

NSW Sexually Transmissible Infections Strategy

Environmental Scan 2006 – 2009

Suggested citation:

NSW Department of Health 2006, *NSW Sexually Transmissible Infections Strategy: Environmental Scan 2006–2009*, Sydney.

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SHPN (AIDB) 060091
ISBN 0 7347 3957 5

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July 2006

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1.1 Why an STI strategy?

The purpose of this document is to provide a statewide strategic policy framework for preventing and managing sexually transmissible infections (STIs) for the period 2006 to 2009. This Strategy identifies priorities and action required to reduce the incidence and prevalence of STIs in New South Wales (NSW) and to reduce their associated morbidity. The development of the *NSW Sexually Transmissible Infections Strategy* is a requirement of the Public Health Outcomes Funding Agreement. The Strategy translates the priorities within the National Sexually Transmissible Infections Strategy into the NSW context, and sits under *Healthy People 2006*.

STIs affect people's physical health, psychosocial wellbeing and relationships and are a significant source of morbidity in NSW. Some STIs also play an important role in facilitating human immunodeficiency virus (HIV) transmission.¹ Controlling STIs depends on a multi-strategic response including: health promotion strategies such as developing personal skills, advocacy, and public policy; the provision of adequate facilities for the diagnosis, treatment and contact tracing of STIs; and ongoing social and medical research.²

In NSW responsibility for diagnosing, treating and managing STIs has been shared between publicly funded sexual health services and general practice. This Strategy continues to ensure that publicly funded sexual health services are an integral component of the response to STIs, as well as recognising the key role of general practice in delivering consistent quality STI clinical services.

This Strategy recognises that prevention and health promotion strategies to reduce transmission are as important as the diagnosis, treatment and management of STIs. Such strategies must be sensitive to the transmission dynamics of STIs (such as infectivity, rate of exposure, and duration of infectiousness), be multifaceted and take account of the broader context of sexual behaviour.

The stigmatised nature of STIs within many cultures in Australia influences both individual health outcomes and the standing of sexual health within the health system. One of the key challenges is to build partnerships across and beyond the health system in order to improve sexual health outcomes for the people of NSW. Throughout this Strategy there is an emphasis on such partnerships.

1.2 STIs and HIV

The prevention of STIs is an important public health priority in its own right. Additionally, it is also a key strategy for preventing HIV transmission given the important role STIs play in facilitating HIV transmission.¹

This epidemiological synergy is believed to account for at least a twofold to fivefold increased risk for HIV infection among individuals with other STIs, including genital ulcerative diseases and nonulcerative, inflammatory STIs.¹ The early detection and treatment of other STIs can be an effective strategy for HIV prevention.

Within Australia, there is some evidence that the epidemic of HIV infection affects similar populations as those with the highest rates of curable STIs.

Strategies to address HIV prevention, transmission and treatment are addressed within the *NSW HIV/AIDS Strategy 2006 – 2009*.

1.3 Goals

The goals of this Strategy are to:

- 1 reduce the transmission of STIs
- 2 reduce morbidity associated with STIs.

This will be achieved by:

- increased community awareness and knowledge of STIs and capacity to reduce the risk of transmission
- increased use of condoms with casual sexual partners

- increased STI testing within priority population groups
- increased diagnosis, treatment and management of STIs.

Three variables influence the spread of STIs: the risk of transmission, the number of partners an individual has; and the period of infectiousness.³ Preventing or reducing the transmission of STIs requires strategies that address these factors. In addressing this mixture of factors, this Strategy includes a focus on promoting condom usage, promoting behaviour change that reduces the risk of STI transmission, ensuring appropriate contact tracing, promoting vaccinations where applicable, educating the public and health care professionals, and ensuring the provision of clinical services to priority population groups.

The increased use of condoms during casual sexual encounters will have a significant beneficial impact on STI transmission.⁴ Promoting condoms to those who are sexually active remains a key strategy. However, as condoms do not provide complete protection against all STIs, particularly herpes simplex virus and human papilloma virus, it remains important that individuals are aware of a range of other prevention strategies that may enable them to further reduce the risk of transmission. For some, reducing the number of partners, avoiding more risky sexual practices, restricting alcohol and other drug use, delaying sexual activity, abstaining from sexual activity, or having only one sexual partner will contribute to reducing the personal risk of STI transmission.

1.4 Priority STIs

This Strategy emphasises particular STIs which:

- have significant morbidity
- are associated with poorer long term health outcomes, such as infertility, if undiagnosed or untreated
- facilitate the transmission of other infections such as HIV
- are disproportionately prevalent within vulnerable populations
- are likely to be amenable to prevention and control efforts.

As a result, this Strategy has given particular priority to chlamydia, gonorrhoea, and infectious syphilis.

Herpes simplex virus and human papilloma virus are not notifiable diseases in NSW, but are believed to be quite common STIs. While this Strategy recognises the importance of promoting general awareness of common

STIs, there is limited understanding of the strategies likely to be effective at preventing and controlling herpes simplex virus and human papilloma virus at population level. Research may be able to assist in identifying effective strategies. As noted within this Strategy, the development of a human papilloma virus vaccine may occur in the very near future and may be an important tool in future efforts to control the spread of the virus.

Hepatitis B is not primarily sexually transmitted. The *NSW Immunisation Strategy 2003-2006* is the key reference document regarding hepatitis B strategies. However, in working with priority population groups, particularly gay and other homosexually active men and people who inject drugs, promoting hepatitis B vaccination can also be appropriately incorporated into some of the actions that aim to prevent the spread of priority STIs.

1.5 Priority populations

This Strategy seeks to protect and promote the health of all people in NSW with respect to STIs. To achieve this, priority has been accorded to populations who have been most significantly affected by STIs. The policy of prioritisation and the consequential targeting of resources is a key strategy for managing and containing STIs within populations.

The framework used to determine priority population groups includes consideration of:

- the epidemiology of STIs
- sexual behaviour risk factors
- access to health services
- equity – including social disadvantage and marginality
- state and Australian Government policies.

Based on this framework, the priority population groups are:

- Aboriginal people
- gay and other homosexually active men
- young people
- sex workers
- people with HIV/AIDS
- people who inject drugs
- heterosexuals with recent partner change.

There is significant overlap between the priority population groups nominated above, and those identified within the *NSW HIV/AIDS Strategy 2006 – 2009*. Young people and heterosexuals with recent partner change are additional priority population groups for this Strategy.

At a local level, there may be a need to recognise local priority population groups such as particular culturally or linguistically diverse groups, young travellers, and itinerant workers.

Within the above population groups, programs and services need to further identify those most at risk.

Publicly funded sexual health clinics have finite capacity and are therefore unable to meet the sexual health needs of the entire community. Section 4.3 identifies strategies to assist in prioritising access.

Culturally and linguistically diverse populations

Within Australia, NSW has the most culturally and linguistically diverse (CALD) population of all states and territories. In NSW about 30 per cent of the population was either born in a non-English-speaking country or had at least one parent born in a non-English-speaking country. Changes in the Australian Government immigration program are expected to result in an increase in the number of people coming from countries with high prevalence of STIs, blood-borne viruses and HIV. In developing programs and services, the diverse needs of recent immigrants need to be considered.

Addressing STIs requires that issues of sex and sexuality are openly and frankly discussed. Efforts to address such issues require sensitivity to the different values and beliefs that different cultures attach to sex and sexuality.

How programs and services take account of the needs of people from culturally and linguistically diverse communities will need to vary depending on context. This may require addressing the fear or lack of understanding of health services that are available and implementing strategies that ensure language and literacy skills do not prevent access to information and services.

This Strategy highlights some particular needs of people from CALD communities that need to be addressed in working with priority population groups. However, all programs and services should consider the needs of CALD communities. Sexual health clinics need to ensure access to services are prioritised for CALD communities where applicable to local population demographics and patterns of immigration settlement. Some CALD communities may feel more able to access sexual health clinics because of the anonymous service they provide as well as the clinic being experienced in the provision of culturally appropriate and sensitive services.

Settings

Consideration should also be given to settings-based responses, as people detained in Correctional Facilities and Juvenile Detention Centres and people living in residential disability services, psychiatric facilities, boarding houses, and large residential institutions may experience significant additional difficulties taking care of their sexual health, maintaining safe sex practices and accessing either health services or the means of prevention.

1.6 Priority issues

This Strategy identifies a number of priority issues:

- promoting general STI awareness
- working with general practice
- prioritising access to and focus of publicly funded sexual health clinics
- promoting STI testing
- improving contact tracing
- developing the workforce;
- strengthening health promotion programming
- research and surveillance priorities.

1.7 Principles

The NSW Department of Health has identified that the following five principles as universally underpinning good public health practice:⁵

- **Population focus** – Aims to improve the overall health status of the population.
- **Focus on prevention, promotion and early intervention** – Gives priority to preventing ill health, promoting good health or wellness and enhancing healthy years of life.
- **Reduce health inequalities** – Aims to reduce differences in health status between groups within the population.
- **Work in partnership** – Establishes and maintains effective partnerships with both health and non-health agencies and organisations.
- **Effective and sustainable public health action** – Aims to use the best available evidence for decision making and to continually improve the knowledge base underpinning public health practice.

A principle specific to sexual health is that contained in the World Health Organization definition of sexual health: freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships.

These principles should shape all publicly funded STI services, programs and activities in NSW.

Within this Strategy there is an emphasis on early detection through testing, including opportunistic screening. Strategies that aim to increase testing, need to be implemented ethically across NSW. Informed consent and pre/post test counselling are an essential component of STI testing.

1.8 A population health approach

Population health refers to the overall health status of a population as measured by both clinical and social outcomes. In adopting a whole of population approach data drawn from epidemiology and surveillance, service utilisation and behavioural, social and medical research is used to guide health service priorities, planning and delivery and inform effective prevention strategies.

Population health interventions are designed to affect whole groups or populations, with the intention of improving the health status of the entire population and reducing inequities in health status between population groups.

The overall health of a population is influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and access to health services.⁶ People who experience greater levels of social disadvantage have been shown to experience poorer health, to be heavier users of health care services and to be less likely to access preventive health services. Engaging disadvantaged populations requires an understanding of how the population experiences sexual health and sexual health related morbidity, and addressing those issues that are considered most salient to those populations.

1.9 Health promotion

Effective and sustained prevention of STIs requires the adoption of a health promotion framework. Health promotion was first fully articulated in the Ottawa Charter for Health Promotion as the process of enabling people to increase control over, and to improve, their health.

The *NSW Sexual Health Promotion Guidelines* articulate the application of a health promotion framework to the field of sexual health promotion. Sexual health promotion is defined as the holistic process of enabling individuals and communities to increase control over the determinants of sexual health, and thereby managing and improving it through their lifetime.

Health promotion is a multi-strategic response, and encompasses individual, population and systemic interventions to:

- create healthy public policy
- develop personal skills
- strengthen community action
- create supportive environments
- reorient health services.

Actions to promote healthy public policy can include advocacy to reduce financial barriers in areas such as Medicare access and rebate levels, regulation of the sex industry as a means of promoting safe working conditions including the practice of safe sex, and removing restrictions on the sale and availability of condoms.

A supportive environment is one in which stigma and discrimination associated with STIs is removed. This can be achieved through social marketing campaigns that place STIs on the public agenda and wider social, education and advocacy strategies to encourage open and honest discussion of sexual health.

Strengthening community action recognises that building supportive environments and developing healthy public policy is a shared responsibility between government, non-government organisations and communities. It also recognises the importance of involving affected communities in improving health outcomes. This Strategy promotes partnership between government, the health sector and community organisations in program implementation.

The development of personal skills is necessary to enable people to increase control over, and to improve their health. Ensuring that people have access to appropriate information, as well as skills in areas such as sexual negotiation, enable people to resist coercion into sexual

activity and help develop self esteem and respect for other people's sexual rights. Particular emphasis is given in this Strategy to young people and school-based curriculum initiatives to increase personal skills.

The re-orientation of health services is necessary to ensure the delivery of quality sexual health services. This includes strengthening the integration of sexual health into primary health care service provision, particularly in general practice. This Strategy also emphasises the importance of partnerships between publicly funded sexual health clinics and general practice.

Ultimately, no single strategy in isolation can be effective in bringing about long-term changes in health outcomes. Effective health promotion is reliant on the synergistic relationship between each of these strategies, with each action informing, supporting and interacting with the others.

Ensuring effective health promotion programming is a key priority during the life of this Strategy.

1.10 Achievements to date

There is a long history of responding to STIs in NSW since the establishment of the Sydney Sexual Health Centre under the Brussels agreement in the 1920s, the aim of which was to diagnose and treat STIs in sailors. Since the 1980s, the capacity of the NSW sexual health program has expanded to incorporate disease prevention and health promotion, targeting individuals and populations.

Some important statewide achievements in the areas of STI prevention and health improvement are highlighted below.

- A considerable expansion of funded *sexual health services* across the state has occurred over the past two decades.
- *The Safe Sex. No Regrets* campaign was launched in February 2005 and uses a wide range of strategies to spread the safe sex message including television advertisements, posters, pamphlets and a website.
- NSW Health has developed *Accreditation Guidelines for NSW Sexual Health Services* in 2005. These Guidelines promote greater consistency between sexual health services and contribute to continuous quality improvement across the publicly funded program in NSW.
- The *Chlamydia – Be Smart, Be Tested Campaign* was implemented in 2003 to promote greater awareness of chlamydia among young people in response to continuing rises in notifications.
- The *HIV/AIDS and Sexual Health Ambulatory Care Minimum Data Set* was developed and implemented in 2005 to facilitate the collection of consistent activity data across NSW publicly funded ambulatory services including sexual health clinics.
- In 2002, NSW Health released the *NSW Sexual Health Promotion Guidelines* as a tool for supporting best practice in sexual health promotion across NSW.
- There has been a range of responses to address the *sexual health needs of young people* across the state including provision of clinical services, community based education, developing peer groups with young people at risk, and implementation of *Talking Sexual Health* in schools.
- The *NSW Aboriginal Sexual Health Advisory Committee* has been established and meets on an ongoing basis. This Committee is chaired by the Aboriginal Health and Medical Research Council of NSW. It has responsibility for monitoring and overseeing Australian Government and NSW Government sexual health and blood-borne viruses strategies and implementation plans.
- *Aboriginal Sexual Health Workers* are based in Area Health Services and Aboriginal Community Controlled Health Services across NSW.
- The Australian Government-funded *Aboriginal and Torres Strait Islander Nucleic Acid Amplification STI Testing Program* is delivered through sexual health services in partnership with Aboriginal Community Controlled Health Services across NSW.
- The *Sexual Health Outreach Workers Network (SHOWNet)* is a partnership between sexual health services, the Sex Workers Outreach Project and other key service providers that develops targeted and coordinated outreach services delivering health promotion and prevention education to sex workers throughout NSW.
- The *STIs in Gay Men Action Group (STIGMA)*, a partnership between Area Health Services, ACON and general practice, meets on an ongoing basis and has played an important role in coordinating cross-area and multi-disciplinary responses to STI outbreaks among gay men. Part of the response has been to develop STI testing guidelines for general practitioners.
- The AIDS Council of NSW has implemented *STI campaigns and resources* targeted at gay men to improve general STI knowledge as well as ensure increased awareness of outbreaks of STIs such as shigella, syphilis and hepatitis A.

- In NSW, sexual health services, methadone program and alcohol and other drug services provide free hepatitis B vaccinations to people at higher risk of sexually acquired hepatitis B. Some sexual health services also provide free hepatitis A vaccinations to members of high-risk populations.

1.11 Relationship to other strategies

This Strategy complements and is linked to a number of other strategic frameworks at the NSW and Australian Government levels.

NSW HIV/AIDS Strategy 2006–2009

The *NSW HIV/AIDS Strategy 2006–2009* outlines priorities for the response to HIV/AIDS in NSW. Given the impact of STIs on HIV transmission, the strategy, where appropriate, identifies actions that can lead to a reduction in HIV and STI transmission. An important target for the strategy is the reduction of gonorrhoea, syphilis and chlamydia.

National Sexually Transmissible Infections Strategy 2005–2008

The *National Sexually Transmissible Infections Strategy 2005–2008* provides the overarching framework for the development of responses to STIs in NSW. The strategy identifies STIs in Aboriginal and Torres Strait Islander communities, STIs in gay and other homosexually active men, and chlamydia control and prevention as key priorities. The *NSW Sexually Transmissible Infections Strategy 2006–2009* has been developed to ensure its compatibility with national goals, objectives and priorities.

National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008

The *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008*, which replaces the National Indigenous Australians' Sexual Health Strategy, provides the overarching national strategic framework guiding HIV/AIDS, STI and hepatitis C service delivery to Aboriginal and Torres Strait Islander Australians. The strategy aims to reduce the transmission of and morbidity caused by HIV/AIDS, STIs and blood borne viruses in the Aboriginal and Torres Strait Islander community and to minimise the social and personal impacts of these infections.

The NSW Department of Health's *NSW HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal People* will coordinate the delivery of stated actions and goals within NSW.

The epidemiology of STIs is shaped by transmission dynamics such as infectivity, the rate of exposure between infected and susceptible individuals, and the duration of infectiousness in individuals. Patterns of STIs within populations are also shaped by social determinants such as poverty, inequality, racial/ethnic discrimination, unemployment, sex ratio, volume of migration, and health care coverage and quality.⁷ Other barriers such as homophobia, may also impede access to health services. Patterns of STIs are also shaped by behavioural factors, including safe and unsafe sex practices, the number of sexual partners, gender, concurrency of sexual partnerships, and access to appropriate education and information.

Complications that can be caused by STIs include pelvic inflammatory disease (PID), cervical cancer, ectopic pregnancy and infertility. STIs also contribute to the mortality statistics through deaths associated with AIDS, liver cancer, anogenital cancers, miscarriage and still births.

STIs place a significant economic burden on individuals, populations and the health system. Late presentation for the diagnosis and management of STIs can reduce an individual's ability to work, and late presentation is far more costly to health services. At a population level, groups with high rates of STIs may experience reduced economic capacity, leading to further disadvantage and reduced access to health services.

STI prevention is often hampered by the general population's limited understanding of the prevalence and impact of STIs within the community, and poor knowledge regarding the modes of transmission of STIs. In the long term, an effective response to STIs must include creating environments that support individuals and populations to maintain their sexual health.

Many major STIs share the capacity to cause infection without symptoms, creating the potential for carriage of asymptomatic and undiagnosed infection. This has significant implications for both individual and population health and must be addressed through increasing community awareness of the existence of asymptomatic STIs, and improving rates of targeted testing in asymptomatic individuals.

Once diagnosed, most STIs can be easily treated and many can be cured. For this reason, access to primary health care or specialist services with the capacity to diagnose and treat STIs is critical. This has been significantly improved by improved technology for non-intrusive testing and in particular the increased sensitivity of nucleic acid amplification methods.

Incidence and prevalence

The incidence of major bacterial STIs decreased from the mid-1980s to the mid-1990s, partly as a result of HIV-related safe sex practices. Since then, however, there have been significant increases.

The number of reported diagnoses is not necessarily an accurate reflection of incidence of disease. Reported diagnoses are often a reflection of testing patterns.

Chlamydia is the most frequently notified infection in NSW. Chlamydia only became a notifiable condition in August 1998. The relative contributions of increased testing and/or higher rates of transmission to the upward trend in annual notifications is unclear.

In 2004, 57 per cent of chlamydia notifications were among women. The relative distribution between women and men has only changed slightly over time with 54 per cent of notifications being among women in 2000.

The number of chlamydia notifications has increased within all age groups. The increase has been greatest in the 15-24 year age group. From 2000 to 2004 numbers in this age group more than tripled and in 2004 they comprised approximately 54 per cent of all notifications. Geographically in 2004, on a population basis, rates were highest in the former Far West (222 per 100,000 population age adjusted), New England (210 per 100,000 population age adjusted) and South Eastern Sydney Areas (210 per 100,000 population age adjusted).

Table 1. Chlamydia notifications in people resident in NSW at diagnosis, 2000 – 2004. Number of notifications, age adjusted rate (per 100,000 population), sex and age, group by year of disease onset.*

Year	Number	Rate	Male	Female	<15	15-24	25-34	35-44	45+
2000	3,482	51	1,607	1,863	37	1,662	1,187	417	174
2001	4,473	66	1,987	2,472	44	2,209	1,525	505	186
2002	5,777	85	2,611	3,155	51	2,814	1,881	706	323
2003	7,734	114	3,439	4,281	69	4,141	2,369	816	335
2004	9,975	147	4,234	5,719	98	5,441	3,033	992	410

* Excludes notifications where the case was an overseas resident. Age and sex tabulations exclude cases where age or sex was missing.

Table 2. Chlamydia notifications by former Area Health Service, 2000–2004 (age adjusted rate per 100,000 population).*

AHS [^]	2000	2001	2002	2003	2004	
	No.	No.	No.	No.	No.	Rate
CSAHS	426	494	715	839	1,102	189
NSAHS	295	435	631	799	1,099	136
SESAHS	786	1,030	1,310	1,522	1,876	210
SWSAHS	199	304	320	544	717	84
WAHS	111	183	218	239	305	90
WSAHS	324	376	457	651	794	101
CCAHS	64	118	171	265	358	138
CHS	13	14	38	59	72	900
FWAHS	66	58	93	86	93	222
GMAHS	103	154	182	303	360	144
HAHS	315	314	466	683	975	180
IAHS	154	156	206	306	376	111
MAHS	47	109	67	138	140	151
MNCAHS	144	148	169	279	379	178
MWAHS	74	120	156	234	262	158
NEAHS	138	175	182	284	360	210
NRAHS	157	190	252	297	433	196
SAHS	64	87	118	188	197	119

* CHS rate is crude rate based on a nominal population of 8,000 people.

[^] See appendix for definition of abbreviations.

Gonorrhoea notifications more than doubled between 1995 and 1999 (428 to 1,282 notifications), and peaked in 2002 at 1506. Gonorrhoea notifications are significantly higher among men than women. In 2004 over 88 per cent of notifications were among men.

Gonorrhoea notifications are highest in the 25-34 year age group. In 2004 notifications from this age group accounted for just over 38 per cent of all notifications. However, the proportional increase by age group has been greatest among 15-24 year olds (80 per cent).

Geographically in 2004, on a population basis, notifications were highest from the former South Eastern Sydney (66 per 100,000 population age adjusted) and Central Sydney Areas (60 per 100,000 population age adjusted).

Table 3. Gonorrhoea notifications in people resident in NSW at diagnosis, 2000–2004. Number of notifications, age adjusted rate (per 100,000 population), sex and age, group by year of disease onset.*

Year	Number	Rate	Male	Female	<15	15-24	25-34	35-44	45+
2000	1,045	16	958	87	4	200	454	272	115
2001	1,355	20	1,195	158	4	299	559	343	150
2002	1,506	22	1,336	166	7	300	599	435	165
2003	1,316	19	1,154	157	7	300	508	363	138
2004	1,429	21	1,265	162	7	360	530	373	159

* Excludes notifications where the case was an overseas resident. Age and sex tabulations exclude cases where age or sex was missing.

Table 4. Gonorrhoea notifications by former Area Health Service, 2000–2004 (age adjusted rate per 100,000 population).*

AHS [^]	2000	2001	2002	2003	2004	
	No.	No.	No.	No.	No.	Rate
CSAHS	212	288	326	270	347	60
NSAHS	80	92	93	100	99	12
SESAHS	461	580	691	573	580	66
SWSAHS	77	115	88	59	72	9
WAHS	19	20	25	25	21	6
WSAHS	66	72	105	90	70	9
CCAHS	15	13	19	11	15	6
CHS	0	4	11	3	4	50
FWAHS	9	21	8	17	6	15
GMAHS	1	6	6	14	7	3
HAHS	17	15	15	29	43	8
IAHS	14	12	27	20	38	11
MAHS	4	9	11	4	9	9
MNCAHS	10	15	10	19	28	12
MWAHS	11	6	11	8	13	8
NEAHS	23	49	23	24	18	11
NRAHS	23	26	30	43	45	20
SAHS	4	9	3	6	7	4

* CHS rate is crude rate based on a nominal population of 8,000 people.

[^] See appendix for definition of abbreviations.

Infectious syphilis notifications reached their highest level in 2004 (300 notifications), with most of the increase occurring between 2001 and 2003. Males account for almost 92 per cent of notifications. The age groups making up the highest proportion of notifications in 2004 were 25-34 year olds (36 per cent) and 35-44 year olds (33 per cent).

In 2004, notifications of infectious syphilis were heavily concentrated in the former South Eastern Sydney and Central Sydney Areas. It must be noted that an unknown (but likely to be small) number of cases of infectious syphilis may go unidentified due to variations in case follow up practice

Table 5. Infectious syphilis notifications (excluding congenital infections) in people resident in NSW at diagnosis, 2000–2004. Number of notifications, age adjusted rate (per 100,000 population), sex and age, group by year of disease onset.*

Year	Number	Rate	Male	Female	<15	15-24	25-34	35-44	45+
2000	82	1	45	37	1	22	29	16	14
2001	66	1	46	20	0	16	15	22	13
2002	128	2	110	18	0	18	40	49	21
2003	241	4	214	27	0	19	70	92	60
2004	300	4	274	26	1	31	108	103	57

* Excludes notifications where the case was an overseas resident. Age and sex tabulations exclude cases where age or sex was missing.

Table 6. Infectious syphilis notifications (excluding congenital infections) for NSW by former Area Health Service, 2000–2004 (age adjusted rate per 100,000 population).*

AHS [^]	2000	2001	2002	2003	2004	
	No.	No.	No.	No.	No.	Rate
CSAHS	13	12	29	45	77	13
NSAHS	6	3	13	13	4	0.5
SESAHS	12	19	57	123	159	18
SWSAHS	3	0	0	8	7	0.88
WAHS	1	1	0	1	0	-
WSAHS	5	7	5	11	19	3
CCAHS	3	1	0	3	1	-
CHS	0	0	1	1	0	-
FWAHS	11	3	1	0	1	3
GMAHS	0	0	1	3	6	2
HAHS	4	3	1	1	9	2
IAHS	0	0	0	8	4	1
MAHS	3	5	2	2	0	-
MNCAHS	5	5	5	6	0	-
MWAHS	1	3	0	1	1	1
NEAHS	10	1	9	10	3	2
NRAHS	5	2	3	5	9	4
SAHS	0	1	1	0	0	-

* CHS rate is crude rate based on a nominal population of 8,000 people.

[^] See appendix for definition of abbreviations.

Data on herpes simplex virus (HSV-1 and HSV-2) and human papilloma virus are not readily available as they are not notifiable infections. However, the Australian Study of Health and Relationships reported that four per cent of respondents had been diagnosed with human papilloma virus and two per cent with herpes simplex virus.⁹

The burden of herpes simplex virus and human papilloma virus may not be evenly spread throughout the population. A study of HIV-negative gay men in NSW found that almost eight per cent of respondents reported a history of genital herpes and just over eight per cent a history of genital warts.⁸

The NSW response to STIs prioritises population groups whose members have been most significantly affected by STIs. This enables resources to be effectively targeted and is a key strategy to contain STIs.

Each Area Health Service and funded non-government organisation is required to determine the particular emphasis given to priority populations by health promotion programs and clinical services. In maximising access to services, consideration must be given to the relative capacity of publicly funded sexual health clinics, general practice and other population health programs. The size of some priority population groups is such, that a strategic objective for specialist clinics and Area-based sexual health programs must be to work with general practice to reduce barriers to access.

The Australian Study of Health and Relationships reported that nearly 20 per cent of participants had ever had an STI and found that, although a variety of predictors were related to STI diagnosis, STIs were not uncommon among people without these risk factors.⁹ Accordingly, every individual in NSW should have access to appropriate STI prevention, diagnosis and management. Sexual health services also have a key role to play in supporting general practice to respond to STIs in the general community.

3.1 Aboriginal people

Aboriginal people are considered a priority population owing to a range of factors including:

- inequality of access to primary health care services
- a much younger demography
- higher rates of bacterial and viral STIs, where such rates are known
- generally poorer health outcomes across a range of indicators
- mobility of the Aboriginal population.

There are significant limitations with surveillance data on STIs in Aboriginal communities in NSW. Where accurate data exists in other jurisdictions, however, notifications for STIs are substantially higher within Aboriginal communities compared with non-Aboriginal communities.¹⁰ A primary reason for this is poorer access to primary health care.

Ongoing efforts to prevent new infections and improve detection and management of STIs, particularly chlamydia, gonorrhoea and syphilis, need to continue. Strategies need to include a focus on behaviour change, such as increased use of condoms, as well as ensuring increased access to services and testing and treating those at increased risk.

With a co-ordinated effort across NSW, involving key partners such as sexual health services, Aboriginal Community Controlled Health Services, Area Health Services, Justice Health and Aboriginal Health, eliminating syphilis transmission within Aboriginal communities is an achievable goal. Such an approach will require ensuring clear role delineation between partners, treatment and management of those with syphilis and contact tracing. Some of the complications of syphilis are seen in pregnancy, in particular in relation to potential miscarriage or congenital syphilis. Preventing and managing syphilis in this context needs to be embedded within antenatal programs.

Early detection and treatment

To achieve a reduction in STIs within Aboriginal communities greater emphasis needs to be given to opportunistic testing of individuals who may be at greater risk. The Aboriginal Health and Medical Research Council of NSW (AH&MRC) is developing an *Early Detection and Treatment of STIs and Blood Borne Viruses Manual* to support primary health care providers in testing and treating STIs and blood borne viruses. The implementation of this manual will be critical to ensure increased early detection, treatment, care and management of STIs across NSW.

The Medicare Benefits Schedule for biennial health checks for Aboriginal and Torres Strait Islander people aged between 15 and 54 should also be promoted as it aims to ensure early intervention and diagnosis of treatable conditions.

Aboriginal health – a priority for all publicly funded sexual health clinics

A key priority for this Strategy is the development of appropriate strategies to ensure improved access by Aboriginal people to publicly funded sexual health clinics. Strategies will vary from Area to Area, and require the allocation of sustained resources, including human resources, over a significant period of time to ensure adequate planning and promotion, and to enable the service to develop rapport and trust with the local community. Outreach clinics to Aboriginal people have proved appropriate and successful in some Areas, particularly if they are undertaken with other health programs and services and offer a holistic service. Other Areas have worked to establish specific days and times for Aboriginal men's and Aboriginal women's clinics. Such services need to be developed in formal partnership with local Aboriginal Community Controlled Health Services and with the input of the local community.

Across NSW, strategies need to be implemented proactively to increase the reach of services to Aboriginal communities. Models that have been effective in providing sexual health services to Aboriginal communities need to be disseminated across the state.

Surveillance

Surveillance of STIs within Aboriginal communities in NSW requires improvement. Accurate, timely and culturally appropriate surveillance is essential to inform program development and implementation. Improving current surveillance of STIs and ascertaining the true prevalence and incidence of specific STIs, such as chlamydia, gonorrhoea and infectious syphilis, within Aboriginal communities has been given a high priority within this Strategy.

Research

Research is required that improves outcomes for Aboriginal communities and enables service delivery and access to all within the community. Establishing research priorities and conducting research projects needs to be undertaken in partnership with the AH&MRC and Aboriginal Community Controlled Health Services and within the guidelines developed by the NSW Department of Health and the AH&MRC Ethics Committee.

Prevention and health promotion

Prevention and health promotion activities remain a key strategy to reduce the rates of STIs within Aboriginal communities. Strategies should aim to increase STI awareness, promote condom use and highlight the asymptomatic nature of many STIs.

Workforce development

Aboriginal sexual health workers play an important role in facilitating access to appropriate services. Workforce development initiatives can assist in continually strengthening their role. Workforce development initiatives also need to extend to health workers in sexual health services in order to build their capacity to provide culturally sensitive services to Aboriginal people. This Strategy also gives much emphasis to supporting the management of STIs in general practice. This includes working with GPs and clinicians working in Aboriginal Community Controlled Health Services to enable the integration of STI and blood-borne virus checks into existing primary health care services. Workforce development initiatives that re-orient health services with specific population groups such as men's clinics, women's clinics and youth groups are also needed.

Coordination and partnerships

The NSW Aboriginal Health Partnership is an agreement between the AH&MRC, as the peak body for Aboriginal Community Controlled Health Services in NSW, and the NSW Government. It provides a framework for the development of partnerships with Aboriginal communities, with a particular emphasis on ensuring that the expertise of Aboriginal communities is bought to the development of health services.

Sexual health initiatives, therefore, need to be undertaken in partnership with Aboriginal communities, Aboriginal Community Controlled Health Services and with other health programs working with Aboriginal people in NSW, including Aboriginal health, child and maternal health, mental health, women's health and men's health services, alcohol and other drug services, the AIDS Council of NSW, Justice Health and the Department of Corrective Services.

The mobility of the population also requires recognition, and underscores the need to work in a cooperative manner across Area Health Services and with interstate services.

NSW HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal People

Specific actions and strategies for improving access to sexual health and related services in order to improve sexual health outcomes for Aboriginal people in NSW are outlined in the *NSW HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal People*.

The Plan, produced by the NSW Department of Health under the guidance of the NSW Aboriginal Sexual Health Advisory Committee and in consultation with the AH&MRC, has recommended that the provision of sexual health services to Aboriginal people in NSW should:

- have community participation and ownership
- adopt a holistic health approach
- be implemented in collaboration and partnership with local communities and key stakeholders
- include an active outreach program
- be evidence-based
- develop the knowledge and skills of the workforce.

Strategic objectives

- 1 Increase the use of condoms with casual and new sexual partners.
- 2 Eliminate syphilis transmission within Aboriginal communities by 2009.
- 3 Increase in early detection and treatment of bacterial and viral STIs.
- 4 Increase in culturally appropriate and sensitive public sexual health service provision.
- 5 Build the skills of the workforce.
- 6 Improve the capacity of and collaboration with Aboriginal Community Controlled Health Services, and GPs who see Aboriginal people, to respond to STIs.
- 7 Improve culturally appropriate STI surveillance and monitoring.
- 8 Increase culturally appropriate STI related research within Aboriginal communities.

3.2 Gay and other homosexually active men

Gay and other homosexually active men are considered a priority population due to:

- epidemiological data showing a higher prevalence of STIs
- the significant role of STIs in facilitating HIV infection
- barriers, such as homophobia, that impede access to health services
- poorer access to appropriate sexual health education for same sex attracted youth
- sexual practice placing gay men at increased risk of STIs.

Reducing the rates of gonorrhoea, chlamydia, and syphilis among gay men is a key priority for this Strategy. Increases in diagnoses of STIs among gay men have occurred in the context of a marked increase in unprotected anal intercourse with casual partners between 1996 and 2001, which has since plateaued.¹¹ A range of explanations for such an increase has been identified, including an increasing perception of HIV as a manageable disease and the use of non-condom based strategies to minimise HIV transmission risk. While most gay men continue to practice safe sex, most of the time, it remains important to continue to promote consistent condom use during casual encounters.

While the use of non-condom based options (such as having sex with a partner of the same HIV serostatus or avoiding ejaculation during unprotected anal intercourse) to reduce risk may have been effective in reducing some of the risk of HIV transmission, such strategies are likely to be contributing to increases in the transmission of other STIs among gay men. Factors shown through research to have some relationship to sexual risk behaviour, such as drug and alcohol use, also need to be addressed.

Episodic outbreaks of shigellosis and hepatitis A among gay men appear to have been contained by well-organised interventions. There is a need, however, to continue to promote vaccination against hepatitis A and hepatitis B among gay men. American research has highlighted the cost-effectiveness of vaccinating homosexual men against hepatitis A.¹²

The re-emergence of syphilis among gay men is of particular concern. Syphilis has been seen in other international cities with gay populations comparable to Sydney, including Brighton, New York and Amsterdam. Research indicates that a significant proportion of people

diagnosed with syphilis are also living with HIV/AIDS. People with HIV/AIDS may experience a greater health impact from syphilis infection and the presence of syphilis may also increase the risk of HIV transmission. Efforts to contain the re-emergence of syphilis have included a social marketing campaign promoting prevention and testing for syphilis. There has also been a strong focus on improving the timeliness and accuracy of notification data on syphilis, in order to strengthen data available to inform service delivery and program planning. Given that syphilis transmission among gay men has almost been eliminated in the past, strategies that have proven effective need to be implemented to significantly reduce transmission rates by 2009. Long term planning also needs to occur if the elimination of syphilis among gay and other homosexually active men is to be achieved.

While so far there have been no reported cases of lymphogranuloma venereum (LGV) in NSW, a case of locally acquired LGV in a bisexual man was recently reported in Victoria.¹³ LGV has been increasingly reported among gay men in a number of European countries, as well as in North America, promoting concerns that an increase may occur among gay and other homosexually active men in Australia.

The overall response to STIs in gay and other homosexually active men in inner Sydney is coordinated by the STIs in Gay Men Action Group (STIGMA). STIGMA has an ongoing role in monitoring and responding to surveillance, and has undertaken initiatives such as the development of STI testing guidelines for general practitioners. The guidelines recommend testing at least once a year for all men who have had any sex with another man in the previous year for gonorrhoea, chlamydia, HIV, syphilis, hepatitis A, hepatitis B. They also recommend that consideration be given to herpes simplex virus (serology). The guidelines recommend more frequent testing for some sub-groups.

STIGMA is continuing to plan and implement a range of interventions addressing STIs among gay and other homosexually active men. Sustaining such interventions is important in creating a culture of regular testing both for HIV and STIs. In regional and rural areas access to appropriate services may also be impediments to promoting regular STI testing.

Strategies targeting gay and other homosexually active men need to take account of factors related to sexual sub-cultures that contribute to different level of STI (and HIV) transmission risk, as well as reflect different social and cultural contexts requiring different intervention approaches.

STI (and HIV) prevalence is higher among gay and other homosexually active men in inner city areas of Sydney. However men living outside these areas are often visitors to the inner city and at such times are equally at risk, and gay men from Sydney also travel to rural and regional areas. This needs to be taken into account in lower prevalence Areas.

Gay men with HIV participate in the same sex cultures as other such men without HIV. Interventions for gay men with HIV are required that relate primarily to sexual sub-cultures as well as interventions that recognise different motivations related to HIV status.

Aboriginal people

Specific activities should also be undertaken with gay and other homosexually active Aboriginal men. Many Aboriginal men are marginalised within the gay community (reflecting patterns within the broader community). Marginalisation and discrimination related to sexuality can also occur within Aboriginal communities. More generally other risk factors, such as poor access to services and social disadvantage, increase the risk that gay and other homosexually active Aboriginal men face.

Health promotion

Complex behavioural change, such as increasing use of condoms and reducing unsafe sex, requires an integrated and sustained health promotion approach. Services funded to undertake sexual health promotion should make use of the *NSW Sexual Health Promotion Guidelines* to develop interventions and programs that contribute to supportive environments and enable individual behaviour change. There is also a need to continue to build our knowledge base of what constitutes effective STI health promotion practice with gay men.

Sex-on-premises venues

Sex-on-premises venues are a key site for health promotion initiatives targeting gay men who may be at increased risk of STIs and offer a point of access to men who may not be reached through other means. The *NSW Communicable Diseases Health and Safety Guidelines for Sex on Premises Venues* (2001) and the AIDS Council of NSW *Code of Practice* for sex-on-premises venues aim to reduce the risk of HIV and STI transmission among sex-on premises venue patrons. ACON has complemented the Code of Practice by providing training for venue staff, developing a resource for patrons of venues and implementing an education workshop program.

Area Health Services, particularly the former Central Sydney and South Eastern Sydney Areas, have contributed significantly to health promotion initiatives targeting venue patrons through sexual health services and HIV/sexual health promotion units.

Non-gay-identifying homosexually active men

The Australian Study of Health and Relationships reported that 1.6 per cent of men identified as gay or homosexual and 0.9 per cent as bisexual. Same sex attraction or experience was reported by 8.6 per cent of men.¹⁴ The study also reported that nearly 6 per cent of the total sample of men had reported some homosexual experience in their lives and 1.9 per cent of men reported homosexual experience in the past year.¹⁵

Interventions targeted at gay men may not reach other homosexually active men who do not have a gay identity or do not come into contact with the gay community. Health promotion programs need to take account of both sexual identity and sexual experience and should not assume that homosexual experience will necessarily equate with gay identity.

Culturally and linguistically diverse backgrounds

The needs of gay and other homosexually active men from culturally and linguistically diverse backgrounds need to be considered when developing and implementing programs and in the provision of services. Research has highlighted how sexual behaviours may appear similar across cultures, but the meanings attached to these behaviours are often quite different across and within cultures.¹⁶ In 2002, the Asian Gay Community Periodic Survey reported that nearly 40 per cent of the sample had never had an STI test and high proportions of these gay men had not disclosed their sexual identity to their doctor.¹⁷

Social context

The experience of discrimination or homophobia, or the fear of encountering discrimination, can be a barrier to accessing services. This may be exacerbated for gay and other homosexually active men living in rural and regional NSW, Aboriginal gay men, same sex attracted young people and gay and other homosexually active men from culturally and linguistically diverse backgrounds.

Enhancing the capacity of health services and other stakeholders to meet the needs of gay and other homosexually active men is critical to improving health outcomes. Strategies to do so might include training health care workers to promote service access, adopting policy at an Area Health Service level to address homophobia, and the integration of relevant content into GP training.

Strategic objectives

- 1 Increase the consistent use of condoms with casual and new sexual partners.
- 2 Reduce rates of syphilis among gay and other homosexually active men by 50 per cent by 2009.
- 3 Increase the proportion of gay and other homosexually active men who are annually tested for STIs.
- 4 Increase the proportion of sexually active gay and other homosexually active men who are vaccinated for hepatitis A and hepatitis B.
- 5 Increase the capacity of GPs and health services to meet the needs of gay and other homosexually active men.

3.3 Young people

Young people (aged 25 and under) are considered a priority population owing to:

- epidemiological data showing a higher rate of notification of STIs
- higher rates of partner change among young people
- barriers to accessing health services.

Young people are a very broad and diverse priority grouping which includes a number of sub-populations such as young people in school, those who are marginalised through factors like homelessness or illicit drug use, people beginning their sexual experience and young adults who are sexually active. Some of these sub-groups relate to patterns of sexual behaviour, and others to social, economic, educational or other factors. An understanding of this broad priority population group reveals that a wide variety of strategies and approaches is required to address the diversity of experience and needs of young people in relation to STIs.

The Australian Longitudinal Study on Women's Health found that the self-reported incidence of ever being diagnosed by a doctor with an STI was 1.7 per cent for chlamydia, 1.1 per cent for genital herpes, 3.1 per cent for genital warts and 2.1 per cent for other STIs among women aged 18-23.¹⁹ It is apparent that young men and young women have different experiences of STIs in relation to symptoms, risk of long term complications and accessing services. This reflects broader social patterns related to access to health care, with young women often being positioned as responsible for sexual health and access to sexual health information and young men reluctant to engage with these issues.

Broad constructs of masculinity may contribute to young men feeling invincible and not needing to access services or look after their health. Some men may find that the risk of infertility has greater salience than STIs, although frequently pregnancy is seen as something to be avoided rather than as reproductive capacity to be maintained.

Chlamydia is the most frequently reported STI diagnosis among young people, making it a priority for programs targeting young people.

Factors associated with STI diagnosis

Among young women factors associated with STI diagnosis include:

- having a previous infection and becoming re-infected¹⁸
- having been pregnant, longer duration of oral contraceptive use, having ever smoked, alcohol use, frequency of consulting a doctor, and how eventful life has been¹⁹
- romantic love and intimacy with condom-less sex equated to a loving and trusting relationship, and reluctance to carry or use condoms for fear of being seen as too sexually assertive;²⁰ and
- the influence of male sexual partners because adolescent females may be less likely to exert influence over condom use by their partner.²¹

Research has also highlighted that excessive alcohol use and illicit drug use is associated with a range of health risk behaviours including unsafe sex, unwanted pregnancy as well as STI diagnosis.^{22,23}

Priority population groups

Young people who are members of other priority population groups within this Strategy are a high priority. Aboriginal young people are considered a particular priority on the basis of inequality of access to services as well as a significantly younger demography than the non-Aboriginal population. Young gay and other homosexually active men are also considered a priority.

Research has also shown that some same sex attracted young people have similar rates of condom use to their heterosexual peers, but higher rates of STIs, and many were also sexually active with opposite sex partners. Education targeting young people should address same sex behaviours for both men and women, but recognise the complex relationship between sexual identity, sexual behaviour and perceptions of risk.²⁴

At a local level there may be a need to recognise other priorities, such as young travellers.

Marginalised young people

Priority should be given to the needs of marginalised young people such as homeless young people, young people in correctional facilities, young people with disabilities and same sex attracted young people.

Research has shown chlamydia rates are higher in marginalised and homeless young people, compared to among senior high school students.²⁵ Research in Melbourne has highlighted that young homeless people, in comparison with secondary school students, are sexually active at younger ages, have more sexual experiences, use condoms less regularly and consistently, and are more likely to have been diagnosed with an STI.²⁶

Outreach strategies may be required to reach marginalised populations of young people. Research has found that outreach services were critical in connecting young people to care and that outreach services were more likely to see homeless young people, those involved in the mental health system, gay and lesbian young people or young people with a history of injecting drug use.²⁷

The Health Outreach Team, Youth Accommodation Association, has undertaken a range of initiatives to address the needs of young homeless people. A significant strategic focus for the organisation over the life of this Strategy is to further build the capacity of youth accommodation workers to respond to sexual health issues through workforce development initiatives.

Access to information and skills

Overall, young people rate family and school as the most reliable sources of information about health issues and diseases.²⁸ International research has reported that those educated by their parents, other relatives, friends and school had higher levels of knowledge than those educated by others, including physicians.²⁹ It was hypothesised that this may be related to the greater number of opportunities these groups have to provide young people with information and to reinforce key messages. As such, a key objective of this Strategy is to support those groups to provide young people with accurate and accessible information.

Young people who have not attended school in Australia, or who attended schools that do not have sex education, may reach adulthood without having had access to appropriate sexual health education. Also, same sex attracted young people may not have received sexual health education relevant to their situation. Active health promotion, as well as passive availability of information, is necessary for these young people.

A large percentage of sexually active young adults experience difficulties with condom use. Impediments to effective condom use include embarrassment, not knowing how to approach the subject, lack of preparedness, unanticipated sexual activity, and concerns about alienating or insulting a partner.³⁰ This highlights that the relationship between information and ability to negotiate safe sex practices is complex, and requires a comprehensive health promotion response to support health education messages.

Access to services

Access to services is an important determinant of young people's experience of risk. Access to accurate information about STIs is vital in prevention strategies, while access to diagnosis and treatment is critical for both improving health outcomes for individuals and preventing further STI transmission.

Research has examined young people's access to primary health care and found that the most prominent barriers were concerns about confidentiality and trust and having to deal with embarrassment and shame in disclosing concerns. Also significant were young people's lack of knowledge of what services were available, what they provided, the competencies/ skills of the providers and how to access them. Socio-economic status appeared to be unrelated to the barriers identified except for cost of access in rural areas.³¹

Service providers have identified young people's access to sexual health care through general practice may be limited by:

- lack of access to a Medicare card
- concerns regarding confidentiality
- difficulties in accessing appropriate transport
- cost of treatment
- lack of choice
- declining rates of bulk billing general practitioners
- fear of being judged or an unsupportive service.

The above issues may be more acute in rural and regional areas. Many of these issues are not necessarily unique to sexual health.

The issues canvassed are not necessarily easily overcome, but some Area Health Services are demonstrating success in addressing these issues by implementing innovative programs. Given the need to prioritise access to sexual health clinics (see section 4.3), the outcomes of innovative programming need to be well disseminated.

Throughout NSW, youth health centres provide limited medical services to more marginalised young people. Research that interviewed young people in youth health centres and homeless young people found that young people are likely to cite a general practitioner as the health professional they are most likely to see when seeking professional health.³¹ Therefore, it is appropriate for sexual health services to develop relationships with local youth health centres as well as general practitioners (see section 4.2) to identify how the services might support each other's work.

Pregnancy

Among young women, having ever been pregnant appears to be associated with a number of important behavioural risk factors including higher number of sexual partners, increased likelihood of having had sex under the influence of drugs, and higher likelihood of ever having had an STI. This points to the possibility of reaching young women at increased risk of STIs through interventions at the point where young women access pregnancy related services, particularly termination services and reproductive health services.³²

Schools

Schools are important sites for reaching young people. Sexual health, relationships and drug issues are addressed in a holistic manner through the Personal Development, Health and Physical Education Syllabus (PDHPE) and Crossroads (mandatory personal development and health education course for year 11 and 12 students in NSW government schools). Principals, teachers, counsellors and parents are all key players in initiatives that aim to build the capacity of schools to address sexual health.

In 2001, the Australian Research Centre in Sex, Health and Society developed the *Talking Sexual Health* resource to assist teachers addressing sexual health in PDHPE. In NSW, the Department of Education and Training, with the support of NSW Health and FPA Health, has ensured professional development support is available for teachers implementing *Talking Sexual Health*. Professional development activities supporting the implementation of *Talking Sexual Health* are coordinated by the NSW Sexual Health Steering Committee. The committee includes representatives from the Department of Education and Training, NSW Health and FPA Health.

Initiatives with schools occur in the context of *Health Promotion with Schools: A Policy for the Health System*. This policy confirms that:

- there are considerable gains to be made from partnerships between the health and education systems
- using a combination of health promotion strategies over time to achieve change is more effective than one-off interventions such as education sessions
- that there is a need to develop a uniform effective code of practice for health workers undertaking health promotion with schools.

It is generally not an effective use of resources for sexual health services to provide young people with direct education via schools.

Creating supportive environments

Even when young people have reasonable knowledge about the transmission and symptoms of STIs, their social contexts may act as barriers to safe sex practices. While providing young people with education, information and peer support is an important strategy, intervention into the social contexts in which young people live their lives is required to create supportive environments for preventing STIs.

The American National Longitudinal Study on Adolescent Health concluded that young people who avoided risk behaviours usually had positive influences in their lives, primarily strong connectedness with their parents.³³ Similarly, US research has found that sexual and reproductive health outcomes for young people are as significantly influenced by policies that mould communities and neighbourhoods as they are by access to services.³⁴ Sexual health promotion has an important potential role in supporting parents to discuss sexuality and sexual health with their children.

Strategic objectives

- 1 Increase the use of condoms with casual and new sexual partners.
- 2 Increase young people's access to general practice and other services.
- 3 Strengthen the capacity of schools and their communities to implement sexual health education programs.
- 4 Create environments which support young people's sexual health.

3.4 Sex workers

Sex workers are considered a priority population because of their significantly higher number of sexual encounters than members of the wider community.

The prevalence of HIV and STIs among Australian female sex workers remains one of the lowest in the world.³⁵ Sex workers have a very high rate of condom use and undertake frequent sexual health check ups.¹¹ Sex workers remain a priority population group to ensure that achievements to date are sustained.

Most brothels in NSW provide a supportive environment for consistent safe sex practices, and the culture of condom use is very strong. Sex workers also play a role in informing clients about the symptoms of STIs and providing information about services that can diagnose and treat STIs. This requires that sex workers have a good understanding of STIs.

Sex workers may be vulnerable to STIs if clients demand unprotected sex. While there are usually structural protections for sex workers in brothels, sex workers with poor working conditions are reliant on their individual capacity to insist on protected sex. Transgender and Aboriginal sistergirl sex workers are often over-represented among street-based workers and face heightened risk.

The adoption of measures by the sex industry which protect the health of the public has been achieved by the promotion of a standardised voluntary approach. This approach has helped to remove barriers to the implementation of effective health policies directed at sex workers, and is largely due to the outreach work and advocacy undertaken by specialist sex worker projects such as the Sex Workers Outreach Project (SWOP). Outreach is a key strategy for accessing this priority population who may only identify as a sex workers while in their workplaces. Within the resources available, there needs to be an ongoing review of how SWOP and sexual health services can best work together to ensure appropriate geographic reach across NSW.

In addition to the statewide network of sexual health services and legislative reform, SWOP provides leadership on engaging with sex workers and tailoring strategies to the needs of the range of populations involved in the sex industry in NSW.

NSW Health is committed to protecting the health and safety of workers in the sex industry. The Department has worked closely with WorkCover NSW and SWOP to develop the *Health and Safety Guidelines for Brothels*, which lists safe sex resources as personal protective equipment, and therefore requires that employers adequately maintain their supply.

Overseas-born sex workers

Overseas-born sex workers may be less likely to practise safe sex owing to:

- greater pressure to practise unprotected sex
- isolation from peer support and information services
- isolation within working environments which do not routinely insist on protected sex
- reduced skills and knowledge in negotiating protected sex
- lack of access to condoms and lubricant.

Overseas-born sex workers may lack adequate access to preventive and health care services and consequently the duration of their infections may be longer than that for resident sex worker populations. It is vital that in outreach to overseas born sex workers consideration is given to cultural issues and the ability of workers to access appropriate services.

Street-based sex workers

Street sex work in NSW is legal only if soliciting occurs away from schools, churches, hospitals and dwellings. Street-based workers are often subjected to harassment from potential clients and local residents. Street-based sex workers are more likely to report injecting drug use and also to report greater difficulty in accessing services for preventive health care. This population often experiences greater difficulty in consistently maintaining safe sex practices, owing to greater pressures, and inconsistent access to condoms and lubricant (particularly for those who are homeless or itinerant). This group is a high priority for clinical services and health promotion in NSW.

Male sex workers

Studies have found that almost one third of male sex workers who attended Sydney Sexual Health Centre had one or more STIs at clinical presentation.³⁶ This was double the prevalence of STIs in female sex workers and significantly greater than the STI prevalence in gay men not involved in sex work. Homosexually active male sex workers were less likely to use condoms consistently with non-clients than gay men. Male sex workers with exclusively female partners were most likely to have unprotected sex with their non-client partners. This indicates the need for STI prevention strategies targeting sex workers to address both their professional and personal risk assessment and negotiation skills. Male sex workers also play an important education role informing their clients about STIs.

Male sex workers are a high priority for clinical services and health promotion in NSW.

Changes in the industry

There are some indicators that the sex industry in NSW may become less centralised over the life of this Strategy. Forces driving this change include decisions made by local governments in relation to development approvals for home-based workers, and advances in communication technology. Research indicates that the use of mobile phones has already drastically changed the social organisation of sex work in many places, increasing the proportion of private workers and generally increasing the extent to which sex workers are free to move about.⁷ While in many ways this is highly advantageous for individual sex workers, it does create new challenges in reaching home-based and mobile populations.

STI testing practices among sex workers in NSW

Sex workers are encouraged to access regular and appropriate testing for STIs in order to improve their own health outcomes and to reduce the risk of transmission to clients and sexual partners. The frequency of STI testing among sex workers should be appropriate for the frequency, risk and nature of work. The Australasian Chapter of Sexual Health Medicine recommends that sex workers are tested for STIs every 3-6 months. Sex workers should also access STI testing when they experience symptoms of STIs or following risk episodes.

Strategic objectives

- 1 Support and promote condom use and ongoing sexual health monitoring by sex workers.
- 2 Support sex worker access to appropriate sexual health services.
- 3 Support efforts to ensure a supportive regulatory environment which supports the health and safety needs of sex workers.

3.5 People with HIV/AIDS

People with HIV/AIDS are considered a priority population for the following reasons:

- higher prevalence of STIs among gay and other homosexually active men with HIV/AIDS;
- STIs have a greater impact on the health of people with HIV/AIDS; and
- the presence of STIs increases the risk of HIV transmission.

STIs may present with unusual features and be less responsive to treatment in people with HIV/AIDS and have a greater health impact. People with HIV/AIDS may experience more frequent recurrences of STIs after treatment.

The presence of STIs can increase HIV viral load in genital secretions and play a role in facilitating HIV transmission. Apart from the importance of addressing STIs in their own right, the prevention and management of STIs is recognised as an important strategy to reduce the risk of HIV transmission.¹

Most people with HIV/AIDS regularly see a GP or a GP prescriber either in general practice or at a sexual health clinic.³⁹ This regular contact creates opportunities for accessing testing and information and having STIs treated. However, people with HIV/AIDS may experience difficulty in addressing sexual health concerns with health staff, owing to fears of being judged for practising unsafe sex or of being reported to public health officials as knowingly placing others at risk of HIV infection. This concern arises despite STI infection not being an accurate indicator of HIV risk practice. This issue needs to be addressed through educating people with HIV/AIDS as a population about their right to access health care, the personal health advantages of STI prevention (and management and diagnosis of STIs when they do occur), and through educating health service providers about strategies for engaging their HIV positive clients in discussions about sexual health. People with HIV/AIDS and their doctors should be encouraged to discuss how STI testing is integrated into routine health monitoring.³⁷

People Living with HIV/AIDS (NSW) have created opportunities for HIV positive people to discuss STIs and safe sex through community forums, workshops, and questionnaires. This experience has indicated the desire of people with HIV/AIDS to participate in discussions about these issues, but to do so in an environment which brings together accurate information and respect for HIV positive peoples' rights to sexual expression.

Gay and other homosexually active men

Gay and other homosexually active men with HIV are a high priority group given epidemiological data that shows a high prevalence of STIs among gay men. As highlighted in section 3.2, reducing rates of gonorrhoea, chlamydia and syphilis among gay and other homosexually active men is a key priority.

Syphilis is of particular concern given recent increases in infectious syphilis notifications among gay and other homosexually active men and research which has indicated that syphilis infection can lower CD4 cell counts and raise HIV viral load in HIV positive men.³⁸

HIV Positive women

In addition to the previously mentioned health impacts of STIs, HIV positive women are also vulnerable to reproductive and gynaecological complications as a result of STIs. The presence of undiagnosed, asymptomatic STIs may eventually result in decreased fertility, and limit women's ability to conceive. Research indicates that a significant number of HIV positive women are thinking about having a child, and maintaining their fertility is important to them.³⁹

As the majority of female HIV notifications in NSW have recently been among women from culturally and linguistically diverse backgrounds sexual health services need to be mindful of, and respond to, the underlying cultural issues for HIV positive women.

People with HIV/AIDS from culturally and linguistically diverse backgrounds

Approximately 20 per cent of people with HIV/AIDS in NSW are from a culturally and linguistically diverse background, including gay and other homosexually active men, women and heterosexual men. Many of these people with HIV/AIDS were born in, or regularly travel to, countries with a high prevalence of STIs. Their HIV clinicians need to ensure that there is access to appropriate information on, and discussion of, STIs.

Strategic objectives

- 1 Increase the consistent use of condoms with casual and new sexual partners.
- 2 Increase the proportion of sexually active people with HIV/AIDS who are regularly tested for STIs.

3.6 People who inject drugs

People who inject drugs are considered a priority population owing to:

- the potentially higher prevalence of STIs among people who inject drugs
- poorer health outcomes across a range of indicators
- poorer access to health services, in particular to primary health care.

There is some research indicating that STIs are more prevalent among people who inject drugs. Street outreach conducted in Melbourne revealed a high prevalence of infections and risk behaviours.⁴⁰ Additionally, the Australian Study of Health and Relationships reported that having ever injected drugs was a predictor of ever having had an STI for both women and men.⁹ While people who inject drugs have been prioritised as population group for the reasons listed above, establishing a clearer picture of STI prevalence within this population remains important.

While people who inject drugs are a priority population group for this Strategy, the impact of excessive alcohol use and illicit drug is often a factor in risk taking behaviour and should be addressed in working with other priority population groups where appropriate.

For many people who inject drugs, the Needle and Syringe Program (NSP) is the major point of regular contact with the health system. The NSP plays an important role in providing information and education, and enhancing access to sexual health services and the broader health system. Ensuring appropriate referral pathways and protocols between NSPs and other services, such as drug and alcohol services and sexual health clinics can be valuable. Education initiatives need to occur in a manner that is appropriate for users of the service. Some NSPs have trialled brief verbal interventions as a way of providing information to people who inject drugs and promoting access to services.

A number of drug and alcohol services have recognised the importance of addressing sexual health needs when people with a long history of problematic substance use enter a residential detoxification service or access the methadone program. In many cases, entering such programs provides an opportunity for people to more fully consider their health.

People who inject drugs may be at heightened risk of hepatitis B infection due to their sexual and injecting practices. The Australian NSP Survey indicates that in

NSW, 51 per cent respondents had been vaccinated.⁴¹ The Australasian Chapter of Sexual Health Medicine has recommended in its *Clinical guidelines for the management of sexually transmissible infections among priority population groups* that people who inject drugs should be immunised against hepatitis B. Free hepatitis B vaccination is available from sexual health services, methadone program, and alcohol and other drug services.

Strategies to address the significant risk of HIV and hepatitis C transmission among people who inject drugs are outlined in the *NSW HIV/AIDS Strategy 2006–2009* and *NSW Hepatitis C Strategy 2006–2009*.

Strategic objectives

- 1 Increase the use of condoms with casual and new sexual partners.
- 2 Increase people who inject drugs access to appropriate services.
- 3 Increase the proportion of people who inject drugs who are vaccinated for hepatitis B.
- 4 Improve links between sexual health services, drug and alcohol services and other programs which work with people who inject drugs so as to increase access to sexual health education and services.

3.7 Heterosexuals with recent partner change

Heterosexuals with recent partner change are a priority group owing to their heightened risk of STI acquisition.

The Australian Study of Health and Relationships found that 13 per cent of men and seven per cent of women aged 16-59 had had sex with two or more people of the opposite sex in the previous year. This was most common among the under-30s. Although many people aged 16-19 had no partners, those who were sexually active were most likely to have multiple partners (41 per cent of young men and 33 per cent of young women who were sexually active). Among people aged 16-59 in regular relationships that had lasted at least one year, five per cent of men and three per cent of women had had sex with at least one other person in the past year.

Over the past few decades in Australia, as the average age at marriage (or long-term defacto relationships) has risen and cohabitation has become acceptable, the period between 'sexual debut' and 'settling down' with one partner has extended. This has greatly increased the need for awareness of STI risk and prevention among the majority of heterosexuals.

Regardless of sexual identity, partner changes may be with opposite sex or same sex partners. This requires a response which recognises the complex relationship between sexual identity, sexual behaviour and perceptions of risk.

The Australian Study of Health and Relationships found that a predictor of recent STI or blood borne virus diagnosis in men and women included bisexual identity.⁹ Research has also highlighted that women who have sex with women and men may be at heightened risk, particularly as bisexual women were many times more likely than heterosexual women to have recently had sex with a gay or bisexual man.⁴² Additionally the female partners of men who have sex with men may not be aware that their male partners are homosexually active, and may consequently make assessments of their risk of STIs based on partial information.

Other groups which may require additional focus include backpackers and travellers, and people ending long term relationships and establishing new relationship.

Strategic objectives

- 1** Increase the use of condoms with casual and new sexual partners.
- 2** Increase the proportion of heterosexuals with recent partner change who are tested for STIs by GPs.

4.1 Promoting general STI awareness

All sexually active members of the population are potentially susceptible to STIs. As such, individuals need access to accurate information about the transmission and prevention of STIs.

The transmission of STIs can be significantly reduced through the consistent and correct use of condoms. The Australian Study of Health and Relationships found that 41 per cent of respondents having casual sex always used condoms with casual partners.⁴³

Knowledge of STIs and the health consequences of common STIs, such as chlamydia, vary across the population. The Australian Study of Health and Relationships found that 57 per cent of women were aware that chlamydia can lead to infertility in women, while only 34 per cent of men were aware of this. There was also a poor understanding of the effect chlamydia can have on men, with only 30 per cent of men and 32 per cent of women aware that chlamydia doesn't only affect women.⁴⁴

An increase in community awareness of STIs will contribute to both individual and population health. To promote awareness of STIs the NSW Department of Health launched '*Chlamydia - Be Smart, Be Tested*' campaign in 2003. The campaign promoted community awareness of chlamydia and the importance of testing. In 2005, the '*Safe Sex. No Regrets.*' campaign was launched by the NSW Health Department. The campaign promoted general awareness of STIs and the use of condoms to prevent infections. The evaluation of the campaign showed that it was effective at raising community awareness of STIs and the use of condoms as a means to prevent infection.

Research has shown that general population campaigns can reduce rates of STIs across populations. A review of the impact and outcomes of STI and HIV awareness campaigns conducted in the UK concluded that the sexual health components of these campaigns influenced sexual behaviour in the general population

and contributed to reduced transmission of STIs through behaviour change and heightened awareness of risky sexual practices.⁴⁵ The review concluded that while general campaigns led to an increase in condom purchasing and usage, and increased attendance at genito-urinary medicine clinics, the benefits were not sustained in the ensuing decade. Accordingly, they argue that general population STI information campaigns should be conducted on a semi-regular basis, to maintain the profile of key messages and sustain behaviour change.

General community awareness campaigns also need to take specific account of the needs of Aboriginal communities and culturally and linguistically diverse communities, including by ensuring that information and education is presented in culturally appropriate and accessible ways. Other cultural factors should also be considered, including that adults who have emigrated from some countries may have received very different or little education in relation to sexual health.

Strategic objectives

- 1 Increase general awareness of STIs, including the asymptomatic nature of many, and the range of prevention strategies to reduce transmission of STIs, including condom use with new or casual partners.

4.2 Working with general practice

General practitioners are the main providers of primary health care services, including sexual health in Australia. The Australian Study of Health and Relationships found that approximately 55 per cent of Australians who were diagnosed with an STI or blood borne virus in the previous year had accessed treatment through general practice while a further eight per cent did so through publicly funded sexual health services. The remaining respondents reported having self-treated; accessed treatment through a pharmacy, an alternative practitioner, or other provider; or had no treatment.⁹

Australian research has indicated that the key trigger for individuals to present to a sexual health service is a symptom or sign of infection. The asymptomatic nature of most STIs means that seeking medical care specifically for STI related symptoms is unlikely to lead to the detection of most infections.

Although many people with asymptomatic infection may not access health care services specifically for STI testing and treatment, they may access primary health care for other health concerns. General practitioners are able to initiate discussion on sexual health and encourage targeted testing among individuals who are considered to be at risk. General practitioners have a vital role in encouraging appropriate testing and reducing the pool of undiagnosed and untreated STIs in the community.

Partnerships with general practice

General practice services are private businesses providing primary health care to members of the community. The Australian Government supports community access to general practice through the Medicare program. A key goal of the NSW Health *General Practice Policy* is to promote collaboration and partnership between the activities of general practice and the NSW public health system to ensure that patients receive continuity of care.

Of particular importance is building links with local divisions of general practice and promoting awareness of local sexual health services for specialist advice, support and referral. Eighty-five per cent of GPs in NSW are members of their local division of general practice. Divisions of general practice are important conduits for information to GPs, and, more generally, to practice nurses and practice managers. They are also important sources of information about the needs of GPs at a local level.

At the Area Health Service level partnerships with divisions of general practice, ensuring training programs offer continuing professional development points, offering GPs a variety of education and training options, have been demonstrated to be effective strategies in developing partnerships with GPs.⁴⁶

Access to resources and training programs

As GPs are the main providers of sexual health services in NSW, it is important that they have access to STI resources and training programs. Education and training programs need to address a variety of issues relevant to general practice including sexual history taking, screening and treating non-complex STI presentations, disease notification, contact tracing, and referral information. Resources and programs should also highlight the sexual health needs of priority population groups.

Specialist training on STIs and sexual health is available through the Australasian Chapter of Sexual Health Medicine, the Australasian Society for HIV Medicine, FPA Health and local sexual health services. It is vital that training for GPs continues to be made available statewide and locally through Area Health Services.

Strategies should encompass working with Aboriginal Community Controlled Health Services to ensure the availability of sexual health training, support, and linkages with GPs whose patients include Aboriginal people.

Sexual history taking

Taking a sexual history is the foundation for individualised risk assessment and creates an opportunity to discuss issues that the patient may not have otherwise raised. Conducting individualised risk assessment in relation to STIs can be a confronting and difficult task. GPs should have the opportunity to increase both their skills and confidence in this area.

Integrating sexual history taking into other consultations may help reduce the discomfort some patients may feel in discussing these issues. Appropriate consultations may include general health check-ups and those related to reproductive health.

Strategic objectives

- 1 Support sexual health service provision by general practitioners by ensuring access to education and training programs.
- 2 Support sexual health service provision by general practitioners by ensuring ready access to information and education resources.
- 3 Improve communication of Area Health Service referral pathways and options available to general practitioners.

4.3 Prioritising access to and focus of publicly funded sexual health clinics

Publicly funded sexual health clinics are important sites of expertise on STI prevention, detection, treatment and care. The role of publicly funded sexual health clinics is to:

- address the STI needs of priority populations through clinical service delivery, health promotion, counselling, and research
- provide clinical management of people with HIV/AIDS

- address the STI needs of individuals with complex medical or social needs
- undertake and provide support for contact tracing
- model best practice, be a site of expertise and contribute to the capacity of other local services addressing STIs
- maintain partnerships and provide referrals to other services as appropriate.

Two critical challenges for sexual health clinics are to align service delivery to members of priority populations and to direct resources to providing greater support to GPs for the diagnosis, treatment and support of people with STIs.

All sexual health clinics in NSW have a significant role in the clinical management of people with HIV. The NSW sexual health clinical infrastructure was expanded significantly in the 1990s to ensure HIV services were geographically accessible across the state.

There is significant diversity across sexual health services in NSW. In some regional centres, services are primarily provided by sexual health nurses while other services, particularly those in metropolitan areas, employ full-time sexual health physicians. Local needs also influence the priority given to different population groups.

Priority populations

Publicly funded sexual health clinics have finite capacity. To ensure services are directed where most needed, sexual health clinics need to prioritise access. Each sexual health clinic will need to determine the emphasis that should be given to the priority population groups nominated within this Strategy. Sexual health clinics need to establish access goals and targets in relation to priority populations, and to develop plans to enable them to achieve their goals and monitor progress. Such plans may need to identify strategies for increasing access to general practice and supporting general practice in addressing sexual health needs.

The prioritisation of access to sexual health clinics should consider whether a patient:

- is a member a priority population group
- presents with STI symptoms
- lacks access or willingness to access general practice
- has limited financial resources that may prevent them accessing appropriate treatment and care
- has complex needs and / or
- has been referred by their GP.

In addition to priority population groups nominated within this Strategy, sexual health clinics may also need to identify other priority population groups such as people from specific cultural and linguistic diverse backgrounds, where applicable to local population demographics and patterns of immigration settlement. Ideally, the identification of a priority culturally and linguistically diverse population at the local level should be made in conjunction with relevant multicultural agencies.

While this Strategy clearly prioritises service provision for specific population groups, any individual with more complex needs or who presents with symptomatic STI infection should be seen. Furthermore while priority should be given to building the capacity of other service providers, where an assessment is made that clients are unlikely to seek services elsewhere, they should also be seen.

Capacity and access

Publicly funded sexual health clinics need to ensure access to their services by those who are the highest priority. Strategies to ensure such access will vary depending on local needs but might, for example, require pro-active strategies such as establishing outreach clinics to target specific population groups or offering clinical services in conjunction with other health service providers and/or non-government organisations.

There are barriers to some priority population groups, particularly young people, accessing general practice. These barriers may include poor access to bulk billing general practices, poor access to general practice services, the cost of prescription medicines, concerns regarding confidentiality, inexperience in independently accessing health care services and embarrassment regarding sexual health issues. Sexual health clinics should explore options to address these barriers. Several Area Health Services have developed effective strategies to address these barriers. Strategies have included providing vouchers systems, establishing GP-led youth sexual health clinics, and assisting GPs in developing youth-friendly practices.

Developing the capacity of general practice

Sexual health clinics are key contributors to developing the capacity of general practice to detect and manage STIs. It is neither possible nor desirable for public sector sexual health services to provide direct services to all people with or at risk of STIs in NSW. Supporting general practice to detect and manage STIs recognises that most STIs are managed through general practice, and that general practice is well placed to address

STIs in a holistic primary health care setting. A broad range of workforce development strategies should be implemented in consultation and appropriate collaboration with local divisions of general practice.

As a result of changes in Medicare, increasing numbers of practice nurses are now being employed. Practice nurses can play an important role in providing sexual health services in general practice.

Accreditation guidelines

The AIDS/Infectious Diseases Branch has commissioned the Australian Council on Healthcare Standards and Quality Management Services to produce guidelines for accreditation of NSW sexual health services to complement the existing accreditation standards of the two organisations. The guidelines outline standards and criteria for measuring outcomes in different functional areas. Every sexual health clinical service will produce an annual report as part of the accreditation process. Common standards and criteria will be developed for the use of all sexual health clinical services in those areas most relevant to this Strategy.

Strategic objectives

- 1 Improve access to sexual health clinics for priority populations.
- 2 Strengthen strong local partnerships with general practice.
- 3 Enhance sexual health training and support for nurses working in specialist settings and in general practice.
- 4 Promote best practice standards within publicly funded sexual health clinics.

4.4 Promoting STI testing

New technology

Developments in the sensitivity and reliability of nucleic acid amplification testing methods have significantly increased the tools available for detecting and diagnosing chlamydia and gonorrhoea. In particular, research with marginalised populations has indicated that urine based testing is considered far more acceptable than clinical examination and potentially removes a powerful disincentive to accessing clinical services.

Funding has been allocated by the Australian Government for the implementation of the Nucleic Acid Amplification/Polymerase Chain Reaction Program. The program makes appropriate STI pathology testing technology available to Aboriginal and Torres Strait Islander people, specifically those living in remote communities.

While clinical examination, serology and microbiology remain critical tools in the detection and diagnosis of STIs, less intrusive testing methods should be used wherever clinically appropriate.

Self-collected specimens

The self-collection of specimens can play an important role in facilitating access to STI testing and diagnoses.

Trials conducted overseas are showing favourable results on the potential of home-based testing for chlamydia.^{47,48} This would enable individuals to collect a urine sample at home and send it directly to a laboratory via the mail. Such strategies enable the removal of some of the barriers individuals face in accessing sexual health care. The feasibility of such innovative strategies should be explored.

Self collection using tampons may assist women's access to STI services. There are many reasons why a woman may be reluctant to undergo a pelvic examination, including cultural reasons, feelings of shame, and the fear of loss of privacy and confidentiality in a small community. Practitioners working in remote clinics also report concerns about their own lack of experience in conducting pelvic examinations, and their concern that their inexperience may result in inadequate specimens being obtained.⁴⁹

Opportunistic testing

Opportunistic testing, with patient consent, is an important strategy for population groups at higher risk of being infected with specific STIs, particularly where individuals may be unlikely to request testing. There is evidence, particularly in relation to chlamydia, that opportunistic testing achieves significant population health outcomes.⁵⁰ Gonorrhoea and infectious syphilis are also priorities for opportunistic testing.

For payment to be eligible under the Medicare Benefits Schedule, opportunistic testing can occur on a symptomless patient to ensure a patient receives medical advice or treatment necessary to maintain their state of health. After taking a sexual history, an individual deemed to be at risk of STIs, can be tested.

Opportunistic testing should only occur with informed consent. Those being tested should be provided with information regarding the consequences of a positive result prior to testing.

Clinical contexts that might be particularly suitable for opportunistic testing for women include those related to reproduction or screening for cervical cancer.

Chlamydia screening program

Research has highlighted that Australia would benefit from a chlamydia screening program, and in particular that a program should screen all sexually active women who are 25 years of age and under.⁵¹

Screening programs for the detection and treatment of chlamydia in women have been associated with marked declines in chlamydia prevalence and a reduced incidence of symptomatic pelvic inflammatory disease.⁵² In particular, women who undergo screening (that is, testing in the absence of symptoms) have a lower incidence of pelvic inflammatory disease than those women who seek care only in response to symptoms.⁵³

Although the long-term sequelae of chlamydia are less serious in men than women, failure to detect and treat chlamydia infections in men is believed to contribute significantly to the maintenance of a large, untreated reservoir of chlamydia infection in the population, and to expose women who may have already been diagnosed and treated to re-infection.⁵⁴ It is important to also target men, particularly those who report unprotected sex with a new partner, otherwise screening programs among women may be less effective.⁵⁵

The first *National Sexually Transmissible Infections Strategy 2005–2008* has identified chlamydia control and prevention as a key priority area. The implementation of the strategy will involve piloting a chlamydia screening program targeted at sexually active young people.⁵⁶

Testing guidelines

Access to appropriate STI testing is considered a priority issue because testing is a key strategy for detecting asymptomatic disease.

The asymptomatic nature of many STIs means that there is an onus on health care workers to use opportunities that arise in clinical interactions to initiate discussions on sexual history and experiences of risk, and to inform clients about the benefits of STI testing. Patients with genital symptoms should have the appropriate diagnostic tests and also be screened opportunistically for other STIs. Based on epidemiology and behavioural risk indicators, there is also a strong argument for regular testing of sexually active members of priority population groups.

The Australasian Chapter of Sexual Health Medicine has outlined the optimal screening practices for gay and other homosexually active men, sex workers, young people and people who inject drugs in their *Clinical Guidelines for the Management of STIs Among Priority Populations*. These Guidelines should continue to be well promoted and be accompanied by appropriate training.

Barriers to testing

Research has highlighted what GPs perceive as some of the barriers to screening in general practice.⁵⁷ The three-test pathology rule, which limits the Medicare rebates a pathologist can claim, was the most common factor that respondents indicated inhibited their screening, particularly in relation to gonorrhoea.

Vaccines

While screening and testing remains important, vaccination against specific infectious diseases is one of the most efficient methods of control. Effective hepatitis A and hepatitis B vaccinations are already available. It is possible in the very near future that an effective vaccine against human papilloma virus will become commercially available. The *National Sexually Transmissible Infections Strategy 2005–2008* has identified that such a vaccine could have a dramatic effect upon incidence of cervical and anal cytological abnormalities.⁵⁶ The availability of such a vaccine will have significant implications at a public policy level, particularly in relation to access and funding, and, as a result, progress in the development of an effective vaccine will need to be carefully monitored during the life of this Strategy.

Strategic objectives

- 1 Promote a culture of appropriate testing for STIs.
- 2 Support GPs in the implementation of appropriate testing practices.
- 3 Reduce actual and perceived barriers to appropriate STI testing.

4.5 Improving contact tracing

Contact tracing is the process of identifying relevant contacts of a person with an infectious disease and ensuring they are aware of their exposure. Contact tracing aims to reduce the transmission of infections through early detection and treatment of STIs and provide information and education to promote behaviour change among those infected or at risk of infection. Contact tracing is not a substitute for community education programs, but should be utilised as an additional strategy when appropriate.

Contact tracing is conducted in a variety of ways across the public health sector. It may be undertaken by counsellors, doctors, nurses, public health officers or other health workers. While the capacity varies in each Area Health Service, research has found that contact tracing undertaken in Australian sexual health services was excellent. Contact tracing is also conducted in general practice settings. Owing to time limitations, contact tracing in general practice settings largely relies on GPs supporting patients to advise their own contacts, in consultation with the GP and practice nurse. Some practices liaise with contacts directly in specific circumstances, based on disease, need and resources.

Contact tracing requires protecting the confidentiality of and providing care for the patient, while also protecting public health, meeting legal obligations and ensuring the health and well-being of contacts.

The *Australasian Contact Tracing Manual*, produced by the Australasian Society for HIV Medicine, and the NSW Health *Contact tracing guidelines for the sexually transmissible diseases and blood borne viruses* policy directive inform practice in NSW. The Sexually Transmitted Infections Research Centre (STIRC) is researching contact tracing procedures for sexually transmissible infections in NSW by sexual health clinics, public health units and GPs. The research aims to identify current procedures and the difficulties encountered by clinicians in undertaking contact tracing for STIs and HIV infection, and can inform a review of current contact tracing practice.

Strategic objective

- 1 To increase the number of contacts treated.

4.6 Strengthening health promotion programming

Health promotion refers to multi-strategic, multi-level interventions that seek to effect individual, population and systemic change concurrently in order to improve individuals' health seeking behaviour and create a more supportive environment for the maintenance of positive health practices. As outlined in the Ottawa Charter for Health Promotion, actions can include developing healthy public policy, developing personal skills, strengthening community action, creating supportive environments and re-orienting health services.

It is necessary to distinguish between health promotion activities – that is, one-off activities that may target individuals or groups – and health promotion programs which involve a range of strategies and which intervene at different levels.

The challenge for health promotion programming is to ensure that services adhere to best practice in planning and implementation and are informed, where available, by evidence. The development of appropriate and effective partnerships is also critical to successful outcomes.

Effective health promotion programming requires an appropriately skilled and knowledgeable workforce. To achieve this there needs to be an emphasis given to enhancing not just the capacity of sexual health promotion officers but also others who can and do input and participate in health promotion programming, such as clinicians, nurses, teachers, public health officers and counsellors. This can contribute to ensuring all sexual health services work towards a common goal of improving the sexual health of the population.

Priority populations for sexual health promotion will in many cases be wider than those prioritised for access to publicly funded clinical services, as health promotion programs should strive to address all members of the priority populations identified in section three of this Strategy. Sexual and population health programs within Area Health Services, and non-government organisations, have a primary role to play in developing, implementing and co-ordinating sexual health promotion programs for priority populations.

An important tool for supporting sexual health promotion within NSW is the *NSW Sexual Health Promotion Guidelines*. These guidelines provide a framework for program development and provide services with operational direction on developing best practice health promotion programs.

Strategic objectives

- 1 Continue to increase the quality of sexual health promotion programs.

4.7 Developing the workforce

A skilled and productive workforce is vital for achieving sustainable improvements in the sexual health of the people of NSW. Workforce development encompasses formal and informal activities that provide opportunities for workers to continuously develop, enhance and improve their skills, theoretical understandings, knowledge and capacities, and cultural understanding and sensitivities for members of priority population groups.

While one-off training programs have an important role, workforce development is significantly informed through the learning that happens through daily work practices and participation in learning opportunities provided in workplaces. Workforce development contributes to continuous improvements in the achievement of organisational goals, and whole-of-organisation responsiveness to the changing needs of consumers.

While each service is responsible for developing strategies for their own workforce, there are a number of statewide programs that support the development of the sexual health workforce including the NSW Workforce Development Program in Hepatitis, HIV and Sexual Health and the range of professional education activities undertaken by the Australasian Chapter of Sexual Health Medicine, the Australasian Society for HIV Medicine, FPA Health, and the Health Outreach Team.

The NSW Department of Health has developed *Core Competency Standards for Aboriginal and Torres Strait Islander Sexual Health Workers in NSW*, which have been supported and incorporated into the distance learning package for the nationally accredited *Diploma of Community Services (Case Management) with a focus on Aboriginal Sexual Health* at the Aboriginal Health and Medical Research Council of NSW, in order to support the role of the Aboriginal sexual health workers.

Workforce development activities should be aligned with the strategic priorities of services. Appropriate workforce development opportunities should be made available to all relevant workers, including clinicians, sexual health promotion staff, general practitioners, women's health nurses, Aboriginal sexual health workers, nurses, counsellors, Justice Health staff and health promotion workers and those working in other program areas such as mental health, drug and alcohol, Aboriginal health and youth health.

Area Health Services and other agencies are encouraged to identify the full range of services that work with priority populations, such as teachers and youth services and to foster workforce development within those services.

Strategic objectives

1. Build the skills of the sexual health workforce and broader contributors to sexual health.

4.8 Research and surveillance priorities

Research and surveillance data provides vital information on behaviour and attitudes along with health outcomes and outbreaks of disease and is critical to inform service delivery and development.

Surveillance

The *NSW Public Health Act 1991* requires that laboratories notify diagnoses of gonorrhoea, syphilis, chlamydia, HIV, hepatitis B, chancroid, granuloma inguinale and lymphogranuloma venereum to the NSW Department of Health. Medical practitioners are required to notify syphilis. Surveillance data are not collected for human papilloma virus and herpes simplex virus.

Notification data provide only a crude indication of overall population prevalence and incidence of disease (particularly incidence) since an accurate estimate of the population at risk is difficult to obtain and notification data may not accurately or completely capture all cases of infection (particularly new infections).

STI surveillance studies undertaken in priority population groups identified in this Strategy provide an indication of prevalence and changes in incidence. In regard to gay and other homosexually active men and HIV positive men, existing studies such as the Health In Men Study and the Sydney Gay Community Periodic Survey, provide this information.

Similarly, the Australian Needle and Syringe Program Survey, an annual survey of users of needle and syringe programs, forms the basis of HIV and hepatitis C surveillance among injecting drug users in Australia.

Elsewhere in Australia, reported rates of STIs in Aboriginal populations are significantly higher than the general population. The nature of STI notification and public health follow-up practices in NSW means that information regarding Aboriginality is not well collected for chlamydia and gonorrhoea. Aboriginal information for infectious syphilis and acute hepatitis B however has a high collection rate. Strategies to improve information on burden of illness, for STIs, in the Aboriginal community need to be implemented in consultation with key partners.

Research

There is a range of research priorities in the areas of STI treatment, health promotion and service provision. Priorities in the areas of treatment and health promotion are also relevant to the Australian Government and other state jurisdictions and should be pursued in collaboration. They include:

- best practice in the treatment of STIs
- studying overseas systems and interventions that are effective
- sexual behaviour and sexual health outcomes of priority population groups
- sexual health knowledge and attitudes
- response to and understanding of the effectiveness in health education and promotion initiatives.

An additional priority is research that can inform the development of strategies likely to be effective at preventing and controlling herpes simplex virus and human papilloma virus at population level.

Access to and analysis of Health Insurance Commission data is necessary to both determine the extent to which diagnoses may be a reflection of changes in testing patterns, as well as to evaluate strategies to increase testing.

Strategic objectives

- 1 Improve knowledge of the prevalence and incidence of STIs in priority population groups.
- 2 Improve culturally appropriate STI surveillance and burden of illness and behavioural research within Aboriginal communities.
- 3 Improve knowledge of strategies to prevent and control herpes simplex virus and human papilloma virus transmission.
- 4 Ensure STI surveillance information is readily available to inform program and service development.
- 5 Undertake high quality research to inform program and service development.

A range of government and non-government agencies have responsibility for the implementation of this Strategy. Partnership is a guiding principle of the Strategy. As such while a particular agency may have a lead role in a functional area it is understood that this will involve participation in decision making by other agencies. The broad lead roles of key agencies are as follows.

NSW Department of Health – AIDS/Infectious Diseases Branch

- Statewide policy development and strategic planning.
- Statewide coordination and monitoring of strategy implementation.
- Funding allocation.
- Performance monitoring and accountability.

NSW Department of Health – Communicable Diseases Branch

- Statewide coordination of surveillance and publication of epidemiological data.
- Identification of changes in disease patterns.
- Identification, investigation and coordination of responses to disease outbreaks.

Area Health Services – sexual health program

- Strategic planning at the area level.
- Funding allocation.
- Program coordination.
- Implementation of prevention and health promotion programs.
- Development of partnerships.

Area Health Services – sexual health clinical services

- Delivery of clinical services to priority populations.
- Sexual health capacity building with other sexual health providers (for example, GPs).
- Provision of expert information to other providers.
- Implementation of prevention and health promotion programs.
- Development of partnerships.
- Contact tracing.

Area Health Services – Public Health Units

- Coordinate surveillance at the Area Health Service level.
- Participate in strategic planning.
- Investigate and coordinate responses to disease outbreaks.
- Support contact tracing by GPs.

General practitioners

- Provision of sexual health clinical services to non-priority populations.
- Provision of services to members of priority populations who choose to access sexual health clinical services through general practice.
- Contribute to prevention and health promotion programs.
- Partners in contact tracing.

Community based organisations (representing priority population groups)

- Implementation of prevention and health promotion programs.
- Advocacy to create supportive environments.
- Provision of support and referral services.
- Development of partnerships.

Agencies with specialist expertise

- Training (for example, Workforce Development Program in Hepatitis, HIV and Sexual Health and FPA Health).
- Research (for example, National Centre in HIV Social Research, National Centre in HIV Epidemiology and Clinical Research, and the STI Research Centre).
- Professional development (for example, Workforce Development Program in Hepatitis, HIV and Sexual Health, and the Australian Sexual Health Nurses Association).
- Agencies working with priority population groups (for example, the Aboriginal Health and Medical Research Council of NSW, and the Multicultural HIV/AIDS and Hepatitis C Service).

The NSW Ministerial Advisory Committee on HIV and Sexually Transmissible Infections is responsible for the overall monitoring of this Strategy. The Ministerial Advisory Committee may also seek the advice of other committees regarding implementation of the Strategy such as the Ministerial Advisory Committee on HIV and Sexually Transmissible Infections Health Promotion Sub-Committee or the Aboriginal Sexual Health Advisory Committee.

NSW Health will establish monitoring and evaluation mechanisms that enable an assessment of the degree to which the priorities articulated within this Strategy have been addressed and the impact that this Strategy has had on the sexual health of the people of NSW.

Monitoring and evaluation will be conducted statewide and at local level and will include non-government and community based organisations.

Each Area Health Service is required to develop a strategic plan which gives effect to the directions established by this Strategy, and which identifies local priority populations, implementation strategies and performance indicators.

The NSW Department of Health will at the end of the life of this Strategy commission an independent process, impact and outcome evaluation of this Strategy. The following table identifies four broad evaluation questions at the level of process, impact and outcome, and the relevant data sources.

Table 7. Strategy evaluation		
Evaluation level	Key questions	Data source(s)
Process	<p>Were the strategies implemented?</p> <p>How well were they implemented?</p>	<ul style="list-style-type: none"> • HIV/AIDS and Sexual Health Ambulatory Care Minimum Data Set • AHS Funding Plans • AHS strategic plans • CAS Minutes • NGO Activity Reports
Impact	<p>Were the objectives achieved?</p>	<ul style="list-style-type: none"> • HIV/AIDS and Sexual Health Ambulatory Care Minimum Data Set • Health Insurance Commission data • Behavioural data • Knowledge and attitude data
Outcome	<p>Were the strategic goals achieved?</p>	<ul style="list-style-type: none"> • Prevalence data • Notification data • Hospital admissions

Action Plan

3.1 Aboriginal people		
Objective	Strategies	Agency/s
<p><i>The NSW HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal People will coordinate the implementation of actions reflected in this Strategy as well as in other key national and state strategies.</i></p>		
<p>1 Increase the use of condoms with casual and new sexual partners.</p>	<ul style="list-style-type: none"> • Implement health promotion programs at the local level that may include building personal skills, implementing social marketing campaigns, increasing acceptability of condoms. • Increase access and availability of condoms, particularly in remote regions. • Implement community awareness and education campaigns on STI prevention and testing. 	<p>AHSs ACCHSs AIDB AH&MRC ACON</p>
<p>2 Eliminate syphilis transmission within Aboriginal communities by 2009.</p>	<ul style="list-style-type: none"> • Enhance surveillance – see <i>section 4.8</i>. • Convene stakeholder forum to coordinate responses and develop action plan. • Identify roles and responsibilities of relevant agencies across AHSs, including PHUs, ACCHSs. • Implement targeted health promotion and education strategies. • Implement strategies to enhance the level of appropriate testing, ensuring appropriate partnerships with antenatal services, and contact tracing. • Review approaches adopted in other states and identify strategies to enhance collaboration. • Implement appropriate across area management systems to improve management and treatment of Aboriginal people with syphilis. 	<p>AIDB AH&MRC AHSs ACCHSs JH ACON</p>
<p>3 Increase in early detection and treatment of bacterial and viral STIs.</p>	<ul style="list-style-type: none"> • Develop activity to support the implementation of the Early Detection and Treatment of STIs and BBVs Manual in local areas. • Explore incentives to encourage improved STI testing among Aboriginal young people. 	<p>AH&MRC AHSs ACCHSs</p>
<p>4 Increase in culturally appropriate and sensitive public sexual health service provision.</p>	<ul style="list-style-type: none"> • Establish formal partnership between SHCs and local ACCHSs to plan for the provision of sexual health services to Aboriginal people. • All SHCs to implement appropriate local strategies to improve access to services by Aboriginal people, which might include: outreach clinics, designated days for Aboriginal clinics, joint service provision with local ACCHSs, etc. • All SHCs routinely review service data and service utilisation by Aboriginal people. • Profile and disseminate case studies of effective initiatives. • Implement initiatives to increase Aboriginal participation in the sexual health workforce. 	<p>SHCs AHSs ACCHSs AIDB ACON</p>

<p>5 Build the skills of the workforce.</p>	<ul style="list-style-type: none"> • Maintain support for statewide network of Aboriginal sexual health workers. • Implement appropriate training programs for sexual health staff that can assist them in planning and implementing sexual health services for Aboriginal people. • Identify strategies at local area level to recruit and train Aboriginal nurses in sexual health. • Identify opportunities to offer a scholarship for Aboriginal nurses to specialise in sexual health. • Implement sexual health training for non-sexual health nurses who work with Aboriginal people. • Provide training for Aboriginal sexual health workers to undertake urine collection. 	<p>AH&MRC AHS SHCs AIDB</p>
<p>6 Improve the capacity of and collaboration with ACCHSs, and GPs who see Aboriginal people, to respond to STIs.</p>	<ul style="list-style-type: none"> • All AHSs, in partnership with ACCHS and divisions of general practice, to ensure provision of CPD accredited courses for GPs at least annually covering core sexual health competencies. • Increase the uptake of Medicare Benefits Schedule Adult Health Checks. 	<p>AHS ACCHSs</p>
<p>7 Improve culturally appropriate STI surveillance and monitoring.</p>	<ul style="list-style-type: none"> • See section 4.8. 	
<p>8 Increase culturally appropriate STI related research within Aboriginal communities.</p>	<ul style="list-style-type: none"> • See section 4.8. 	

3.2 Gay and other homosexually active men		
<p>1 Increase the consistent use of condoms with casual and new sexual partners.</p>	<ul style="list-style-type: none"> • Develop and sustain local integrated health promotion responses, including clinical responses, to STIs. • Ensure appropriate targeting of health promotion and education interventions in settings such as sex-on-premises venues, Internet, beats. • Maintain coordinated interagency response through STIGMA. • Pilot models, such as STIGMA, in AHSs to coordinate responses to STIs among gay and other homosexually active men. • Document and evaluate sexual health promotion programs addressing STIs in gay men. • Provide health promotion programs to sub populations who may experience particular risks. • Continue to address drug and alcohol use and sexual risk behaviours amongst gay men. • Undertake research to increase understandings of effective sexual health promotion strategies. • Develop a discussion paper that examines the synergies between HIV education and STI education and its implications for programs. 	<p>ACON AHSs STIGMA SHCs AIDB</p>
<p>2 Reduce rates of syphilis among gay and other homosexually active men by 50 per cent by 2009.</p>	<ul style="list-style-type: none"> • Review evidence of strategies that have been effective at eliminating/reducing syphilis. • Promote consistent condom use during anal intercourse with casual sexual encounters – <i>see above</i>. • Ensure increased awareness of the re-emergence of syphilis. • Trial innovative health promotion strategies. • Promote regular sexual health testing – <i>see below</i>. • Develop a long term plan for the elimination of syphilis transmission among gay and other homosexually active men. 	<p>ACON AHSs STIGMA SHCs AIDB</p>

<p>3 Increase the proportion of gay and other homosexually active men who are annually tested for STIs.</p>	<ul style="list-style-type: none"> • Develop health promotion interventions to increase awareness of the need for regular testing. • Address actual and perceived barriers to regular testing. • Ensure adequate sexual health clinical capacity given local context. • Pilot recall systems for GPs and SHCs with gay and other homosexually active clients for periodic STI testing. • Ensure ongoing monitoring of sexual health testing practices. 	<p>ACON AHSs SHCs STIGMA MHAHS</p>
<p>4 Increase the proportion of sexually active gay and other homosexually active men who are vaccinated for hepatitis A and hepatitis B.</p>	<ul style="list-style-type: none"> • Continue to promote hepatitis A and hepatitis B vaccination. • Maintain provision of free vaccination through sexual health clinics. 	<p>STIGMA AHSs ACON SHCs</p>
<p>5 Increase the capacity of GPs and health services to meet the needs of gay and other homosexually active men.</p>	<ul style="list-style-type: none"> • Continue to promote STIGMA guidelines. • Integrate relevant information in sexual health training targeted at GPs. • Continue to offer GP training and support in gay men's sexual health through accredited CPD courses, clinical attachment, etc. • Adopt anti-homophobia policy at AHS level. 	<p>STIGMA AHSs SHCs ASHM ACON</p>

<h3>3.3 Young people</h3>		
<p>1 Increase the use of condoms with casual and new sexual partners.</p>	<ul style="list-style-type: none"> • Develop health promotion programs targeted at priority population groups that address factors associated with STI diagnosis. • Ensure health promotion programs targeting young people address the impacts of alcohol and other drug use on behavioural choices. • Provide accessible information to young people using appropriate media, including new media technologies. • Support implementation of sexual health promotion programs in youth refuges. • Continue providing information on NSW Health sexual health website, FPA Health website, FPA Health fact sheets and other resources and youth oriented websites. 	<p>SHCs Justice Health AHSs FPA AIDB HOT</p>
<p>2 Increase young people's access to general practice and other services.</p>	<ul style="list-style-type: none"> • Ensure appropriate access to sexual health clinical services by young people who are members of other priority population groups. • Initiate projects to support access to general practice by young people. • Develop partnerships and initiatives with other organisations and researchers working to improve young people's access to GPs (such as NSW Centre for the Advancement of Adolescent Health and the 'GP's in schools' projects). • Ensure appropriate provision of sexual health services in juvenile justice facilities. • See section 4.2. 	<p>SHCs AHSs Justice Health</p>
<p>3 Strengthen the capacity of schools and their community to implement sexual health education programs.</p>	<ul style="list-style-type: none"> • Establish a statewide agreement between NSW Health and the Department of Education and Training. • Coordinate professional development activities to support implementation of <i>Talking Sexual Health</i> through the NSW Sexual Health Steering Committee. • Support schools and their communities to continue to implement, monitor and evaluate Talking Sexual Health. 	<p>AIDB AHSs FPA DET</p>

<p>4 Create environments which support young people's sexual health.</p>	<ul style="list-style-type: none"> ● Establish formal partnerships between youth health services and sexual health services. ● Develop strategies for ensuring appropriate access to STI information and screening for young women accessing termination services. ● Implement workforce development initiatives across NSW to enhance the capacity of youth accommodation workers. 	<p>AHSS FPA HOT WDP SHCs</p>
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3.4 Sex workers		
<p>1 Support and promote condom use and ongoing sexual health monitoring by sex workers</p>	<ul style="list-style-type: none"> ● Provide targeted outreach based health promotion programs, including peer based education programs. ● Improve knowledge among sex workers about STI identification, testing and treating. ● Ensure programs include a specific focus on male, street based, and overseas-born sex workers. ● Develop health promotion and education programs for clients of sex workers, particularly targeting male clients of male sex workers. ● Promote appropriate testing practices. 	<p>SWOP SHCs AHSs</p>
<p>2 Support sex worker access to appropriate sexual health services</p>	<ul style="list-style-type: none"> ● Develop local strategies to ensure appropriate access to sexual health clinics. ● Maintain and extend outreach programs targeting street based sex workers. ● Maintain Sexual Health Outreach Workers Network. ● Review the geographic reach of existing outreach activities across NSW and appropriate models to service rural and regional areas. 	<p>AIDB SWOP SHCs AHSs</p>
<p>3 Support efforts to ensure a supportive regulatory environment which supports the health and safety needs of sex workers.</p>	<ul style="list-style-type: none"> ● Monitor the impact of legislation and local government policy on sex workers. 	<p>SWOP AIDB CAS</p>

3.5 People with HIV/AIDS		
<p>1 Increase the consistent use of condoms with casual and new sexual partners.</p>	<ul style="list-style-type: none"> ● Implement sexual health education and health promotion programs. ● Promote regular STI testing. 	<p>ACON PLWH/A AHSs STIGMA</p>
<p>2 Increase the proportion of sexually active people with HIV/AIDS who are regularly tested for STIs.</p>	<ul style="list-style-type: none"> ● Promote the implementation of Clinical Guidelines for the Management of STIs Among Priority Population. ● s100 GPs and health care worker training programs address the issue of the impact of STIs in people with HIV/AIDS. ● Identify appropriate strategies to incorporate regular STI testing into ongoing health monitoring. 	<p>ACON PLWH/A STIGMA AHSs WDP ASHM MHAHS</p>

3.6 People who inject drugs		
<p>1 Increase the use of condoms with casual and new sexual partners.</p>	<ul style="list-style-type: none"> ● Develop appropriate local strategies to provide sexual health information and education for NSP attendees and people who inject drugs. ● Provide sexual health information through NUAA News. ● Incorporate sexual health into community based education and health promotion programs. 	<p>AHSS NUAA Justice Health ACON</p>

<p>2 Increase service access for people who inject drugs.</p>	<ul style="list-style-type: none"> • Develop appropriate local strategies to increase access to services these might include: developing referral pathways and protocols; promoting access to sexual health clinics; joint outreach clinical services with other programs; enhancing the capacity of other services; enhancing the capacity of general practice. 	<p>AHSS SHCs Justice Health ACON NUAA</p>
<p>3 Increase the proportion of people who inject drugs who are vaccinated for hepatitis B.</p>	<ul style="list-style-type: none"> • Provide information and education on hepatitis B vaccinations to NSP clients. • Promote access to free hepatitis B vaccination through sexual health services, methadone program and alcohol and other drug services. 	<p>AHS SHCs Justice Health NUAA ACON</p>
<p>4 Improve links between sexual health services, drug and alcohol services and other programs which work with people who inject drugs so as to increase access to sexual health education and services.</p>	<ul style="list-style-type: none"> • Establish partnerships between sexual health services and drug and alcohol services to identify how to best address the sexual health needs of people who inject drugs. • Provide training and support to enhance the capacity of local partners (such as detoxification facilities, methadone) to address sexual health issues among people who inject drugs. 	<p>AHSS SHCs</p>

3.7 Heterosexuals with recent partner change

<p>1 Increase the use of condoms with casual and new sexual partners.</p>	<ul style="list-style-type: none"> • Implement general STIs awareness campaigns – see section 4.1. • Implement targeted health promotion campaigns – where groups are identifiable – for those at heightened risk (such as, heterosexuals who also have same sex partners, women partners of bisexual men, ‘swingers’, bisexuals, travellers, people from high HIV/STI prevalence countries). 	<p>AHSS AIDB NGOs MHAHS</p>
<p>2 Increase the proportion of heterosexuals with recent partner change who are tested for STIs by GPs.</p>	<ul style="list-style-type: none"> • Provide appropriate training and support for GPs, particularly to undertake sexual histories – see section 4.2. 	<p>AHSS SHCs MHAHS</p>

4.1 Promoting general STI awareness

<p>1 Increase general awareness of STIs, including the asymptomatic nature of many, and the range of prevention strategies to reduce transmission of STIs, including condom use with new or casual partners.</p>	<ul style="list-style-type: none"> • Implement health promotion and social marketing campaigns to promote general STI awareness and/or in response to specific STIs. • Incorporate information on the efficacy of condoms and asymptomatic nature of key STIs in health promotion and social marketing campaigns. • Implementation of culturally appropriate health promotion programs for priority population groups. • Promote existing services such as the FPA Health HealthLine, FPA Health website and NSW Health website as sources of information on STIs and sexual health. 	<p>AIDB AHSS FPA</p>
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4.2 Working with general practice		
1 Support sexual health service provision by general practitioners by ensuring access to education and training programs.	<ul style="list-style-type: none"> • Develop partnerships with GP organisations and CPD education providers to develop a statewide GP Training module that includes counselling, sexual history taking, contact tracing and the range of tests to be conducted for specific populations. • Develop partnerships with other organisations working to improve access and build capacity of GPs (such as NSW Centre for the Advancement of Adolescent Health). • Develop a strategy to enhance the STI and sexual health education currently included in undergraduate medical degrees. • In partnership with GP organisations, all AHSs provision of CPD accredited training and support, including annual courses, clinical attachment and small group work. • State-wide CPD accredited training is provided in advanced sexual health competencies. • Disseminate outcomes from education and training programs that have proven to be effective in supporting GPs. • Develop a strategic approach to integrating STIs into practice nurse training. 	AIDB AHSS FPA ACSHM
2 Support sexual health service provision by general practitioners by ensuring ready access to information and education resources.	<ul style="list-style-type: none"> • Maintain and promote sexual health information line based at SSHC, and FPA Health HealthLine. • Develop a communication strategy for providing regular updates on current epidemiological and behavioural risk information to GPs. • Develop tools and resources to assist GPs in assessing risk and identifying appropriate tests. • A state-wide website profiling all content relevant to the provision of sexual health services be developed and maintained. • The state-wide website be adaptable for inclusion in websites of other services with provision of local information. • Information is circulated regularly (at least annually) regarding sexual health risk and where appropriate specific to local AHS. 	WDP FPA AIDB AHSS SSHC SHCs ACSHM
3 Improve communication of Area Health Service referral pathways and options available to general practitioners.	<ul style="list-style-type: none"> • AHS based profiles of all relevant services be developed. • Referral pathways and protocols be established for all publicly funded sexual health clinics from GPs. • Strategies implemented to promote referral pathways and options to general practitioners. 	AHSS SHCs

4.3 Prioritising access to and focus of publicly funded sexual health clinics		
1 Improve access to sexual health clinics for priority populations.	<ul style="list-style-type: none"> • Establish goals and targets in relation to access by priority populations, and develop, implement and review plan to achieve goals. • Develop assessment tool for prioritising access. • Develop local strategies to support better access to GPs. • Review processes to ensure the input of priority population groups and key partners in service planning. • Implement strategies as outlined in the <i>NSW HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal People</i>. 	SHCs AHSS AIDB
2 Strengthen local partnerships with general practice.	<ul style="list-style-type: none"> • Establish/strengthen relationships with local divisions of general practice. • Establish local training and support program for general practice. • Disseminate outcomes from effective initiatives. 	SHCs AIDB
3 Enhance sexual health training and support for nurses working in specialist settings and in general practice.	<ul style="list-style-type: none"> • Establish partnerships between ASHNA, the College of Nursing, Australian Practice Nurses Association, and NSW Health. 	ASHNA College of Nursing AIDB APNA

<p>4 Promote best practice standards within publicly funded sexual health clinics.</p>	<ul style="list-style-type: none"> ● Implement Accreditation Guidelines for Sexual Health Services to improve consistency of service delivery across NSW. ● Finalise the HIV/AIDS and Sexual Health Ambulatory Care Minimum Data Set. ● Promote strategic planning, networking and support through the NSW Sexual Health Medical Directors Meetings. 	<p>SHCs AIDB</p>
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4.4 Promoting STI testing		
<p>1 Promote a culture of appropriate testing for STIs.</p>	<ul style="list-style-type: none"> ● Provide appropriate support and training to GPs – see section 4.2. ● Implement health promotion and education campaigns to promote appropriate STI testing among priority population groups. ● Promote information on non-intrusive STI testing methods in education and health promotion programs. ● Support implementation of Australian Government-funded chlamydia screening pilot program. 	<p>AIDB AHSs SHCs ACCCHS ACON SWOP NUAA FPA</p>
<p>2 Support GPs in the implementation of appropriate testing practices.</p>	<ul style="list-style-type: none"> ● Include information about the sensitivity, reliability and acceptability of non-intrusive methods of testing for STIs is included in all relevant sexual health training. ● Commission journal articles to increase awareness about the role and reliability of non-intrusive testing procedures. ● Implement strategies to promote ACSHM guidelines. ● Ensure appropriate training for GPs – see section 4.2. ● Promote awareness of the availability of Medicare rebates for STI testing of asymptomatic patients. 	<p>AIDB AHSs WDP ASHM SHCs ACSHM</p>
<p>3 Reduce actual and perceived barriers to appropriate STI testing.</p>	<ul style="list-style-type: none"> ● Continue efforts to realign Australian Government policy on STI screening in the absence of symptoms and the ‘three test’ rule. ● Explore the feasibility of a pilot home based testing trial. ● Establish a working group to coordinate a response to the availability of an HPV vaccine. 	<p>AIDB ACSHM SSHC CAS</p>

4.5 Improving contact tracing		
<p>1 To increase the number of contacts treated.</p>	<ul style="list-style-type: none"> ● Convene a workshop to review research and current practice. ● Clarify roles and capacity of general practice, sexual health services, public health units, primary health care workers (particularly Aboriginal Health workers) to undertake contact tracing. ● Review the use of new media technology, such as email and SMS, and other innovative approaches to undertake contact tracing. ● Revise the NSW Health <i>Contact tracing guidelines for the sexually transmissible diseases and blood borne viruses</i>. ● Implement appropriate training program, particularly for sexual health services and primary health care workers to support implementation of the circular. ● Develop patient education material to assist with implementation of patient initiated contact tracing. 	<p>AIDB STIRC</p>

4.6 Strengthening health promotion programming		
<p>1 Continue to increase the quality of sexual health promotion programs.</p>	<ul style="list-style-type: none"> ● Sexual health promotion programs to adhere to best practice in planning, implementing and evaluating health promotion programs. ● All sexual health staff involved in health promotion to be appropriately trained in health promotion planning and evaluation. ● Evaluate and disseminate outcomes from innovative health promotion programming. 	<p>AHSs WDP ACON FPA SWOP</p>

4.7 Developing the workforce			
1	Build the skills of the sexual health workforce and broader contributors to sexual health.	<ul style="list-style-type: none"> Each AHS needs to incorporate into local HIV Health Promotion Workforce Development Plans, identification of workforce development needs for sexual health services staff (including appropriate budget allocation and assessing staff's culturally appropriate/sensitive skills in working with priority population groups). Funded NGOs to identify workforce development needs of staff in relation to STIs. Local identification of workforce development strategies with other agencies and health programs. For example Aboriginal primary health care workers, women's health, teachers, mental health, drug and alcohol, etc. Support the implementation of the AH&MRC <i>Diploma of Community Services (Case Management) with a focus on Aboriginal Sexual Health</i>. 	AHSs WDP NGOs JH AH&MRC

4.8 Research and surveillance priorities			
1	Improve knowledge of the prevalence and incidence of STIs in priority population groups.	<ul style="list-style-type: none"> Monitor findings from research projects such as the longitudinal component of the Australian Study of Health and Relationships, Health in Men, etc. Investigate the possibility of incorporating questions on STIs into the NSP attendees survey. 	AIDB CDB
2	Improve culturally appropriate STI surveillance and burden of illness and behavioural research within Aboriginal communities.	<ul style="list-style-type: none"> Ensure appropriate collection of data on service access by Aboriginal people, such as through MDS. Enhance links between AH&MRC, ACCHSs and research centers. Review and enhance existing surveillance systems. 	CDB AH&MRC AIDB
3	Improve knowledge of strategies to prevent and control HSV and HPV transmission.	<ul style="list-style-type: none"> Undertake literature review of strategies that have been effective in preventing and controlling HSV and HPV. Identify potential intervention strategies that could be trialled in NSW. 	AIDB
4	Ensure STI surveillance information is readily available to inform program and service development.	<ul style="list-style-type: none"> Publish a regular report on the occurrence of STIs in NSW. Interact with the national developments undertaken via the CDNA STI surveillance. Access Health Insurance Commission data in order to provide regular reports regarding STI testing patterns. 	CDB
5	Undertake high quality research to inform program and service development.	<ul style="list-style-type: none"> Formalise links between the NSW Health sexual health sector (AHS and NGO) and relevant research organisations. Research into factors that enhance and inhibit testing, diagnosis, and treatment of STIs among priority population groups. Research into understanding sexual behaviour and barriers to safe sex practice. Ongoing behavioural monitoring studies of priority population groups. Research into new models of STI testing. Promote sexual health services journal clubs to improve use of research in practice. Implement strategies to improve knowledge transfer and dissemination of research. 	AIDB CDB NCHSR NCHECR STIRC

Abbreviations

ACCHS	Aboriginal Community Controlled Health Service	IAHS	former Illawarra Area Health Service
ACON	AIDS Council of NSW	JH	Justice Health
ACSHM	Australasian Chapter of Sexual Health Medicine, Royal Australasian College of Physicians	MAHS	former Macquarie Area Health Service
AH&MRC	Aboriginal Health and Medical Research Council of NSW	MDS	HIV/AIDS and Sexual Health Ambulatory Care Minimum Data Set
AHS	Area Health Service	MHAHS	Multicultural HIV/AIDS and Hepatitis C Service
AIDB	AIDS/Infectious Diseases Branch, NSW Department of Health	MNCAHS	former Mid-North Coast Area Health Service
AMS	Aboriginal Medical Service	MWAHS	former Mid-West Area Health Service
APNA	Australian Practice Nurses Association	NCHECR	National Centre in HIV Epidemiology and Clinical Research
ASHM	Australasian Society for HIV Medicine	NCHSR	National Centre in HIV Social Research
ASHNA	Australian Sexual Health Nurses Association	NEAHS	former New England Area Health Service
BBV	blood-borne virus	NGO	non-government organisation
CALD	culturally and linguistically diverse	NRAHS	former Northern Rivers Area Health Service
CAS	NSW Ministerial Advisory Committee on HIV and Sexually Transmissible Infections	NSAHS	former Northern Sydney Area Health Service
CCAHS	former Central Coast Area Health Service	NSP	Needle and Syringe Program
CDB	Communicable Diseases Branch, NSW Department of Health	NUAA	NSW Users and AIDS Association
CDNA	Communicable Diseases Network of Australia	PHU	Public Health Unit
CHS	former Corrections Health Service (now Justice Health)	PLWH/A	People Living with HIV/AIDS (NSW)
CPD	Continuing Professional Development	RACGP	Royal Australian College of General Practitioners
CSAHS	former Central Sydney Area Health Service	SAHS	former Southern Area Health Service
DET	NSW Department of Education and Training	SESAHS	former South Eastern Sydney Area Health Service
DJJ	Department of Juvenile Justice	SHC	sexual health clinic
FWAHS	former Far West Area Health Service	SSHC	Sydney Sexual Health Centre
GAMMA	Gay and Married Men's Association	STD	sexually transmitted disease
GMAHS	former Greater Murray Area Health Service	STI	sexually transmissible infection
GP	general practitioner	STIGMA	Sexually Transmissible Infections in Gay Men Action Group
HAHS	former Hunter Area Health Service	STIRC	Sexually Transmitted Infections Research Centre
HCW	health care worker	SWOP	Sex Workers Outreach Project, ACON
HIC	Health Insurance Commission	SWSAHS	former South Western Sydney Area Health Service
HIV	human immunodeficiency virus	WAHS	former Wentworth Area Health Service
HOT	Health Outreach Team	WDP	NSW Workforce Development Program in Hepatitis, HIV and Sexual Health
HPV	human papilloma virus	WSAHS	former Western Sydney Area Health Service
HSV	herpes simplex virus		

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