

# STI & BBV Manual

EARLY DETECTION AND TREATMENT OF SEXUALLY  
TRANSMISSIBLE INFECTIONS AND BLOOD-BORNE VIRUSES



A manual for improving access  
to early detection and treatment  
programs for Aboriginal People  
and Communities in NSW

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# INTRODUCTION

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Sexually Transmissible Infections (STIs) and Blood Borne Viruses (BBVs) are a significant health issue in New South Wales and in particular 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.

Early detection and treatment (screening) programs are recognised as an important component of STI and BBV strategies and have led to significant reductions of STIs and BBVs in some communities across Australia. In NSW there is currently no consistent approach to early detection and treatment programs within primary health services such as Aboriginal Community Controlled Health Services (ww) and General Practice clinics. This Manual provides a framework for the planning, delivery and evaluation of early detection and treatment programs for STIs and BBVs 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 clinics and other services which deliver primary health care. While treatment is an essential component of early detection and treatment programs, this is not a comprehensive treatment manual. Reference to national or state treatment guidelines 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 is shared and access is equitable for those most at risk of acquiring STIs and BBVs.

This project is linked with key policy initiatives at the national and state levels, including the following strategies:

- *Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013*
- *Second National Sexually Transmissible Infections Strategy 2010–2013*
- *Sixth National HIV Strategy 2010–2013*
- *National Hepatitis B Strategy 2010–2013*
- *Third National Hepatitis C Strategy 2010–2013*
- *NSW HIV/AIDS Strategy 2012–2015 A New Era*
- *NSW STI Strategy 2006–2009 (New Strategy currently being developed)*
- *NSW Hepatitis C Strategy 2006–2009 (New Strategy currently being developed)*
- *NSW HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006–2009 (New Plan currently being developed)*

The resource *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 recommended as a resource for any practitioner working in sexual health.

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# PRINCIPLES

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

## Aboriginal Community Control

Aboriginal Community Controlled Health Services (ACCHS) were established as a result of inadequate and discriminatory health service provision 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
- delivers a holistic and culturally appropriate health service to the community 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 address the current inequity.

## Age groups

While people of any age can acquire an STI or BBV, 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 BBVs, and among different risk groups and 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 BBVs in an Aboriginal community context. A holistic approach recognises that STIs and BBVs can be addressed in conjunction with any of the following:

- adult health checks
- other illnesses
- issues affecting general health and the physical body
- 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 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 for 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 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 associations with the word 'screening' because of a range of factors which include policies of forced removal of children and discriminatory government screening programs. We use 'early detection and treatment programs' as much as practical for this reason.

## Sexually Transmissible Infections and Blood Borne Viruses (STIs and BBVs)

This Manual will focus on the following STIs and BBVs: chlamydia, gonorrhoea, syphilis, trichomonas, hepatitis B, hepatitis C and HIV. While viral STIs such as genital herpes and genital warts are common, early detection and treatment programs are not as relevant and appropriate for these conditions.

# HOW TO USE THIS MANUAL

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This Manual is divided into four parts. Each part can be used as a stand-alone resource.

## **PART A:**

### **BACKGROUND INFORMATION**

This section provides background information about STI and BBV early detection programs, including an overview of the epidemiology of STIs and BBVs 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 BBV early detection and treatment programs within an Aboriginal community context, including Continuous Quality Improvement (CQI) cycles, sustainability, 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 BBV early detection and treatment programs.

# PART A

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## Background information



# *Chapter 1:* THE EPIDEMIOLOGY OF STIs AND BBVs

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## key points

- Chlamydia and hepatitis C are the most commonly notified diseases in Australia
- Most cases of chlamydia, gonorrhoea and infectious syphilis occur among people aged under 30 years
- A person's risk of getting a STI can be influenced by:
  - Young age (15 to 30 years)
  - Individual behaviour
  - Living in a community where STIs and BBVs are common
  - The level of access to health services
- Diagnosis rates of hepatitis C and B are higher among Aboriginal people compared to non-Aboriginal people
- Diagnosis rates of HIV among Aboriginal people are similar to that among non-Aboriginal people, but exposure categories for HIV transmission differ significantly
- Having any STI can facilitate HIV transmission

# 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, when and 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 BBV epidemiology

STIs and BBVs are a diverse group of pathogens with rates of diagnosis varying between communities, populations and areas. Despite these variations, there are some key issues to remember regarding the epidemiology of STIs and BBVs.

### Key issues regarding STIs and BBVs

- STIs such as chlamydia are common especially among people who:
  - Are aged 15 to 30 years
  - Engage in unsafe sex
  - Live in a community where STIs are common
  - Have limited access to appropriate services
- STIs and BBVs commonly cause no symptoms, or mild symptoms that often go unrecognised
- People are often unaware that they are at risk of acquiring a STI or BBV
- 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 BBVs 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 BBVs can lead to serious physical, psychological and social problems
- STIs and BBVs can facilitate the transmission of HIV.

## Notifications of common STIs and BBVs

In Australia all cases of chlamydia, gonorrhoea, syphilis, viral hepatitis and HIV are notified to Health Departments for collation and analysis. While demographic information is collected there are considerable gaps in the reporting of Aboriginal and Torres Strait Islander status for gonorrhoea, chlamydia and hepatitis which impacts on our understanding of both incidence and prevalence of these infections among Aboriginal people in NSW. As a result our understanding of the pattern of distribution and transmission of those infections is often reliant on data extracted from other jurisdictions where Aboriginal status is more complete.

### Chlamydia

Chlamydia is the most commonly notified disease in Australia with a significant increase in notifications being reported in the last five years. Most chlamydia is diagnosed amongst young people aged 15-29 years.

Chlamydia is asymptomatic in up to 85% of people with chlamydia, highlighting the need for early detection and treatment programs. Rates of diagnosis are often higher in regional and remote areas. In 2011, 9% of diagnosed cases nationally were among Aboriginal and Torres Strait Islander people, providing a rate of diagnosis overall of 3.5 times that for the non-Indigenous population. NSW data is not included in the national data set, as Aboriginality is not identified in more than 90% of cases.

### Syphilis and gonorrhoea

Syphilis and gonorrhoea affect two population groups in Australia; young Aboriginal people living predominantly in remote communities of Australia and gay men in urban areas across Australia. While syphilis and gonorrhoea are much less commonly diagnosed than chlamydia in NSW, occasional clustered outbreaks do occur in communities in NSW reinforcing the need for early detection and treatment of STIs and ongoing surveillance and monitoring of disease.

### HIV infection

HIV diagnoses occur in the Aboriginal and Torres Strait Islander population at similar rates to the non-Indigenous population; however, the reason for transmission among those populations differs significantly.

Figure 1 shows the differences in reported exposure categories between the two populations for the period 2006 – 2010.

The rate of HIV diagnosis is higher in major cities and regional areas than in rural and remote locations

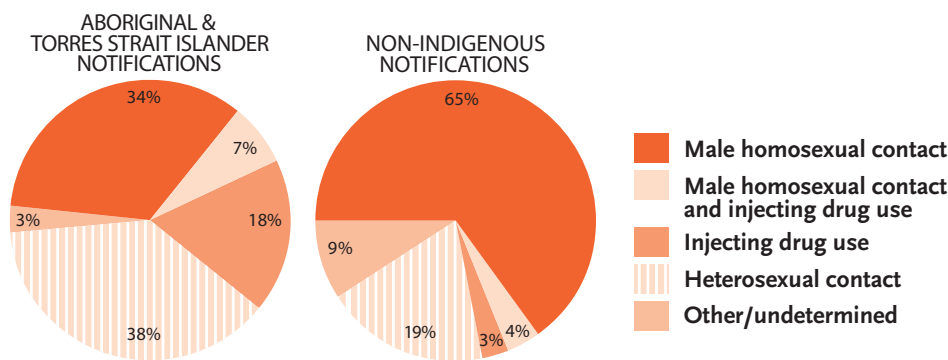


Figure 1. HIV diagnoses, 2006 – 2010, by HIV exposure category and Aboriginal & Torres Strait Islander status

## Hepatitis B

While hepatitis B is preventable with vaccination, transmission continues to occur among unvaccinated adults and in particular men who have sex with men, sex workers, people who inject drugs, prisoners and people living with HIV and/or hepatitis C. It is estimated that 16% of chronic hepatitis B cases in Australia occur among Aboriginal and Torres Strait Islander people (O’Sullivan et al 2004).

## Hepatitis C

Hepatitis C is the second most commonly notified disease in Australia after chlamydia.

- It is estimated that approximately 16,000 Aboriginal people in Australia are living with chronic hepatitis C, comprising around 8% of all chronic hepatitis C cases in Australia (Ministerial Advisory Committee on AIDS, UNSW, 2006)
- Priority populations for prevention and treatment for hepatitis C virus (HCV) include people who inject drugs, people recently incarcerated or released from incarceration
- Sharing injecting equipment is a major source of infection.

## Other STIs

Other STIs to be mindful of, are trichomonas, genital herpes and genital warts. Studies from central and northern Australia indicate high rates of infection with trichomonas among women tested. As data is limited, it is unclear how common trichomonas infection is among Aboriginal women living in NSW; however, one study identified remoteness as a critical factor for infection with trichomonas in NSW. Genital warts and herpes are common STIs and should be considered when conducting a thorough sexual health check up, but there is currently no simple test that can be used for testing asymptomatic people in the context of an early detection and treatment program.

Human Papilloma Virus (HPV) is associated with genital warts and cervical cancer. A vaccine is available to prevent HPV and reduce the risk of cervical cancer in women; however, vaccinated women should continue to have regular Pap smears in accordance with national guidelines.



# Who is at greatest risk of acquiring STIs and BBVs?

STIs and BBVs affect different populations due to a range of factors including age, mode of transmission and location. Table 1 outlines who is at highest risk of acquiring STIs and BBVs and what STIs and BBVs are common among those groups. Many people may belong to more than one risk group.

Table 1:  
Common STIs and BBVs among high-risk groups in Australia

RISK GROUP	STI & BBV
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, hepatitis B
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
- People who are homeless
- People with mental health issues.

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

## What are the common symptoms of STIs and BBVs?

STIs and BBVs commonly cause no symptoms, or minor symptoms that often 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 (pelvic) pain, pain with sex (dyspareunia), abnormal bleeding
- **Both:** any genital sores, lumps, rashes, itch or pain, rectal bleeding or discharge
- **Pregnant women:** vaginal discharge, bleeding and/or pain in early or mid pregnancy (threatened or complete 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 BBVs?

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

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

**Table 2:**  
**Possible medical consequences of STIs and BBVs**

STI & BBV	DURATION OF POSSIBLE INFECTIVITY *	POSSIBLE CONSEQUENCES OF INFECTION **
Chlamydia/Gonorrhoea	Months to years (chlamydia)/ Up to 12 months (gonorrhoea)	<b>Men:</b> Epididymitis & infertility <b>Women:</b> Pelvic Inflammatory Disease (PID), ectopic pregnancy & infertility <b>During pregnancy:</b> miscarriage, preterm birth, post partum infection, neonatal infection
Trichomonas	<b>Women:</b> up to 5 years <b>Men:</b> up to 4 months	<b>During pregnancy:</b> premature rupture of membranes
Syphilis	Sexual transmission: up to 24 months	<b>During pregnancy:</b> miscarriage, intrauterine death, congenital syphilis Tertiary syphilis (rare)
Genital warts (Human Papilloma Virus)	Mother to baby: up to 8 years Months to years	Cervical cancer
Genital herpes (Herpes Simplex Virus)	Lifelong	Recurring genital ulcers neonatal infection
Chronic hepatitis B or C	Lifelong for hepatitis B Possibly lifelong for hepatitis C	Chronic liver disease, cirrhosis, liver cancer
HIV	Lifelong	Immune suppression, neonatal infection

\* Australasian Contact Training Manual: Edition 4, 2010. Australasian Society for HIV Medicine.  
\*\*Having a STI increases the risk of HIV transmission.

## *Chapter 2:*

# THE PRINCIPLES OF EARLY DETECTION AND TREATMENT OF STIs AND BBVs

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### key points

- Early detection and treatment refers to the detection and management of STIs and BBVs among people who have no symptoms and would otherwise have gone unrecognised
- The primary aims of early detection and treatment programs are to:
  - Detect infection early to prevent or limit complications of STIs and BBVs developing
  - Prevent onward transmission of STIs and BBVs
  - Reduce the prevalence of STIs and BBVs in the community
- Most people with STIs and BBVs have no symptoms therefore early detection and treatment is an important component of an overall sexual health strategy
- To be effective, early detection and treatment programs should be:
  - Directed to people at greatest risk of STIs and BBVs
  - Offered proactively to people at greatest risk of STIs and BBVs when they access health services

## 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. Examples of early detection and treatment programs include taking a blood sugar level annually to check for diabetes and cervical (Pap) smear screening to detect abnormalities that may lead to cervical cancer.

With regard to early detection and treatment of STIs and BBVs, testing should be offered proactively to people at risk in order to treat infection early before symptoms and complications develop. This is an important strategy for detection and treatment of STIs such as chlamydia which cause no symptoms in up to 80% of people infected but can lead to poor reproductive health outcomes if not detected and treated.

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

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

- Detect infection early to prevent transmission of STIs and BBVs
- Prevent or limit complications of STIs and BBVs developing
- Reduce the prevalence of STIs and BBVs in the community
- Reduce HIV transmission in the community
- Provide opportunities to give information and education.

## Who do early detection and treatment programs most benefit?

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

- Have no symptoms (asymptomatic) or minor symptoms that may 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.

If only those who disclosed symptoms or a risk history were offered testing and treatment the majority of people with STIs and BBVs would remain undetected and untreated (see Diagram 1, p.20). 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 BBVs.

# Importance of early detection and treatment programs

The diagram below represents everyone in the community with a STI or BBV. The top two figures represent the 10% of people who will usually be detected and treated for a STI or BBV.

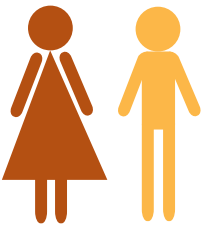
The bottom eighteen figures represent the 90% of people who have a STI or BBV but who would *not* usually be detected and treated.

Diagram 1:

**People who are usually detected as having an STI or BBV:**

- Present with symptoms
- Are aware of being at risk
- Disclose risk taking behaviour
- Access services and practitioners recognise signs and symptoms or risk and offer appropriate tests

10%  
DETECTED



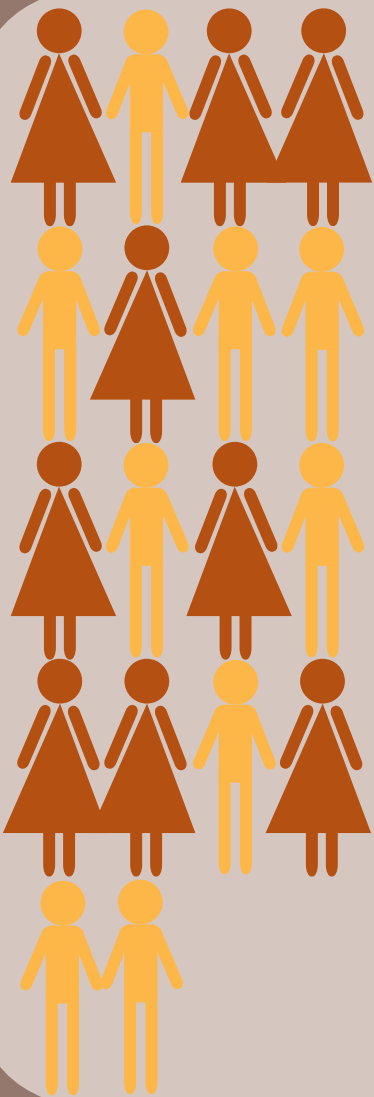
**People who are not usually detected:**

- Are asymptomatic or have minimal symptoms
- Are not aware of their own or partner's risk taking behaviour
- Do not disclose risk taking behaviour
- Have limited access to appropriate services
- Access services but practitioners do not recognise risk and do not offer testing and treatment

90%

UNDETECTED

UNDETECTED



# 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 in Table 3.

Some STIs and BBVs such as chlamydia, gonorrhoea and syphilis fit all of these criteria. For others, only **some** of the criteria fit but this can still be an important strategy. For example, while there is no simple treatment for infections like hepatitis B and 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.

**Table 3:**  
**Principles used to determine appropriateness of early detection and treatment programs**

Criteria for early detection and treatment programs <sup>1</sup>	Chlamydia as an example
The health problem must be significant in the community being tested	Chlamydia is a significant health problem among 15–30 year olds
The consequences of untreated infection should be well understood	Untreated, chlamydia can cause PID, infertility, ectopic pregnancy and poor outcomes in pregnancy
There should be an early stage of the infection that can be detected	Chlamydia can be detected early before symptoms or complications have developed
There should be an accurate test to detect infection at an early stage	NAAT/PCR are accurate tests for detection of chlamydia
The test should be acceptable to the community	Self-collected swabs or urine samples make testing easy and acceptable
Intervals for repeating the test should be determined	Protocols currently recommend: Annual screening for 15–30 year olds 3–6 monthly screening for certain risk groups Repeat testing at three months among people detected with chlamydia following infection
Treatment at an early stage should be of more benefit than at a later stage	Early detection and treatment prevents or limits complications developing
The benefit of early detection and treatment should outweigh the physical and psychological risks associated with it	Treatment of chlamydia early is associated with less risks than managing complications
The benefits associated with early detection and treatment should outweigh the costs of treating complications as a result of not detecting disease early	It is more cost effective to detect and treat infection early than it is to treat the complications of infection
There should be adequate health service provision for the treatment and management of cases detected	There is adequate health service provision available for the treatment and management of cases detected

<sup>1</sup> Adapted from The principles and practice of screening for disease. By Wilson J, Junger G. Geneva: World Health Organization, 1968.

## Who should early detection and treatment programs be directed at?

To be most effective, early detection and treatment programs should be directed to those at greatest risk of STIs and BBVs. Spending a lot of time and resources testing people who are unlikely to be at risk of a STI or BBV has limited benefits and diverts resources away from where they are needed most. However, people of any age can get STIs and BBVs and sometimes it is 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 BBVs are common (high prevalence populations)

People at high risk of STIs and BBVs because they belong to either a specific age or risk group 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 for chlamydia and gonorrhoea to all 15- to 30-year-olds when they are presenting at your health service.

While gonorrhoea is notified much less frequently than chlamydia among Aboriginal people in NSW, the rates remain high enough in many regions to warrant routine testing, and many communities remain vulnerable to the possibility of outbreaks. The decision to routinely test for gonorrhoea when testing for chlamydia should therefore be guided by local prevalence data.

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

While people of any age can get a STI or BBV, the number of infections among the total population aged less than 15 and older than 30 is relatively low, therefore testing everyone in those age groups to detect the relatively few with infection is not cost effective. Tests like the NAAT/PCR<sup>2</sup> become less accurate when used in populations where an infection is uncommon and can result in false positive test results. False positive test results can have significant implications particularly for young people and their families. Despite this, NAAT/PCR tests are still appropriate when offering testing to those in these lower and upper age groups if they require testing based on sexual history or declared risk behaviour and will be more effective if testing is limited to the subgroup within the low prevalence population who are at high risk or present with symptoms of infection.

<sup>2</sup> Nucleic Acid Amplification Test/Polymerase Chain Reaction

### 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 BBVs, 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, p.16). Infections such as HIV, gonorrhoea and syphilis also affect other risk groups such as men who have sex with men. Routine testing for STIs and BBVs among specific risk groups may therefore need to be guided by risk factors rather than by age alone.

### b) Persons aged less than 15 years

Overall, there is also a low prevalence of STIs and BBVs among those aged less than 15 years, though infections can occur as a result of:

- Transmission from mother to baby (0–6 months)
- Sexual abuse (any age)
- Consensual sexual activity (between 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 BBVs.

**There are several important issues that need to be considered before testing people under 15 years of age.**

#### Issues to consider before testing people aged 15 years or younger for STIs and BBVs

##### Consent to testing and treatment

- 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
- Anyone under the age of 14 requires the consent of a parent or guardian
- Further information on testing minors can be obtained from the NSW Ministry of Health<sup>3</sup>

<sup>3</sup> See the NSW Health Policy Directive Consent to Medical Treatment – Patient Information Policy Document 2005.



## Sexual activity among persons aged 14 and 15 years old

Evidence from national surveys shows a significant number among this age group are sexually active.

This age group is particularly vulnerable to teenage pregnancy, drug and alcohol use, mental health issues and sexual abuse.

Rates of STIs and BBVs begin to increase in this age group, therefore it is important that they have access to appropriate information, testing and treatment.

Practitioners should be familiar with issues regarding consent to testing and mandatory reporting guidelines when working with this age group.

## 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.

The majority of children who are abused do not acquire a STI or BBV.

Not assessing children appropriately can lead to abuse being overlooked as well as children not at risk being falsely identified. Both 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.

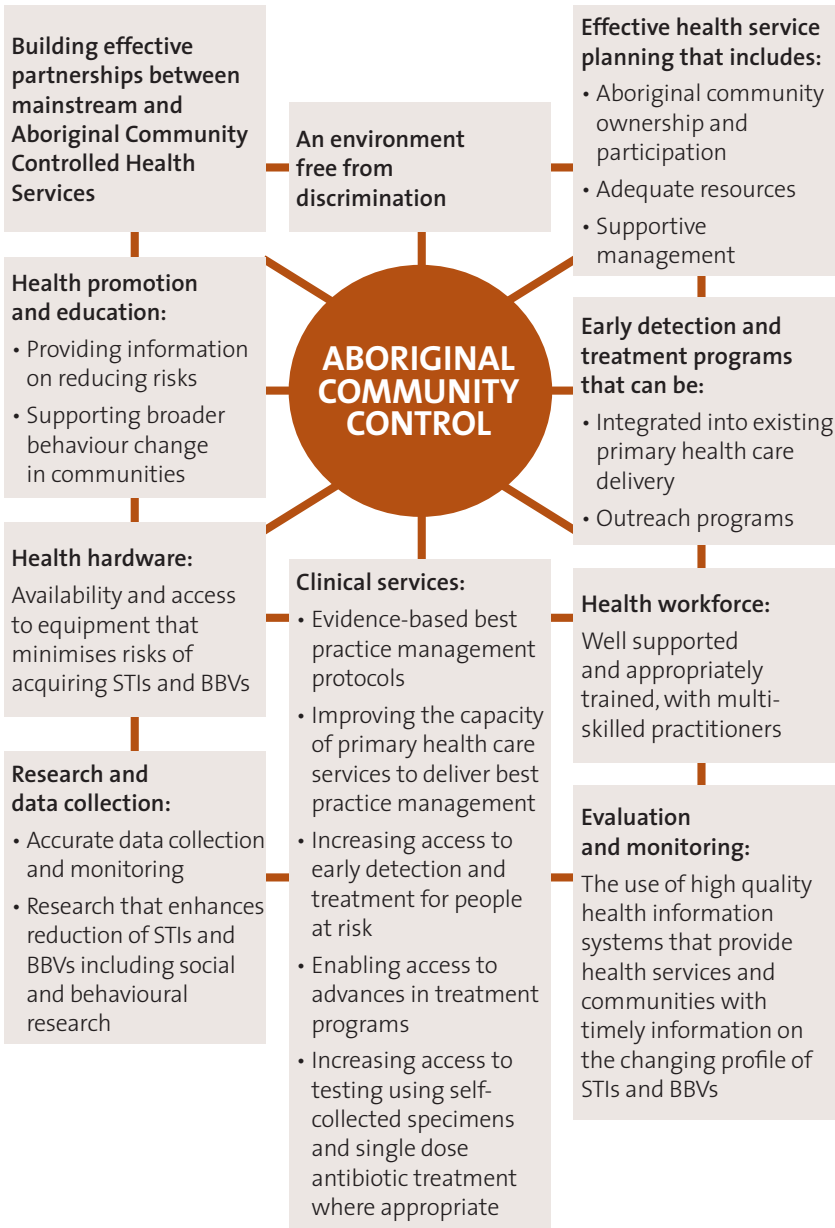
Sexual abuse is a serious problem. If there are any concerns about children at risk, then appropriate staff and services need to be involved in assessing and managing those children.

There have been recent changes to the legislation that supports child protection and child wellbeing in NSW, including the *Keep Them Safe* reforms. For more updated information see *Child Wellbeing* and *Child Protection NSW Interagency Guidelines*.

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

Early detection and treatment programs are not a stand-alone strategy, but an important component of sexual health programs. They should be implemented as whole of clinic practice alongside prevention education and other clinical programs that opportunistically can offer STI and BBV testing.

Diagram 2:  
Core components of a Sexual Health Strategy  
applicable to Aboriginal communities<sup>4</sup>



<sup>4</sup> Adapted from Nganampa Health Council *8 Ways to beat HIV*.

## *Chapter 3:*

# IMPROVING ACCESS TO STI AND BBV EARLY DETECTION AND TREATMENT SERVICES

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### key points

- Access to services is essential for successful STI and BBV 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 BBVs can be delivered through existing services without requiring a lot of additional resources. People at risk of STIs and BBVs do attend a variety of health services for other related or unrelated health problems, 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 consider how STI and BBV testing can be offered as standard and normalised during care for at-risk groups when they present at services. 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.

Health services should strive to:

- 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 that 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 BBVs access?

The reasons why people access different health services are 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, and personal preference.

TABLE 4:  
Examples of health services that Aboriginal people at risk of STIs and BBVs 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 Service	Emergency Departments Obstetrics and Gynaecology Departments

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 BBV
- Identify that they could be at risk of getting a STI or BBV
- Identify with a particular community or risk group that the service specifically caters for
- Already have a STI or BBV 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 BBVs. In this context it is usually straightforward to discuss issues regarding STIs and BBVs.

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 BBVs.

Most people with STIs and BBVs 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 BBVs 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**, routine Pap smears, and when people present for reproductive health and contraception issues, to incorporate

sexual health tests as part of a holistic check up, making it more acceptable to clients and practitioners.<sup>5</sup>

Further information is available in Chapter 6 on incorporating STI/BBV checks with other clinical presentations.

## 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 the following:

- What health services do people at risk already access?
- Do they present to these health services specifically for STI and BBV 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 BBVs?
- 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.

## Considerations for access

Some of the things that need to be considered are outlined below.

### Health service infrastructure

- Location of the service
- Distance between the service and the community
- Availability of transport
- Private areas and appropriate points of access for men and women
- Opening hours that are appropriate for the community
- Providing clinics for specific groups such as youth.

### Workforce

- Ensure privacy and confidentiality are respected
- Culturally sensitive service delivery
- Non-judgemental and non-discriminatory attitudes and behaviour

<sup>5</sup> Information regarding the Aboriginal and Torres Strait Islander Adult Health Checks is available from the Commonwealth Government Department of Health and Ageing.

- Have an appropriate mix of staff including male, female and Aboriginal practitioners
- Support staff to attend training to ensure a skilled workforce who can deliver STI and BBV programs
- Support staff to work collaboratively within the service and in partnership with other services to maximise the use of different skills and expertise.

## Management

- Integrate early detection and treatment of STIs and BBVs 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 BBVs
- Use single dose antibiotic treatment when appropriate to ensure adherence to medication and effective cure rates.

## Partnerships

Improving access to STI and BBV 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 BBVs.

Where partnerships don't exist they should be considered to improve access. The development of a Plan for Working Together, a memorandum of understanding (MOU), or a service level agreement 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.

## Example of partnerships – Bulgarr Ngaru

This example highlights flexible and creative ways of accessing hard-to-reach groups and building positive relationships.

### Building partnerships to enable prison outreach

Aboriginal Health Workers from Bulgarr Ngaru Aboriginal Community Controlled Medical Service, Grafton, have been working with Justice Health Nurses to provide an outreach service to Aboriginal men incarcerated in Grafton prison.

This partnership can provide a link between inmates, their families and community, especially where there are difficulties around access by family members. The establishment of ongoing contact with Aboriginal men in a high-risk situation enables engagement around safe behaviours in hepatitis C prevention and sexual health, education about BBV transmission, building the rapport and trust of health workers by inmates, and ongoing contact with a high-risk population.

Often sexual health or BBV information will be 'packaged' within a conversation about tattooing, for example, something that inmates are interested in, and once a relationship has been established the inmate is more likely to receive a message about safe tattooing or blood awareness. A relationship built up in the prison setting can also be continued after release.





# PART B

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## Early detection and treatment programs



## Chapter 4:

# MODELS OF STI AND BBV EARLY DETECTION AND TREATMENT PROGRAMS

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### 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:
  - Integrating programs into existing health service delivery
  - Reorientating existing health service delivery to access at-risk groups
  - Delivering outreach or community based programs
- The easiest and most cost-effective strategy is to integrate testing for STIs and BBVs 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 BBV early detection and treatment program delivery

## How can STI and BBV 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 BBV early detection and treatment into existing health service delivery
2. Reorient existing health service delivery
3. Conduct outreach or community based programs.

More practical detail about how to integrate early detection and treatment and how to deliver outreach programs is provided in Chapters 5 and 6.

## Integrating STI and BBV 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 quick and easy testing routinely to all people aged 15 to 30 and other identified risk groups.

### **Integrating STI/BBV early detection and treatment programs into existing primary health care delivery – some issues to consider:**

- Requires less time, resources and costs to implement than outreach programs
- There is increased 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
- Testing can be incorporated in an easy and acceptable way into routine service delivery provided to people already accessing services
- Normalises and de-stigmatises testing and treatment

- Gives generalist staff an opportunity to become more skilled in the management of STIs and BBVs
- Can be offered by more staff, in many circumstances on a continual basis, making it more sustainable in the long term
- Need 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 a STI/BBV check into existing health service delivery

A STI and BBV 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 including antenatal checks, contraception, pregnancy tests, urinary tract infections (UTIs) or referrals for termination of pregnancy or insertion of contraception devices
- Pap smears – for women who are 18 years or older, or who have been sexually active for more than 2 years, whichever is later
- Unrelated health issues (opportunistic testing)
- Vaccinations for hepatitis B, hepatitis A or HPV.

### 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.

Integrating testing within ACCHS requires all clinical staff offering testing to at-risk groups in a consistent way. Ideally this should be led by key personnel within the service.

For more information on offering testing, please go to Chapter 6.

## Reorienting 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.

Working with local community based organisations such as youth groups/organisations, employment programs schools and sporting groups will facilitate enhanced access to these clinics.

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

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

## 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 BBV 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 timeframe
- 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
- Employment programs
- Temporary or crisis accommodation settings
- 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 BBVs to other programs

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

Linking early detection and treatment of STIs and BBVs 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 tests for STIs and BBVs. If it's 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 BBV 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 BBVs 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 5:

# DECIDING WHAT TESTS TO TAKE AND HOW TO TAKE THEM

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### key points

- Whether a simple or full STI/BBV check up is offered is influenced by both the reason for offering testing and the context of health service delivery
- A simple STI check up involves the use of self-collected specimens which:
  - are acceptable, quick and easy to collect
  - can be offered by all practitioners
  - can be offered in almost all settings
  - are suitable for early detection among people at risk of STIs but who have no symptoms
  - can be easily integrated into routine primary health care delivery
- A full STI and BBV check up involves taking a thorough history, examination and tests for STIs and BBVs and:
  - should be offered to people of any age who present with any signs or symptoms of STIs/BBVs or who request a check up
  - should be offered by practitioners accredited to take a thorough history and examination

## Simple and Full checks ups

When delivering early detection and treatment programs, whether a simple or full STI/BBV check is offered will depend on the reason why the person has presented and the context in which testing is offered. What tests are taken should be guided by what STIs and BBVs are common in the region and among specific risk groups.

While it is always ideal to offer a thorough sexual health check up if possible, the inability to take a sexual history or risk assessment should not be a barrier to gaining consent to STI and BBV testing. A simple STI/BBV check up may be the most appropriate in many circumstances particularly among young men and women who may have presented for other reasons, who have no symptoms and where time and availability of skilled practitioners is limited.

## Simple STI and BBV checks

A **simple** STI check up usually involves taking self-collected specimens at a minimum, and blood tests if possible.

### Advantages of a simple STI and BBV check:

- 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 BBV check includes:

- Obtaining consent to testing
- If appropriate, 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 syphilis, hepatitis B, hepatitis C, HIV if possible.

## Full STI and BBV checks

A **full** STI and BBV 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 a STI or BBV or have identified risk factors. While full STI and BBV 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.

### Full STI and BBV checks should be offered to anyone of any age presenting to any health service if they:

- Present with any genito-urinary symptoms
- Had a STI or BBV detected on an asymptomatic screening test
- Are a sexual contact of someone with a STI or BBV
- Disclose a risk history, or are concerned that their partner's behaviour could be putting them at risk
- Request a sexual health check up.

### Full STI and BBV check ups involve\*:

- Taking a thorough social and sexual history
- Examination: speculum and bimanual examination for women
- Tests (as described in more detail in Table 5, p.46):
- 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 BBVs are common in the region, the specific risk group, risk assessment and the local laboratory. Check with local protocols on what tests are recommended in state or national guidelines.

\*\*A high vaginal swab for MCS is useful to check for candida, bacterial vaginosis and trichomoniasis. A high vaginal swab for PCR should only be taken if trichomonas is common in the community being tested. More information regarding what tests should be offered to different risk groups is outlined in STIPU guidelines – [www.stipu.nsw.gov.au/content/Document/Priority\\_Populations.pdf](http://www.stipu.nsw.gov.au/content/Document/Priority_Populations.pdf)

Irrespective of whether you are offering simple or full check ups, the principles and practices of testing should be followed including:

- Ensure privacy and confidentiality
- 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 Chapters 6 and 9 for further information pertaining to these issues.

## What is a risk assessment?

Ideally a thorough sexual and social history should be taken by a skilled practitioner as part of a thorough check up. A simplified risk assessment can also assist practitioners to identify whether a person has symptoms or risk factors for specific STIs or BBVs which may require an examination or further tests.

### A simple risk assessment:

#### Questions for 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 abnormal menstrual bleeding?

## How often should **early detection** and treatment of STIs and BBVs be offered?

Current protocols recommend annual testing for young people and more frequent screening for other groups such as men who have sex with men.

Recent evidence suggests that annual testing among young women may not be frequent enough to prevent pelvic inflammatory disease developing; however, evidence is lacking to guide how frequently testing should be offered.

Current protocols recommend a STI and BBV check:

- Once a year for 15- to 30-year-olds
- More frequently for anyone who frequently changes partners or presents with symptoms
- At first antenatal visit for all pregnant women and in 3rd trimester for those at higher risk
- At three months following treatment of chlamydia and/or gonorrhoea to check for re-infection.

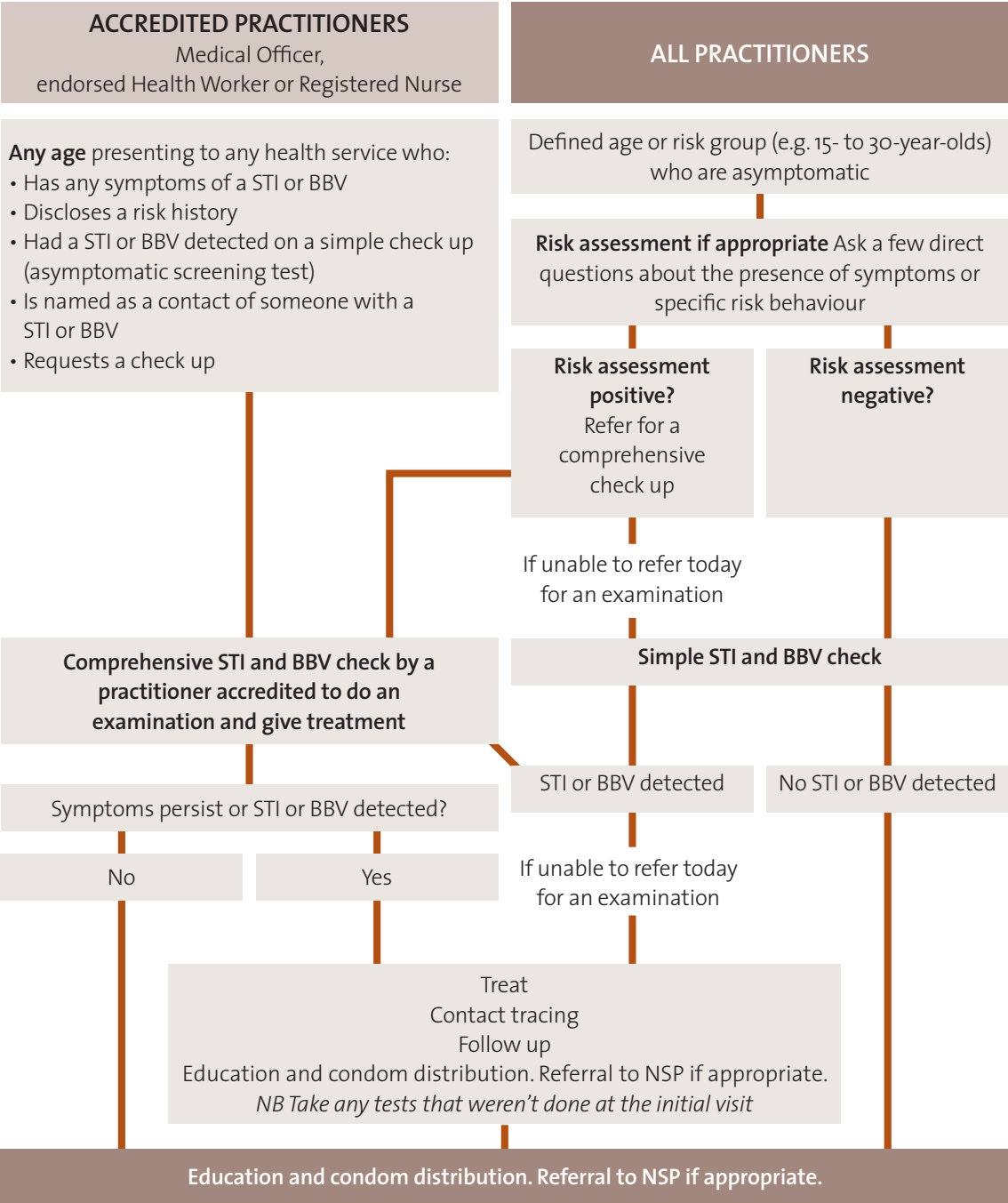
## Choosing **what type** of STI and BBV check to do

Use the flow chart (Diagram 3) as a guide to what type of check up should be offered.

DIAGRAM 3:  
Choosing Simple or Full check ups

Working through the flow chart will determine:

- What tests will be taken
- Whether a simple or comprehensive STI and BBV check will be offered.



## Specimen collection for STIs and BBVs

There are a number of different approaches to testing and different tests that can be taken as part of a STI and BBV 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 BBVs are common in the risk group?

Tables 5 and 6 should be used together as a guide to what STIs and BBVs are common among different risk groups and what specimens can be taken for testing. The prevalence of some STIs and BBVs, 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.

More information and fact sheets on taking self-collected specimens can be accessed through the NSW STI programs unit (STIPU) website.

**TABLE 5:**  
**Common STIs and BBVs among different risk groups**

RISK GROUP	STI & BBV
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 6:  
What specimens can be taken for the  
detection of STIs and BBVs

STI OR BBV	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	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 6:

# INTEGRATING STI AND BBV TESTING INTO ROUTINE PRIMARY HEALTH SERVICE DELIVERY

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### key points

- Integrating STI/BBV testing into routine primary health service delivery is the easiest and most effective way to ensure young people are provided with appropriate information, testing and treatment
- Currently there are low rates of STI testing among the age group at highest risk (15 to 25) who are already accessing services
- Young men and women do access primary health care services but differ with regard to the reason for presentation and frequency of visits
- The successful integration of STI/BBV testing into routine antenatal screening provides an example of how testing can be integrated into other consultations in a way that is easy, acceptable and sustainable
- Testing coverage rates could increase significantly by addressing current gaps in testing and systematically integrating STI/BBV testing into:
  - Routine and opportunistic health checks for 15- to 30-year-old men and women
  - Reproductive health presentations among young women

## Integrating STI/BBV testing

Despite the availability of accurate tests, effective single dose treatment and health promotion campaigns, a sustained decline in the prevalence of chlamydia across Australia has yet to be observed. However, there are examples of successful programs that have measured significant and sustained reductions in chlamydia and gonorrhoea. Factors central to the success and sustainability of programs include:

- Supportive and effective management
- Integration of early detection of STIs and BBVs into routine primary health care delivery
- High testing coverage rates among young men and women
- Continuous evaluation, feedback and utilisation of quality data to guide program activity or Continuous Quality Improvement (CQI)
- Program co-ordinators who drive the program and support the capacity of health services and staff to integrate early detection and treatment of STIs and BBVs into routine primary health care delivery.

## Current gaps in STI/BBV testing and management

There is limited information available regarding the implementation and outcomes of STI/BBV early detection and treatment programs delivered through ACCHS in NSW. However, data from recent studies and CQI programs conducted in a range of primary health care services indicate some consistent findings with regard to the detection and management of STIs and BBVs which have implications for program delivery.

Consistent findings include the following:

- Most chlamydia infections are among people aged 15 to 25 years
- 15- to 19-year-old women and 20- to 25-year-old men are the age groups at highest risk of chlamydia
- Overall, there are low testing rates among 15- to 25-year-olds already accessing services
- Many more women than men are tested for STIs and BBVs which is due mainly to testing women at the time of antenatal and cervical screening
- Very little testing is occurring consistently among young women outside of antenatal and cervical screening
- The low rates of testing among men is not simply a result of men not accessing services, but due to young men not being offered testing in an appropriate and consistent way when they do access services.

Significant opportunities are being missed for integrating STI/BBV testing into routine primary health care delivery among 15- to 30-year-olds, including:

- Routine health screening such as adult health checks among both men and women
- Reproductive health visits among women particularly for contraception, pregnancy tests, urinary tract infection (UTI) and referral for instrumentation of the genital tract
- HPV and hepatitis B vaccination
- Low rates of testing for other STIs/BBVs (e.g. HIV, syphilis, hepatitis B/C) among people detected with chlamydia and/or gonorrhoea or who present with STI symptoms, as STI contacts or who request a sexual health check up
- Low rates of follow up testing at three months to check for re-infection with chlamydia or gonorrhoea
- Significant gaps in the management of women presenting to primary and tertiary health care services with signs and symptoms of STIs including poor outcomes in pregnancy
- People identified with chronic hepatitis B and C not receiving adequate information, management and referral.

## Addressing **current gaps** in STI/BBV testing

Addressing the current gaps in STI/BBV testing among 15- to 30-year-olds already accessing services should be relatively straightforward particularly if services already have good systems in place that facilitate effective service delivery.

The early detection of STIs and BBVs has been successfully integrated into routine antenatal screening in many services in a consistent, easy and acceptable way. Antenatal screening therefore provides a good example of how STI/BBV testing can be integrated easily into other consultations and routine health screening.

### **Antenatal screening – an example of how early detection of STIs and BBVs can be easily integrated into routine service delivery**

**All** antenatal women are offered routine tests at regular intervals in pregnancy irrespective of their individual risk, to prevent or limit poor health outcomes for women and their babies. Women are informed about what tests are taken and why, and can choose to opt out of any testing. Most consent to testing but some may request more information or decide to be tested at a later visit.

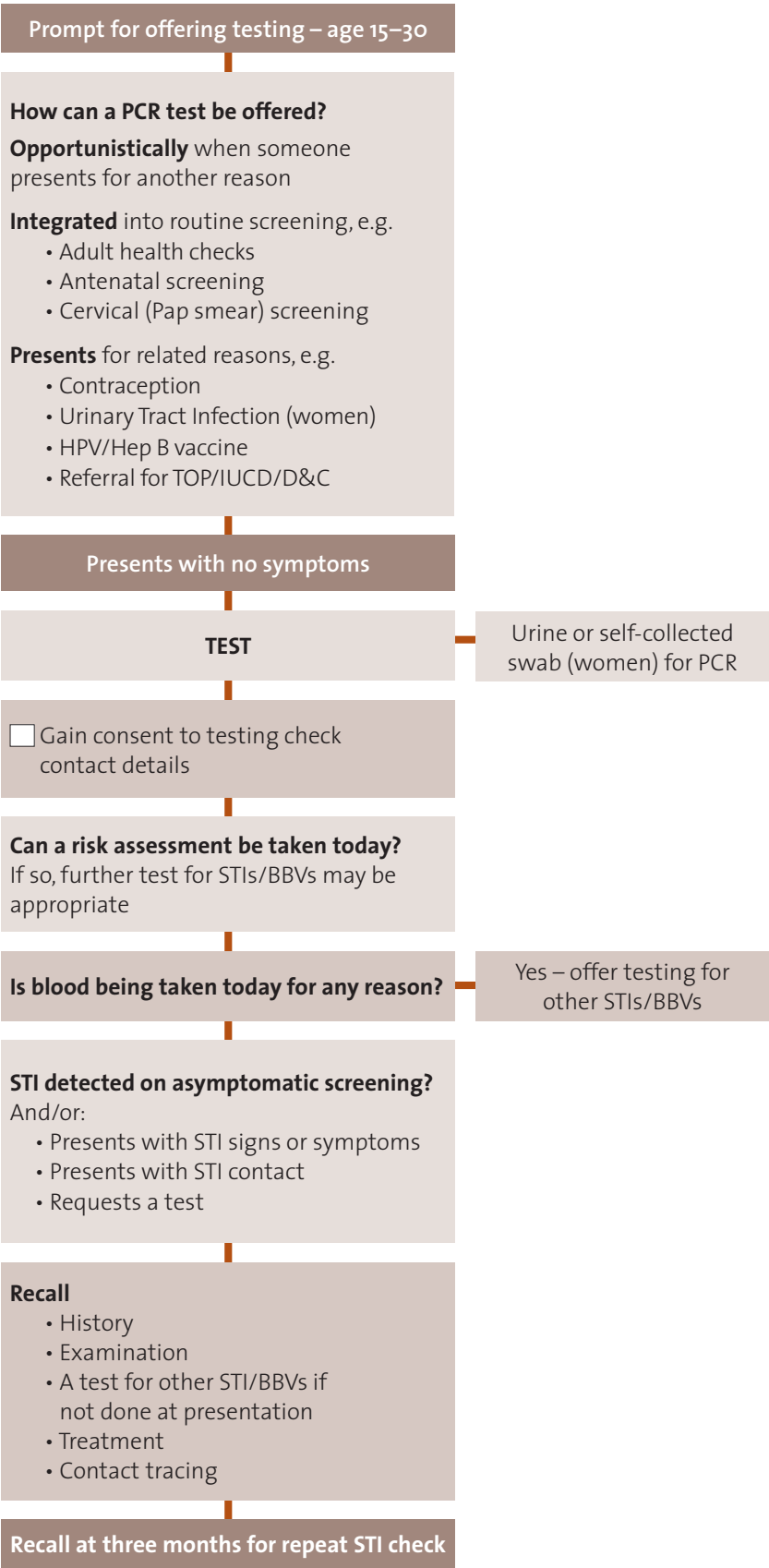
Consent to testing must be gained for all tests conducted but this can be done in a straightforward manner:

- Explain that ALL antenatal women are offered routine tests at their first antenatal visit
- Explain what tests are offered
- Explain why testing is important
- Obtain verbal consent for testing
- Provide an opportunity for women to ask questions or raise any concerns.

In a similar way early detection of STIs and BBVs can be offered routinely to young people who access services for various reasons but who we know are at risk simply because of their age. While it is important to encourage young people to access services and request a check up, health services should be proactively offering early detection of STIs and BBVs to 15- to 30-year-olds in a consistent, normalised and appropriate way.

Be mindful that it is not always easy for young people to request testing for STIs and BBVs and they may use indirect ways to ask for a check up, such as asking for a Pap smear, or a women's or men's health check.

DIAGRAM 4:  
Early detection (asymptomatic/population screening)



Health checks or consultations where integrating STI/BBV testing for 15- to 30-year-olds is appropriate include:

- Antenatal screening
- Cervical (Pap smear) screening
- Adult health checks
- Initial health screening such as blood pressure, blood sugar level, urinalysis and weight that are often routinely taken at presentation
- Reproductive health visits for women and in particular consultations relating to:
  - Contraception
  - Pregnancy tests
  - Urinary tract infections (UTI)
  - Referral for instrumentation of the genital tract (TOP, IUCD insertion)
  - HPV or hepatitis B vaccination.

## Taking a sexual history or risk assessment among 15- to 30-year-olds

While taking a sexual history and offering a thorough check up is always the ideal, this is often difficult to achieve in the context of primary health services. Factors that impact on the ability to do this easily include the following:

- Clients may feel uncomfortable or may be unwilling to disclose information about their sexual history, particularly if they have presented for unrelated reasons
- Practitioners may feel uncomfortable if they lack the skills and experience to take a sexual history
- The relationship or gender of the practitioner to the client may make it difficult or inappropriate to take a sexual history
- There may be limited time available to take a sexual history.

Most of these barriers can be managed by ensuring a sensitive approach and asking permission to ask questions about their sexual history or other risk behaviour. Practitioners who do have the skills and experience to take a history in an appropriate way should be encouraged to do so, however the inability to take a sexual or risk history should not pose a barrier to offering STI and BBV testing.

In the same way that routine antenatal screening is offered on the basis of pregnancy alone and not on the basis of real or perceived risk factors, testing for STIs such as chlamydia should also be directed to people who we know may be at risk simply because of their age. STI testing should be offered routinely to 15- to 30-year-olds based on the knowledge that STIs are common in this age group, even though most people will have no symptoms or not think that they are at risk. Therefore, while the presence of symptoms or identifiable risk factors may determine whether an examination or other tests should be done, their absence should not influence the decision to offer testing to that age group.

In contrast, STIs among people aged over 30 are much less common, therefore their individual risk assessment will influence whether STI/BBV testing is offered.

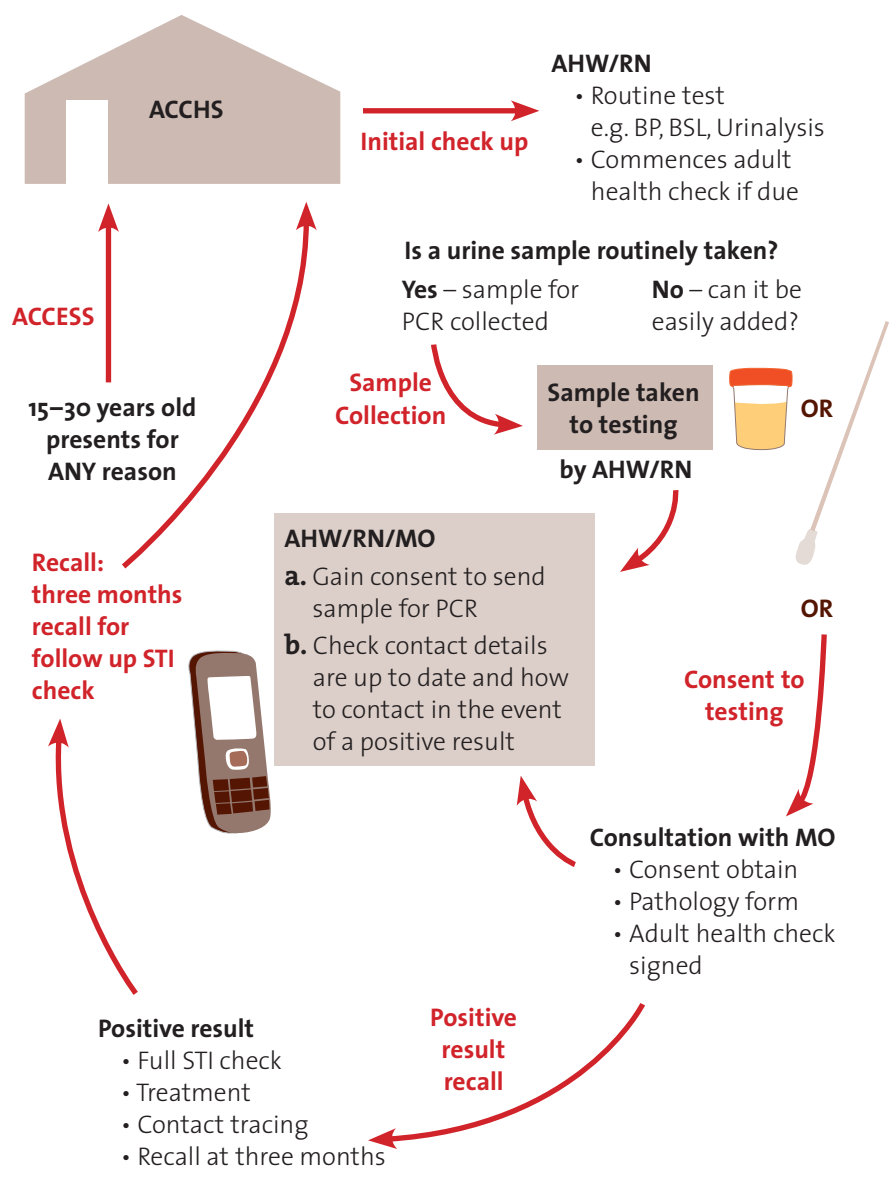
## Utilising health service systems to integrate early detection of STIs and BBVs

The integration of early detection of STIs and BBVs is easier if consistent and effective systems are already in place in the health service. Identify what systems are in place or could be strengthened that would facilitate the integration of STI and BBV testing into routine health service delivery.

For example, urine samples are taken frequently for urinalysis, pregnancy tests or urine culture. Urine is taken routinely for urinalysis at presentation to many health services as part of initial health screening along with blood pressure, weight and blood sugar level. If a urine sample is already collected, gaining consent to send the sample for chlamydia and gonorrhoea PCR is usually straightforward. If it is not taken routinely, consider taking a urine sample routinely for urinalysis among 15- to 30-year-olds, not only to check for other health issues, but to also facilitate sample collection and consent for PCR testing.

Taking blood can add time to a consultation and may not always be necessary or appropriate. However, if blood is taken for any reason it is usually straightforward to gain consent for testing for other STIs and BBVs. Not offering STI and BBV testing to people who are already having urine and/or blood samples collected represents significant missed opportunities for integrating early detection of STIs and BBVs in a simple and acceptable way.

DIAGRAM 5:  
Integrating early detection of STIs  
(asymptomatic/population screening)  
into routine primary health care





## How to gain consent to testing

Whether people consent to testing is influenced by the way in which it is offered. Young men and women are more likely to consent if they understand that testing is offered routinely to certain age groups and why, and that testing can be done quickly and easily.

Starting the conversation with questions such as ‘do you think you might have a STI?’ or ‘do you want a STI check?’ will often result in a refusal as most will have no symptoms and may not consider themselves at risk. Young men and women may also be worried about what a STI check up might involve and may be unsure or fearful of what they are consenting to. However, if the offer of testing is approached in a similar way to antenatal or other routine health screening, that it is being offered to everyone aged 15 to 30, the majority of people will consent to testing.

### Gaining consent to STI and BBV testing

Key information should be given so that informed consent to testing can be given. Below are examples of how consent can be gained in a simple way.

Even though you are here for another reason today, I want to let you know that we offer all 15- to 30-year-olds a regular check up for chlamydia and gonorrhoea

Testing can be done simply with a urine or swab test that you can take yourself

You’ve already taken a urine sample today – would you be happy to send this sample to the laboratory to check for chlamydia and gonorrhoea?

If you want to have a full STI/BBV check, that involves also taking a blood test – do you want to have a blood test today to check for HIV/syphilis/Hepatitis B/C as well? (if yes, provide appropriate information)

How would you like to be contacted if the test comes back positive so that we can give you treatment? (check details are up to date)

Do you have any questions or would you like more information about STIs and BBVs?

Turnover of staff is an issue for most health services and presents challenges for the sustainability of programs. While relying on only a few practitioners within a service to offer STI and BBV testing and management can lead to short term gains, programs risk falling over if those individual staff members leave. Programs are more likely to be successful and sustainable if early detection of STIs and BBVs is integrated into routine service delivery involving a team approach.

**Factors that contribute to the successful and sustainable integration of early detection of STIs and BBVs include the following:**

- Have a systematic and coordinated whole of team approach
- Develop or strengthen systems in a way that supports easy integration of testing
- Identify where samples such as urine and/or blood are already collected or could be routinely collected
- Identify who should obtain consent to testing
- Ensure good communication so that staff are clear about how samples will be collected, who will gain consent to testing, how to contact a client in the event of a positive result
- Ensure new and visiting staff are orientated to relevant protocols or systems within the service
- Regularly extract and give feedback of data to staff, to help identify any gaps and fine tune programs (CQI).



# PART C

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## **Planning, implementing and evaluating early detection and treatment programs**

## *Chapter 7:*

# REQUIREMENTS FOR STI AND BBV EARLY DETECTION AND TREATMENT PROGRAMS

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### 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.

**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 NSW
  - NSW Users AIDS Association (NUAA)
  - Australasian Society for HIV Medicine (ASHM)
  - NGOs providing education/health promotion.

**Community based organisations:**

  - Youth centres
  - Gay and lesbian organisations.

**Networks:**

  - NSW Aboriginal STI, HIV and Hepatitis C Workers Network
  - NSW Aboriginal Drug and Alcohol Network
  - Australasian Sexual Health Nurses Association.

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
- appropriate Aboriginal consultation processes have taken place
- 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 the NSW Ministry of Health.

## 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.

## 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.

## 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 BBVs
- 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 Ministry of 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 BBVs
- Maximise the capacity of individuals and communities to maintain and enhance sexual health



- Maximise mental and physical wellbeing associated with sexuality, sexual function and relationship issues.

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 and gender
- 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 BBVs
- Symptoms of STIs and BBVs (promoting early presentation for testing if the person has been at risk or is symptomatic)
- Complications of untreated infections
- Transmission and prevention of STIs and BBVs
- Testing and treatment of STIs and BBVs
- Where to access condoms and needle and syringe programs (NSP)
- 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 and NSW Ministry of 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 10 for more detail on program sustainability).

## *Chapter 8:*

# PLANNING THE DELIVERY OF STI AND BBV EARLY DETECTION PROGRAMS

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### 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?
  - Will a risk assessment will be done at the time of testing?
  - What equipment and medications will be needed?

## 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.

Other considerations:

- 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, employment 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 their roles and responsibilities, what information will be collected and how it will be fed back to health service staff and/or community members.

## 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
- Whether there is enough space and appropriate facilities available if a temporary clinic site is utilised
- Whether the location and facilities are acceptable to both male and female participants
- Whether transport will need to be arranged
- Whether the location will enable adherence to occupational health and safety guidelines
- 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
- Toilets that are located close to the clinic room and can be accessed separately by men and women
- 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 and waiting times are kept to a minimum.

## 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 to receive pathology results. 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 explaining the following:

- 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 BBVs will be tested for and what specimens will be taken
- 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 5 outlines the difference between doing simple and full STI and BBV 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 BBVs will require a lot more time and resources than others. In general, deciding what tests and specimens to take will be influenced by:

- Who will be invited to participate (e.g. youth)
- What STIs and BBVs are likely to be identified among the participants
- How many people are expected to participate
- How much time and resources are available
- 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 BBVs, 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
- What information may need to be notified and to whom (notifiable diseases).

**Who can give consent to testing and treatment of STIs and BBVs?**

- 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. Written consent forms are not necessary but can be useful by providing information in a standard way.

**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.

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. A summary discussion of pre-test discussion should include:

- Reason for testing and risk assessment
- Timing of risk and option of post-exposure prophylaxis (PEP)
- Need for other STI and BBV testing
- History of testing
- Confidentiality and privacy issues around testing
- Ensuring there is informed consent for the test
- Natural history and transmission information (if appropriate)
- Prevention of transmission and risk reduction through behaviour change
- Implication of a positive or indeterminate test result, including availability of treatment
- Implications of a negative test result
- Explanation of the window period
- General psychological assessment and assessment of social supports in the event of a positive result
- Logistics of the test: time taken for results to become available and the need to return for results.

**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
- Whether the laboratory are able to collate the results that can be used in a report.
- Decide who will be responsible for reviewing the results.

**Follow up any positive results**

- Collate the results into a report
- File or store results.

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 ensure efficient processing of the increased number of 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.

## 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 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 about 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, and 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 11. 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
- 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 BBVs. 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 may 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 9:*

# 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 transport need to be arranged?
- How will the different spaces and rooms be utilised to enable giving education, obtaining consent and 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 inform 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
  - To label specimens and pathology forms
  - To educate participants, either prior to or post testing.

## Specimen collection, storage and transportation

- 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 could 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 BBVs

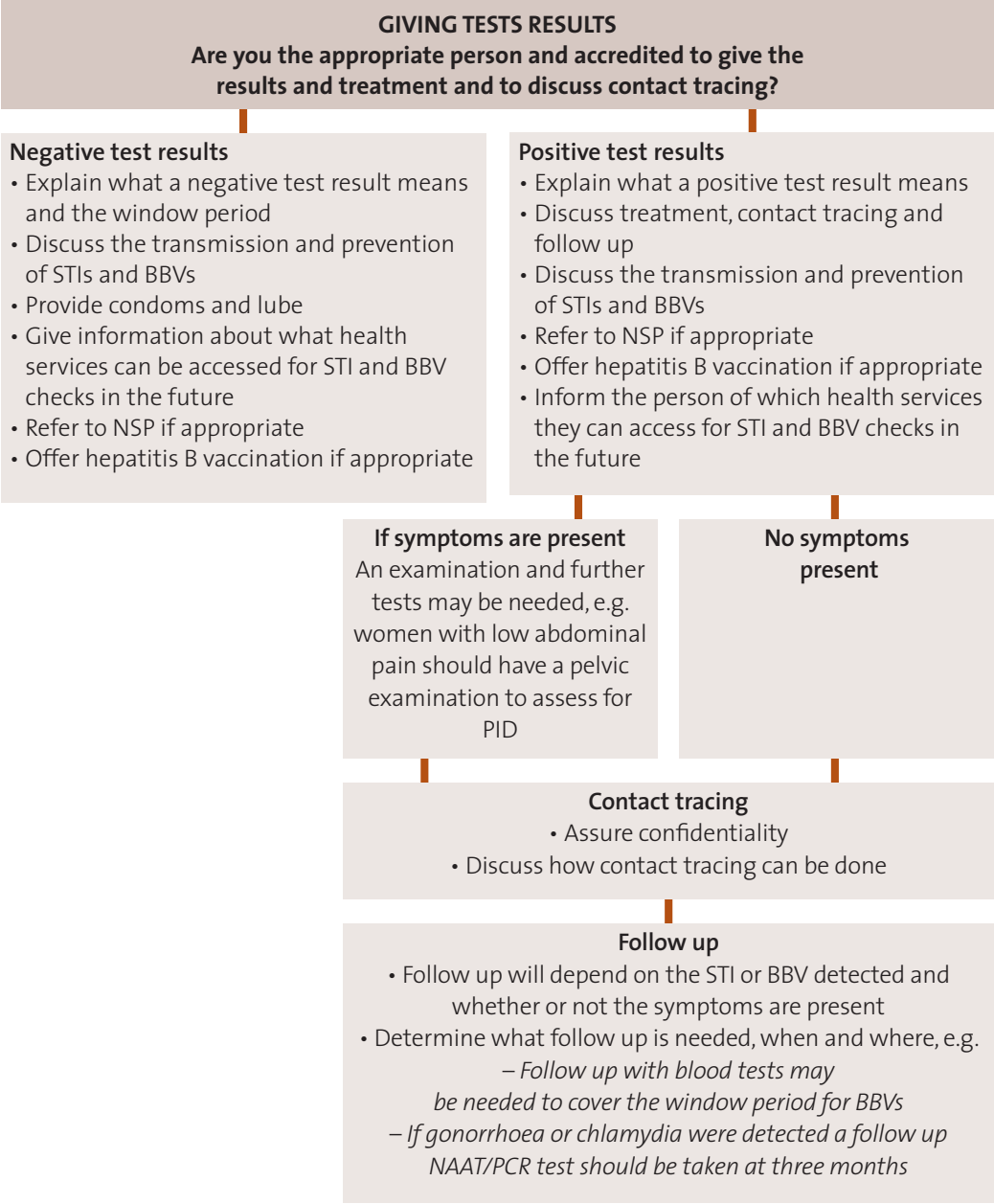
- Discuss window period and need or not to retest
- Provide condoms and lube
- Inform people what health services they can access for STI and BBV checks in the future
- Refer to Needle and Syringe Program (NSP) (if appropriate)
- Offer hepatitis B vaccination (if appropriate).

### 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
- Offer blood tests to check for other STIs and BBVs if not done at the initial visit (HIV, syphilis, hepatitis C and hepatitis B if appropriate)
- Discuss treatment
- Explain the importance of contact tracing regular and casual partners to prevent re-infection and transmission to others and ensure appropriate steps are taken for the follow up of contacts.

Diagram 6:  
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 being taken. Treatment should be given by a practitioner who is accredited to do so and should be consistent 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 re-infection 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 BBV
- Document all treatment and follow up on the case management forms and in the person's notes.

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

### Follow up

What follow up is needed will depend on what STI or BBV 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 three months to check for re-infection for both gonorrhoea and chlamydia.

### 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
- The planning, delivery and follow up
- 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) or Working Together agreement 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 the information will 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.

## 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 re-infection and transmission to others.

The aims of contact tracing are to:

- Interrupt the ongoing transmission of infection
- Identify people who are infected and provide treatment and minimise potential complications of infection
- Prevent re-infection from untreated partners
- Help limit the prevalence of infection in the population.

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. phone, letter, home visit).

More detailed information regarding contact tracing can be found in the Australasian Contact Tracing Manual 2010.



## *Chapter 10:*

# EVALUATION AND SUSTAINABILITY OF EARLY DETECTION & TREATMENT PROGRAMS

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### key points

- Evaluation is an essential component of any STI and BBV early detection and treatment program and involves:
  - 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 BBV early detection programs is to reduce the prevalence and complications associated with STIs and BBVs 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 BBV, 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 three 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 BBVs
- Shared care arrangements.

## STI performance indicators as an evaluation tool

Key Performance Indicators (KPIs) are increasingly being used in Aboriginal health to monitor and improve program outcomes and clinical service delivery. STI performance indicators are relatively new in development compared to other areas of health but in some states and territories they are being considered for inclusion in mandatory sets of health indicators reportable annually. STI KPIs are intended to enable consistent assessment of actual practice and allow comparisons of STI programs over time and services. The decision to implement STI KPIs is a decision for individual health services to determine. Specifically, STI KPIs enable:

- a measurement of current STI program and clinical service delivery initiatives in health services
- assistance in planning program and clinical service delivery improvements
- an assessment of progress in achieving best practice.

Reporting against STI indicators will depend on the capacity of existing electronic patient management systems and other systems in each health service. Details on specific data requirements and the suggested methods of calculation of rates are not provided here as they vary significantly between services.

Should your service be considering furthering the implementation of an early detection and treatment program we have included a sample set of indicators relevant to early detection and treatment of STI and BBV. The frequency of reporting (e.g. six monthly or annually) as well as reporting by Aboriginal status, by separate age groups (e.g. five year age groups) and by gender will need to be considered with management and all staff involved in program and clinical service delivery.

For some indicators, systems and serious work will be required while others may be implemented simply.

### Sample set of indicators

- Number of condoms distributed monthly and monitoring most successful points of distribution in community and health services
- Number of needle and syringe packs distributed through the

- ACCHS, NSP or vending machines
- Number of education sessions conducted with community members and sites of education sessions (e.g. schools, prisons)
- Number of STI tests conducted each month collated through laboratory reports; specifically:
  - Number of chlamydia tests conducted among men/ women and by age group
  - Number of gonorrhoea tests conducted
  - Number of positive tests for either infection
  - Number of HIV tests conducted per month especially for positive results for any other STI test.

## Sustainability

When establishing STI and BBV early detection and treatment programs, it is important to 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 BBV 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 BBVs 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 BBV early detection and treatment programs sustainable**

- Always involve communities and health service staff
- Incorporate STI and BBV 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 BBVs
- 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 feedback information to health services and communities.

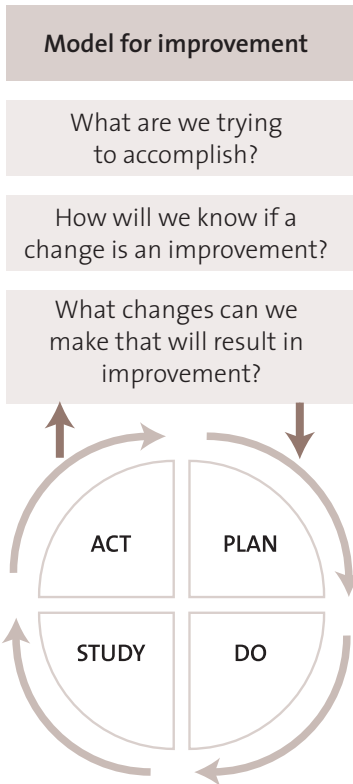
# Continuous Quality Improvement as a strategy for sustaining early detection and treatment programs

Continuous Quality Improvement (CQI) programs are common in many ACCHSs and are aimed at improving health outcomes through a systematic and continuous and cyclic approach.

A number of key elements are essential for CQI programs to work effectively. Firstly, engage all staff involved in the program. Secondly, use a team approach in problem solving and taking action. Thirdly, the outcome of the CQI program should be patient centred and driven by information and organised for efficiency.

CQI programs work with a variety of tools and techniques such as Process Mapping or, more commonly, the Plan Do Study Act (PDSA) cycle to assist in the identification of opportunities for service and program delivery improvement, action planning, and measuring and monitoring improvements. The following diagram shows a model of improvement using the PDSA cycle.

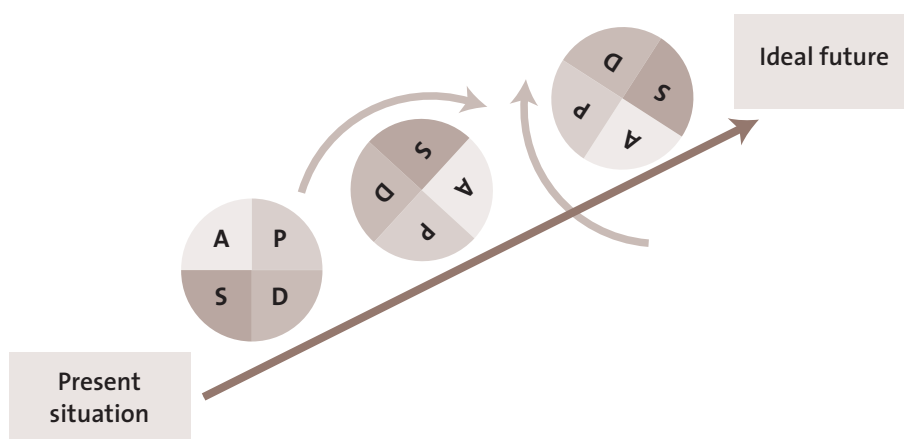
Diagram 7:  
Plan Do Study Act cycle



1. **Plan:** Identify an opportunity and plan for change.
2. **Do:** Implement the change on a small scale.
3. **Study:** Use data to analyse the results of the change and determine whether it made a difference.
4. **Act:** If the change was successful, implement it on a wider scale and continuously assess your results. If the change did not work, begin the cycle again.

The PDSA cycle can seek “incremental” improvement over time or a “breakthrough” improvement all at once. The following diagram depicts the use of the PDSA cycle for small incremental changes over time.

**Diagram 8:**  
**Incremental improvements PDSA cycle**



Source: PDSA cycle: [www.sa-health.wikidot.com/pdsa-cycle](http://www.sa-health.wikidot.com/pdsa-cycle)

To assist you in getting started with CQI, an example of using the PDSA cycle is provided below.

## Example

Overall goal of improving the number of men with completed adult health checks inclusive of completed chlamydia and gonorrhoea tests:

**Plan:** Determine over a defined study period, the number of males who attended the clinic and had an adult health check completed. Of these how many had a chlamydia and gonorrhoea test taken? The service works out strategies to improve this outcome.

**Do:** equates to delivering on the issue, during the next study period of the CQI process. The service works as a team to deliver on suggested strategies to improve completed male adult health checks with chlamydia and gonorrhoea tests completed.

**Study:** equates to objectively looking at the delivery, by monitoring and measuring the number of adult health checks completed with chlamydia and gonorrhoea tests completed. Included with this study could be age groups where completed, rates of positive results, age groups where no positive results were yielded.

**Act:** in this scenario, it relates to addressing gaps in service delivery, improving strategies and modifying service delivery where required to make the program patient centred and efficient for the health service.





# PART D

## Tools and references



## *Chapter 11:* RESOURCES

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this section contains

- A checklist for equipment and medication
- A checklist for planning
- Acronyms and glossary of terms
- Contacts and resources
- References

TABLE 7:  
Equipment and medications

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

TABLE 8:  
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"/> What are the most common STIs and BBVs affecting the 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 workplace health and safety	
<input type="checkbox"/> Plan health promotion and education with community and clinic	
<input type="checkbox"/> Develop consent forms	
<input type="checkbox"/> Collection and use of data (MOU)	
<input type="checkbox"/> Which data will be collected and how?	

Plan the details of the program	NOTES
<input type="checkbox"/> Decide on the dates for:	
<div><input type="checkbox"/> informing the community</div> <div><input type="checkbox"/> delivering the program follow up</div> <div><input type="checkbox"/> feedback</div>	
<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 through the venue 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:	
<div><input type="checkbox"/> community or participants</div> <div><input type="checkbox"/> participating health services</div> <div><input type="checkbox"/> funding bodies</div>	

# ACRONYMS

ACCHS	Aboriginal Community Controlled Health Service
ACON	AIDS Council of NSW
AH&MRC	Aboriginal Health and Medical Research Council of NSW
AHC	Adult Health Checks
AHS	Area Health Service
AHW	Aboriginal Health Worker
AIDS	Acquired Immune Deficiency Syndrome
ASHM	Australasian Society for HIV Medicine
BBV	Blood Borne Virus
BP	Blood Pressure
BSL	Blood Sugar Levels
CQI	Continuous Quality Improvement
D&C	Dilation and Curettage
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
IDU	Injecting Drug Use
IUCD	Insertion of Uterine Contraceptive Device
KPI	Key Performance Indicator
MCS	Microscopy, Culture and Antibiotic Sensitivities
MO	Medical Officer
MOU	Memorandum of Understanding
MSM	Men Who Have Sex With Men
NAAT	Nucleic Acid Amplification Test
NGO	Non Government Organisation
NSP	Needle and Syringe Program
NUAA	NSW Users and AIDS Association
NSW	New South Wales
PCR	Polymerase Chain Reaction
PDSA	Plan Do Study Act
PID	Pelvic Inflammatory Disease
PROM	Premature Rupture of Membranes
RN	Registered Nurse
SHS	Sexual Health Service
STI	Sexually Transmissible Infection
TOP	Termination of Pregnancy
UTI	Urinary Tract Infection





## GLOSSARY

### STIs and BBVs

#### Blood Borne Viruses (BBVs)

Infections that can be spread by blood to blood contact. BBVs 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 BBVs 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 spread by direct sexual contact and can cause granulomatous lesions on the genitals that are usually red, beefy and painless. Donovanosis is now rare in Australia.

#### 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 a 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 which may lead to chronic liver disease, cirrhosis and cancer of the liver.

## 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. Infection persists in 55-85% of those infected.

## HIV

The Human Immunodeficiency Virus is a virus that 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 venereum (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, characterised 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 rate 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 and 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 re-infection.

### **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 BBV.

### **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 produces 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 BBVs 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.

## 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.

## 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.

## 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.

## Hepatitis A

Hepatitis A is not routinely tested for as part of a STI and BBV 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 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 those 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 people with chronic hepatitis B infection.

## 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 ensure 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 BBVs. 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.

### 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.

# CONTACTS

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

## Aboriginal Health & Medical Research Council of NSW

**Web:** [www.ahmrc.org.au](http://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, NSW 2012

## Aboriginal Community Controlled Health Services:

SERVICE	LOCATION	NUMBER
Aboriginal Medical Service Co-operative	Redfern	02 9319 5823
Albury Wodonga Aboriginal Health Service Incorporated	Albury	02 6042 1200
Armajun Aboriginal Health Service Incorporated	Inverell	02 6721 9777
Armidale Aboriginal Health Service	Armidale	02 6774 9450
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 Incorporated	Condobolin	02 6895 4311 02 6895 3615
Coomealla Health Aboriginal Corp	Dareton	03 5027 4824
Coonamble Aboriginal Health Service Incorporated	Coonamble	02 6822 3995
Cummeragunja Housing & Development Aboriginal Corp	Cummeragunja	03 5869 3343
Aboriginal Medical Service Western Sydney	Mt Druitt	02 9832 1356
Casino Aboriginal Medical Service Aboriginal Corporation	Casino	02 6662 3514 02 6662 3599
Durri Aboriginal Corporation Medical Service	Kempsey	02 6562 1604 02 6562 6733 02 6562 4919
Galambila Aboriginal Health Service Incorporated	Coffs Harbour	02 6652 0800
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 Incorporated	Menindee	08 8091 4237 08 8091 4487
Murrin Bridge Aboriginal Health Service Incorporated	Murrin Bridge	02 6898 1687
Nambucca Valley Aboriginal Health Service Incorporated	Nambucca Heads	01 6568 9055
Ngambra Aboriginal Health Service Incorporated	Queanbeyan	02 6297 4152



Orange Aboriginal Health Service Incorporated	Orange	02 6363 1343
Parkes Aboriginal Health Service Incorporated	Parkes	02 6862 4324
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 Incorporated	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 Incorporated	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 Incorporated/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 1831
Bourke Sexual Health Service	Bourke	02 6872 2145
Broken Hill Sexual Health Sexual Assault Line	Broken Hill	08 8080 1556 08 8080 1609
Campbelltown Community Health Centre	Campbelltown	02 4628 5878
RPA Sexual Health	Camperdown	02 9515 1200
Sexual Health Clinic, St George Hospital	Caringbah	02 9113 2742
Outreach Clinic, Cessnock Community Health	Cessnock	02 4991 0438
Coffs Harbour Sexual Heath Clinic (Clinic 916)	Coffs Harbour	02 6656 7865
Outreach Clinic FPA Health, Hunter St	Newcastle	02 4929 4485
Cooma Community Health Centre	Cooma	02 6455 3201
Dareton Com Health Ctr, 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 5882 2900
Greater Western Area Sexual Health	Dubbo	02 6841 2480
Eden Community Health Centre	Eden	02 6496 1436
Forster Sexual Health Service – Lakes Clinic	Forster	02 6555 1800
Central Coast Area Health Service – HIV and Sexual Health Service	Gosford	02 4320 2114
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

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 9113 2742
Lightning Ridge Sexual Health Service	Lightning Ridge	02 6829 1022
Lismore Sexual Health Service – SHAIDS	Lismore	02 6620 2980
Liverpool Sexual Health Centre, Bigge Park 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 1206
Narooma Community Health Centre	Narooma	02 4475 7200
Newcastle Sexual Health Clinic	Newcastle	02 4929 4485
Shoalhaven Sexual Health Clinic	Nowra	02 4423 9353
Orange Sexual Health Centre FREECALL	Orange	02 6392 8600 1800 816 925
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
Hawkesbury Sexual Health and HIV Clinic	Richmond	02 4657 1622
Northern Sydney Sexual Health Service (Clinic 16)	St Leonards	02 9462 9500
Albion St Centre	Surry Hills	02 9332 9600
Sydney Sexual Health Centre NSW Sexual Health Info Line	Sydney	02 9382 7440 1800 451 624
Clinic 468	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
Help lines: Sexual Health Hotline		1800 451 651
PEP Hotline (Post Exposure Prophylaxis)		1800 737 669

## RESOURCES

### AUSTRALASIAN SOCIETY FOR HIV MEDICINE (ASHM)

**Web:** [www.ashm.org.au](http://www.ashm.org.au)

**Ph:** 02 8204 0700

**Fax:** 02 9212 2382

- The Australasian Contact Tracing Manual (4th edition 2010).
- ASHM Directory: HIV, hepatitis and related services 2006 – 2007

### Contact tracing e-Learning modules

ASHM and Western Australia Health have online contact tracing e-Learning modules for Health Care Workers working with hard-to-reach populations, including Indigenous Australians, people in rural and remote settings, people who are highly mobile as a function of their employment or other factors. The link is [www.ashm.org.au/default2.asp?active\\_page\\_id=341](http://www.ashm.org.au/default2.asp?active_page_id=341)

### DEPARTMENT OF HEALTH AND AGEING

**Web:** [www.health.gov.au](http://www.health.gov.au) (under 'Publications')

**Contact:** National Mailing and Marketing

**Ph:** 02 6269 1000

**Email:** [nmm@nationalmailing.com.au](mailto:nmm@nationalmailing.com.au)

**Fax:** 02 6260 2770

- Third National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2010 – 2013
- Second National Sexually Transmissible Infections Strategy 2010 – 2013
- Sixth National HIV/AIDS Strategy 2010 – 2013
- Third National Hepatitis C Strategy 2010 – 2013
- National Hepatitis B Strategy 2010 – 2013
- 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 KIRBY INSTITUTE

**Web:** [www.kirby.unsw.edu.au](http://www.kirby.unsw.edu.au)

**Ph:** 02 9385 0900

**Fax:** 02 9385 0920

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

## NSW HEALTH – SEXUAL HEALTH PLUS

**Web:** [www.health.nsw.gov.au/sexualhealth](http://www.health.nsw.gov.au/sexualhealth)

The Sexual Health Plus section of the NSW Health website provides a portal with links to NSW Health strategies, reports, services, policy directives and guidelines, as well as national research, policies and agencies relating to sexually transmissible infections (STIs) and blood borne viruses (BBVs).

### General information and fact sheets on STIs and BBVs can be found through the following resources

#### ACON

**Web:** [www.acon.org.au](http://www.acon.org.au)

**Ph:** 02 9206 2000 (Sydney) 1800 063 060 (NSW regional)

**Fax:** 02 9206 2069

#### HEPATITIS AUSTRALIA

**Web:** [www.hepatitisaustralia.com](http://www.hepatitisaustralia.com)

**Ph:** 02 6232 4257

**Fax:** 02 6232 4318

#### FAMILY PLANNING NSW

**Web:** [www.fpnsw.org.au](http://www.fpnsw.org.au)

**FPA Healthline:** 1300 658 886

#### HEPATITIS NSW

**Web:** [www.hepatitisc.org.au](http://www.hepatitisc.org.au)

#### HEP C HELPLINE

**Ph:** 02 9332 1599 (Sydney) 1800 803 990 (NSW Regional)

#### STI PROGRAMS UNIT

**Web:** [www.stipu.nsw.gov.au](http://www.stipu.nsw.gov.au)

**Ph:** 1800 451 624 (NSW Regional)

## 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.  
[www.racp.edu.au/page/sexual-health-publications](http://www.racp.edu.au/page/sexual-health-publications)

*Clinical Guidelines for the Management of Sexually Transmissible Infections Among Priority Populations*  
[www.stipu.nsw.gov.au/content/Document/Priority\\_Populations.pdf](http://www.stipu.nsw.gov.au/content/Document/Priority_Populations.pdf)

Additional online resources are available to provide assistance for people in letting their partner know that they have been diagnosed with a STI or BBV: [www.letthemknow.org.au](http://www.letthemknow.org.au)

### Carpa Women's Business Manual

[www.carpa.org.au/manual%20intro.htm](http://www.carpa.org.au/manual%20intro.htm)

### Books and Published Papers on STI and BBV Early Detection and Treatment Programs

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. *Sexually Transmitted Infections* 2005;81:pp. 53-8.

Couzos S, Murray R (eds) 2003, *Aboriginal Primary Health Care: An Evidence Based Approach*. Melbourne: Oxford University Press 2003

Fagan P. Sexual health service provision in remote Aboriginal and Torres Strait Islander settings in Far North Queensland: sexual health symptoms and some outcomes of partner notification. *Venereology* 2001; 14(2).

Kaldor J, Skov S (eds). 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. *Venereology* 2002; 14 (Supplement).

Mak D, Johnson GH, Plant AJ. A syphilis outbreak in remote Australia: epidemiology and strategies for control. *Epidemiology and Infection* 2004;132(5):805-12.

Mak D, Johnson GH, Marshall LJ, Mein JK. Control of genital chlamydial infection in the Kimberley region of Western Australia. *Medical Journal of Australia*, 2004;180(1):45.

Mak D, Plant AJ, Bulsara MK. Quality of sexually transmitted infection clinical management and contact tracing outcomes in a remote area of high sexually transmitted infection endemicity. *Sexually Transmitted Infections* 2004;31(8):449-54.

Miller, G, McDermott, R, McCulloch, K, Leonard, D, Arabena, K, Muller, R. The Well Person's Health Check: A population screening program in Indigenous communities in North Queensland, Australia. *Australian Health Review* 2002;25(6):140-51.

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. *Medical Journal of Australia*, 1999;170:429-32.

Plummer D & Forrest B. Factors affecting Indigenous Australians' access to sexual health clinical services. *Venereology* 1999;12:47-52.

Skov SJ, Miller PJ, Hateley W, Bastian I, Davis J, Tait P. Urinary diagnosis of gonorrhoea and chlamydia in men in remote Aboriginal communities. *Medical Journal of Australia* 1997;166(9):468-71.

## References

- Aboriginal Health and Medical Research Council of NSW (AHMRC) and Mandala Consulting. *Increasing Access to Services in NSW for Aboriginal People at Risk of Contracting or who Have Blood Borne Infections*. Sydney: AHMRC, 2004.
- Australian Medical Association (AMA). *Undue Punishment? Aboriginal and Torres Strait Islanders in Prison: An Unacceptable Reality*. Melbourne: AMA, 2006.
- Australasia Society for HIV Medicine (ASHM). *Australasian Contact Tracing Manual: Edition 2*. Sydney: ASHM, 2002.
- Commonwealth Department of Health and Aged Care. *STD control in remote Aboriginal communities: A manual for clinic workers*. Canberra: Commonwealth of Australia, 1999.
- Department of Health and Ageing. *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008*. Canberra: Commonwealth of Australia, 2005.
- Department of Health and Ageing. *National Sexually Transmissible Infections Strategy 2005–2008*. Canberra: Commonwealth of Australia. 2005.
- Department of Health and Ageing. *National Hepatitis C Strategy 2005–2008*. Canberra: Commonwealth of Australia, 2005.
- Department of Health and Ageing. *National HIV/AIDS Strategy 2005–2008*. Canberra: Commonwealth of Australia, 2005.
- Department of Health and Ageing. *Helping You to Stay Healthy: Information on the Aboriginal and Torres Strait Islander Adult Health Check*. Canberra: Australian Government (undated).
- Dore G, Wallace J, Locarnini S, Desmond P, Gane E, Crawford D. *Hepatitis B in Australia: Responding to a Diverse Epidemic*. Undated.
- Eisen Damon P. Locally acquired lymphogranuloma venereum in a bisexual man. *Medical Journal of Australia*, 2005; 183 (4): 218–219.
- Huang RL, Torzillo PJ, Hammond VA, Coulter ST, Kirby AC. Epidemiology of sexually transmitted infections on the Anangu Pitjantjatjara Yankunytjatjara lands: results of a comprehensive control program. *Medical Journal of Australia*, 2008; 189: 442–5.
- Hunter New England Area Health Service (HNEAHS) 'DEADLY Sex', Aboriginal Sexual Health Early Detection and Treatment Project, 2010.
- Jones R, PDSA cycle: [www.sa-health.wikidot.com/pdsa-cycle](http://www.sa-health.wikidot.com/pdsa-cycle) Accessed August 2012
- Langley GL, Nolan KM, Nolan TW, Norman CL, Provost P. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers, 2009.
- Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis C Sub-Committee Hepatitis C Virus Projections

Working Group: Estimates and Projections of the Hepatitis C Virus Epidemic in Australia 2006, UNSW October 2006.

National Centre for HIV Epidemiology and Clinical Research (NCHECR). *Australian NSP Survey National Data Report 2001–2005*. Sydney: NCHECR, University of NSW, 2006.

National Centre for HIV Epidemiology and Clinical Research (NCHECR). *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia: Annual Surveillance Report 2006*, Sydney: NCHECR, The University of NSW, 2006.

National Centre for HIV Epidemiology and Clinical Research (NCHECR). *Australian NSP Survey National Data Report 2000–2004*. Sydney: NCHECR, The University of NSW, 2005.

National Centre for HIV Epidemiology and Clinical Research (NCHECR). *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia: Annual Surveillance Report 2005*, NCHECR, The University of NSW, Sydney; Australian Institute of Health and Welfare, Canberra, 2005.

National Aboriginal Community Controlled Health Organisation. *National guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples*. Melbourne: The Royal Australian College of General Practitioners, 2005.

National Centre in HIV Epidemiology and Clinical Research (NCHECR). *Australian NSP Survey National Data Report: Prevalence of HIV, HCV and Injecting and Sexual Behaviour Among IDUs at Needle and Syringe Programs 2001–2005*. Sydney: NCHECR, The University of NSW, 2006.

National Centre in HIV Epidemiology and Clinical Research (NCHECR). *Australian NSP Survey National Data Report: Prevalence of HIV, HCV and Injecting and Sexual Behaviour Among IDUs at Needle and Syringe Programs 2000–2004*. Sydney: NCHECR, The University of NSW, 2005.

NSW Department of Health. *NSW Sexual Health Promotion Guidelines 2002*. Sydney: NSW Department of Health, 2002.

*NSW Health Aboriginal Health Impact Statement & Guidelines: Incorporating Aboriginal Health Needs and Interests in Health Policies & Programs*. [www.health.nsw.gov.au/resources/publichealth/aboriginal/pdf/ahis\\_guidelines.pdf](http://www.health.nsw.gov.au/resources/publichealth/aboriginal/pdf/ahis_guidelines.pdf)

Oakeshott P, Kerry S, Aghaizu A *et al*. Randomised controlled trial of screening for Chlamydia trachomatis to prevent pelvic inflammatory disease: the POPI (prevention of pelvic infection) trial. *BMJ* 2010;340:c1642.

O'Sullivan BG, Gidding HF, Law M, Kaldor JM, Gilbert GL, Dore GJ. Estimates of chronic hepatitis B virus infection in Australia, 2000. *Australian and New Zealand Journal of Public Health* 2004;28(3):212–6.



The Royal Australasian College of Physicians, Australasian Chapter of Sexual Health Medicine. *Clinical Guidelines for the Management of Sexually Transmissible Infections Among Priority Populations*. Sydney, 2004.

Ryder N, Bourne, CP, & Donovan, B 2011. Different trends for sexually transmissible infections despite increased testing of men who have sex with men. *International Journal of STD and AIDS* 2011;22:335–37.

Sexual Health Society Of Victoria (SHSOV) *National Management Guidelines for Sexually Transmissible Infections*, 7th edition, SHSOV, 2008.

Sexual Health and Blood Borne Virus Unit, Centre for Disease Control. *NT Guidelines for the Management of Sexually Transmitted Infections in the Primary Health Care Setting*. Sexual Health and Blood Borne Virus Unit, Centre for Disease Control, Department of Health and Families, 2008

Silver B. Use of quality improvement strategies to address endemic rates of STI in remote primary health care services. Australasian Sexual Health Conference, Canberra 2011.

Smith A, Agius P, Mitchell A, Barrett C, Pitts M. Secondary Students and Sexual Health 2008, *Monograph Series* No. 70, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University, 2009.

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