

Acknowledgments

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Introduction

Sexually Transmissible Infections (STIs) and Blood Borne Infections (BBIs) are a significant problem in NSW. They particularly affect people who are young, marginalised or who have limited access to health services. These factors along with other issues discussed in this manual contribute to the higher burden of ill health experienced by Aboriginal people as a consequence of STIs and BBIs.

Early detection and treatment (screening) programs are recognised as an important component of STI and BBI strategies and have led to significant reductions of STIs and BBIs in some communities across Australia. In NSW there is currently no consistent approach to early detection and treatment programs within primary health services. This manual provides a framework for the planning, delivery and evaluation of early detection and treatment programs for STIs and BBIs within

Aboriginal Community settings. The manual has been designed as a practical tool for use within a range of clinical settings including, Aboriginal Community Controlled Health Services, specialist Sexual Health Services, General Practice settings and other services which deliver sexual health programs. While treatment is an essential component of early detection and treatment programs, this is not a comprehensive treatment manual and reference to local protocols and policies is recommended as a supplement.

An important principle underlying this manual is the development of sustainable and effective partnerships between service providers. Partnerships are critical to the success of effective early detection and treatment programs by ensuring expertise across sectors are shared and access is equitable and accessible for those most at risk of acquiring STIs and BBIs.

This project is linked with key policy initiatives at the national and state levels, including the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008*, the *National Sexually Transmissible Infections Strategy 2005 – 2008*, the *National HIV/AIDS Strategy 2005 – 2008*, the *National Hepatitis C Strategy 2005 – 2008* and the *NSW HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal People* developed by the NSW Health Department and the Aboriginal Health & Medical Research Council. Other strategies considered during the development of this manual were the NSW Hepatitis C Strategy, NSW STI Strategy and NSW HIV/AIDS Strategy. All the above strategies identify Aboriginal people as a priority population.

The *STD control in remote Aboriginal communities: A manual for clinic workers* (Commonwealth Department of Health and Aged Care 1999) was referenced in the development of this manual and is an important supplementary guide for overall STI programs and is recommended as a resource for any practitioner working in sexual health.

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Preface

PRINCIPLES

Particular consideration should be given to the following principles used in the development of this manual and which apply when working with Aboriginal communities in NSW.

Aboriginal Community Control

Aboriginal Community Controlled Health Services (ACCHSs) were established as a result of inadequate and discriminatory delivery within mainstream health systems, and the need for services which were culturally appropriate and sensitive to the needs of Aboriginal people.

Community Control is a process, which allows Aboriginal communities to be involved in their own affairs in accordance with the protocols or procedures determined by the community.

An Aboriginal Community Controlled Health Service:

- is an incorporated Aboriginal organisation which is initiated by and based in an Aboriginal community
- is governed by a body, which is elected by the local Aboriginal community members
- delivers a holistic and culturally appropriate health service to the community that it serves.

Access and Equity

In the development of this manual it is recognised that increased commitment and goodwill are required to ensure Aboriginal people have equitable access to health services, and that resourcing Aboriginal sexual health should reflect the current inequity.

Age groups

While people of any age can acquire a STI or BBI, the majority of notifications occur among young adults. The age group 15 to 30 years has been used for consistency throughout the manual, however the upper and lower limits of this age group can vary with specific STIs and BBIs, and among different risk groups and geographic locations.

Diversity

It should be recognised that Aboriginal communities are not homogenous and that this should be reflected in the delivery of programs and services to communities.

Flexibility

A flexible approach is required in the delivery of health services to Aboriginal people and their communities. This manual is intended as a broad framework that can be adapted to local communities' needs and structures.

Holistic health service delivery

A holistic approach is fundamental to success in addressing STIs and BBIs in an Aboriginal community context. A holistic approach recognises that STIs and BBIs cannot be addressed in isolation from any of the following:

- other illnesses
- issues affecting general health and the physical body, and
- the social, cultural and emotional experiences of the people concerned.

Partnerships

This manual is intended to demonstrate that partnership arrangements at a local level between Aboriginal Community Controlled Health Services and mainstream health service providers, particularly specialised sexual health clinics, are critical for effective early detection and treatment programs.

Self Determination

Self Determination is a fundamental principle that is critical to the success of Aboriginal Community Controlled health programs. Allowing communities to be engaged and fully determine the processes and outcomes of health programs will ensure effectiveness and sustainability of programs.

TERMINOLOGY

The following terminology is used throughout this manual.

Aboriginal

This manual refers only to Aboriginal people except when existing national data is cited. Mindful of the small percentage of Torres Strait Islander people living in NSW and the importance of ensuring access to services to Torres Strait Islander people, reference to Aboriginal people in this manual also refers to and encompasses Torres Strait Islander peoples.

Community

The term 'community' has been used to refer to any group of people who either live in a specific locality or because they access a common place. Therefore the term 'community' could refer to any group of people including:

- All Aboriginal people living in a region
- A defined age or risk group
- Places where people at risk could be found together (e.g. correctional facilities, youth centres).

Early detection and treatment programs

Many Aboriginal people in NSW have negative connotations associated with the word 'screening' because of a range of factors which include policies of forced removal of children and discriminatory government screening programs. We propose to use education, early detection, treatment and management of STIs and BBIs or for short early detection and treatment programs, in order to address this issue.

Sexually Transmissible and Blood Borne Infections

While viral STIs such as genital herpes and genital warts are common, the manual will focus mainly on other STIs and BBIs including chlamydia, gonorrhoea, syphilis, hepatitis B, hepatitis C and HIV.

How to use this manual

This manual is divided into 4 parts. Each part can be used as a stand alone resource.

PART A: BACKGROUND INFORMATION

This section provides background information about STIs and BBIs early detection programs including: an overview of the epidemiology of STIs and BBIs in Aboriginal communities in NSW, the principles of early detection and treatment programs and why they are important as a strategy for improving access to services for those at greatest risk.

PART B: EARLY DETECTION AND TREATMENT PROGRAMS

This section contains information that needs to be considered prior to implementing early detection and treatment programs including; improving access to services for those most at risk, and options for selecting the most appropriate mode of delivering programs within different health service contexts.

PART C: PLANNING, IMPLEMENTING AND EVALUATING EARLY DETECTION AND TREATMENT PROGRAMS

This section is a practical guide on how to implement and evaluate STI and BBI early detection and treatment programs within an Aboriginal community context, including; community consultation, ownership and engagement, workforce issues, logistics of program delivery, evaluation and sustainability of programs.

PART D: TOOLS AND REFERENCES

This section contains a practical easy to use checklist of equipment and medications that may be needed to deliver STI and BBI early detection and treatment programs.

Chapter 1

The Epidemiology of STIs and BBIs

KEY POINTS

- Chlamydia and hepatitis C are two of the most commonly reported notifiable diseases in Australia.
- In jurisdictions where accurate data exists, there are unacceptably high rates of STIs for Aboriginal people, compared to non-Aboriginal people.
- Exposure categories for HIV in the Aboriginal population differ significantly from the non-Aboriginal population.
- The rate of diagnosis of HIV per head of population among Aboriginal people is now slightly higher than that among non-Aboriginal people.
- A person's risk of getting an STI or BBI can be influenced by:
 - *Young age (15 to 30 years)*
 - *Individual behaviour*
 - *Living in a community where STIs and BBIs are common*
 - *The level of access to health services.*
- Having any STI can facilitate HIV transmission.
- Many STIs are easy to test for and treat.
- Untreated, STIs and BBIs can lead to serious physical, psychological and social problems.
- A person may have an STI (e.g. chlamydia) or BBI (e.g. hepatitis C) and have no symptoms.

What is epidemiology?

Epidemiology is the study of the pattern and distribution of a disease or health problem within a population and involves collecting information such as who is affected, why they are affected and where they live geographically. Knowing this information can help to identify where programs and resources should be directed in order to prevent and control diseases.

Key Issues regarding STI and BBI epidemiology

STIs and BBIs are common amongst all Australians; particularly young people aged 15 to 30. The rates of STIs and BBIs vary between different communities and geographic areas. Despite these variations, there are general key issues regarding the epidemiology of STIs and BBIs.

Key Issues regarding STIs and BBIs

- STIs and BBIs are common especially among people who:
 - Are aged 15 to 30 years
 - Have specific risk taking behaviour
 - Live in a community where STIs and BBIs are common
 - Have limited access to appropriate services.
- STIs and BBIs often cause no symptoms or mild symptoms that often go unrecognised.
- People are often unaware that they are at risk of acquiring a STI or BBI.
- Shame and stigma can prevent disclosure of risk taking behaviour.
- Practitioners may be unaware of signs and symptoms and don't always offer appropriate testing and treatment.
- Most STIs and BBIs can be detected using simple tests.
- Many STIs can be treated using single dose antibiotic treatment.
- Treatment can prevent complications developing and prevent transmission to others.
- Untreated STIs and BBIs can lead to serious physical, psychological and social problems.
- STIs and BBIs can facilitate the transmission of HIV.

Notifications of common STIs and BBIs

Accurate information about STIs and BBIs amongst particular populations can be difficult to obtain. Where accurate data does exist, chlamydia, gonorrhoea, syphilis and hepatitis B and C are notified more among Aboriginal than other Australians.¹

¹ In NSW there are limitations in collecting accurate data which are currently being resolved.

Chlamydia is the most commonly notifiable disease in Australia. Chlamydia predominantly affects 15–30 year olds with a significant increase in notifications being reported over the preceding five year period. While syphilis and gonorrhoea are much less common than chlamydia, in NSW both STIs are reported more among men who have sex with men and Aboriginal people compared to other risk groups.

Genital herpes and genital warts are common STIs which are associated with significant social and medical outcomes. For example, Herpes Simplex Virus (HSV) can cause genital ulcers which can increase the risk of HIV transmission, and Human Papilloma Virus (HPV) is associated with genital warts and cervical cancer. While genital herpes and warts should be considered when conducting a thorough sexual health check up, there is currently no simple test that can be used for testing asymptomatic people in the context of an early detection and treatment program.

Other sexually transmissible infections to be aware of include donovanosis, trichomonas and lymphogranuloma venereum (LGV). Donovanosis is not generally found in NSW, though it does occur in Aboriginal communities in northern and remote Australia. Studies from central and northern Australia indicate high rates of trichomonas among women tested. It is unclear how common it is among women living in NSW as data is limited. LGV is an uncommon STI, and not endemic in Australia. LGV usually occurs in people who have lived in countries where it is prevalent (Eisen 2005).

STI notifications

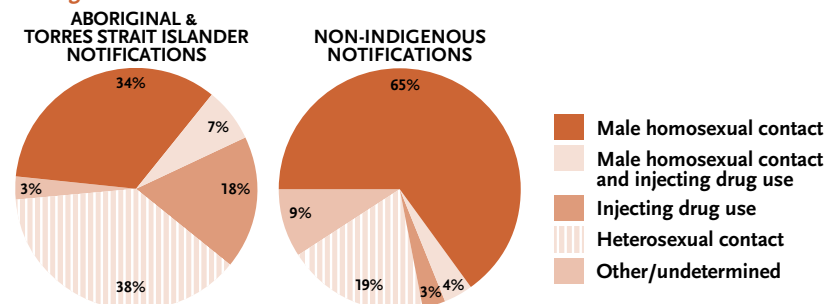
- Data on some STI notifications by Aboriginal status is poor in NSW.
- In other jurisdictions where there is adequate data;
 - substantially higher rates of diagnosis of chlamydia, gonorrhoea and syphilis were recorded among Indigenous people compared with non-Indigenous people, especially among Indigenous people living in remote areas of Australia (NCHECR 2006, p.16).
- Higher rates of STIs are attributed to a range of factors, reflecting the marginalisation and social disadvantage experienced by Aboriginal people.

The data available for hepatitis B, hepatitis C and HIV shows some important differences in notifications amongst Aboriginal Australians compared to the total population. These differences are summarised in the boxes below.

Hepatitis C and hepatitis B notifications in Australia

- Hepatitis C is one of the most commonly notifiable diseases in Australia.
- In states and territories where accurate data is collected, the rate of Aboriginal notifications for hepatitis C is twice that of non Aboriginal people (Department of Health and Ageing 2005a).
- Sharing injecting drug equipment is the major source of transmission of hepatitis C.
- Imprisonment is an independent risk factor for acquiring hepatitis C.
- Hepatitis C antibody prevalence among Indigenous participants of the Australian Needle and Syringe Program Survey increased from 61% in 2001 to 71% in 2005 (NCHECR 2006a).
- Aboriginal IDU are more likely to acquire hepatitis C at a younger age (AH&MRC and Mandala Consulting 2004).
- Hepatitis B is transmitted blood to blood, sexually and other body fluids.
- An estimated 16% of chronic hepatitis B in Australia are Aboriginal cases (Dore, Wallace, Locarnini, Desmond, Gane & Crawford 2005).
- People in custodial settings are also a risk group for hepatitis B (Dore et al 2005).
- Aboriginal people in Australia are 10 times more likely to be imprisoned than a non Aboriginal person (AMA 2006).

DIAGRAM 1. HIV diagnoses, 2001 – 2005, by HIV exposure category and Aboriginal & Torres Strait Islander status



SOURCE: State and Territory health authorities (NCHECR 2006b)

HIV/AIDS notifications among Aboriginal & Torres Strait Islander people compared to non-Indigenous people in Australia

- During the period 2001-2005:
 - A higher proportion of Aboriginal & Torres Strait Islander cases occurred among women (33% of Aboriginal & Torres Strait Islander cases vs. 11% of non Indigenous cases) (NCHECR 2006b).
 - A higher proportion of Aboriginal & Torres Strait Islander cases compared with non Indigenous cases occurred as a result of heterosexual contact (38% Aboriginal cases vs. 19% non Indigenous).
 - A higher proportion of cases occurred among injecting drug users compared with non Indigenous cases (18% Aboriginal notifications vs. 3% non Indigenous notifications) (NCHECR 2006b).
- Although the numbers are small, the rate of diagnosis of HIV per head of population among Aboriginal & Torres Strait Islander people is slightly higher than among non Indigenous people.
- The average age of diagnosis is younger (NCHECR 2005).
- The rate of AIDS incidence remains higher than the non Indigenous population which has continually declined since 1994 (NCHECR 2006b).

What influences a person's risk of acquiring STIs and BBIs?

The historical, political and social context in which a person lives can directly and indirectly influence rates of STIs and BBIs within a population. A person may be at risk because of specific behaviour, or simply because they are young and live in a community where STIs and BBIs are common and access to health services is limited. While people of any age can be affected, some groups of people are at greater risk than others as a result of a combination of risk factors (Table 1). The marginalisation and

social disadvantage experienced by Aboriginal people has resulted in poorer access to services which impacts on sexual health as it does with other health problems.

Who is at highest risk of acquiring STIs and BBIs?

Table 1 outlines who is at highest risk of acquiring STIs and BBIs and what STIs and BBIs are common among those groups. Many people will belong to more than one risk group.

Table 1. Common STIs and BBIs among high risk groups in Australia

RISK GROUP	STI & BBI
15 to 30 year olds*	Chlamydia
Anyone who has ever been in a correctional facility	Hepatitis B, hepatitis C
Sharing equipment used to inject drugs, sharing tattooing or body piercing equipment	Hepatitis B, hepatitis C, HIV
Men who have sex with men (MSM)	Gonorrhoea, chlamydia, syphilis, HIV
All the above risk groups	Genital herpes, genital warts

*Other infections including gonorrhoea, syphilis, trichomonas and hepatitis B may also be common. Check local data to determine inclusion of these within early detection and treatment programs.

There may be other groups at high risk in the community such as:

- People who misuse alcohol or other substances
- Sex workers or people who exchange sex for favours
- Homeless people
- People with mental ill health
- Heterosexuals with recent partner change.

It is important to be familiar with the priority groups in your community and which STIs and BBIs are common among them.

What are the common symptoms of STIs and BBIs?

STIs and BBIs often cause no symptoms or minor symptoms that go unrecognised. When symptoms do occur they may include the following:

- Men: discharge, pain on passing urine (dysuria), pain or swelling in the testes
- Women: vaginal discharge, lower abdominal pain, abnormal bleeding, pain with sex (dyspareunia)
- Both: any genital sores, lumps, rashes, itch or pain, rectal bleeding or discharge
- Pregnant women: vaginal discharge, bleeding or pain in early or mid pregnancy (threatened miscarriage), premature rupture of membranes, post partum pelvic infections.

- Hepatitis: abdominal discomfort, nausea, intolerance to fatty foods or alcohol, dark urine, yellowing of the skin or eyes (jaundice)
- HIV: severe flu like illness, any infection that looks unusual, is more severe or lasts longer than usual or doesn't respond to usual treatment.

What are the consequences of infection with STIs and BBIs

STIs and BBIs can have significant physical, psychological and social consequences. Having a STI or BBI can increase the risk of HIV transmission. In addition, the medical complications of untreated STIs and BBIs are outlined in Table 2 below.

Table 2. Possible medical consequences of STIs and BBIs

STIs AND BBIs	APPROXIMATE TIME OF INFECTIVITY IF UNTREATED*	POSSIBLE CONSEQUENCES OF INFECTION**
Chlamydia/Gonorrhoea	Months to years (chlamydia)/ Up to 12 months (gonorrhoea)	Men: epididymitis & infertility Women: Pelvic Inflammatory Disease (PID), ectopic pregnancy & infertility During pregnancy: miscarriage, premature rupture of membranes, premature delivery, neonatal infection, post partum infection
Trichomonas	Indefinite	During pregnancy: premature rupture of membranes
Syphilis	Sexual transmission: up to 24 months Mother to baby: up to 8 years	During pregnancy: miscarriage, intrauterine death, congenital syphilis Tertiary syphilis (rare)
Genital warts (Human Papilloma Virus)	Unknown – probably years	Cervical cancer
Genital herpes (Herpes Simplex Virus)	Lifelong	Recurring genital ulcers, neonatal infection
Chronic hepatitis B and C	Lifelong	Liver damage, cirrhosis, liver cancer
HIV	Lifelong	Immune suppression, AIDS

*Australasian Society for HIV Medicine, Australasian Contact Training Manual: Edition 2, 2002.

**NB: Having an STI or BBI increases the risk of HIV transmission.

The psychological and social impacts are difficult to measure but can be far reaching and not only affects the individual but can also impact on relationships, families and the broader community.

Chapter 2:

The Principles of Early Detection and Treatment of STIs and BBIs

KEY POINTS

- Early detection and treatment refers to the detection and management of a disease or a health problem in people who have a health problem, but who have no symptoms.
- The primary aims of an early detection and treatment program are to:
 - Prevent transmission of STIs and BBIs
 - Prevent or limit complications of STIs and BBIs developing
 - Reduce the prevalence of STIs and BBIs in the community
 - Reduce HIV transmission in the community.
- Early detection and treatment programs should be directed at people at greatest risk of STIs and BBIs to have the maximum benefit and to be cost effective.
- Early detection and treatment programs should be offered proactively to high prevalence populations who are at risk of STIs and BBIs but who have no symptoms.
- Testing among low prevalence populations should be limited to the subgroup that present with signs or symptoms or have a history suggesting risk of infection.
- Early detection and treatment of STIs and BBIs is an important component of an overall sexual health strategy.

What is early detection and treatment?

Early detection and treatment refers to the detection and management of a disease or a health problem in people who have a health problem, but who have no symptoms. People likely to be at risk of a particular health problem are offered testing (screening) proactively, so that it can be detected and treated early, before symptoms and complications develop.

Early detection and treatment programs are used for detecting a variety of different health problems. For programs to be cost effective, testing is offered at defined intervals to people most likely to have the health problem. Examples of early detection and treatment programs include:

- Mammograms every 2 years for women aged 40 years and over for early detection of breast cancer
- Blood sugar level once a year for adults for early detection of diabetes.

What are the aims of STI and BBI early detection and treatment programs?

The aims of STI and BBI early detection and treatment programs are to:

- Prevent transmission of STIs and BBIs
- Prevent or limit complications of STIs and BBIs developing
- Reduce the prevalence of STIs and BBIs in the community
- Reduce HIV transmission in the community.

In addition, early detection and treatment programs provide opportunities to give information and education, and improve access to health services for people at risk.

Who do early detection and treatment programs most benefit?

Early detection and treatment of STIs and BBIs provide most benefit to people who are at risk but who:

- Have no symptoms (asymptomatic) or minor symptoms that go unrecognised
- May not be aware that their behaviour or their partner's behaviour could be putting them at risk
- Do not want to disclose risk taking behaviour
- Have limited access to appropriate testing and treatment.

Because of reasons listed above, if only those who disclosed symptoms or a risk history were offered testing and treatment the majority of people with STIs and BBIs would remain undetected and untreated (see Diagram 2). Therefore offering early detection and treatment to those who are likely to be at risk but who may not seek health care is an important strategy for reducing the transmission of STIs and BBIs.

DIAGRAM 2: Importance of Early Detection and Treatment programs

The whole iceberg represents everyone in the community with a STI or BBI. The tip of the iceberg represents the minority of people who will usually be detected and treated for a STI or BBI.

The bottom of the iceberg (most of it) will include people who have a STI or BBI but would not usually be detected and treated.

PEOPLE WHO ARE USUALLY DETECTED

- Present with symptoms
- Aware of being at risk
- Discloses risk taking behaviour
- Practitioner recognises signs and symptoms or risk behaviour and offers appropriate tests



PEOPLE NOT USUALLY OFFERED TESTING:

- Asymptomatic or minimal symptoms
- Not aware of their own or partner's risk taking behaviour
- Do not disclose risk taking behaviour
- Limited access to appropriate services
- Access services but practitioners do not recognise risk and do not offer testing and treatment

What are the criteria for early detection and treatment programs?

The decision to carry out early detection and treatment programs is based on how well the disease or health problem fits the criteria outlined below.

The criteria for early detection and treatment programs²

- The health problem must be significant in the community being tested.
- The consequences of untreated infection should be well understood.
- There should be an early stage of the infection that can be detected.
- There should be an accurate test to detect infection at an early stage.
- The test should be acceptable to the community.
- Intervals for repeating the test should be determined.
- Treatment at an early stage should be of more benefit than at a later stage.
- The benefit of early detection and treatment should outweigh the physical and psychological risks associated with it.
- The costs associated with early detection and treatment should outweigh the costs of treating complications as a result of not detecting disease early.
- There should be adequate health service provision for the treatment and management of cases detected.

Some STIs and BBIs such as chlamydia, gonorrhoea and syphilis fit **all** of these criteria. For others that only fit **some** of the criteria, this can still be an important strategy. For example, while there is no simple treatment for infections like hepatitis C and HIV, early detection enables information and treatment to be given which reduces the chance of complications developing and limits transmission to others. In the longer term this leads to improved health outcomes for both the individual and the community.

² Adapted from *The principles and practice of screening for disease*. By Wilson J, Junger G. Geneva: World Health Organization, 1968.

World Health Organisation criteria for screening – using chlamydia as an example

- Chlamydia is a significant health problem among 15 to 30 year olds.
- Untreated, chlamydia can cause serious health problems such as PID, infertility, and poor outcomes in pregnancy.
- In the early stage of infection chlamydia can be detected from the lower genital tract before symptoms or complications have developed.
- There is an accurate test that can detect both symptomatic and asymptomatic infection (NAAT/PCR).
- Self collected specimens such as urine or self collected swabs make testing easy and acceptable.
- Most protocols currently recommend annual testing for 15 to 30 year olds and other risk groups.
- Single dose oral antibiotics are an effective and acceptable treatment that prevent or limit complications and stop transmission to others.
- The psychological and physical risks of detecting and treating infection early are far less than those associated with managing complications of untreated infections such as infertility and miscarriage.
- It is cost effective to detect and treat infection early than to treat the complications of infection.
- There is adequate health service provision available for the treatment and management of cases detected.

Who should early detection and treatment programs be directed at?

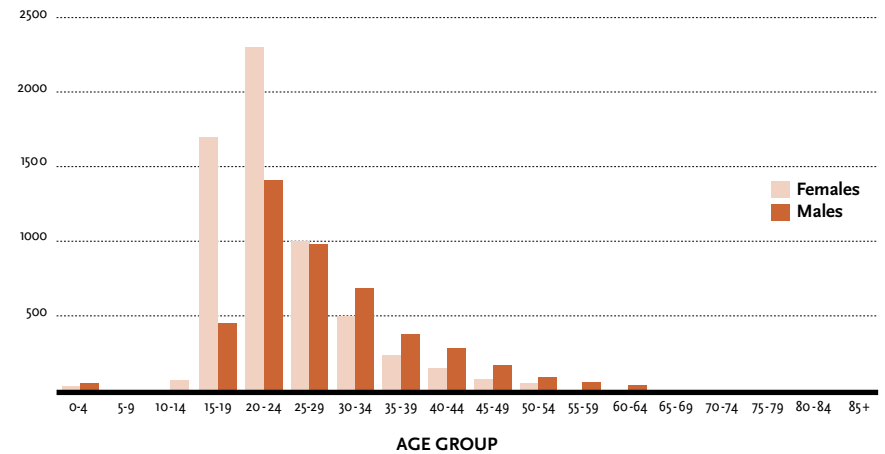
For early detection and treatment programs to be cost effective and have maximum benefit for the individual and community, programs need to be directed to those at greatest risk. Spending a lot of time and resources testing people who are unlikely to be at risk usually has limited benefits and diverts resources away from where they are needed most. However people of any age can get STIs and BBIs and it is often difficult to identify who is at risk within a community. A combination of different strategies should be used to try and identify as many people as possible who do have an infection, in the most cost effective way.

1. Strategies for early detection in communities where STIs and BBIs are common (high prevalence populations)

People at high risk of STIs and BBIs either because they belong to a specific age or risk group (high prevalence populations) should be proactively offered testing at regular intervals. This is known as asymptomatic or population based screening of **high prevalence populations**. The easiest and most cost effective way to do this

is to offer testing to all 15 to 30 year olds, as the majority of STIs and BBIs occur amongst this age group. For example, Diagram 3 shows that between July 2004 – June 2005, the most common group affected by chlamydia in NSW was 15–30 year olds. The rates are higher amongst women in this age group. This maybe due to true differences in rates, however it may also reflect the lower level of testing among men compared to women in this age group. For other STIs, like HIV and gonorrhoea, the upper age limit may be slightly different.

DIAGRAM 3: Chlamydia notifications in NSW from July 04 – June 05: a high prevalence population example.



2. Strategies for early detection in communities where STIs and BBIs are uncommon (low prevalence populations)

While people of any age can get a STI or BBI, the number of infections among the **total** population aged less than 15 and older than 30 is low. Testing **everyone** within a low prevalence population is not a cost effective strategy as a lot of people would have to be tested to detect the small numbers who have an infection.

a) Persons aged over 30 years

In some communities it may be possible to identify a subgroup of older people who are at high risk of STIs and BBIs, such as people who change partners frequently, people who do not use condoms consistently with a new sexual partner, or people who misuse alcohol or other drugs. However in many communities identifying people who may be at risk can be difficult without taking a detailed history. In general, the most effective way to access the subgroup at risk is to ensure appropriate management of people who present with specific symptoms or risk factors (See Table 1, Chapter 1).

b) Persons aged less than 15 years

Overall there is also a low prevalence of STIs and BBIs among those aged less than 15 years even though infections can occur as a result of;

- Transmission from mother to baby (0–6 months)
- Sexual abuse (any age)
- Consensual sexual activity (older teenagers)

While people under 15 may be at risk, it is inappropriate to test **all** young people in this age group to identify those with STIs and BBIs. There are several important issues that need to be considered before testing people under 15 years of age.

1. Consent to testing

There are issues regarding consent that you need to be aware of when testing and treating people for STIs and BBIs.

- Anyone aged 16 years and over is able to give consent
- 14 and 15 year olds (minors) can give consent themselves as long as they adequately understand and appreciate the nature and consequences of testing and treatment
- Testing anyone under the age of 14 requires the consent of a parent or guardian.

Further information on treating minors can be obtained from the NSW Health Department.³

2. Sexual activity amongst persons aged 14 and 15 year olds (minors)

A significant number of 14 and 15 year olds are sexually active and the rates of STIs and BBIs start to increase in this age group. This age group is a particularly vulnerable group with respect to STIs and BBIs, sexual abuse, teenage pregnancy, drug and alcohol use and mental health issues. While these issues are complex and beyond the scope of this manual, it is important that this age group has access to testing and treatment. There are, however, legal obligations that need to be taken into account when testing and treating 14 and 15 year olds. It is essential that advice from local managers is sought regarding the most appropriate way to do this.

³ See the NSW Health Policy Directive Consent to Medical Treatment – Patient Information Policy Document 2005. Available at www.health.nsw.gov.au/Policies/PD/2005/pdf/PD2005_406.pdf (pages 19 and 20)

3. Sexual abuse

Identifying and managing children at risk of sexual abuse is important and needs to be managed appropriately and sensitively. There is no single ‘screening’ test that can be used to determine whether sexual abuse has occurred or not, and the majority of children who are abused do not acquire an STI or BBI as a result. Not assessing children appropriately can lead to abuse being overlooked, as well as children not at risk being falsely identified, both of which have significant implications for the child, the family and community. Children at risk of sexual abuse need to be assessed by specialists experienced in assessing historical, behavioural and clinical findings and interpreting test results in the context of overall findings. Sexual abuse is a serious problem, and if there are concerns about children at risk, the appropriate staff and services need to be involved in assessing and managing children.⁴

4. Accuracy of test results in low prevalence populations

Some tests, particularly Nucleic Acid Amplification Test (NAAT)/Polymerase Chain Reaction (PCR) are less accurate when used in populations where an infection is uncommon. This means that if everyone in a low prevalence population is tested (population screening) some people would test positive to the test even though they don’t actually have the infection (false positive test result). A false positive test result can have significant implications, particularly for young people and their families. Despite this, NAAT/PCR tests may still be appropriate and will be more accurate if testing is limited to the **subgroup** within the low prevalence population and those who are high risk or present with symptoms of infection.

How do early detection and treatment programs fit into a sexual health program or strategy?

Early detection and treatment programs are an important component of sexual health strategies (see Diagram 4). The *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008* (Department of Health & Ageing 2005a), the *NSW Health STI Strategy 2006–2009* and the *National Sexually Transmissible Infections Strategy 2005-2008* (Department of Health & Ageing 2005b) highlight the importance of early detection and treatment programs in addressing STIs and BBIs in Aboriginal communities.

⁴ Legal obligation needs to be set as per “the Interagency Guidelines for Child Protection interventions”. Go to NSW Health website: www.health.nsw.gov.au/policy/hsp/publications/2000interagencyguidelines.pdf

DIAGRAM 4:
Core components of a Sexual Health Strategy applicable to Aboriginal communities.⁵



⁵ Adapted from Nganampa Health Council *8 Ways to beat HIV*.

Chapter 3: Improving Access to STI and BBI Early Detection and Treatment Services

KEY POINTS

- Accessing groups at risk of STIs or BBIs may include a range of strategies such as enhancing partnerships, supporting staff to work collaboratively and ensuring existing services are included in program development and delivery.
- Access to services is essential for successful STI and BBI early detection and treatment programs and can be improved by ensuring:
 - People at risk have access to information, testing and treatment delivered through existing services and outreach programs
 - Services are appropriate and acceptable to the community
 - Partnerships are strengthened or developed between service providers.

Service delivery

Early detection and treatment of STIs and BBIs can be delivered through existing services without requiring a lot of additional resources. People at risk of STIs and BBIs *do attend* a variety of health services for other related or unrelated health problems (see Table 3), so it is important to make sure that they are offered testing and treatment in an appropriate way when they present to a health service. To do this, health services and staff need to be imaginative and flexible to make sure services are accessible and to increase the opportunities to offer early detection and treatment to those at risk.

Making services accessible

Access is not just about people attending health services, but about health services providing appropriate services and management to their clients in a way that is acceptable to them.

For adequate access, health services should:

- Provide a variety of services
- Be non judgemental, private and confidential
- Be physically accessible to the community
- Be acceptable to the community
- Provide appropriate management: information, education, testing and treatment
- Provide outreach services for clients who are marginalised or who have difficulty accessing services.

Having a choice of services which are appropriate and acceptable to **all** members of the community is not always possible, particularly in areas where services are limited. Therefore, it is important to identify barriers to access that are specific to the region, community or risk group, and work in partnership with existing services to reduce them. Barriers could be relevant for the whole community or specific for particular risk groups.

What services do people at risk of STIs and BBIs access?

The reasons why people access different health services is varied but will be influenced by what services are available in the region, whether there are services that specifically cater to their needs, the cost of the service, as well as personal preference.

TABLE 3: Examples of health services that Aboriginal people at risk of STIs and BBIs may already access

PRIMARY HEALTH SERVICES	SPECIALISED HEALTH SERVICES	PUBLIC HOSPITALS
Aboriginal Community Controlled Health Services Community Health Services Private General Practices	Sexual Health Services Family Planning Clinics Justice Health Services Antenatal Clinics Mental Health Services Drug and Alcohol Services Adolescent Health Services	Emergency Departments Obstetrics and Gynaecology Departments

Primary Health Care Services such as Aboriginal Community Controlled Health Services

In contrast, Primary Health Care Services deliver health care to all ages presenting with a wide range of health problems. While sexual health services are usually offered, it may be a small component of overall service delivery even though the service may be accessed by a significant number of people at risk of STIs and BBIs.

Most people with STIs and BBIs have no symptoms and may not know they are at risk, so while they may access primary health services, only a small percentage will do so specifically for sexual health issues. In this context it can be confronting and difficult for both clients and practitioners to discuss sexual health issues. The challenge for health services is therefore how to improve access to information, testing and treatment of STIs and BBIs for people who are at risk and are accessing the service, but for other reasons.

Opportunities exist for health services in initiatives such as the Adult Health Check to incorporate sexual health tests as part of a holistic check up making it more acceptable to clients and practitioners.⁶

⁶ Information regarding the Aboriginal and Torres Strait Islander Adult Health Checks is available from the Commonwealth Government Department of Health and Ageing.

Specialised Sexual Health Services

The majority of people who attend Sexual Health Services do so because they:

- Have symptoms that they think could be due to a STI or BBI
- Have no symptoms but identify that their behaviour could have put them at risk of getting a STI or BBI
- Identify with a particular community or risk group that the service specifically caters for
- Already have a STI or BBI such as HIV or hepatitis C for which they are receiving ongoing management
- Do not wish to attend their usual health service for sexual health issues.

When people go to a sexual health service they have usually recognised that they may be at risk and are seen by practitioners experienced in managing STIs and BBIs. In this context it is usually straightforward to discuss issues regarding STIs and BBIs.

Improving access to existing services

There are many ways to improve access to services for at risk groups. Strategies should focus on improving access for young and marginalised groups.

In order to improve access it is important to recognise what is currently occurring in the community with the intention of identifying any gaps in service provision.

Consult with the community and consider issues relevant to your area with regard to:

- What health services do people at risk already access?
- Do they access these health services specifically for STI and BBI related issues or for other related or unrelated problems?
- If they access services for other reasons, how can you make sure that they are offered appropriate testing and treatment for STIs and BBIs?
- Do you need to make your service more 'user friendly' to those at risk?
- Do you need to deliver services outside the health service to access those at risk (outreach)?

It may not be possible to address all barriers but consultation and being responsive to the needs of the community should address some of these. Some of the things that need to be considered are outlined below.

1. Infrastructure of the health service

- The location of the service
- The distance between the health service and the community
- Whether transport to the health service is available
- Private areas and appropriate points of access for men and women
- Operating hours that are appropriate for the community
- Providing clinics for specific risk groups such as men's health, women's health or youth clinics
- Providing outreach to communities that are difficult to access.

2. Workforce

- Ensure privacy and confidentiality protocols are abided by
- Culturally sensitive service delivery
- Non judgmental and non discriminatory attitudes and behaviour
- Having an appropriate mix of staff including male, female and Aboriginal practitioners
- Supporting staff to attend training to ensure a skilled workforce who can deliver STI and BBI programs
- Supporting staff to work collaboratively within the service and in partnership with other services to maximise the use of different skills and expertise.

3. Management

- Integrate early detection and treatment of STIs and BBIs into routine primary health care delivery
- Use tests that are accurate and acceptable to the community such as self collected specimens
- Ensure appropriate management, contact tracing and follow up of those identified with STIs and BBIs
- Use single dose antibiotic treatment when appropriate to ensure adherence to medication and effective cure rates.

Partnerships

Improving access to STI and BBI early detection and treatment programs can be influenced by partnerships between different services enabling expertise and knowledge to be shared.

Partnerships are particularly effective when they are between services that have access to youth or high risk groups with services that have the staff with the clinical and cultural skills needed to deliver sexual health programs.

Collaboration between these services can utilise the different skills of staff and resources from different organisations and increase access to programs. Aboriginal Sexual Health Workers can play a vital role in providing the expertise to deliver programs in collaboration with services such as corrections facilities that have easy access to people at risk of STIs and BBIs.

Where partnerships don't exist they should be considered to improve access. The development of a memorandum of understanding (MOU) to outline roles and responsibilities of health services may be useful and can provide reassurance to the Community regarding the use of and confidentiality of data. The formation of steering committees can also be useful to give guidance and support to programs and ensure representation and involvement of key stakeholders.

Chapter 4: **Deciding what tests to take and how to take them**

KEY POINTS

- There are two types of STI and BBI check ups; simple and comprehensive.
- Simple checks:
 - involve the use of quick and easy tests
 - can be offered by a range of practitioners
 - can be offered in almost all settings
 - are best offered to high risk population groups.
- Comprehensive STI and BBI check ups:
 - should be offered to people of any age who present with signs or symptoms
 - should be offered by practitioners accredited to take a thorough history and examination.

Simple and Comprehensive check ups

When delivering early detection and treatment programs there are two ways of testing that will ensure that the delivery of the program is effective in achieving its objectives. Both simple and comprehensive STI and BBI checks can be integrated into primary health care delivery. Whether a simple or comprehensive check up will be conducted will be determined by; the risk groups and what STI and BBI should be tested for, how much time is available, the capacity of staff and resources available for the delivery of the program.

Simple STI and BBI checks

A simple STI and BBI check up is an acceptable way using quick and easy tests. A simple STI and BBI check up is a modified version of a comprehensive check up which usually involves taking self collected specimens such as first void urine and if possible blood tests. While a simple check up does not replace a comprehensive check up, it may be the most appropriate and cost effective check up to offer in many circumstances, particularly among groups who are difficult to access and where time and availability of skilled practitioners is limited. e.g. outreach.

Advantages of simple STI and BBI checks:

- Self collected specimens can be used (urine or swabs) making testing quick, easy and more acceptable to the community
- Can be offered by a wide range of practitioners working in a variety of health care settings
- Can be incorporated into primary health care delivery to defined age or risk groups when they present to health services without symptoms.
- Are practical when delivering outreach or community based programs
- Increases access for at risk groups to testing and treatment.

A simple STI and BBI check can include:

- A simplified risk assessment: a few direct questions are asked about the presence of symptoms and specific risk behaviour
- First void urine or self collected swab (women) for gonorrhoea and chlamydia PCR
- Blood for one or more of the following: syphilis, hepatitis B, hepatitis C, HIV.

What tests are taken will depend on what STI and BBI are common in the region, the specific risk group, risk assessment and the local laboratory. Check with local protocols what tests are recommended.

Comprehensive STI and BBI checks

A comprehensive STI and BBI check up involves taking a thorough sexual and social history, an examination and tests. They should be offered to people of any age who present with any signs and symptoms of an STI or BBI or have identified risk factors. While comprehensive STI and BBI check ups are the ideal, to offer them there needs to be:

- Adequate time
- Practitioners who are appropriately accredited and skilled to take a history and examination
- Clients consenting to an examination.

Comprehensive STI and BBI checks should be offered to **anyone of any age** presenting to **any health service** when they:

- Present with any genitourinary symptoms (see Chapter 1, Table 2)
- Had a STI or BBI detected on an asymptomatic screening test
- Are a sexual contact of someone with a STI or BBI
- Disclose a risk history, or are concerned that their partner's behaviour is putting them at risk
- Request a check up
- Report sexual assault

Comprehensive STI and BBI check ups involve*:

1. Taking a **thorough social and sexual history**
2. **Examination:** speculum and bimanual examination for women
3. **Tests (as described in more detail in Table 5, pg 40):**
 - First void urine (men) or endocervical swab (women) for gonorrhoea and chlamydia
 - High vaginal swab (for women) for trichomonas**
 - Throat and/or rectal swabs for gonorrhoea and chlamydia if sexual history suggests exposure
 - Blood for syphilis, HIV, hepatitis B and C
 - Swab for herpes PCR if sores are present.

* What tests are taken will depend on what STIs and BBIs are common in the region, the specific risk group, risk assessment and the local laboratory. Check with local protocols on what tests are recommended.

** A high vaginal swab for MCS is useful to check for candida, bacterial vaginosis and trichomonas. A high vaginal swab for PCR should only be taken if trichomonas is common in the community being tested.

Irrespective of whether you are offering simple or comprehensive tests, the principles and practices of testing should be followed including:

- Privacy and confidentiality are ensured
- Pre-test information and consent is given
- Testing is conducted in a safe and secure environment
- There is appropriate follow up of both positive and negative test results
- Follow up of any other issues that occur as a result of testing.

See chapter 6 and 7 for further information pertaining to these issues.

What is a risk assessment?

In an ideal situation when offering a sexual health check up, a thorough sexual and social history should be taken by a skilled practitioner in order to guide what examination and tests need to be taken. However it may not always be possible due to limited time and resources. In addition, practitioners with the appropriate skills or accreditation to take a thorough history and examination may not be available. A simplified risk assessment is a method for generalist health workers to identify whether a person has symptoms or risk factors for specific STIs or BBIs which may require further tests or an examination.

Talking with an Aboriginal Health Worker prior to conducting a risk assessment will help address the use of appropriate language and other sensitivities in asking the following questions within a simplified risk assessment.

A simplified risk assessment:

Both men and women:

- Do you have any sores or rashes on the genitals?
- Have you had a new partner in the last 6 months?
- When was the last time you had sex without a condom?
(You could add: Was this with your regular or casual partner?)
- Have you ever injected drugs?
- Have you ever shared any equipment used for tattooing or body piercing?

Men:

- Do you have any pain on passing urine or pain in the testes?
- Do you have any discharge from the anus or penis?

Women:

- Do you have any discharge from the vagina?
- Do you have any pelvic or low abdominal pain or any pain with sex?
- Have you had any bleeding in between menstrual periods?

How often should early detection and treatment of STIs and BBIs be offered?

Frequency of testing will depend on the particular risk group, the STI or BBI being tested for and availability of funding. Check with local protocols but in general most protocols recommend a STI and BBI check:

- Once a year for 15 to 30 year olds
- Once a year for men who have sex with men
- More frequently for anyone who frequently changes partners or presents with symptoms
- At first visit for all ante-nates and in 3rd trimester for those at higher risk.

The *National guide to a preventative health assessment in Aboriginal and Torres Strait Islander peoples* recommends annual sexual and reproductive health counselling for all adults and testing for chlamydia, gonorrhoea and syphilis every one to two years in areas where rates are high (National Aboriginal Community Controlled Health Organisation 2005).

The Aboriginal and Torres Strait Islander Adult Health Check is an initiative that provides funding for a holistic adult health check for 15 to 54 year olds every two years. This adult check recommends incorporating an assessment for STI risk. (Department of Health and Ageing undated).

These guidelines recommend that the age groups, the tests and frequency of testing will be influenced by local data.

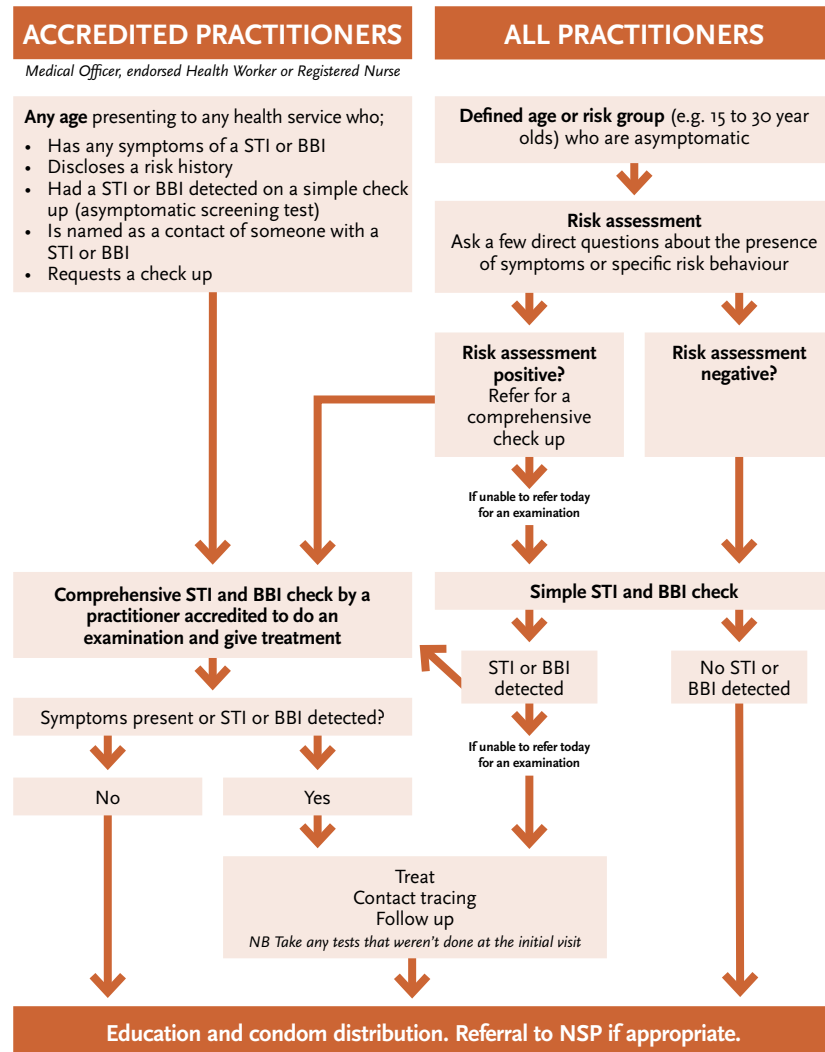
Choosing what type of STI and BBI check to do

Use the flow chart (Diagram 5) as a guide to what type of check up should be offered.

DIAGRAM 5: Choosing Simple or Comprehensive Checkups

Working through the flow chart will determine:

1. What tests will be taken
2. Whether a simple or comprehensive STI and BBI check will be offered.



Specimen collection for STIs and BBIs

There are a number of different approaches to testing and different tests that can be taken as part of a STI and BBI early detection program. Some of the issues that need to be considered include;

- Who is the risk group that the program is directed at?
- What STIs and BBIs are common in the risk group?

Tables 4 and 5 should be used together as a guide to what STIs and BBIs are common among different risk groups and what specimens can be taken for testing. The prevalence of some STIs and BBIs, such as gonorrhoea may vary among different risk groups and in different geographic areas. When deciding what to test for and which specimens to take, check local protocols.

TABLE 4: Common STIs and BBIs among different risk groups

RISK GROUP	STI & BBI
15 to 30 year olds*	Chlamydia
Anyone who has ever been in a correctional facility	Hepatitis B, hepatitis C
Sharing equipment used for injecting drugs, sharing tattooing or body piercing equipment.	Hepatitis B, hepatitis C, HIV
Men who have sex with men (MSM)	Gonorrhoea, chlamydia, syphilis, HIV

*Other infections like gonorrhoea, syphilis, trichomonas and hepatitis B may also be common. Check local data to determine inclusion of these within early detection and treatment programs.

TABLE 5: What specimens can be taken for the detection of STIs and BBIs

STI OR BBI	IDEAL SPECIMEN	
	WOMEN	MEN
Chlamydia, Gonorrhoea (asymptomatic)	First void urine OR self collected swab for NAAT/PCR	First void urine for NAAT/PCR
Chlamydia, Gonorrhoea (symptoms present)	Endocervical swab for microscopy, culture and antibiotic sensitivities (MCS) AND Endocervical swab for PCR	External urethral swab for MCS AND First void urine for PCR
Chlamydia, Gonorrhoea (if MSM or history suggests exposure)	**	Throat swab for MCS Rectal swab for MCS. Swab for chlamydia PCR*
Trichomonas (if prevalent in the region or community)	High vaginal swab (HVS) for MCS#	Not routinely tested for
Syphilis Hepatitis B Hepatitis C HIV	Blood	

* NAAT/PCR may be appropriate however these tests have not yet been validated for use on throat or rectal swabs and results should be interpreted with caution
 # PCR testing for trichomonas is available through some laboratories, however it should only be taken if trichomonas is common in the region or community and the health service has funding for PCR testing. Check local protocols.
 ** Throat and rectal swabs are not routinely taken for asymptomatic women. If it is appropriate to take swabs (e.g. women presenting with rectal symptoms) follow the same guidelines recommended for taking throat and rectal swabs for men.

Chapter 5: Models of STI and BBI Early Detection and Treatment Programs

KEY POINTS

- Early detection and treatment programs should be delivered using a combination of different strategies
- Programs can be delivered in partnership between health services to maximise the use of skills and resources

The three main ways of delivering early detection and treatment programs are:

- 1. Integrating programs into existing health service delivery**
 - 2. Reorientating existing health service delivery to access at risk groups**
 - 3. Delivering outreach or community based programs.**
- The easiest and most cost effective strategy is to integrate testing for STIs and BBIs into routine primary health care delivery to 15 to 30 year olds and others at risk.
 - Outreach and community based programs should be directed at priority groups who have limited access to existing services.
 - Holistic program delivery is the ideal but may not be feasible due to resource and logistical limitations. This should not, however, deter STI and BBI early detection and treatment program delivery.

How can STI and BBI early detection and treatment programs be delivered?

A combination of strategies should be used to optimise delivery of early detection and treatment programs. Before deciding which strategies to utilise, consider what is already being delivered and think about:

- How existing programs can be strengthened
- What gaps, if any, exist and how these can be addressed
- Which program will be most acceptable to the community and can be delivered in the most cost effective and sustainable way.

The three models of delivering early detection and treatment programs are to:

- 1. Integrate STI and BBI early detection and treatment programs into existing health service delivery**
- 2. Reorientate existing health service delivery**
- 3. Conduct outreach or community based programs.**

While either a simple or comprehensive check up (see Chapter 4) could be delivered in all of these models, the model will be influenced by the time and resources available and the capacity of health staff delivering the program. This chapter will focus on how a simple check up for asymptomatic people can be delivered using the different models. However, remember that when someone presents with symptoms or discloses specific risk taking behaviour, they should be offered a comprehensive check up if possible.

1. Integrating STI and BBI early detection and treatment programs into existing primary health care delivery

The easiest and most effective strategy for implementing early detection and treatment is to offer simple testing routinely to all people aged 15 to 30 and other identified risk groups.

Integrating programs into existing primary health care delivery: some issues to consider

- Programs may be easily incorporated into routine service delivery.
- Integrating programs requires less time, resources and costs to implement than outreach programs.
- Integrating programs increases access to testing and treatment for people at risk.
- Information and education can be given to people at risk who may not otherwise have sought out that information.
- Normalises and destigmatises testing and treatment.
- Gives generalist staff an opportunity to become more skilled in the management of STIs and BBIs.
- Can be offered by more staff, in many circumstances on a continual basis, making it more sustainable in the long term.
- Needs to be directed at the right age or risk groups to be cost effective.
- May not reach high risk groups who do not access the service.
- Can be confronting for both clients and practitioners and needs to be offered in an appropriate and sensitive way.

EXAMPLES OF INTEGRATING AN STI/BBI CHECK INTO EXISTING HEALTH SERVICE DELIVERY

An annual STI and BBI check could be offered when 15 to 30 year olds present for:

- Aboriginal and Torres Strait Islander Adult Health Check or other annual adult or well person's health check
- Reproductive health issues
- Pap smears – for women who are 18 years or older, or who have been sexually active for more than 2 years, whichever is later
- For people who present with unrelated health issues (opportunistic testing)
- Antenatal checks
- Contraception
- Emergency contraception
- Referral for termination of pregnancy
- Vaccinations for hepatitis B, hepatitis A.

Offering testing

Offering testing can be confronting for both clients and practitioners if it is not done in the right way. While recognising that there are barriers to offering testing, most of these can be overcome by some forward planning taking into account the following;

- Use a sensitive approach
- Normalise testing for the defined age or risk groups
- Inform clients why testing is being offered
- Give information about the benefits of testing and treatment

Giving information and offering testing can be made simpler by providing clients with written information and for practitioners to use standard checklists. Remember that people always have the right to refuse testing, but are more likely to consent to testing if they understand why it is being offered.

2. Reorientating existing health service delivery to increase access for risk groups

This model involves tailoring programs for groups who may have difficulty accessing services. The programs are delivered within existing health service infrastructure. Providing clinics in this way does not usually require extra resources but will involve some reorganisation within the health service, such as ensuring the clinic hours and staff are accessible and acceptable to the community or risk group. Many existing services already offer specialised clinics on certain days, for example men's health clinics, antenatal clinics and women's health days. Alternatively, specific clinics may be developed with partner organisations to improve access to at risk groups.

Some examples of specific clinics to improve access for at risk groups:

- Women's health clinic
- Antenatal clinics
- Men's health clinic
- Youth clinics.
- Methadone clinics
- Partnerships with Justice Health

Working with local community based organisations such as youth groups/ organisations, employment programs such as Community Development Employment Program (CDEP) or sporting groups will facilitate enhanced access to these clinics.

3. Outreach and community based programs

Outreach and community based programs are delivered outside existing health services and specifically target people who have limited access to health services. Outreach programs can be an ideal way of reaching high risk groups but involve comprehensive community consultation and require considerable planning, time and resources to implement. They should be considered where local data indicate a need but should not be at the expense of good primary health care. Successful outreach programs rely on collaboration and partnerships between different practitioners and services, so as to maximise the use of skills and expertise and maximise access to high risk groups who may attend a variety of different services.

Outreach and community based programs: some issues to consider

- Increases access to at risk groups who have limited access to health services.
- Can be adapted to suit community needs.
- Provides anonymity and reduces the stigma of having a STI and BBI check up.
- Strengthens links between the community and health services leading to improved access and education.
- Requires good planning, adequate time, human and financial resources.
- Many people can be tested and treated within a short time frame.
- May be difficult to sustain in the long term.
- Should not be delivered at the expense of good primary health care delivery.

Programs can be delivered directly within the community or through community based organisations including:

- Youth centres
- Sport and recreation centres
- Community centres
- TAFE colleges/CDEP
- Women's refuges
- Drug and alcohol or rehabilitation services
- Sex on premises venues
- Programs delivered through Justice Health clinics in correctional settings.

Linking early detection and treatment of STIs and BBIs to other programs

However you decide to deliver STIs and BBIs early detection and treatment programs, implementation will be enhanced by taking a whole of health approach.

Linking early detection and treatment of STIs and BBIs to some programs will be straightforward. When taking pap smears or offering annual adult health checks for young adults it is usually easy and appropriate to offer simple test for STIs and BBIs. If it is not possible to deliver other programs that the community requests, take the opportunity to improve links between the community and other programs or health services.

Delivering holistic programs may not always be possible due to limited time and resources. Holistic outreach programs that incorporate STI and BBI checks will involve a multidisciplinary team, with extensive follow up for all general health conditions.

Don't set unrealistic goals or promises; be up front with the community about what can be offered and why. Explain why delivering other things may not be practical or achievable. It may be useful to run a small but manageable pilot program initially before embarking on a larger program.

Before linking early detection of STIs and BBIs to other programs, think about:

- Who the program is aimed at and what other health interventions are appropriate for that age or risk group?
- What tests are being taken and how easy is it to add on and follow up other tests?
- Can other programs or interventions be added on within the available time frame and resources?
- What follow up will be required for the early detection of other health problems and what other staff and services will need to be involved?
- Which health service is funding and delivering the program?

Chapter 6: Requirements For STI and BBI Early Detection and Treatment Programs

KEY POINTS

Planning an early detection and treatment program involves the following:

- Community consultation and engagement
- Partnerships
- Ensuring adequate time, human and financial resources
- Health promotion and education
- Workplace safety and infection control
- Collection and use of data
- Sustainability

Community consultation and ownership

Before planning and delivering programs it is essential that the community is consulted and involved. How you go about engaging the community, will to some extent, depend on whether the program will be delivered by an ACCHS or other health service and whether the program will be delivered within existing services or as a community based outreach program.

If delivering programs within an ACCHS, discussions with the Chief Executive Officer (CEO) of the service will need to occur to ensure adequate procedures and community protocols are followed.

If delivering from other services, completion of an **Aboriginal Health Impact Statement** will ensure that:

- protocols are followed and that
- appropriate Aboriginal consultation processes have taken place, and that
- the health needs and interests of Aboriginal people have been properly considered in the proposed program.

Further information regarding the Aboriginal Health Impact Statement can be obtained from NSW Health.⁷

Community ownership and engagement

Community ownership and support is essential for participation and success of programs, therefore engaging the community from the outset ensures communication is open and transparent. Listen to the concerns of the community and adapt programs as much as possible to suit their needs, but don't set unrealistic goals or promises. Even if it is not possible to deliver other programs, there could be opportunities to improve links between the community and other programs or health services. Similarly, informing the community of the intentions of the program, expected outcomes and the desired input from the community is essential to making any program successful.

⁷ For further information, or a copy of the report NSW Health Aboriginal Health Impact Statement & Guidelines: Incorporating Aboriginal Health Needs and Interests in Health Policies & Programs, go to the: NSW Health website: www.health.nsw.gov.au/pubs/a/pdf/ab_impact

Partnerships

Partnerships and networks which exist in many regions can be effective by utilising a combination of staff, skills and resources to deliver programs. Partnerships are particularly effective when they are between services that have access to youth or high risk groups and services that have the staff with the clinical and cultural skills needed to deliver sexual health programs.

Examples of health and community based services that could be or are working in partnerships to deliver early detection and treatment programs.

Health services:

- Aboriginal Community Controlled Health Services
- Aboriginal Community Controlled Health Related Services
- Sexual Health Services
- Community Health Services
- Justice Health Services
- General Practices
- Public hospitals e.g. antenatal clinic
- Substance misuse services.

Non government organisations such as:

- Family Planning NSW
- ACON Sydney and regional offices
- Hepatitis C Council of NSW
- NSW Users AIDS Association (NUAA)
- Australasian Society for HIV Medicine (ASHM)
- NGO's providing education/health promotion.

Community based organisations:

- Youth centres
- Gay and lesbian organisations.

Networks:

- NSW Aboriginal Sexual Health Workers Network
- NSW Aboriginal Drug and Alcohol Network
- Australasian Sexual Health Nurses Association.

Resources

The amount of time and human and financial resources needed to deliver programs should never be underestimated. Always be mindful of what resources are available and how they can be utilised effectively. Start with a program that is manageable and build on it over time.

Key resources for program delivery

- How much time will it take to organise and deliver the program?
- Human resources
 - How many people are needed to deliver the program?
 - What mix of skills is required?
 - Which staff members are able to participate?
- Financial resources
 - Can the program be delivered within existing resources?
 - What additional resources are needed?
 - Are resources needed for staff travel or accommodation?
 - Will the health service be able to cover the cost of equipment and medications?
 - Is additional funding available from government or non government organisations?

Workforce

Successful programs rely on having a skilled, knowledgeable, respected and committed workforce who can work as a team. The workforce will need a mix of skills and experience including:

- Key people who can liaise between program staff and the community to support and drive the program
- Educators to provide education and health promotion on STIs and BBIs
- Clinicians to provide clinical services: pre test counselling, specimen collection, venipuncture, dispensing medications and carrying out examinations at follow up
- Administrative staff to provide support.

Always utilise staff with the skills and experience most appropriate for the community. At the same time staff should be encouraged and supported to undertake training to increase knowledge and skills in areas that will enhance their ability to deliver programs in areas such as clinical skills, education, counselling and cultural awareness.

Before providing clinical services, Aboriginal Health Workers must attain core competencies, and should be encouraged and supported to do so. However not having attained all core competencies should not prevent program delivery, it just means ensuring that staff who do have the appropriate accreditation are involved to deliver that component of the program. Aboriginal Health Workers who do not have clinical skills are still vital to providing support to clinicians by being able to liaise with communities, providing education, contact tracing and ensuring programs are delivered in a way that is appropriate and acceptable to the community.

Workplace health and safety

Never compromise on safety when delivering programs. There should be adequate space and facilities to enable standard precautions including safe disposal of sharps and infectious waste, as well as personal safety and security. Be familiar with what steps to take and who to notify in the event of a breach of infection control such as needle stick injuries. Workplace health and safety should be in accordance with NSW Health and local health service policy and guidelines.

Health Promotion and Education

Health promotion and education are important components of early detection and treatment programs. These can be provided at different times – prior to, at the time of delivering a program, or as part of a follow up with the community or individual. The overall aims of sexual health promotion are to:

- Minimise the transmission and complications of STIs and BBIs
- Maximise the capacity of individuals and communities to maintain and enhance sexual health
- Maximise mental and physical well-being associated with sexuality, sexual function and relationship issues.

(NSW Department of Health 2002)

Developing resources takes considerable time and money, so utilise resources that are already available through different organisations. Use resources to enhance participation in the program and keep participants interested and occupied on the day. Keep in mind that anything additional should enhance participation not detract attention away from it, and needs to be done within the constraints of available human and financial resources.

Work in partnership with other organisations, particularly those who already have links with the community. Focus on prevention, promotion and early intervention and make sure that information is delivered in a culturally appropriate way. Also consider who the program is being delivered to and whether information specific to that group will need to be given, taking into account their:

- Age
- Specific risk behaviours
- Baseline knowledge
- Level of literacy.

Identify who will give the information and how it will be given to participants. Depending on the community and number of participants, information could be given to them as a group before the day of testing. While participants will still need to give consent on the day of testing, they will be much better informed if information has been given beforehand.

Always give accurate information and present it in a positive way. Don't use scare tactics as that approach usually frightens people away from accessing testing and treatment, reinforces negative attitudes and increases shame and stigma for the individual. Focus on positive messages around prevention, early detection and management in a culturally appropriate manner including information regarding:

- The asymptomatic nature of STIs and BBIs
- Symptoms of STIs and BBIs
- Complications of untreated infections
- Transmission and prevention of STIs and BBIs
- Promote early presentation for testing if the person has been at risk or is symptomatic
- Testing and treatment of STIs and BBIs
- Where to access condoms and needle and syringe programs
- What services are available and how to access them.

Collection and use of data

Health information that is accurate, reliable and meaningful is an important resource that should be used for planning and delivering health services, and which should ultimately lead to improved health for Aboriginal people. While data can provide important information, its collection and use must be in accordance with NSW Aboriginal Health Information Guidelines, the AH&MRC Ethics Committee Guidelines, NSW Health Policy and consistent with Commonwealth legislation. These policies outline protocols regarding the collection, ownership, storage, security, access, release and use of data including:

- Maintaining the confidentiality and privacy of individuals and communities
- Mandatory reporting of information such as notifiable diseases, according to NSW and Commonwealth government legislation
- How and for how long data should be stored for
- Who has access to data.

Where the collection and use of health information specifically relates to Aboriginal Communities, consent to use of information must also be obtained from Aboriginal Communities or Community Controlled Health Services and or Ethics Committees. Such consent should be documented and complied with.

Sustainability

Whether a program will be sustainable may be difficult to predict from the outset and may depend on several factors including the evaluation of the program or the availability of ongoing funding. While it may not be possible to ensure that a program will be sustainable in the future, throughout the planning and delivery of the program it is important to think about how it can be done in a way that can be maintained (see Chapter 9 for more detail on program sustainability).

Chapter 7:

Planning the Delivery of STI and BBI Early Detection Programs

KEY POINTS

Before delivering the program, plan the specific details including:

- When and where will the program be held?
- How will the community be informed?
- What tests will be taken?
- Decide whether a risk assessment will be done at the time of testing
- What equipment and medications will be needed?

The following chapter outlines in detail the requirements for delivering an outreach or community based program some of which will also be relevant for delivering programs within existing services.

Identify the community

Identify the community members who will be invited to participate. Keep in mind the priority of the community as well as the capacity of the community to be involved in the program.

- Define who the program will be directed at e.g.
 - *All 15 to 30 year olds living in a town*
 - *Anyone aged 15 and older attending a youth centre*
 - *The local football team*
 - *People in correctional facilities*
- What is the size of the community and is it manageable?
- Does the community already have links to the health service, or will links have to be made?
- How will the community access the program?

Identify key services and people who can liaise with the community and health staff in order to deliver the program, and encourage participation. Make sure that everyone understands their roles and responsibilities in ensuring a successful project, and are acknowledged accordingly. Key services and people could be:

- Aboriginal Community Controlled Health services
- Community leaders such as Elders or council members
- People who can liaise between the communities and program staff (e.g. Aboriginal Health Workers, Community Development Employment Program (CDEP) project officers, youth workers, sport and recreation officers).

Communicate with the community verbally and in writing, to outline the population who will be offered an early detection and treatment program, what tests will be offered, which health services and staff will be involved and the roles and responsibilities of both health and community staff.

Where will the program be held?

When deciding on the location for delivering the program, take into account:

- The estimated number of participants
- The number of staff involved
- Whether an established clinic will be used

- If a temporary clinic is set up, is there enough space and appropriate facilities available?
- If both men and women are participating will separate areas be needed or could the same space be used on different days?
- Whether the location is acceptable to the participants
- Ease of access to the location for participants, and whether transport will need to be arranged
- Will the location enable occupational health and safety for the staff and participants?
- Consideration for disabled access/facilities.

Visit the site where the program will be delivered to ensure there is adequate space and facilities for both initial testing and follow up of people with positive results. Rooms or spaces will be needed for the following:

- An area for reception and displaying resources, a room for giving education and information to participants and for carrying out simple health checks (such as weight, height and blood pressure)
- A 'clinic' room for carrying out follow up and/or examinations which must be private with a lockable door, blinds or curtains on any windows, and a sink and running water
- Areas or rooms for taking blood must be in a space where occupational health and safety can be assured. If there is more than one staff member taking blood they should each have their own space and sharps containers
- Toilets that are located close to the clinic room, which men and women can access separately and discretely
- An area for storage of specimens with a fridge or eskies.

Once the site has been identified, think about how things will flow on the day. How will people access the site, will they attend on their own accord, or will transport have to be arranged? How will you ensure that there is a steady flow of participants so that people don't all arrive together and don't have to wait around for a long time.

When will the program be held?

The amount of time needed will depend on what the program will involve, the number of participants and availability of resources. It is better to anticipate more rather than less time. It may require delivering the program over more than one day, particularly if both men and women are participating.

Organise the dates for delivering the program and for follow up. Ensure that there are no other clashes with cultural or significant events within the community. Follow

up should be conducted as soon as possible after testing, taking into account how long it will take pathology results to be returned. Check with the laboratory how long it will take to get results and ways to streamline this process. If there are a large number of people being tested it may take the laboratory longer than usual to process specimens.

Informing the participants

Inform the potential participants about the program and when and where it will be held. How this is advertised will depend on the community and how they access information. A variety of methods could be used including:

- Posters in accessible places (clinic, local store, youth centre, toilets)
- Local radio
- Newsletters
- Invitation letters sent to community members.

Organise a visit to the community prior to the day of testing to provide information to community members regarding the program. Provide information regarding the following:

- Explain the benefits of early detection and treatment for both individuals and the community
- Who will be invited to participate
- How will consent be obtained
- Which STIs and BBIs will be tested for and what specimens will be taken
- Explain if any other tests will be done
- What will happen to the test results and how confidentiality will be maintained
- When and how results will be given
- Treatment, follow up, contact tracing
- Collection and use of data.

What tests will be taken?

Chapter 4 outlines the difference between doing simple and comprehensive STI and BBI check ups, as well as linking to other health programs. Make sure there are adequate resources for following up people with positive results. Keep in mind that follow up of some STIs and BBIs will require a lot more time and resources than others. In general, deciding what tests and specimens to take will be influenced by:

- Who is the specific risk group?
- What STIs and BBIs are most common in that group?
- How many people are expected to participate?
- How much time and resources are available?

- What is the skill level and experience of staff available?

Pre-test Information and Consent

Consent must always be given before testing anyone for any health problem. In order to give consent a person must have the capacity to understand the implications of testing and treatment and be able to give consent freely. With regard to testing for STIs and BBIs, the person must be given specific information and understand:

- What tests will be done
- What specimens will be taken and how they will be collected
- When and how results will be given
- What will happen in the event of a positive result (treatment, contact tracing, other tests or examination)
- What information remains confidential (coding of results)
- What information may need to be notified and to whom (notifiable diseases).

Who can give consent to testing and treatment of STIs and BBIs?

- Anyone aged 16 years and over is able to give consent
- 14 and 15 year olds (minors) can give consent themselves as long as they understand and appreciate the nature and consequences of testing and treatment
- Testing anyone under the age of 14 requires the consent of a parent or guardian.

Consent can be obtained verbally or in writing and must be documented that it has been given. Written consent forms are not necessary but can be useful by providing information in a standard way.

In addition to the above, when obtaining consent for HIV testing assess the person's risk of exposure and explore their support networks and ability to cope in the event of a positive result. Specific information should be given including:

- What is HIV, how it is transmitted and how to prevent transmission
- The difference between HIV and AIDS
- What a negative test result means
- What a positive test result means
- What the 3 month window period is and whether further testing may need to be done to cover the window period
- A brief explanation of the legal issues associated with a positive result
- Explanation of coded notification and confidentiality procedures.

When testing is refused, document the reasons why and offer the test at another time. Explore the reasons why the test was refused and discuss any issues or concerns. People may require more information or time to think about the implications of having a test before they feel comfortable about being tested.

Informing the laboratory and collection of results

If a large number of participants are expected, inform the laboratory in advance so that they can do their own planning to ensure efficient processing of the specimens, quick turnaround time and delivery of results. Provide them with estimates of the amount of equipment that will be needed, allowing adequate time for the delivery of supplies.

Coding pathology specimens and forms

If using a code instead of the participants full name, check with the laboratory:

- If they will accept a code
- What will be used for a code: e.g. a number or the first 2 initials of first name and surname
- What other information will be needed

A record will need to be kept so that results can be decoded.

Talk to the laboratory manager about:

- When the program will be held
- What tests and specimens will be taken
- Approximate number of specimens
- How and when the specimens will be delivered to the laboratory
- What and how much equipment will be needed and how long it will take to order
- Turnaround time for results to be received
- When and how results will be received (fax, electronic download, picked up from the laboratory)
- Whether the laboratory are able to collate the results that can be used in a report.

Decide who will be responsible for:

- Collecting the results from the laboratory
- Collating the results into a report
- Filing or storing results.

Participation lists and pathology forms

The more that can be organised in advance, the more time will be saved and the smoother things will run on the day. The following things can be organised in advance:

1. Community participation lists

Names of potential participants could be obtained from the community health centre, council, or the organisation where the program is being delivered. A consent process may apply for release of this information.

The list can also be used to tick off when results are received and will be useful when it comes to writing the report. If the names of potential participants are not known until the day of testing, make sure this information is recorded on a similar list.

2. Pathology forms

Estimate how many pathology forms will be needed and fill out as much of the form as possible beforehand. Check with the laboratory what information is needed on the specimens and forms and whether it is possible to pre-print pathology forms or use rubber stamps to put information onto the forms such as, name and provider number of the doctor, address of the health service where results should be sent to

3. Sticky labels

Preparing sticky labels for forms and specimens can greatly reduce the workload involved on the day of testing. Sticky labels may be generated from electronic medical record/software or produced in a spreadsheet.

If preparing sticky labels check the following:

- What size do labels need to be for forms and specimens
- What information should be on labels
- How many labels will be needed for each participant for pathology forms and specimens.

Equipment and medications

A detailed checklist for the equipment and medications needed to deliver the program is outlined in Chapter 10. The amount of equipment and medications needed should be estimated depending on the expected number of participants and participating staff. Equipment will include:

- General equipment needed in the clinic and education room
- Equipment for taking urine and blood specimens
- Other equipment needed for doing examinations and giving treatment
- Medications for treating people with positive results and their contacts
- Equipment for storing and transporting specimens such as a refrigerator, eskies and ice bricks
- Personal Protective Equipment (PPE)
- Sharps and waste management
- Materials for data collection and recording of medical treatment information.

Only an accredited health worker can provide treatments for some STIs and BBIs. Check whether medications will be available through current clinic stocks or whether they will have to be ordered and if so how long it will take to order them. The amount of medication needed to treat people with positive results will vary with the community tested, but there may be information available that would give an indication of how many positive results are expected. Estimate the number of positive results expected and double that number to ensure enough for treating contacts. **Treatment of syphilis** will involve treating those with new infections as well as those with latent infections. Small amounts of other medication should be included in case of allergies or for treatment of other infections noted at the time of examination.

Chapter 8: Program Delivery and Follow Up

KEY POINTS

To ensure that the delivery of the program runs smoothly make sure:

- Staff are clear about their roles and responsibilities
- There is a steady flow of participants
- Specimens are labelled, stored and transported appropriately
- Participants receive both positive and negative results at follow up
- Treatment and counselling is given to those with positive results
- Contact tracing is initiated and followed through.

How will the community participate on the day of testing?

With good planning things should run smoothly. Each staff member involved must be clear about what their role on the day will be, and how they will work together as a team.

Some things to think about beforehand include:

- How many people are expected to participate?
- How will participants access the clinic; will they be expected to turn up by themselves or will transport need to be arranged?
- How will the different spaces and rooms be utilised to enable giving education, obtaining consent, taking specimens?
- Will each staff member carry out all the tasks or will each staff member be assigned to a different task and if so how will participants flow from one practitioner to the other?

Staff will be needed for the following tasks:

- To ensure that there is a regular flow of participants through the clinic and that participants don't all turn up at the same time
- To give information to people about what they are being tested for
- To instruct participants how to do a first void urine or take other specimens
- To take blood and other tests
- To label specimens and pathology forms
- To provide education to participants either prior or post testing.

Specimen collection, storage and transportation

- Confidentiality and sensitive issues that are mindful of cultural protocols should be adhered to when collecting specimens
- Local policies and guidelines should be followed when taking urine and blood specimens
- Staff need to be accredited to take and label specimens
- Urine specimens for NAAT/PCR and blood specimens should be stored and transported cold in an esky with ice bricks
- Specimens should be transported to the laboratory as soon as is practical.

Follow up of pathology results

Test results should always be given in private in a way that does not identify people with positive results. Ideally, all participants should be asked to return for follow up irrespective of whether an abnormal result is detected or not. If only those with positive results were asked to return this would identify them within the community.

Negative results

Give information about the following:

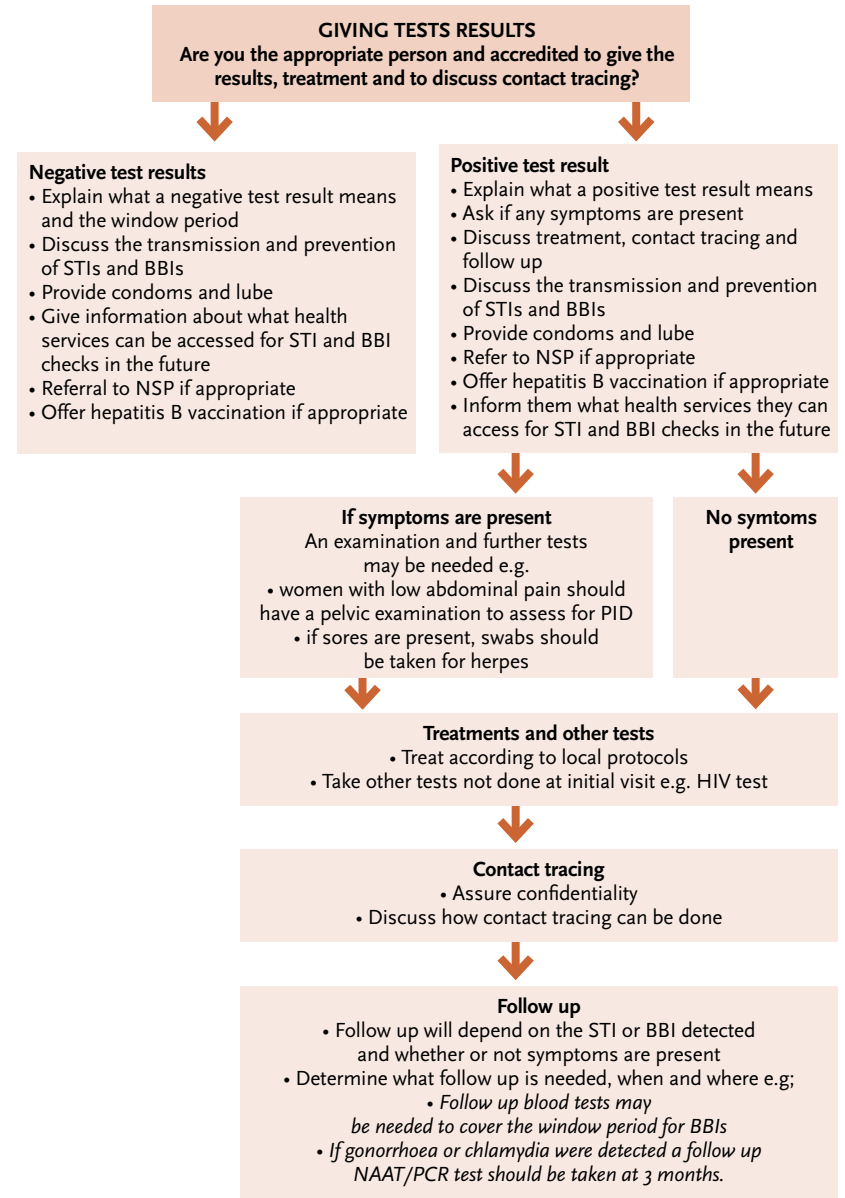
- Explain what a negative test result means
- Discuss the transmission and prevention of STIs and BBIs
- Discuss window period and need or not to retest
- Provide condoms and lube
- Inform them what health services they can access for STI and BBI checks in the future
- Refer to Needle and Syringe Program (if appropriate)
- Offer hepatitis B vaccination (if appropriate).

Positive results

In addition to giving general information as above, in the event of a positive or abnormal test result:

- Explain what a positive test result means
- Check whether any symptoms are present by asking specific questions (e.g. do you have any low abdominal pain, discharge, pain on passing urine, genital sores or rashes?)
- If symptoms are present an examination or further tests may need to be taken (e.g. if genital sores are present, an examination and swabs for herpes should be taken as well as blood for syphilis if not done initially, women with low abdominal pain should be assessed for PID)
- Ask about any specific risk factors or concerns
- If not done already offer an HIV test (ensure pre-test information and consent is given)
- Discuss treatment, transmission to others if not treated
- Explain the importance of contact tracing and ensure steps are taken for the follow up of contacts.

DIAGRAM 7: Follow up of Pathology Results



Treatment

How antibiotic treatment is dispensed will vary depending on the health service. Ideally treatment should be provided and observed. Treatment should be given by a practitioner who is accredited to do so and should be in line with regional or health service protocols.

When giving treatment:

- Check any drug allergies
- Discuss the benefits of treatment and consequences if not treated
- Discuss the importance of treating partner(s) and risk of reinfection and transmission to others if not treated
- Discuss possible side effects and other relevant issues such as how long before they should resume sexual activity, use of condoms until infection is treated
- Discuss ongoing use of condoms/contraception
- Discuss safer injecting practices
- Explain the importance of follow up; this will vary depending on the STI or BBI
- Document all treatment and follow up on the case management forms and in the person's notes.

Treatment of BBIs is beyond the scope of this manual. However, people should be referred to specialist services for follow up and assessment for treatment, if a BBI is detected.

Follow up

What follow up is needed will depend on what STI or BBI was detected. In general, follow up is important to check adherence to treatment, resolution of symptoms and that partner(s) have been treated, however repeating tests at follow up may not be necessary or cost effective. Repeating a PCR test as a 'test of cure' is not recommended if appropriate treatment was given, as treatment is highly effective and PCR tests may take several weeks to become negative after treatment. A repeat swab for gonorrhoea should be taken for MCS if gonorrhoea was detected on culture. A repeat PCR test is recommended at 3 months to check for reinfection for both gonorrhoea and chlamydia.

Contact tracing

While contact tracing is not always easy or straightforward it is an essential part of management, so as to identify and treat other people with the infection and to prevent reinfection and transmission to others. Refer to the *Australasian Contact Tracing Manual* (ASHM 2002) for more detailed information. In general:

- Contact tracing should always be done in private
- Ensure that the practitioner's gender and relationship to the client is appropriate
- Explain why contact tracing is important and the consequences of not contact tracing
- Explain that their name and information will remain confidential
- Contact tracing for most STIs should go back 3 to 6 months
- Take a detailed sexual history for the last 6 months (regular and casual partners, gender of partners, sexual activity, condom use, other risk factors)
- Contact tracing for hepatitis C and HIV may need to go back longer than 6 months ago; a detailed risk history will need to be taken to determine when the person was likely to have been infected
- Talk about ways in which contact tracing can be done (e.g. AHW, phone, letter, home visit).

Chapter 9: Evaluation and Feedback

KEY POINTS

Evaluation and feedback are essential components of any STI and BBI early detection and treatment program and involve:

- Evaluating the process of delivering the program
- Evaluating the short and long term outcomes of the program
- Feeding back information to communities, health services and staff
- Refining program activities over time

Evaluation and feedback are an essential part of any health program to determine whether the program was worthwhile and to reflect on what went well, what didn't go so well and how things can be improved or refined in the future. Whether the program was delivered through an existing service or as an outreach or community based program, the ongoing participation of both the community and health services and staff will be enhanced by informing them of the outcomes.

Evaluating the process

Evaluating the process is about looking at how the program was delivered, and identifying any gaps that can be improved upon next time. Discussions should involve the staff who participated in delivering the program as well as the participants or community representatives and could include the following:

- Was there adequate planning?
- Were staff members well organised?
- Were staff members clear about their roles and responsibilities?
- Did the delivery and follow up of the program run smoothly?
- Were the participants properly informed about the program?
- Was the participation of the target group adequate?
- Were the participants or community happy with the way the program was delivered?
- How can the program be improved for next time?

Evaluating the outcome

The long term goal of STI and BBI early detection programs is to reduce the prevalence and complications associated with STIs and BBIs in the community. Evaluating long term outcomes means measuring trends over time. It may take several years before these outcomes can be seen so in the short term make sure that there is adequate measurement and documentation which can be compared over time. Some of the things that should be measured in the short term include:

- What proportion of the target group participated (this will only be able to be measured if the number of potential participants is known)
- What was the total number of tests taken by gender and age group
- Among the total number of tests taken, what proportion of tests were positive, compare by individual STI and BBI, gender and age group
- The proportion of people with positive results who were treated within a given time frame
- The number of named contacts tested and treated
- The proportion of people with gonorrhoea or chlamydia who had a follow up test taken at 3 months.

There may be other positive outcomes that flow on either directly or indirectly as a result of delivering the program. Some may be difficult to measure but should be documented where possible and include:

- Improved access for the community to health services
- Increased testing and treatment of at risk groups through existing services
- Increased education sessions delivered to the community
- Increased condom distribution
- Increased skills of practitioners for managing STIs and BBIs
- Shared care arrangements.

Feeding back information

Information about the process and outcomes of the program should be fed back to:

- Participants and community representatives
- Participating staff and health services
- Funding bodies if relevant.

Giving feedback to communities enhances their ownership, participation and sustainability of programs, and also provides an opportunity for the community to give feedback to the program staff. It is equally important to give feedback to the staff who participated in delivering the program, to inform them of the value and outcomes of their contribution. Information given must be relevant and appropriate, and not breach the confidentiality of individuals and communities. Feedback can be given in a number of ways such as verbally at meetings, or in written or pictorial reports. When giving feedback think about:

- How it should be given
- Who it should be given to
- Report on the planning, delivery and follow up
- Report on the outcome of the program
- What went well, what didn't go so well, how can things be improved or refined
- When should the program be repeated, should it be delivered in the same way to the same group
- Acknowledgement of the community and staff members involved in delivering the program.

Written reports

Written reports can be brief and to the point but are important so that the process and outcomes of the program are documented. Reports may be required by funding bodies, and are also essential to being able to monitor what has happened over time as a result of the program.

There is a lot of value in informing other health services and practitioners about the success or otherwise of programs, not only to inform them of the outcomes but also to learn from people's experience in best practice in delivering programs. Information can be presented at regional or national meetings or conferences, as well as in newsletters or journals. **If information is going to be presented at such forums, participating individuals and communities must consent to this information being used in this way.** Communities may be understandably hesitant so it is important to outline exactly what the benefits to other health services and communities are by doing this, what information will be presented and what information will be kept confidential.

Consider writing up a simple memorandum of understanding (MOU) between health services and participating communities prior to the implementation of the program to clarify what will happen with information and provide communities with a choice of options about what can and cannot be discussed. If communities do not consent to the outcome of the program being discussed, it may still be acceptable to them for the process of the program to be discussed. An MOU should outline:

- That the confidentiality of individuals and communities will be maintained
- What information will be reported
- How the information will be presented
- Who will the information be presented to
- Ownership and storage of data.

Communities will be more willing to consent to sharing information if they feel confident that their confidentiality will be maintained and understand that doing so will benefit other practitioners, health services and ultimately other communities.

Sustainability

Now that you have delivered a successful STI and BBI early detection and treatment program, think about how programs can be sustainable in the longer term. The easiest and most effective way to ensure programs are sustainable is to support health services and practitioners to incorporate programs into routine health care delivery. Initially a lot of support may be needed to help health services and staff not experienced in running STI and BBI early detection and treatment programs. Over time, as support is given to build the capacity of services to run programs the amount of external support will decrease.

The epidemiology of STIs and BBIs and best practice in testing and treatment will change over time. Keep up to date with these changes so that they are incorporated into refining programs over time.

Making STI and BBI early detection and treatment programs sustainable

- Always involve communities and health service staff
- Incorporate annual STI and BBI checks into routine primary health care delivery to young people and others at risk
- Continue to improve access to testing and treatment for at risk groups
- Support initial and ongoing training of staff in best practice management of STIs and BBIs
- Work in partnership to help build the capacity of staff and other health services to run programs
- Concentrate outreach programs on priority groups who are difficult to access
- Determine when outreach programs should be repeated
- Share information and resources and learn from other people's experience
- Monitor and evaluate program activity and feed back information to health services and communities

Chapter 10: Checklist

THIS SECTION CONTAINS

- A checklist for planning
- A checklist for equipment and medication
- A resources list
- References

Overall planning

DECIDE HOW THE PROGRAM WILL BE DELIVERED AND TO WHOM	NOTES
<input type="checkbox"/> Identify the community or target group	
<input type="checkbox"/> Estimate the number of participants	
<input type="checkbox"/> What health or other services do the target group already access?	
<input type="checkbox"/> How will the program will be delivered (through existing services, outreach or community based)	
<input type="checkbox"/> List participating health services	
<input type="checkbox"/> List participating staff members	
<input type="checkbox"/> Is there an appropriate mix of skills, male, female and Aboriginal practitioners	
<input type="checkbox"/> Estimate the amount of time needed to deliver the program, and whether staff will be available to participate	
<input type="checkbox"/> Ensure there adequate financial resources available	
PLAN THE OVERALL PROGRAM	NOTES
<input type="checkbox"/> Inform and engage the community	
<input type="checkbox"/> Identify key people in the community who need to be informed	
<input type="checkbox"/> Identify key people who can liaise between the program staff and community	
<input type="checkbox"/> Where will the program be delivered	
<input type="checkbox"/> Visit the site to check whether there are adequate facilities	
<input type="checkbox"/> Ensure Work place health and safety	
<input type="checkbox"/> Plan health promotion and education	
<input type="checkbox"/> Develop consent forms	
<input type="checkbox"/> Collection and use of data (MOU)	

PLAN THE DETAILS OF THE PROGRAM	NOTES
<input type="checkbox"/> Decide on the dates for;	
<input type="checkbox"/> informing the community	
<input type="checkbox"/> delivering the program	
<input type="checkbox"/> follow up	
<input type="checkbox"/> feedback	
<input type="checkbox"/> What tests and specimens will be taken	
<input type="checkbox"/> What tests or examination will be done at follow up for those with positive results	
<input type="checkbox"/> Inform the laboratory	
<input type="checkbox"/> Check or order equipment	
<input type="checkbox"/> Check or order medications	
<input type="checkbox"/> Participation lists (if applicable)	
<input type="checkbox"/> Sticky labels	
<input type="checkbox"/> Pathology forms	
<input type="checkbox"/> Consent forms	
<input type="checkbox"/> Determine how and when pathology results will be received	
<input type="checkbox"/> Advertising the program in the community	
<input type="checkbox"/> Flow of participants decided upon	
<input type="checkbox"/> Follow up	
EVALUATION AND FEEDBACK	NOTES
<input type="checkbox"/> Results collated	
<input type="checkbox"/> Report written	
<input type="checkbox"/> Feedback given to the;	
<input type="checkbox"/> Community or participants	
<input type="checkbox"/> Participating health services	
<input type="checkbox"/> Funding bodies	

Equipment and medications

EQUIPMENTS	MEDICATIONS
General	
<input type="checkbox"/> Desk/chairs/bed	<input type="checkbox"/> Azithromycin
<input type="checkbox"/> Linen/blue sheets	<input type="checkbox"/> Ciprofloxacin
<input type="checkbox"/> Lamp	<input type="checkbox"/> Ceftriaxone (1% xylocaine to mix with)
<input type="checkbox"/> Disinfectant /hand wash	<input type="checkbox"/> LA Bicillin
<input type="checkbox"/> Participation lists	<input type="checkbox"/> Metronidazole
<input type="checkbox"/> Sticky labels	
<input type="checkbox"/> First aid kit	
Blood and urine specimens	
<input type="checkbox"/> Pathology forms	Other medications
<input type="checkbox"/> Pathology bags	<input type="checkbox"/> Doxycycline
<input type="checkbox"/> Gloves	<input type="checkbox"/> Tinidazole
<input type="checkbox"/> Sharps containers	<input type="checkbox"/> Valacyclovir
<input type="checkbox"/> Infectious and non infectious waste bags	<input type="checkbox"/> Famcyclovir
<input type="checkbox"/> Urine jars	<input type="checkbox"/> Emergency contraception (Postinor 2)
<input type="checkbox"/> Tourniquets	
<input type="checkbox"/> Vacutainers	Resources
<input type="checkbox"/> 23 gauge needles	<input type="checkbox"/> Condoms/lube
<input type="checkbox"/> Serum tubes	<input type="checkbox"/> Education resources/ videos/ pamphlets etc
<input type="checkbox"/> Alco wipes	<input type="checkbox"/> Referral to NSP
<input type="checkbox"/> Cotton wool balls	
<input type="checkbox"/> Band-aids	
<input type="checkbox"/> Eskies (and tape)	
<input type="checkbox"/> Ice bricks	
<input type="checkbox"/> Personal Protective Equipment	
Other equipment	
<input type="checkbox"/> Urinalysis dipsticks	
<input type="checkbox"/> Urine pregnancy tests	
<input type="checkbox"/> Needles	
<input type="checkbox"/> Syringes	
<input type="checkbox"/> PCR swabs	
<input type="checkbox"/> Charcoal or Stuart's media swabs	
<input type="checkbox"/> Glass slides	
<input type="checkbox"/> Herpes swabs	
<input type="checkbox"/> Speculums	

ACRONYMS

ACCHS	Aboriginal Community Controlled Health Service
ACON	AIDS Council of NSW
AH&MRC	Aboriginal Health and Medical Research Council of NSW
AHS	Area Health Service
AHW	Aboriginal Health Worker
AIDB	AIDS and Infectious Diseases Branch, NSW Department of Health
AIDS	Acquired Immune Deficiency Syndrome
AMS	Aboriginal Medical Service
ASHAC	Aboriginal Sexual Health Advisory Committee NSW
ASHM	Australasian Society for HIV Medicine
ASHW	Aboriginal Sexual Health Worker
BBI	Blood Borne Infection
CDEP	Community Development Employment Program
D&A	Drug and alcohol
GP	General Practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
HW	Health Worker
IDU	Injecting drug use
JH	Justice Health
MO	Medical Officer
MOU	Memorandum of Understanding
MSM	Men who have sex with men
NAAT	Nucleic Acid Amplification Test
NCHECR	National Centre for HIV Epidemiology and Clinical Research
NGO	Non Government Organisation
NSP	Needle and Syringe Program
NUAA	NSW Users and AIDS Association
OATSIH	Office for Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Ageing
PCR	Polymerase Chain Reaction
PID	Pelvic Inflammatory Disease
PROM	Premature rupture of membranes
RN	Registered Nurse
STI	Sexually Transmissible Infections
SHS	Sexual Health Service

GLOSSARY

STIs and BBIs

Blood Borne Infections (BBIs)

Infections that can be spread by blood to blood contact. BBIs can be spread by sharing needles or other equipment for injecting drugs, tattooing or body piercing or from mother to baby during pregnancy or at delivery (HIV, Hepatitis B and C, syphilis). Some BBIs can also be spread by both sexual contact and blood to blood contact (HIV, Hepatitis B, syphilis).

Sexually Transmissible Infections (STIs)

Infections that can be transmitted as a result of oral, anal or vaginal sex. STIs can be transmitted from one person to another in different ways and as a result of different sexual activity. Some STIs are transmitted as a result of skin to skin contact (genital herpes, genital warts, syphilis), while others require contact with body fluids (gonorrhoea, chlamydia, trichomonas, hepatitis B, HIV).

AIDS

The Acquired Immune Deficiency Syndrome is a group of signs and symptoms caused by immune deficiency as a result of infection with the Human Immunodeficiency Virus (HIV).

Chlamydia

Chlamydia can be spread by oral, anal or vaginal sex without a condom, or from mother to baby at delivery. Most people with chlamydia have no symptoms or have mild symptoms that go unnoticed. Chlamydia can be detected using self collected specimens such as urine and can be treated with single dose antibiotics. If not treated, chlamydia can cause serious problems such as PID, ectopic pregnancy, infertility and poor outcomes in pregnancy.

Donovanosis

Donovanosis is now uncommon in Australia, most cases are found in northern or central Australia. Donovanosis can cause granulomatous lesions on the genitals that are usually red, beefy and painless. Transmission is by direct contact during sexual activity.

Genital herpes

Genital herpes is caused by Herpes Simplex Virus (HSV). Many people with HSV have no symptoms or mild symptoms that go unrecognised. HSV can cause ulcers on genital skin and around the mouth (cold sores). HSV is spread by skin to skin contact and can be transmitted as a result of oral, anal or vaginal sex.

Genital warts

Genital warts are the most common viral STI and are caused by Human Papilloma Virus (HPV). HPV is spread by skin to skin contact and can cause visible warts on genital skin. Some strains of HPV can infect the cervix causing cell changes that can show up on Pap smears. In some women, these changes can lead to cancer of the cervix if not treated.

Gonorrhoea

Gonorrhoea is a STI which can be spread by oral, anal or vaginal sex without a condom. It infects the same type of cells as chlamydia and causes similar problems. Many people with gonorrhoea have no symptoms. Gonorrhoea is easy to test for and can be treated with single dose antibiotics. If not treated, gonorrhoea can lead to serious complications such as PID, ectopic pregnancy, infertility and poor outcomes in pregnancy.

Hepatitis A

Hepatitis A is a virus that affects the liver. It can be spread when the virus excreted in faeces comes into contact with the mouth. This can occur as a result of eating/drinking contaminated food or water, or as a result of sexual practices that involve anal to oral contact.

Hepatitis B

Hepatitis B is virus that affects the liver. It can be spread by contact with infected blood or body fluids as a result of sexual contact, blood to blood contact or from mother to baby at delivery. About 90% of people infected as an adult will clear the infection within 6 months, while 10% of people will develop a chronic infection.

Hepatitis C

Hepatitis C is a virus that affects the liver. It can be spread when blood of someone who is infected with hepatitis C enters the blood stream of another person. Approximately 25% of people infected will clear the virus within 6 months. Approximately 75% of people infected will not clear the virus and will have an ongoing or chronic infection which may lead to chronic liver disease.

HIV

The Human Immunodeficiency Virus is a virus which affects the white blood cells and eventually destroys the body's natural ability to fight infections.

HIV positive

Means that the person has been infected with HIV.

Lymphogranuloma venereum (LGV)

Lymphogranuloma venerum (LGV) is caused by a strain of Chlamydia. Transmission is through direct contact with an open lesion. LGV is rare in Australia.

Syphilis

Syphilis is a STI that can be transmitted during oral, anal or vaginal intercourse. Syphilis can also be transmitted from mother to baby during pregnancy or at delivery leading to serious consequences such as miscarriage or congenital syphilis. Syphilis is detected by a blood test and is treatable with penicillin.

Trichomonas

Trichomonas is a protozoa that can be transmitted during vaginal sex. In women it can cause vaginal and vulval itch and discharge and premature rupture of membranes in pregnancy. In men it infects the urethra but doesn't usually cause symptoms.

Other terminology

Antibody

A protein secreted by the immune system in response to an infection. Many blood tests rely on detecting antibodies in a person's blood to different viruses and bacteria. The presence of antibodies indicates that the person has been exposed to a particular infection at some stage in their life.

Asymptomatic

Having an infection or disease but having no symptoms. The lack of symptoms may make people unaware that they have a health problem.

Cirrhosis

The term "cirrhosis" refers to advanced liver damage, characterized by dense scarring (fibrosis), nodular regeneration, and architectural disorganisation. Cirrhosis is the end point of many types of liver damage. Some causes include excessive alcohol consumption, iron overload, chronic viral hepatitis, autoimmune diseases, and chronic bile duct obstruction.

Community

Community refers to any group of people, that either lives in the same region or who have something in common such as behaviour, culture or religion. In this manual the term 'community' has been used to refer to Aboriginal communities as well as groups of people defined by age or risk behaviour and could represent a small or large number of people.

Early detection and treatment (screening)

Early detection and treatment, or screening, is the detection of a disease (or health problem) in people who have the disease but who have no symptoms and who otherwise would not have been identified. The criteria for early detection and treatment are outlined in chapter 2.

Ectopic pregnancy

A pregnancy that develops outside the uterus, most commonly in one of the fallopian tubes that leads from each ovary to the uterus.

Epidemiology

Epidemiology is the study of the pattern and distribution of a disease or health problem within a population. Having information about who is affected, where they are located geographically, what is the cause, and why did it occur can be used to help control and prevent disease or health problems.

Epididymitis

Epididymitis is an inflammation of the epididymis (an oblong structure attached to the upper part of each testis). Epididymitis can occur as a result of untreated chlamydia and gonorrhoea, causing redness, swelling and pain.

False negative test result

When a test result is negative in a person who does actually have the disease.

False positive test result

When a test result is positive in a person who does not actually have the disease.

Infertility

Infertility is the inability to fall pregnant after one year of regular intercourse without contraception.

Low prevalence populations

Refer to populations among whom the overall number of infections is low.

Needle and syringe programs (NSP)

Needle and Syringe Programs are authorised programs that distribute, dispose of or sell needles and syringes and other new injecting equipment. NSPs are often the first point of contact for people who inject drugs, and service provision can include education, referrals into drug treatment and primary care, clinical services, health promotion services.

Nucleic Acid Amplification Tests (NAAT)

NAAT are laboratory tests that amplify the genetic material (DNA) from an organism to a level that it can be detected. PCR is one type of NAAT.

Pelvic Inflammatory Disease (PID)

PID is an infection of the upper genital tract in women (uterus, fallopian tubes and/or ovaries). Between 10–30% of women with untreated gonorrhoea or chlamydia will develop PID. However, laboratory tests are often negative. Symptoms include lower abdominal pain, pain with sex, abnormal bleeding and discharge. Symptoms are often mild and may go unnoticed. Untreated, PID can cause damage to the fallopian tubes leading to increased risk of ectopic pregnancy and infertility. PID in early pregnancy can lead to miscarriage. PID should be treated with antibiotics as soon as possible to prevent damage to fallopian tubes. Sexual contacts need to be treated to prevent reinfection.

Polymerase Chain Reaction (PCR)

A laboratory method that amplifies the genetic material (DNA) from an organism to a level that it can be detected. PCR has advantages over conventional tests as it is more sensitive and less affected by the time and conditions under which specimens are transported to the laboratory. PCR can also be used on self collected specimens making testing easier and more acceptable.

Premature Rupture of Membranes (PROM)

Rupture of the membranes before 37 weeks gestation and before the onset of labour.

Prevalence

Is the number of cases of disease detected amongst a defined population at a given point in time. It refers to how common a disease is in a community.

Risk behaviour

Any behaviour, sexual or otherwise, that can result in the transmission of a STI or BBI.

Safer sex

Sexual activity in which there is no exchange of blood or body fluids such as semen, vaginal fluids or blood.

True negative test result

When a test result is negative in a person who does not have the disease.

True positive test result

When a test result is positive in a person who does have the disease.

Window period

Refers to the time it takes from a person being exposed to an infection (e.g. HIV) to when the person to produce antibodies against the infection which can then be detected in a blood test.

NOTES ON TESTING

Make sure that whatever is tested for, there are adequate resources to be able to follow up people with positive results. Also keep in mind that following up some STIs and BBIs such as hepatitis C and HIV will require a lot more time and resources than others and may need referral. Some of the things that need to be considered are outlined below.

Gonorrhoea and chlamydia

While the treatment for uncomplicated gonorrhoea and chlamydia is straightforward with single dose antibiotics, women should be assessed further for PID and pregnancy which could alter management and follow up.

Genital warts

There is no screening test that can check if someone has come into contact with Human Papilloma Virus (HPV) which causes genital warts. The effect of HPV may show up on Pap smears, however the diagnosis of genital warts is a clinical diagnosis.

Genital herpes

The diagnosis of genital herpes is made by taking a swab from the base of a genital sore or ulcer. While there is a blood test available that indicates whether someone has been exposed to Herpes Simplex Virus (HSV), this blood test is not recommended as a screening test. It should only be used in special circumstances and the result interpreted in view of clinical findings. The majority of people have been exposed to HSV so most people will have a positive blood test, however this does not indicate whether HSV is the cause of a genital sore.

Interpreting syphilis results

Interpreting positive syphilis results can be difficult and should be done by an experienced practitioner. The client's history of previous results and treatment history will be needed to determine if treatment is required and if so what treatment is needed. This information should be obtained before returning for follow up, and consent from the client may be required if accessing information from other laboratories or health services.

Hepatitis B

It may not be necessary to test all participants for hepatitis B as many people will be immune to hepatitis B as a result of past infection or vaccination and some will already have been diagnosed with a chronic infection. It may be possible to identify who have already been tested or vaccinated through the local ACCHS, SHS or public health unit. Talk to the appropriate person about whether hepatitis B should be tested for. If so, there should be clear documentation of whether people are already immune. Vaccination should be offered to those who are not immune and follow up arranged for chronic hepatitis B carriers.

Hepatitis A

Hepatitis A is not routinely tested for as part of a STI and BBI check up. However some risk groups (MSM) are at higher risk of hepatitis A and may be suitable to be offered vaccination for hepatitis A or the combined hepatitis A and B vaccine. For guidelines on hepatitis A and B vaccination, check with local protocols, NSW health and Australian immunisation guidelines.

Hepatitis C

People with positive hepatitis C tests will need to be referred for further follow up that will involve taking a detailed risk history and additional blood tests (HCV PCR) to determine whether they have cleared the infection or have a chronic infection.

HIV

While it is important to offer HIV testing to people at risk it is not always appropriate to do that through a community wide program. If there is sufficient time to give pre-test information and counselling and ensuring informed consent it may be feasible to offer testing as part of the program. If not HIV testing should be offered at follow up to those who test positive to other STIs or BBIs. Provision should be made to ensure that those people tested for HIV receive their results in person and there is a clear plan for management in the event of a positive result.

CONTACTS

To find the Aboriginal Sexual Health Worker in your area, contact the:

Aboriginal Health and Medical Research Council of NSW

Web: www.ahmrc.org.au

Phone: 02 9212 4777

Fax: 02 9212 7211

Address: Level 3, 66 Wentworth Ave, Surry Hills, NSW 2010
PO Box 1565 Strawberry Hills 2012

Contact numbers for local Aboriginal Community Controlled Health Services are as follows:

SERVICE	LOCATION	NUMBER
Aboriginal Medical Service Co-Operative	Redfern	02 9319 5823
Albury Wodonga Aboriginal Health Service Inc.	Albury	02 6042 1200
Armajun Aboriginal Health Service Incorporated.	Inverell	02 6721 9777
Awabakal Newcastle Aboriginal Co-Operative Ltd	Hamilton	02 4969 1765 02 4969 2108 02 4969 2424
Balranald Aboriginal Health Service Incorporated	Balranald	03 5020 0330
Biripi Aboriginal Corporation Medical Centre	Taree	02 6552 2154 02 6552 7579
Bourke Aboriginal Health Service Ltd	Bourke	02 6872 3088
Brewarrina Aboriginal Health Service Ltd	Brewarrina	02 6839 2150
Brungle Aboriginal Health Service	Brungle	02 6944 9036
Bulgarr Ngaru Medical Aboriginal Corporation	Grafton	02 6643 2199 02 6642 2484
Condobolin Aboriginal Health Service Inc.	Condobolin	02 6895 4311 02 6895 3615
Coomo Health Aboriginal Corp	Dareton	03 5027 4824
Coonamble Aboriginal Health Service Inc.	Coonamble	02 6822 3995
Cummeragunja Housing & Development Aboriginal Corp	Cummeragunja	03 5869 3343
Daruk Aboriginal Community Controlled Medical Service Co-op Ltd	Mt Druitt	02 9832 1356
Dharah Gibinj Aboriginal Medical Service Aboriginal Corp	Casino	02 6662 3514 02 6662 3599
Dhoongang Aboriginal Health Service Inc.	Port Macquarie	0423 385 505
Durri Aboriginal Corporation Medical Service	Kempsey	02 6562 1604 02 6562 6733 02 6562 4919
Galambila Aboriginal Health Service Inc.	Coffs Harbour	02 6652 0800

SERVICE	LOCATION	NUMBER
Griffith Aboriginal Medical Service Incorporated	Griffith	02 6964 4533 02 6962 7650
Illawarra Aboriginal Medical Service Aboriginal Corporation	Wollongong	02 4229 9495
Katungul Aboriginal Corporation Community & Medical Services	Narooma	02 4476 2155 02 4476 2772
Menindee Aboriginal Health Service Inc.	Menindee	08 8091 4237 08 8091 4487
Murrin Bridge Aboriginal Health Service Inc.	Murrin Bridge	02 6898 1687
Nambucca Valley Aboriginal Health Service Incorporated	Nambucca Heads	01 6568 9055
Ngambra Aboriginal Health Service Inc.	Queanbeyan	02 6297 4152
Orange Aboriginal Health Service Incorporated.	Orange	02 6363 1343
Parkes Aboriginal Health Service Inc.	Parkes	02 6862 4324
Pat Dixon Medical Centre Aboriginal Medical Service	Armidale	02 6774 9450 02 6774 9470
Peak Hill Aboriginal Medical Service Incorporated.	Peak Hill	02 6869 1640
Pius X Aboriginal Corporation	Moree	02 6752 1099
Riverina Medical & Dental Aboriginal Corporation	Wagga Wagga	02 6921 7292
South Coast Medical Service Aboriginal Corporation	Nowra	02 4428 6666 02 4428 6609 02 4428 6629
Tamworth Aboriginal Medical Service Inc.	Tamworth	02 6766 5211
Tharawal Aboriginal Corporation	Campbelltown	02 4628 4837
Thubbo Aboriginal Medical Co-op Ltd	Dubbo	02 6884 8211 02 6884 8212
Tobwabba Aboriginal Medical Service Inc.	Forster	02 6555 6271
Walgett Aboriginal Medical Service Co-operative Limited	Walgett	02 6828 1059 02 6828 1611
Weimija Aboriginal Corporation	Broken Hill	08 8087 2263
Wellington Aboriginal Corp Health Service	Wellington	02 6845 3545 02 6845 4077
Yerin Aboriginal Health Service Inc. / Eleanor Duncan Centre	Wyong	02 4351 1040
Yoorana-Gunya Family Violence Healing Centre Aboriginal Corp	Forbes	02 6851 5111

Sexual Health Services

SERVICE	LOCATION	NUMBER
Albury Sexual Health Service	Albury	02 6058 1800
Bourke Sexual Health Service	Bourke	02 6872 2145
Broken Hill Sexual Health	Broken Hill	08 8080 1556 08 8080 1609
Campbelltown Community Health Centre	Campbelltown	02 9977 3288
Royal Prince Alfred Hospital – Women & Babies/Sexual Health	Camperdown	02 9515 8984 02 9718 7655
Canterbury Sexual Health Centre	Campsie	02 9560 3057
Sutherland Sexual Health Clinic	Caringbah	02 9540 7226
Outreach Clinic Cessnock	Cessnock	02 4991 0438
Coffs Harbour Sexual Health Clinic (Clinic 916)	Coffs Harbour	02 6656 7865
Outreach Clinic FPA Health	Cooks Hill	02 4929 4485
Cooma Community Health Centre	Cooma	02 6455 3201
Dareton Community Health Centre	Dareton	03 5021 7200
Wentworth/Balranald Sexual Health Service	Dareton	03 5021 7200
Kirketon Road Centre	Darlinghurst	02 9360 2766
Taylor Square Private Clinic	Darlinghurst	02 9331 6151
Deniliquin Sexual Health Service	Deniliquin	03 5881 9690
Macquarie Area Sexual Health	Dubbo	02 6841 2480
Eden Community Health Centre	Eden	02 6496 1436
Forster Sexual Health Service – Lakes Clinic	Forster	02 6555 6822
The Lakes Clinic	Forster	02 6555 6822
Central Coast Area Health Service – HIV and Sexual Health Service	Gosford	02 4367 5911
Holden St Clinic	Gosford	02 4320 2114
Goulburn Sexual Health and Hepatitis C Service	Goulburn	02 4827 3913
Grafton Community Health	Grafton	02 6640 2402
Griffith Community and Mental Health Centre	Griffith	02 6966 9900
Outreach Clinic ACON	Islington	02 4927 6808
Blue Mountains Sexual Health/HIV Clinic	Katoomba	02 4784 6560
Nepean Sexual Health & HIV Clinic	Kingswood	02 4734 2507
Short St Centre	Kogarah	02 9350 2742
Rozelle Hospital – Sexual Health Clinic	Leichhardt	02 9556 9189
Lightning Ridge Sexual Health Service	Lightning Ridge	02 6829 1022
Lismore Sexual Health Service – SHAIDS	Lismore	02 6620 2980
Liverpool Sexual Health Centre	Liverpool	02 9827 8022
Moruya Community Health Centre – Sexual Health Service	Moruya	02 4474 1561
Luxford Road Sexual Health Clinic	Mt Druitt	02 9881 1733
Narooma Community Health Centre	Narooma	02 4476 2344
Newcastle Sexual Health Clinic	Newcastle	02 4923 6909
Shoalhaven Sexual Health Clinic	Nowra	02 4423 9353

SERVICE	LOCATION	NUMBER
Orange Sexual Health Clinic	Orange	02 6392 8600
Parramatta Sexual Health Centre	Parramatta	02 9843 3124
Port Macquarie Sexual Health Service	Port Macquarie	02 6588 2750
Queanbeyan Community Health Centre – Sexual Health Service	Queanbeyan	02 6298 9233
Southern Area Sexual Health/Hepatitis C Service	Queanbeyan	02 6124 9922
Hawkesbury Sexual Health and HIV Clinic	Richmond	02 4578 1622
The Clinic Ward 117	Rozelle	02 9650 3057
Northern Sydney Sexual Health Service (clinic 16)	St Leonards	02 9926 7414
Albion St Centre	Surry Hills	02 9332 9600
Sydney Sexual Health Centre	Sydney	02 9382 7440 1800 451 624
Bligh Street Clinic	Tamworth	02 6766 3095
Taree Sexual Health Service – Manning Clinic	Taree	02 6592 9421
Tweed Valley Sexual Health Service – Clinic 145	Tweed Heads	07 5506 6850
Wagga Wagga Sexual Health Service	Wagga Wagga	02 6938 6492
Illawarra Sexual Health Service	Warrawong	02 4276 2399
Kempsey Sexual Health Service	Kempsey	02 6562 6066

RESOURCES

AUSTRALASIAN SOCIETY FOR HIV MEDICINE (ASHM)

Web: www.ashm.org.au

Ph: 02 8204 0700 Fax: 02 9212 2382

- The Australasian Contact Tracing Manual (2nd edition 2002).
- ASHM Directory: HIV, hepatitis and related services 2006 – 2007

DEPARTMENT OF HEALTH AND AGEING

Web: www.health.gov.au (under 'Publications')

Phone: National Mailing and Marketing

Ph: 02 6269 1000 Fax: 02 6260 2770

- National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
- National Sexually Transmissible Infections Strategy 2005 – 2008
- National HIV/AIDS Strategy 2005 – 2008
- National Hepatitis C Strategy 2005 – 2008
- The Management of HIV/AIDS: A resource guide for Indigenous primary health care organisations.
- The National Hepatitis C Resource Manual.
- STD control in remote Aboriginal communities: A manual for clinic workers

THE NATIONAL CENTRE IN HIV EPIDEMIOLOGY AND CLINICAL RESEARCH

Web: www.med.unsw.edu.au/nchecr

Phone: 02 9385 0900

Fax: 02 9385 0920

- HIV/AIDS, Hepatitis C and Sexually Transmissible Infections in Australia: Annual Surveillance Reports from 1997

NSW DEPARTMENT OF HEALTH

Web: www.health.nsw.gov.au

Ph: 02 9391 9000

Fax: 02 9391 9101

- Communicable Diseases Branch (2004). Blood Borne Viruses and Bacterial STI Notification Data Quarterly Report: July to September 2003.
- NSW Health Department and AH&MRC of NSW. February 2001. NSW Aboriginal Health Promotion Plan. Directions Paper.
- NSW Aboriginal Health Information Guidelines. August 1998.
- NSW Health Aboriginal Health Impact Statement and Guidelines. 2003
- NSW HIV/AIDS Statement of Strategic Directions 2002-2003 NSW Health.
- NSW Aboriginal Health Information Guidelines. 1998
- Surviving our Success. NSW HIV/AIDS Health Promotion Plan 2001-2003.
- Guidelines for counselling associated with HIV antibody testing. Circular 92/20. 1992
- NSW Health information privacy code of practice. Circular 99/18. 1999
- Patient information and consent to medical treatment. Circular 99/16. 1999
- Protecting children and young people. Circular 2003/16. 2003
- The Interagency Guidelines for Child Protection interventions
- NSW Sexual Health Promotion Guidelines 2002

General Information and fact sheets on STIs and BBIs can be found at the following websites;

AIDS COUNCIL OF NSW

Web: www.acon.org.au
Ph: 9206 2000 (Sydney)
1800 063 060 (NSW regional)
Fax: 9206 2069

AUSTRALIAN HEPATITIS COUNCIL

Web: www.hepatitisaustralia.com
Ph: 02 6232 4257
Fax: 02 6232 4318

FAMILY PLANNING NSW (FORMERLY FPA HEALTH)

Web: www.fpahealth.org.au
FPA Healthline: 1300 658 886

HEPATITIS C COUNCIL OF NSW

Web: www.hepatitisc.org.au

HEP C HELPLINE:

Ph: 9332 1599 (Sydney)
1800 803 990 (NSW Regional)

SYDNEY SEXUAL HEALTH CENTRE

Web: www.sesahs.nsw.gov.au/sydhosp/SSHC.asp
ph: 9382 7440 (Sydney)
1800 451 624 (NSW Regional)
Fax: 9382 7475

Other resources

The Venereology Society of Victoria in conjunction with the Australasian College of Sexual Health Physicians. National Management Guidelines for Sexually Transmissible Infections. Venereology Society of Victoria Inc. 2002.

Clinical Guidelines for the Management of Sexually Transmissible Infections among Priority Populations www.acshp.org.au/sexual_health/guidelines/default.htm

Books and Published Papers on STI and BBI Early Detection and Treatment Programs

Aboriginal Primary Health Care: An Evidence Based Approach. Sophia Couzos, Richard Murray (editors). Melbourne: Oxford University Press 2003

Bradshaw CS, Pierce LI, Tabrizi SN, Fairley CK, Garland SM. Screening injecting drug users for sexually transmitted infections and blood borne viruses using street outreach and self collected sampling. *Sex Transm Infect.* 2005 Feb;81(1):53-8.

Screening for sexually transmissible infections in primary health care: theory and effectiveness. Proceedings of a workshop held in conjunction with the Australasian Sexual Health Conference, 2001: A Sex Odyssey, Sydney May 2001. Edited by John Kaldor and Steven Skov. *Venereology*, Volume 14 (Supplement) 2002.

Plummer D, Forrest B. (1999). Factors affecting Indigenous Australians' access to sexual health clinical services. *Venereology*, 12, 47-52.

Miller PJ, Torzillo PJ, Hateley W. The impact of improved STD diagnosis and treatment on the prevalence of gonorrhoea and chlamydia in remote Aboriginal communities on the Anangu Pitjantjatjara Lands. *Med J Aust* 1999;170:429-32.

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