Islander people accessing services and therefore cannot claim to represent the diversity of community experience.
- Quantitative data were incomplete for some Programs and measures.
- The Programs operate alongside other health services, policies and initiatives.
- Changes in BBV and STI outcomes cannot be attributed solely to the Programs.
- Conclusions were drawn where evidence from different sources supported them.
- Some areas of the evidence do not allow firm conclusions.