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SEXUAL HEALTH STRATEGY
Foreword

This Strategy is the first time that sexual health planning has been undertaken for the Sydney Local Health District, a district with high rates of sexually transmissible infections (STIs) and Human Immunodeficiency Virus (HIV). Our strategy recognises the important human rights issues associated with sexual health, in particular, the need to actively engage affected groups and priority populations in developing, monitoring and evaluating sexual health policies, plans and programs and the important issues associated with non-discrimination and equity for populations who may be marginalised.

The strategic direction outlined for SLHD sexual health services aims to:

- Reduce the transmission of STIs (including HIV and hepatitis B) and, hepatitis C.
- Reduce the negative impacts of sexually transmitted infections on health status and on personal and social well-being.

Specifically, this strategy provides a broad strategic direction supporting the prevention, promotion, screening, monitoring, contact tracing, surveillance and treatment of STIs through service-related actions and health promotion.

Integral to this endeavour is increasing community awareness of STIs, promoting the use of condoms with casual sex partners, increasing STI testing in priority populations, and increasing the effectiveness, range and appropriateness of diagnosis, treatment and management of STIs. This strategy seeks to address issues associated with the sexual health of local priority populations and the implementation of national, state and local plans that are relevant to sexual health. Importantly, it is also a strategy designed to improve public and population health. Research is integral to the strategy.

It is our privilege to deliver this strategy which will positively impact on the health of our local populations.

Dr Teresa Anderson
Chief Executive
Sydney Local Health District

The Hon. Ron Phillips
Chairperson
Sydney Local Health District Board
SEXUAL HEALTH STRATEGY: STIs 2013 - 2018
Introduction

Sexually Transmissible Infections (STIs) are a high public health priority for Australian communities as they are a significant source of morbidity that are directly amenable to control through prevention and population health interventions.

STIs can result in acute symptoms, chronic infection, pain and longer term sequelae including infertility, ectopic pregnancy, cervical or anal cancer and death. Some STIs can be transmitted by routes other than sexual contact, including blood-to-blood contact and from mother to child during pregnancy and childbirth (NSW Health 2010). While some STIs, such as chlamydia, and gonorrhoea are curable, others such as Human Immunodeficiency Virus (HIV) and Herpes Simplex Virus (HSV) result in chronic lifelong infections.

Since the emergence of HIV/AIDS an increasing level of attention has been given to groups at particular risk of contracting STIs to ensure that these priority populations have access to well-conceived high quality prevention, early intervention and treatment programs and services.

The delivery of high quality population level data and both basic and clinical research has been crucial in the development of evidence to ensure the delivery of timely and appropriate responses to sexual health issues.

Partnerships with affected populations, priority populations, professionals, community and Government agencies have also been critical in ensuring the delivery of appropriate and effective services, prevention strategies and responses.

Ongoing success of programs and strategies that address sexual health issues include a need for sustained leadership, community education, shared effort and innovation particularly in the face of current epidemics of chlamydia, infectious syphilis and renewed concerns about the spread of HIV, especially among sexually active gay men.

The key objectives of this strategy are to:

- Reduce the transmission of sexually transmissible infections (STIs) (including HIV and hepatitis B) and hepatitis C.
- Reduce the negative impacts of sexually transmitted infections on health status and on personal and social well-being.

Most sexual health service provision and education occurs within the primary care sector by General Practitioners (GPs). Thus the provision of support, education and resources to GPs and primary care providers is a high priority strategy.

Sexual Health Services provide a specialist tier of care for priority populations. Currently sexual health clinics are provided for the Sydney Local Health District (LHD) at Royal Prince Alfred Hospital (RPA). Specific strategies are in place to ensure that sexual health clinics target those populations which have the highest priority needs, namely, gay and other men who have sex with men (MSM), sex workers, people who inject drugs (PWIDs), Aboriginal groups and young people. This strategy includes a model for best practice Sexual Health Service provision.

Sexual health promotion is provided by the HIV and Related Programs Funded Services (HARP) Health Promotion teams of the Sexual Health Service. The activities of the HARP Health Promotion Teams are guided by state strategies as well as the SSWAHS Strategic Framework for HARP Funded Services 2008-2012 (SSWAHS 2008).

The Process of Planning

A Steering Committee was formed to guide the development of the Sexual Health Strategy. The Steering Committee established three sub-committees which were responsible for the following:

- To summarise the national, state and district policies and plans of relevance and list the many responsibilities of sexual health services associated with these plans.
- To review the current implementation status of recommendations arising from the various policies and plans.
• To update and develop epidemiological and demographic information of relevance to sexual health.
• To collate data from sexual health services to highlight activity, the access of priority groups and trends in sexual health.
• To devise consultation approaches relevant to each of the identified priority groups.
• To conduct a consultation process.

As part of the planning process, formal consultation opportunities were offered to:
• Non-government organisations providing services to priority populations.
• Clinical Stream Leaders and Hospital General Managers.
• Partners in service provision to priority populations e.g. drug health, mental health, community health, youth health, Aboriginal health.
• General Practitioners.
• Government funded services outside of SSWAHS providing substantial services to SSWAHS priority population.
• Clients of services and affected communities.

Planning Context
This strategy has been developed within the context of a significant number of national and state-wide health policies, plans, procedures and legislation. These include:
• 2nd National Sexually Transmissible Infections Strategy 2010-2013 (DOHA 2010).
• 6th National HIV Strategy 2010-2013 (DOHA 2010).
• 1st National Hepatitis B Strategy 2010-2013 (DOHA 2010).
• 3rd National Hepatitis C Strategy 2010-2013 (DOHA 2010).
• 3rd National Aboriginal & Torres Strait Islander Blood Borne Viruses & Sexually Transmissible Infections Strategy 2010-2013 (DOHA 2010).

At the State level, this strategy is consistent with the State Immunisation Strategy, the HIV Strategy, the Hepatitis C Strategy and the STI Strategy.
VISION AND OBJECTIVES

Vision
This strategy, through sexual health service delivery, health promotion, collaboration, research and evaluation, aims to:

- Reduce the transmission of sexually transmissible infections (STIs) (including HIV and hepatitis B) and, hepatitis C.
- Reduce the negative impacts of sexually transmissible infections on health status and on personal and social well-being.

Objectives
This strategic document provides a direction for future local action in relation to:

- Community education and health promotion designed to prevent STIs and hepatitis C.
- The implementation of localised responses to recommendations and requirements associated with relevant international, national, state and local plans, policies, legislation and procedures.
- The provision of targeted services and responses for priority populations including screening, monitoring, contact tracing, surveillance and treatment of STIs.
- The education and support of primary health care providers and mainstream healthcare workers to ensure the provision of high quality sexual health care and sexual health promotion.
- The development and maintenance of strong partnerships with key providers within the public health sector, relevant community organisations, affected communities, clinicians, researchers and other relevant groups.
- The continued development of a strong evidence, research and evaluation basis for sexual health service delivery, strategy, policy and planning. This includes supporting local research and evaluation endeavours.
SEXUALLY TRANSMISSIBLE INFECTIONS

Introduction
There are over 30 different bacteria, viruses and parasites which are sexually transmissible. In NSW during 2010, chlamydia was the most commonly notified STI. The rates of chlamydia and syphilis have doubled since 2003 while HIV and gonorrhoea rates have remained stable over the same period. Other non-notifiable STIs such as genital warts and genital herpes are also highly prevalent.

Approaches to prevention focus on safe sex, vaccination programs (for hepatitis A and B, and HPV), needle and syringe programs (for hepatitis C and HIV) and a raft of strategies derived from strong partnerships and co-operation with affected communities.

Early detection of these infections and good clinical management and support are critical in reducing their negative impacts in terms of health status, personal and social well-being.

Chlamydia
Chlamydia is caused by the bacterium, Chlamydia trachomatis. Sequelae of untreated chlamydia include ectopic pregnancy, pelvic inflammatory disease (PID) and epididymitis.

Chlamydia is the most commonly notified disease in NSW, with young women aged 15-24 years being most frequently affected, and young heterosexual males also having high rates of infection. In males, symptomatic chlamydia manifests as urethritis, while in females the cervix is primarily affected resulting in abnormal vaginal discharge and abnormal vaginal bleeding.

However, chlamydia is mostly asymptomatic and is often unknowingly transmitted through unprotected sexual encounters. Australia-wide prevalence ranges from 0.5% to 19.7%. The number and rates of chlamydia notifications across NSW and in the Sydney and South Western SLHDs have increased dramatically over the past ten years and are now considered to be at epidemic levels.

Chlamydia can be treated with antibiotics.

Infectious Syphilis
Syphilis is a systemic infection caused by the spirochete Treponema pallidum. Infectious (early) syphilis results in a primary lesion (chancre) and secondary eruption affecting skin and mucous membranes.

In the cervix or rectum the painless chancre may often be unnoticed. If untreated, syphilis can result in chronic end-organ complications. Syphilis can also enhance the transmission of HIV.

There has been an epidemic of infectious syphilis in inner Sydney males over the past decade, with men aged 35-39 years being most affected. The prevalence of infectious syphilis remains low in females. Research has indicated that MSM are the predominant group affected by infectious syphilis, especially HIV positive MSM.

Syphilis can be treated with antibiotics.

Gonorrhoea
Gonorrhoea is caused by the bacterium Neisseria gonorrhoeae. Urethral infection in men mostly results in an acute urethral discharge. In women, genital infection is often asymptomatic but may result in mucopurulent cervicitis.

Female genital infections can result in serious sequelae for the affected woman and neonates. Pharyngeal and anorectal infections may also occur. Gonorrhoea infection particularly affects MSM between the ages of 20 and 34 years.

Gonorrhoea can be treated with antibiotics.
HIV

The Human Immunodeficiency Virus (HIV) is a lentivirus. HIV is incorporated into the genetic material of CD4 white blood cells, leading to destruction of the CD4 cells and resultant damage to the immune system.

HIV infection can initially be asymptomatic, although some people experience a seroconversion illness, typically 2 weeks after acquisition of infection, with non-specific symptoms such as tiredness, fever, diarrhoea, rash, and other ‘flu-like symptoms. Indications of symptomatic HIV infection may include lack of energy, fevers and night sweats, persistent thrush in women and prolonged bouts of diarrhoea. During advanced stages of HIV infection, a person may develop any of a number of conditions including Kaposi’s Sarcoma (KS), Pneumocystis Jirovecii (Carinii) Pneumonia (PCP), Toxoplasmosis, Cytomagalovirus disease (CMV) and Candidiasis (thrush) in the oral cavity, oesophagus or lungs.

Drug treatment for HIV is combination antiretroviral therapy (cART) which is sometimes also termed highly-active antiretroviral therapy (HAART). These treatments are required for a person’s lifetime. As a result of these highly effective treatments, HIV is now considered to be a chronic disease, with those affected expected to live long lives. This re-definition has substantial implications for HIV diagnosis, management and care for both people living with HIV and their partners. Thus lifestyle issues, ageing with HIV, smoking cessation, oral hygiene, osteopenia, osteoporosis, dementia and a range of other physical and mental health conditions associated with ageing are now major issues for HIV positive populations. There is strong evidence for higher rates of cardiovascular disease, cancers, cognitive and neurological disorders among people with HIV. An estimated 20,171 people were living with diagnosed HIV infection in Australia at the end of 2009. While the majority are MSM, there are a significant number of diagnoses in the heterosexual community, particularly in culturally and linguistically diverse (CALD) communities from countries with high HIV prevalence.

A further issue for people with HIV is co-infection with other STIs. The rates of syphilis, for example, have been increasing at epidemic rates in HIV infected MSM. The Public Health Unit reported in August 2010 that out of all syphilis infections; 216 or 40% of the total cases were among people who were HIV positive. The suggested reasons for the increase in syphilis notifications in people with HIV include high rates of unprotected anal intercourse with casual partners (UAIC), seeking sex partners via the internet, transmission by oral sex and increased frequency of HIV serosorting (actively seeking a sexual partner of the same HIV status in order to have unprotected anal sex).

Of particular concern in metropolitan Sydney are highly sexually active gay men i.e. those who have had more than 10 sexual partners in the previous 6 months. In view of the frequently asymptomatic nature of STIs, the ability of other STIs to enhance HIV transmission, and the high STI prevalence among HIV-positive MSM; efforts to increase the frequency of STI testing, including testing at the same time as regular HIV monitoring, are warranted in this population.

Genital Warts

Human papillomavirus (HPV) infection may cause benign anogenital warts but infection with high-risk HPV types can cause anogenital and oropharyngeal cancers. Four point two percent of Australian adults report being diagnosed with genital warts and rates of HPV-associated anal and oropharyngeal cancers are increasing in Australia and throughout the world.

The HPV vaccine has, since 2007, been available to girls in the first year of high school, and from 2013 onwards, all Australian boys will also be vaccinated at school.

Treatment of visible warts may be done in a variety of ways, including ablative treatments such as cryotherapy. However, these treatments often do not eradicate the wart virus.

Genital Herpes

Herpes Simplex Virus Type 1 (HSV1) and Type 2 (HSV2) are viral infections. HSV2 affects around 12% of the Australian population, with the highest prevalence in those aged 35-44 years. HSV2 almost always affects the anogenital region; however, HSV1 is an increasingly identified cause of anogenital herpes, especially among younger people. This is not a notifiable disease in NSW.

Antiviral medicines can be used to help treat and prevent outbreaks of anogenital herpes.
**Hepatitis C (HCV)**

The hepatitis C virus is a member of the flavivirus family of ribonucleic acid (RNA) viruses. The virus is transmitted by blood-to-blood contact. In Australia, most HCV is not sexually transmitted, but results from sharing of injecting paraphernalia among injecting drug users. In some overseas countries, HCV may be acquired via poorly sterilised equipment or inadequately screened blood being transfused. In SLHD prevalence rates are higher in people from CALD backgrounds.

Although hepatitis C damages the liver, most people remain asymptomatic for decades. Some people experience ‘flu-like symptoms. Chronic hepatitis C may lead to cirrhosis of the liver, liver failure or liver cancer.

There is no vaccine which prevents HCV. Treatments for people with hepatitis C are pegylated interferon and ribavirin, commonly termed ‘combination therapy’ or pegylated interferon alone.

**Hepatitis B (HBV)**

Hepatitis B is an infectious hepatitis caused by the hepatitis B virus (HBV). This infection has two possible phases; acute and chronic.

Acute hepatitis B refers to newly acquired infections and, in most people with acute hepatitis, symptoms resolve over weeks to months and they are cured of the infection. However, a small number of people develop a very severe, life-threatening form of acute hepatitis called fulminant hepatitis.

Chronic hepatitis B is an infection with HBV that lasts longer than 6 months. Prevalence rates are significantly higher in CALD communities, with estimates of between 2-12% dependent on country of birth. Chronic hepatitis B may lead to cirrhosis of the liver, liver failure or liver cancer. Approximately half of liver cancers in SLHD occur in people who were born overseas in high prevalence countries such as Vietnam, China, Korea, Indonesia and Hong Kong. Indeed, 75-80% of all liver cancers are a result of chronic viral hepatitis.

HBV can be prevented by an effective vaccine which has been part of the Australian childhood vaccination schedule for several years. The most common form of treatment is with antiviral medications such as lamivudine, adefovir, entecavir and tenofovir. Interferon is less commonly used.
SYDNEY LOCAL HEALTH DISTRICT (SLHD) DEMOGRAPHY and SEXUAL HEALTH EPIDEMIOLOGY

Demography

The Sydney Local Health District comprises the Local Government Areas (LGAs) of City of Sydney (part), Leichhardt, Marrickville, Canterbury, Canada Bay, Ashfield, Burwood and Strathfield. It covers 126 square kilometres and has a population density of 4,210 residents per square kilometre (ABS 2006). The distribution of this population by age grouping and LGA is outlined in Figure 1. The boundaries are indicated in Map.1.

Map 1: SLHD Defined Area
The population of SLHD, at 582,100 is projected to grow to 612,914 by 2016 and to over 650,000 in the next twenty years (Figure 1).

Figure 1: SLHD Population 2006 census
Table 1: Selected demographic indicators by LGA

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<tr>
<th>LGA</th>
<th>2011 pop.</th>
<th>Pop aged 15-29 years</th>
<th>Percent aged 15-29 (%)</th>
<th>No. and % born Overseas</th>
<th>Most Common Language Spoken at Home (No. and %)</th>
<th>No. and % Aboriginal (%)</th>
<th>SEIFA Index</th>
<th>Projected Population 2016</th>
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<tr>
<td>City of Sydney</td>
<td>105,175</td>
<td>36,153</td>
<td>34.3</td>
<td>39,609 (40.5%)</td>
<td>Mandarin 5,210 (5.3%)</td>
<td>1,714 (1.8%)</td>
<td>1,131</td>
<td>110,249</td>
</tr>
<tr>
<td>Leichhardt</td>
<td>55,651</td>
<td>9,443</td>
<td>16.9</td>
<td>14,940 (28.6%)</td>
<td>Italian 1,587 (3%)</td>
<td>514 (1.0%)</td>
<td>1,159</td>
<td>54,093</td>
</tr>
<tr>
<td>Marrickville</td>
<td>81,489</td>
<td>18,469</td>
<td>22.7</td>
<td>26,094 (34.1%)</td>
<td>Greek 4,235 (5.5%)</td>
<td>1,111 (1.5%)</td>
<td>1,068</td>
<td>82,241</td>
</tr>
<tr>
<td>Ashfield</td>
<td>43,683</td>
<td>10,189</td>
<td>23.3</td>
<td>18,247 (44.3%)</td>
<td>Mandarin 3,740 (9.1%)</td>
<td>233 (0.6%)</td>
<td>1,084</td>
<td>45,663</td>
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<tr>
<td>Burwood</td>
<td>34,305</td>
<td>9,736</td>
<td>28.3</td>
<td>17,065 (52.6%)</td>
<td>Mandarin 4,126 (12.7%)</td>
<td>120 (0.4%)</td>
<td>1,061</td>
<td>37,443</td>
</tr>
<tr>
<td>Strathfield</td>
<td>37,141</td>
<td>10,578</td>
<td>28.5</td>
<td>18,531 (52.7%)</td>
<td>Korean 3,133 (8.9%)</td>
<td>103 (0.3%)</td>
<td>1,082</td>
<td>39,136</td>
</tr>
<tr>
<td>Canada Bay</td>
<td>79,905</td>
<td>16,936</td>
<td>21.2</td>
<td>26,914 (35.5%)</td>
<td>Italian 6,674 (8.8%)</td>
<td>286 (0.4%)</td>
<td>1,110</td>
<td>87,497</td>
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<tr>
<td>Canterbury</td>
<td>144,751</td>
<td>31,294</td>
<td>21.6</td>
<td>66,130 (48.1%)</td>
<td>Arabic 18,175 (13.2%)</td>
<td>794 (0.6%)</td>
<td>965</td>
<td>144,875</td>
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<tr>
<td>SLHD</td>
<td>582,100</td>
<td>14,2798</td>
<td>24.5</td>
<td>227,530 (41.5%)</td>
<td>NA</td>
<td>4,875 (0.9%)</td>
<td>1,082</td>
<td>601,197</td>
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<tr>
<td>NSW</td>
<td>6,575,217</td>
<td>1,768,184</td>
<td>21.1</td>
<td>1,778,548 (25.7%)</td>
<td>Arabic 184,252 (2.7%)</td>
<td>172,621 (2.5%)</td>
<td>1,011</td>
<td>7,603,502</td>
</tr>
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1 NSW Health Population Projection Series (2009)
2 ABS Census (2011)

The SLHD is culturally, linguistically and socially diverse. In terms of STIs, young people have the highest rates of partner change and highest rates of infections. The LGAs with the highest proportion of people aged 15-29, the population at highest risk of contracting STIs, are the City of Sydney, Marrickville, Burwood and Strathfield (Table 1). However, Canterbury and the City of Sydney have the largest population under the age of 30 years.

Access to health services can be an issue, especially amongst the most socially vulnerable groups or among young people who are also members of other STI priority populations such as young intravenous drug users or young gay men.

SLHD has a high concentration of gay and other MSM. The SSWAHS Strategic Framework for HARP Funded Services (2008), using data compiled from the Australian Study of Health and Relationships (Grulich et al 2003), estimates the MSM population to number about 10% of the total population, or about 58,210 people. The NSW Sexually Transmissible Programs Unit (STIPU) suggests that across NSW, 2.5% of adult males are gay or bisexual and another 8.6% have same sex attraction or same sex experience. However, a study in inner Sydney (Madeddu et al 2006), indicated that the proportion of men who identified as homosexual ranged from 4.4% to 48.1% and from 9.8% to 51.5% reported same-sex attraction. This study found that HIV prevalence in the inner Sydney areas was high, ranging from 9.1% to 21.3%. Of all people living with HIV in NSW, 14-15% are estimated to live in the SLHD. The most recent data of HIV notifications in SLHD are outlined further in this document.

At the 2011 census, there were 4,875 people who identified as either Aboriginal or Torres Strait Islander (herein referred to as Aboriginal people) living in SLHD. The proportion of SLHD residents who identify as Aboriginal is 0.9%; considerably lower than the overall proportion of NSW who are Aboriginal (2.5%). The Sydney (South and West Statistical Local Areas) and Marrickville LGAs have the highest number of Aboriginal residents (1,714 and 1,111 respectively), with the lowest number of Aboriginal people residing in Strathfield LGA (102).

Consistent with State and National figures, the age profile for Aboriginal people in SLHD is younger than the non-indigenous population. In particular 24% of the Aboriginal population is aged under 15 and less than 1% is aged over 65, compared with 15% and 12% respectively for the non-Aboriginal LHD population.
Aboriginal people are widely recognised as having poorer health and poorer access to appropriate health services as well as a reduced life expectancy, when compared to the non-Aboriginal population. Aboriginal people are at higher risk of STIs. National data shows that chlamydia, gonorrhoea, hepatitis B and C continue to be reported at disproportionately high rates among Aboriginal and Torres Strait Islander people, although infectious syphilis rates have declined. HIV is reported at levels similar to the general population (National Centre for HIV Epidemiology and Clinical Research 2010).

Aboriginal people are recognised as having poorer access to appropriate health and sexual health services; thus, notification data may provide an underestimation of the prevalence of blood-borne viruses (BBVs) and STIs. Although NSW and national surveillance data on Aboriginal and Torres Strait Islander populations are incomplete, HIV, STIs and hepatitis B and C continue to be a significant source of morbidity among Aboriginal people in NSW.

In the SLHD, as in other areas, there are sex services premises in every LGA. The Australian Study for Health and Relationships (Gruich et al 2003), found that 0.9% of men and 0.5% of women had been paid for sex. The Sex Workers Outreach Project (SWOP) estimates that 87% of sex workers are female, 10% male and 3% transgender (HARP Strategic Framework 2008). The majority of sex workers work from premises or are engaged as escorts.

The sex industry in NSW is culturally and linguistically diverse, with the majority of the women currently being from east and south-East Asia; many of whom are non-English-speaking. There is increasing evidence that the rates of HIV and STIs among brothel-based sex workers are at an historic low as a result of successful screening, testing and language-appropriate education programs provided by sexual health services, multicultural health services and community organisations (Donovan et al 2010). However, these STI prevention efforts need to be maintained as there is a high turnover of brothel-based sex workers. Collection of data and surveillance of male sex workers may be more difficult as they tend to be less brothel-based, to work via electronic communication methods, more likely to practice unsafe sex in non-commercial relationships and more likely to use illicit drugs (Donovan et al 2010). Street workers are considered to be more vulnerable to unsafe sex and unsafe injecting practices. The Canterbury Road industrial area is identified as a sex work area, from which street workers regularly operate (HARP Strategic Framework 2008).

Estimating the population of people who inject drugs (PWIDs) is problematic as there are several different approaches used (HARP Strategic Framework 2008) including using figures from the National Drug Strategy Household Survey, hospital deaths and hospitalisations, drug-related arrests, HCV notifications and the number of needle and syringe units distributed. National and state Hepatitis C strategies estimate that about 90% of new, and 80% of existing, Hep C infections are attributed to needle-sharing. While hepatitis C is not classified as an STI, there is a risk of transmission if the blood of one person enters the bloodstream of another person during intercourse. This mode of transmission appears to be especially common among HIV positive MSM. HIV can also be transmitted through needle-sharing. There is some international (US) evidence that PWIDs have higher rates of STIs than the general population, however, further research is needed to assess the generalisability of this finding to the Australian or local context.

All SLHD LGAs have substantially higher proportions of people from non-English-speaking backgrounds than the NSW State average. Across SLHD, 43% of residents speak a language other than English at home. The proportion and numbers of people speaking another language ranged from 64% (87,793 people) in Canterbury LGA to 15% (7,892 people) in Leichhardt LGA. In the whole LHD 7% of the population describe themselves as not speaking English well, or not at all. The main languages spoken were Mandarin (28,712 people), Arabic (26,665 people), Greek (24,654 people) and Cantonese (22,881 people).

Certain LGAs show high proportions of particular cultural groups than the SLHD average. For example most Italian speakers live in Canada Bay and Ashfield, whilst most Arabic speakers live in Canterbury.

A number of these populations are at increased risk of BBVs and STIs, including HIV, based on epidemiological studies. Data indicates that other groups at risk include people from Thailand, sub-Saharan Africa and the Philippines. The SLHD is also home to a substantial number of newly arrived refugees and humanitarian entrants. Almost 1,000 newly arrived humanitarian entrants have settled in the Canterbury LGA in the past five years, predominately from war-torn countries such as Sierra Leone, Sudan, Iraq and China. Many of these people have lived in refugee camps for long periods and have high rates of infectious diseases, injuries, stress and have had limited access to health services and preventative health care information. Populations with limited English proficiency may have relatively poorer access to health and health-related services. Further, those CALD populations with high international mobility may be more prone to contracting HIV and other STIs in countries with high prevalence rates.
Transgender people experience substantial levels of discrimination, harassment and violence on a daily basis. Unfortunately there are no quantitative statistics to reinforce this situation for a variety of reasons including the lack of census data collected about transgender people (The Gender Centre 2011). Transgender people may also identify with a sexual health priority population. An example could be a female-to-male transgender who identifies as MSM, or a male-to-female transgender who works in the sex industry.

Another priority population is heterosexuals who have recently changed sexual partners. Based on the STIPU indicator (STIPU 2008), 13% of men and 7% of women aged 16-59 had sex with two or more partners of the opposite sex in the previous year. This was most common in those aged under 30 years.

The SLHD is characterised by socio-economic diversity, with pockets of both extreme advantage and extreme disadvantage. The LGAs with the highest proportion of the population being Centrelink customers include Canterbury, Marrickville and Ashfield. Mean taxable income is lowest in the Canterbury LGA, which has a higher index of disadvantage than the rest of the state.

**STI (including HIV and Hepatitis B) and Hepatitis C rates across the SLHD**

STI notification data indicates higher levels of incidence for the major STIs and hepatitis C in the SLHD particularly in the City of Sydney and Marrickville, compared to the rest of the state. STIs which are notifiable include gonorrhoea, chlamydia, syphilis and HIV. Figure 2 shows the notifications for the SLHD from 1999-2009. This demonstrates a reduction in all STI notifications except for syphilis and chlamydia, which are considered to be at epidemic levels.

Table 2 and Figure 3 show the major STI notification rates (not including HIV) by LGA for SLHD. Numbers are aggregated for the years 2004-2009 so as to protect identity and to ensure sufficient power for conversion to rates.

*Figure 2 Selected SLHD STI and Hepatitis B and C Notifications 1999-2009*
Hepatitis B shows different notification patterns across SLHD than the other STIs (Figure 3). Canterbury has the highest notification numbers, followed by Sydney and Marrickville. However, the rates for hepatitis B are highest in Strathfield, Burwood, Canterbury and Ashfield, reflecting those areas with highly culturally diverse populations who come from countries with high hepatitis B prevalence. Much of the hepatitis B notified in these statistics has been transmitted by mother to child, rather than being sexually transmitted. There are slightly more males than females reported with hepatitis B, reflecting the higher rates in the MSM population. The numbers are greater for those aged over 30 years in both the male and the female populations, reflecting the chronicity of many hepatitis B infections.
Hepatitis C numbers are highest in Sydney, Marrickville and Canterbury. The rates are by far the highest in the City of Sydney LGA, followed by Marrickville and then Ashfield and Leichhardt. These numbers probably reflect populations of injecting drug users or people who have injected drugs at some time. There were more notifications for males than females and the greatest number of hepatitis C notifications was for the population of men aged over 30 years followed by females in the same age group.

Based on reported cases, hepatitis B and C transmission in Australia continues to occur predominantly among people with a recent history of injecting drug use (National Centre for HIV Epidemiology and Clinical Research 2010). However, statistics on hepatitis C by country of birth are not collected. Globally, hepatitis C is more prevalent in many countries in Asia, the Middle East, Latin America and Southern Europe than it is in Australia, and some of these countries of birth are common in the SLHD population.

While the majority of syphilis notifications in SLHD are non-infectious cases there has been a substantial increase in infectious syphilis. These cases are concentrated in MSM. This epidemic of infectious syphilis has been increasing rapidly since 1998 when the disease first became notifiable (see Figure 4).

*Figure 4: Infectious syphilis notifications by gender and year in SLHD*

Similarly, an epidemic of genital chlamydia has been evident in SLHD since 1998, predominately among younger people (see Figure 5). In the 5 years from 2004-2009, 513 cases of rectal chlamydia were notified in the SLHD among males. In this same period only 17 females were notified with rectal chlamydia. In 2010, 14 cases of Lymphogranuloma venereum (LGV) were notified in SLHD. LGV is an invasive form of chlamydia infection which affects lymphatics and lymph nodes. It is caused by serovars L1, L2, or L3 of *Chlamydia trachomatis*. It has been reported among MSM, especially those who are co-infected with HIV.
HIV prevalence is much higher in the SLHD than in other parts of NSW. Within the SLHD, prevalence in the City of Sydney and Marrickville LGAs is almost five times that experienced in Leichhardt, Ashfield and Burwood. Sydney and Marrickville LGAs have HIV rates of 268 and 245 per 100,000 population, respectively. HIV rates are also high in Leichardt, Ashfield and Burwood with 57, 50 and 45 per 100,000 population affected, respectively.

Source: AIDB 2010
HIV notifications in the SLHD in the past five years have remained steady with a very slight downward trend (Figure 6). However, the number of new notifications each year still remains substantial. HIV notifications are predominately in males aged 25-39 years. The majority of HIV is diagnosed among MSM. The second most commonly reported exposure category is heterosexual contact, and third most common is injecting drug use. The real picture is frequently more complicated, with people sometimes engaging in multiple risk behaviours. People newly diagnosed with HIV live mainly in the City of Sydney and Marrickville LGAs.

Women newly diagnosed with HIV are predominately in the 25-39 year age group (Figure 4.15) and represent about 6% of the total HIV cases reported in SLHD.

In SLHD where country of birth was reported among people newly diagnosed with HIV, 68% were Australian-born. However, country of birth was recorded as ‘unknown’ in 10% of all HIV cases, indicating that the data are not always collected.

Other than Australia, new HIV diagnoses commonly occurred among people born in the UK, those born in other European countries and New Zealand, African countries, Thailand, Indonesia/Malaysia and the Philippines/Pacific Islands also had substantial numbers of HIV notifications.

Late HIV presentation (an AIDS diagnosis within three months of a first HIV positive test result) is strongly associated with being born in a non-English speaking country (National Centre in HIV Epidemiology and Clinical Research 2010). For the years 1997-2006 more than 50% of AIDS diagnoses were among people born in Asia, Africa, Latin America, the Middle East, and Europe (excluding UK/Ireland). Nationally, of newly diagnosed cases attributed to heterosexual contact, 58% were people from high prevalence countries or had partners from high prevalence countries (National Centre in HIV Epidemiology and Clinical Research 2010).
SERVICE CONTEXT

Primary Care Services

General Practitioners are often the first point of contact with the healthcare system for people with STIs. For non-English-speaking communities, including refugee communities, the (private) bilingual GP is frequently sought as the preferred primary care provider (Knox & Britt 2002; Stuart et al. 1996).

The Sexual Health Service conducts regular accredited training programs for GPs as well as offering a telephone consultation service, individual mentoring and clinical and medical student placements. These programs are delivered as a joint initiative of the HARP Health Promotion Service, Sexual Health Clinic staff, the Divisions of General Practice, Australasian Society for HIV Medicine (ASHM) and STIPU. State-wide telephone support is also available via the Sexual Health Infoline.

Secondary and Tertiary Care Services

Sexual Health Clinics

The primary sexual health clinic for the SLHD is RPA Sexual Health which provides a comprehensive range of clinical services. No outreach clinics are currently provided.

In the SLHD, sexual health specialists and registrars manage all STIs including HIV, as well as participating in HIV outpatient clinics at the Royal Prince Alfred Hospital.

General clinics are conducted Monday to Friday. All services are targeted towards priority populations, as per the NSW STI Strategy. Triage practice, dedicated clinics and capacity building of GPs and other health care providers reflects this emphasis. A number of dedicated clinics are in place to enhance access for priority populations; these include:

- Evening clinics for MSM, with the additional benefit of access to the RPA after-hours pharmacy for HIV clients.
- CALD sex worker clinics (currently Chinese-specific) with interpreters available.
- Smoking cessation clinic for clients with HIV.
- Women’s clinics prioritising women from drug and alcohol rehabilitation services; a collaboration with the RPA Hepatitis C Clinical Nurse Consultant.

The core business of the clinical service includes:

- Triage and referral for asymptomatic low risk clients.
- Delivery of clinical and counselling services to symptomatic and priority populations.
- STI testing and treatment.
- Sexual health counselling.
- Hepatitis B vaccination.
- HIV testing and counselling.
- HIV treatment and management.
- Post-exposure prophylaxis for HIV.
- Men’s and women’s sexual health check ups.
- Sex worker check ups.
- Needle and syringe distribution.
- Free condoms and lubricant.
- Contact tracing.
- Capacity building, education and support to general practice and other health care providers.
- Expert information and advice on STI and HIV.
- Participation in STI and HIV research.
• Participation in STI and HIV prevention and health promotion programs.
• Development of partnerships to ensure appropriate client referrals between services.

This clinic records over 8,500 occasions of service per year, with over 2,000 individual clients. The activity at the clinic has progressively increased over the past five years (see Figures 6.1 and 6.2). Approximately 70% of the clients are male and almost three quarters of the consultations are with males. The activity data has been restricted to the past 2.5 years as service changes make previous data unreliable.

The RPA precinct is an ideal location for this service because of concentration of high risk clients in the local area and easy access to the tertiary services provide by RPA Hospital.

**Accessibility to Priority Populations**

A key service-related concern is the relative accessibility of the sexual health clinic to its priority populations. Figure 7 shows the activity data by priority population. (Note the data does not reflect occasions or client numbers as people may be counted a few times if they reflect different population groups e.g. gay sex worker.) The data demonstrates the increasing emphasis on accessing those populations which are at highest risk of contracting HIV or other STIs. Figure 7 and Figure 8 show that HIV positive clients comprise a substantial proportion of the activity at RPA Sexual Health, with HPV-related consultations having the second highest activity numbers. Syphilis, chlamydia, gonorrhoea and herpes were diagnosed at similar levels.

*Figure 7: RPA Sexual Health Clients by Priority Population 2005-2010*
Health Promotion Teams

In addition to clinical services, the Sexual Health Service includes a Health Promotion Team located in the SLHD. The team responds to STI, HIV and hepatitis C through priority population portfolios including: Aboriginal women, Aboriginal men, MSM, sex workers, people with HIV, people living with hepatitis C and injecting drug users. There are also specific projects for service and workforce development.

The prevention and health promotion programs include:

- Resource development.
- Awareness raising and social marketing campaigns.
- Capacity building, education and support to general practice and other health care providers.
- Workforce development.
- Collaboration with key stakeholders with an emphasis on community-based organisations.
- STI and HIV education to community groups.
- Sex worker outreach.
- Identifying and responding to needs of local priority populations through community consultation.
- Working in partnership with the public health unit to respond to public health issues and STI outbreaks as well as emerging trends in sexual health.
- Quality improvement, research and evaluation activities.
- Working with clinical services to improve the accessibility of priority populations to sexual health services.
- Trialling innovative models of service delivery to priority populations.

MSM are appropriately a large focus of the health promotion and workforce development work undertaken by HARP Health Promotion across the Area. In the SLHD there is an additional gay men’s project officer and a designated position for working with people with HIV. Much of this work is undertaken in close partnership with organisations such as ACON, Positive Life NSW, STIPU and local General Practice divisions.
The Aboriginal Sexual Health Workers (ASHWs) have a unique role; working across both the Health Promotion Team and the sexual health clinical service. Work with the Aboriginal community has a particularly strong focus on young people, the Aboriginal workforce and hepatitis C. Work undertaken under the current HARP Strategic Plan include the Hepatitis C Retreat, participation in local men’s groups, Sexual Health and BBV education for community and workforce, HARP related services support and liaison, resource development, outreach testing and participation with local youth centres and community events such as “Close The Gap” and “NAIDOC Week”. ASHWs conduct STI testing through outreach to community settings and events. Community engagement is a significant component of their role: building trust, delivering education and encouraging referral to clinical services.

Sex worker outreach and sex worker clinic support remains a strong focus across the area. This work is conducted in partnerships with Sex Workers Outreach Program (SWOP), Scarlet Alliance, and the Multicultural HIV and Hepatitis C Service (MHAHS). Work is also guided by SHOWnet and related working groups. Sex worker specific resources have been developed in multiple languages to provide a sexual health supportive environment in parlours and increase their access to SHCs.

Work undertaken within the period of the current HARP Strategic Framework (SSWAHS 2008) includes ongoing sex worker outreach, a Chinese parlour based sex worker needs assessment, supporting dedicated sex worker clinics, resource development and establishing a relationship with private sex workers that operate or reside in the area.

Work with CALD communities is not a specific focus of HARP health promotion however may be addressed through crossover work with other projects such as the gay men’s projects, Hepatitis projects and sex worker outreach/liaison. Work with CALD communities is done in partnership and/or consultation with key agencies such as MHAHS and the Multicultural Health Service. Current projects include media campaigns, sex worker consultation and workforce development. Comprehensively addressing the sexual health needs of CALD communities, including PWID is potentially a gap in service provision and in need of review.

PWIDs are a prime focus of the Hepatitis C projects in close partnership with Drug Health Services.

Young people are a priority population, especially if they belong to other priority populations. Work with young people is undertaken in close association with Youth Health Services, Family Planning NSW and other relevant organisations.

Research and Evaluation

Data, research and evaluation are key elements of a quality sexual health service. Research in the SLHD has included biomedical, clinical, epidemiological and population-based research and evaluation. Integral to sexual health policy, planning and service provision is an evidence-based approach. Wide ranging research approaches have been required including studies which examine sexual health prevalence and risk factors, clinical trials, case studies, qualitative studies examining attitudes or behavioural issues and literature reviews. Evaluations of service and health promotion programs have regularly been undertaken.

RPA Sexual Health and its predecessor, Livingstone Road Sexual Health Clinic in Marrickville, have a long history of clinical and public health research. Much of the research has been in collaboration with other Sexual Health Clinics, RPA HIV clinic or with the HARP Health Promotion team.

A key component of research is to collect and integrate clinical and service data, access public health notification data and to generate and collate data related to emergent sexual health research questions and issues.
BEST PRACTICE IN SEXUAL HEALTH

Introduction

Sexual health best practice is informed by strongly held principles which impact on all aspects of sexual health service delivery. The best practice model is determined largely by the NSW STI Strategy (2010-2013) which requires collaborative initiatives in prevention, detection, treatment, research and surveillance to reduce the transmission and morbidity associated with STIs. The NSW STI Programs Unit (STIPU) has been established to provide leadership to clinical and health promotion services; particularly to orient services towards priority populations. Fundamental to best practice is incorporating evidence.

Principles Guiding Best Practice in Sexual Health

The principles associated with best practice Sexual Health Service provision include the following:

- A commitment to human rights, equal opportunity, gender, non-discrimination and advocacy.
- Affirming the right for an individual to be treated with dignity and respect, including respecting confidentiality and privacy.
- The meaningful participation of, and collaboration with, affected communities and groups in Sexual Health Service development, planning, implementation, monitoring and evaluation.
- A partnership approach to policy, planning, health promotion and service delivery.
- Ensuring an appropriate balance between health promotion, prevention, early intervention, treatment and education based on local epidemiology, demography and scientific evidence.
- A strong population health and equity approach which sets local priorities for direct service and health promotion provision, based on the following:
  - Populations with current high rates of STIs.
  - Populations which are at risk of STI epidemics.
  - Populations which may not readily access mainstream services.
  - Populations which are particularly socially vulnerable.
  - Local needs and issues.

Elements of a Best Practice Service Model

The core elements of a best practice sexual health service model are the following:

- Health promotion, prevention and community education.
- Partnerships with General Practitioners and primary care providers.
- High quality sexual health clinical services targeting priority populations.
- Partnerships with affected populations, clinicians, researchers and other relevant groups.
- A strong scientific research and evidence base for service, strategy, policy and planning.
- A strong partnership with the relevant Public Health Unit.
- Incorporation of new medical and social media technology.

The interrelated elements of a Best Practice Sexual Health Service are illustrated diagrammatically in Figure 9. This model is in part derived from STIPU planning tools.
Figure 9: Best Practice Sexual Health Service Model

**High Quality Sexual Health Clinical Services**
- High quality clinical services, counselling for priority populations
- Testing, including outreach testing, screening, vaccination
- Needle and syringe program
- Capacity building, education, support to primary care providers
- Professional education, support and supervision
- STI and HIV research
- Participation in health promotion and prevention
- Partnerships with communities, GPs, public health
- Contact tracing
- Ensuring policies, processes, procedures conform with best practice standards and legal requirements

**Health Promotion, Prevention and Community Education**
- Resource development
- Awareness raising and social marketing campaigns
- Capacity building, education and support to general practice and other health care providers
- Collaboration with key stakeholders with an emphasis on community-based organisations
- STI and HIV education to community groups; community consultation
- Undertaking research and work in partnership with the Public Health Unit to respond to emerging trends in sexual health
- Sex worker outreach

**Partnerships with Community and Priority Population Groups to:**
- Implement appropriate prevention, health promotion and clinical service models
- Promote advocacy
- Refer for support and care
- Ensure appropriate planning, policy and service development

**Partnerships with the Public Health Unit**
- Coordinate STI surveillance & maintain the national notifiable diseases database
- Provide STI surveillance reports to STI clinics, health promotion, and GPs
- Investigate and coordinate responses to notifiable disease outbreaks

**Explore New Technology**
- Rapid Testing and Home-based testing
- Drug Technology e.g. Pre-Exposure Prophylaxis
- Social Technology- SMS, websites, social media sites, on-line test results
- Electronic Medical Records

**Elements of Best Practice Sexual Health Service**

**Partnerships with Related Health Services**
Examples include Youth Health, Drug Health, HIV services, Women’s Health, Aboriginal Health, Multicultural Health, Refugee Health, Family Planning NSW. The purpose is to:
- Coordinate treatment, care and referral
- Collaborate in health promotion, education and prevention programs and strategies
- Ensure appropriate planning, policy and service development

**Research, Teaching & Evaluation**
- Epidemiological research
- Clinical research
- Intervention and promotion evaluation and assessment
- Quality Improvement and service evaluation
- Literature reviews related to service delivery, planning, strategy and policy
- Undergraduate, postgraduate & professional development
- Accreditation of staff meets relevant professional standards
Sexual Health Clinics

The core business of the sexual health clinical service includes:

- Triage and referral for asymptomatic low risk clients. Triage practice, dedicated clinics and capacity building of GPs and other health care providers should aim to promote access to those population groups which have been shown to be at high risk of contracting STIs. Priority populations include MSM, sex workers, people who inject drugs, Aboriginal populations and at-risk young people.

- Delivery of clinical and counselling services to symptomatic and priority populations:
  - STI testing and treatment.
  - BBV assessment and referral.
  - Sexual health counselling.
  - Hepatitis B vaccination.
  - HIV testing and counselling.
  - HIV treatment and management.
  - Post-exposure prophylaxis for HIV.
  - Men’s and women’s sexual health screening.
  - Sex worker counselling.
  - Needle and syringe program.
  - Provision of free condoms and lubricant.
  - Contact tracing.

- Capacity building, education and support to general practice and other health care providers. This includes support to Sexual Assault Services.

- Expert information and advice on STI and HIV.

- Participation in STI and HIV research and identifying and responding to emerging trends.

- Participation in STI and HIV prevention and health promotion programs.

- Development of partnerships with primary, secondary and tertiary services to ensure appropriate client referrals between services.

Integral to best practice clinical delivery is ensuring that policies, processes and procedures conform with national, state and local plans, policies, guidelines and strategies, legal requirements, accreditation requirements and best practice procedure manuals. Examples include:

- The Sexual Health Service Accreditation Guidelines.
- The NSW Sexual Health Standard Operating Procedures Manual.
- NSW STIPU Core Business Statement.
- NSW STI Strategy.
- National STI Strategy.

Health Promotion Teams

The core business of the prevention and health promotion team includes:

- Resource development.
- Awareness raising and conduct of social marketing campaigns.
- Capacity building, education and support to general practice and other health care providers.
- Collaboration with key stakeholders with an emphasis on community-based organisations.
- Community consultation.
- STI and HIV education to community groups.
- Sex worker outreach.
- Research and work in partnership with the public health unit to respond to emerging trends in sexual health.
Partnerships with General Practice and Primary Care Providers

In NSW, primary care services provide the bulk of STI testing, counselling, individual health promotion and prevention education. Sexual health services partner with primary care providers and organisations to ensure support, education and advice provision and to maximise the effectiveness of GP roles in Sexual Health. GP roles in sexual heath include:

- Provision of clinical services and counselling to the general public and to priority populations wishing to access GPs.
- Contributing to health promotion and prevention programs and patient education.
- Initiating contact tracing.
- Referring to relevant sexual health services, community organisations and support services.

Engagement with Affected Populations and Other Relevant Groups

The importance of strong and co-operative partnerships with affected populations is based on the human rights ideal of involving those affected in order to empower them to have greater control over their own health and healthcare.

Engaging affected communities is essential as a means of promoting priority access to care and support for those population groups which have traditionally been marginalised. The process of positively influencing intimate sexual behaviours in an appropriate way requires expert implementation of appropriate prevention, education and health promotion programs. The active involvement of communities ensures that planning, policy and service development is sensitive, appropriate, acceptable and maximally effective.

Partnerships with Related Health Services

There are a range of health services which frequently partner with Sexual Health Services either in service delivery, policy development or health promotion. This includes other district health services, non-government organisations and community based health organisations. Such collaborations ensure that treatment, care and referral is appropriate and that health promotion, education and prevention programs and strategies and relevant and well-devised.

Key partners include AMS Redfern, Youth Health, Drug Health, HIV services, Women’s Health, Aboriginal Health, Multicultural Health, Refugee Health and Family Planning.

There are a number of community-based agencies and groups which also routinely work in partnership with sexual health services and health promotion teams. These include, for example, ACON, Positive Life NSW, Metropolitan Gay Men’s HIV Prevention Interagency (MGM), Sexually Transmissible Infections in Gay Men Action (STIGMA), NSW HIV Positive Health Promotion Interagency, the Multicultural HIV and Hepatitis C Service, Hepatitis NSW, SHOW Network (Sexual Health Outreach Workers), Sex Workers Outreach Project (SWOP) and Scarlet Alliance.

Partnership with the Public Health Unit (PHU)

The role of the PHU is to undertake and coordinate STI surveillance and ensure that the national notifiable diseases data base is maintained. STI surveillance is an epidemiological activity which measures and estimates disease incidence, burden of disease and sexual and other risk behaviours.

Research, Teaching and Evaluation to inform policy, planning and service delivery

A key component of sexual health services is undertaking research and evaluation related to service delivery, planning, strategy and policy. Research includes:

- Epidemiological research.
- Clinical research.
- Quality Improvement.
- Literature reviews.

Teaching roles include participation in undergraduate, postgraduate and professional education, including supervision of clinical placements.
Incorporation of New Medical and Social Media Technology

Rapid HIV Testing (RHT) involves technology that provides a HIV antibody screening test result within thirty minutes. This increases access to test results, reduces undiagnosed infection rates and improves client experience. A similar rapid test for chlamydia has not as yet been found to be reliable.

Pre-Exposure Prophylaxis (PrEP) is proven to reduce the risk of HIV infection in HIV-negative people through the use of antiretroviral medications (ARVs). The applications in the urbanised Australian environment are yet to be determined.

Social technology has particular applications to sexual health settings. Through embracing new social technologies we are able to explore a range of strategies to increase service efficiency. New strategies include electronic SMS appointment reminder system, electronic booking systems and contact tracing websites. Recent literature has shown these strategies to be useful in improving screening rates and receipt of results, and reducing waiting lists and time spent with sexual health clinicians.

Contact tracing websites have been shown to improve contact with recent sexual partners who may have contracted an STI/HIV. These websites provide an option for people who have been diagnosed with an STI to contact their previous partners anonymously via email, SMS or letter. These websites also provide information, contact details, and support for people who have been advised that they may have been exposed to an STI.

The Sexual Health Service have identified a number of key areas in new medical and social technologies to explore and implement over the next five years.
<table>
<thead>
<tr>
<th>New Technology</th>
<th>Strategy for Sexual Health Services in SLHD</th>
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| Rapid testing in NSW                        | 1.1 HIV To monitor RHT trials in Australia and explore their application with relevant interagencies and service partners.  
  1.2 Chlamydia trachomatis (CT) Further research and medical advances are needed in CT POC testing before implementation.  
  1.3 Syphilis Further research is needed before rapid Syphilis POC is used in Australia. SLHD & SWLHD SHSs will monitor RHT trials in Australia and participate in discussions through relevant interagency meetings and with service partners.  
  1.4 Community outreach testing SLHD & SWLHD SHSs to actively conduct community outreach CT testing among disadvantaged/marginalised young people, particularly Aboriginal young people. |
| Pre-Exposure Prophylaxis (PrEP)             | To monitor PrEP trials in Australia and around the world, as well as participate in discussions through relevant interagency meetings and service partners.                                                                                                                                                                                                                                                                  |
| Anal Human Papillomavirus Infection (HPV)   | Anal pap tests in high risk populations are still an inaccurate predictor of high-grade anal dysplasia on biopsy. Further research is needed to increase the sensitivity and specificity of screening methods to better identify anal diseases. SLHD SHS will continue to regularly perform digital examination in those at high risk of anal cancer to facilitate early detection of anal cancer. RPA Sexual Health is planning to participate in a study of anal cancer screening in collaboration with The Kirby Institute, UNSW. |
| SMS Reminder Systems                        | To explore the possibility of implementing an electronic SMS appointment reminder system at SLHD SHS to decrease the median wait time for patients and reduce the non-attendance rate. Explore SMS STI screening reminders for at risk patients, in particular MSM to increase re-screening rates.                                                                                                                                                     |
| Contract Tracing Websites                   | To ensure that SLHD SHS patients are aware of contact tracing websites to allow them to anonymously notify their previous/current sexual partners of their potential exposure to STIs.                                                                                                                                                                                                                       |
| Computer-assisted Self Interviews for Sexual History Taking (CASI) | To allocate resources to explore the possibility of implementing CASI as part of routine care within SLHD SHS to shorten the duration of time allocated to triaging and consulting clients, particularly low-risk clients.                                                                                                                                                                                                                     |
| Electronic Medical Records (EMR)            | SLHD SHS to work in partnership with the HARP Unit and IM&TD to efficiently implement the eMRs.                                                                                                                                                                                                                                                                                                                                                                        |
| Home-based Chlamydia screening              | Further research is needed before home-base chlamydia testing can be used as an effective strategy to increase testing rates among at risk populations. SLHD SHS to participate in further research and discussions regarding strategies to increase chlamydia testing rates among at-risk young people.                                                                                                                                                                                   |
| Online test result system                   | Explore the possibility of receiving and providing STI test results online to improve service efficiency and receipt of test results.                                                                                                                                                                                                                                                                                                                                 |
| Test results via mobile phone messaging     | Explore the possibility of delivering test results through mobile phone messaging to improve service efficiency and increase receipt of test results.                                                                                                                                                                                                                                                                                                                   |
| Express Clinics                             | To explore the possibility of introducing an express clinic for asymptomatic patients to reduce the average visit time for patients.                                                                                                                                                                                                                                                                                                                               |

**Best Practice Structure**

In order to ensure that the service objectives and functions are most effectively implemented, it is considered ideal that the structure of Sexual Health Services promotes collaborative work between the key partners. The most essential relationship in the Best Practice Model is the clinical and health promotion services in each LHD. These health services need to have a strong working relationship and ideally following the same priorities and strategic directions.
STRATEGIC ISSUES

Strategic Issue One:
Implementing the Best Practice Model across SLHD in response to local needs and equity issues

- Implementing the Best Practice Model, as outlined in Figure 9: Best Practice Sexual Health Service Model.
  - Delivery of high quality STI clinical and counselling services to symptomatic individuals and priority populations.
  - Maintain RPA Sexual Health on the RPA campus to ensure both an accessible site to high risk clients and strong links to the tertiary services provide by RPA Hospital.
  - Ensure a permanent site for RPA Sexual Health on the RPA Campus is finalised in 2013.
  - Maintain and strengthen service participation in local, state, national and international clinical research projects.
  - Provide ongoing professional education, support and other up-skilling opportunities for sexual health staff.
  - Pilot, evaluate, and where efficacious, introduce new technology, both clinical and communication technology.
  - Deliver prevention and health promotion programs, in collaboration with Sexual Health Services and in collaboration with other sector partners as outlined in the HARP Strategic Framework (2008-2012).
  - Explore opportunities for innovative service delivery in other parts of the district.

Strategic Issue Two:
STI and HIV prevention, screening and care for gay and other men who have sex with men

- HIV prevention and risk management strategies (including promoting condom usage, harm minimisation, STI screening, and the distribution of HIV post exposure prophylaxis) in collaboration with other services and partners.
- Chlamydia, syphilis, gonorrhoea and other STI prevention, early intervention and clinical care.

Strategic Issue Three:
Strengthening the capacity of General Practitioners to deliver STI and HIV clinical care

- Work with, educate and support General Practitioners to provide effective STI and HIV prevention, screening, referral and clinical care.
- Continue the partnerships with ASHM and the Inner West Sydney Medicare Local focused on facilitating sexual health up-skilling and clinical guidance for GPs and practice nurses.

Strategic Issue Four:
Supporting and caring for people with HIV

- HIV early intervention and support.
- Prevention of onward transmission.
- Health promotion, lifestyle maintenance.
- Comprehensive, holistic shared care.
Strategic Issue Five:
STI and HIV prevention, screening and care for Aboriginal people

- Increase collaborative work with the Aboriginal Medical Service (AMS), Redfern to support the provision of HIV and STI clinical and health promotion services.
- Chlamydia prevention including education, access to condoms.
- Outreach screening and treatment particularly targeting chlamydia.
- Continue to pilot innovative models for community-based testing, screening and education.
- Engage with Juvenile Justice Services to provide information, education and ensure resources are appropriate for newly released young people.
- Ensuring culturally respectful, appropriate services and health promotion is provided through a variety of strategies including:
  - Aboriginal cultural sensitivity training.
  - Re-organising service parameters to ensure access.
  - Continued employment of Aboriginal health workers.
  - Collaborations with Aboriginal community controlled health services.

Strategic Issue Six:
STI and HIV prevention, screening and care for Sex Workers

- Ensure low rates of HIV and STIs in sex workers through encouraging safer sex environments in parlours.
- Promote outreach to street workers in collaboration with key partners.
- Maintain outreach to sex worker parlours especially those employing sex workers from CALD backgrounds.
- Maintain access to sex worker-specific sexual health clinics.

Strategic Issue Seven:
STI and HIV prevention, screening and care for other vulnerable and marginalised groups including, for example, disadvantaged young people, people who inject drugs, homeless people, people with mental health problems, CALD communities with high prevalence rates of STIs.

- Improve the accessibility and appropriateness of STI screening.
- Work in collaboration with Youth Health Services, Drug Health services, Mental Health services, Multicultural HIV and Hepatitis C Service and other relevant partners to promote safe injecting practices and STI prevention.
- Provide access to sterile injecting equipment as a secondary Needle and Syringe Program (NSP).
- Reduce the transmission of STIs and HCV through health promotion and prevention activities.
- Increase access to STI and HCV testing and treatment through health promotion strategies.
- Improve access to chlamydia screening in general practice for young people.
- Outreach screening, treatment and education, particularly targeting chlamydia for disadvantaged young people.
- Upskilling Aboriginal, drug health and youth health nurses in sexual health through programs and clinical placements.
Priority Strategic Actions for SLHD

1. Establish a SLHD Sexual Health Committee responsible for implementing this strategy. The Committee should be chaired by a SLHD executive and include representation from sexual health services, internal partners, external partners and from the community.

2. Continue implementing the Best Practice Model in SLHD including undertaking clinical audit, research, GP education and targeting MSM as a priority population.

3. Enhance the efficiency and excellent service provision to priority populations through implementing new technologies including:
   a. Rapid HIV testing
   b. SMS reminders
   c. Electronic medical records
   d. Computer Assisted Self Interviews for Sexual History Taking (CASI)

4. Further increase the capacity to appropriately service MSM through identifying, training, mentoring and supporting GPs in the inner west.

5. Increase the focus on Aboriginal populations through:
   a. Strengthening the partnership with Redfern Aboriginal Medical Service
   b. Identifying an appropriate model of outreach to Aboriginal communities
   c. Undertaking Aboriginal Health Impact Statements

6. Expand the capacity of the Sexual Health Service in accordance with local needs, activity and epidemiological trends.
APPENDIX ONE: ACKNOWLEDGEMENTS

This Sexual Health Strategy was guided by the Sexual Health Steering Committee and a number of sub-committees of that group.

**Sexual Health Strategy Steering Committee**

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<tr>
<th>Chair:</th>
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<tbody>
<tr>
<td>Dr Katherine Moore</td>
<td>General Manager, Community Health, Sydney and South West SLHDs until March 2011</td>
</tr>
<tr>
<td>Ms Alison Derrett</td>
<td>A/General Manager, Community Health, Sydney and South West SLHDs from March 2011</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Members:</th>
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<tbody>
<tr>
<td>Mr Robert Ball</td>
<td>HARP, Health Promotion, SWSLHD, from December 2010.</td>
</tr>
<tr>
<td>Ms Susanne Benjamin</td>
<td>Public Health Unit</td>
</tr>
<tr>
<td>Ms Diana Bernard</td>
<td>HARP, Health Promotion until December 2010.</td>
</tr>
<tr>
<td>Mr Timothy Duck</td>
<td>Research and Evaluation, HARP Health Promotion, SLHD and SWSLHD</td>
</tr>
<tr>
<td>Dr Christopher Bourne</td>
<td>STIPU Unit (until November 2010)</td>
</tr>
<tr>
<td>Dr Christopher Carmody</td>
<td>Clinic Manager, Campbelltown Sexual Health Clinic</td>
</tr>
<tr>
<td>Dr Pamela Garrett</td>
<td>Senior Planner, Sydney South West Area Health Service</td>
</tr>
<tr>
<td>Ms Loretta Healey</td>
<td>Area Senior Counsellor, Sydney and South Western SLHD Sexual Health Services</td>
</tr>
<tr>
<td>Mr Geoff Honnor</td>
<td>ACON, Director of Community Health</td>
</tr>
<tr>
<td>Mr Rob Lake</td>
<td>CEO, Positive Life, NSW</td>
</tr>
<tr>
<td>Mr David Lawrence</td>
<td>A/Manager Planning Western Division</td>
</tr>
<tr>
<td>Mr George Long</td>
<td>A/Director Aboriginal Health, SSWAHS</td>
</tr>
<tr>
<td>Ms Renee Lovell</td>
<td>Manager HARP Health Promotion, Sydney and SWSLHD</td>
</tr>
<tr>
<td>Ms Julie Mclean</td>
<td>Central Sydney GP Network</td>
</tr>
<tr>
<td>Ms Renee Moreton</td>
<td>HARP Unit</td>
</tr>
<tr>
<td>Dr Tadgh McMahon</td>
<td>Manager, Multicultural HIV and Hepatitis Service</td>
</tr>
<tr>
<td>A/Professor Catherine O’Connor</td>
<td>Director, Sydney and South Western SLHD Sexual Health Services</td>
</tr>
<tr>
<td>Dr Yoges Paramsothy</td>
<td>Clinic Manager, Liverpool Sexual Health Clinic</td>
</tr>
<tr>
<td>Ms Miranda Shaw</td>
<td>A/Director Community Health, Specialist Services</td>
</tr>
<tr>
<td>A/Professor David Templeton</td>
<td>Clinic Manager, RPA Sexual Health</td>
</tr>
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# APPENDIX TWO: ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCESS</td>
<td>Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance project</td>
</tr>
<tr>
<td>ACON</td>
<td>ACON</td>
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<tr>
<td>ARVs</td>
<td>Antiretroviral Medications</td>
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<tr>
<td>ASHM</td>
<td>Australian Society for HIV Medicine</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
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<tr>
<td>CASI</td>
<td>Computer Assisted Self Interviewing</td>
</tr>
<tr>
<td>CT</td>
<td><em>Chlamydia trachomatis</em></td>
</tr>
<tr>
<td>eMR</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>HARP</td>
<td>HIV/AIDS and Related Programs</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HPV</td>
<td>Human Papillomavirus</td>
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<tr>
<td>HSV</td>
<td>Herpes Simplex Virus</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<tr>
<td>LGV</td>
<td>Lymphogranuloma venereum</td>
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<tr>
<td>LHD</td>
<td>Local Health District</td>
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<tr>
<td>MSM</td>
<td>Men Who Have Sex with Men</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>PFSHS</td>
<td>Publicly Funded Sexual Health Service</td>
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<tr>
<td>PHU</td>
<td>Public Health Unit</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
</tr>
<tr>
<td>PWID</td>
<td>People Who Inject Drugs</td>
</tr>
<tr>
<td>POC</td>
<td>Point Of Care</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-exposure Prophylaxis</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practice</td>
</tr>
<tr>
<td>RHT</td>
<td>Rapid HIV Testing</td>
</tr>
<tr>
<td>SHS</td>
<td>Sexual Health Service</td>
</tr>
<tr>
<td>SLHD</td>
<td>Sydney Local Health District</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
<tr>
<td>STIGMA</td>
<td>STIs in Gay Men’s Action Group</td>
</tr>
<tr>
<td>STIPU</td>
<td>NSW Sexually Transmissible Infections Programs Unit</td>
</tr>
<tr>
<td>SWOP</td>
<td>Sex Workers Outreach Program</td>
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</tbody>
</table>
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This artwork was commissioned by the Aboriginal Women’s Project for display at RPA Sexual Health and for use as an Aboriginal specific resource. This piece is titled “The Healing Place”. It was produced by Aboriginal Artist, Colin Wightman.