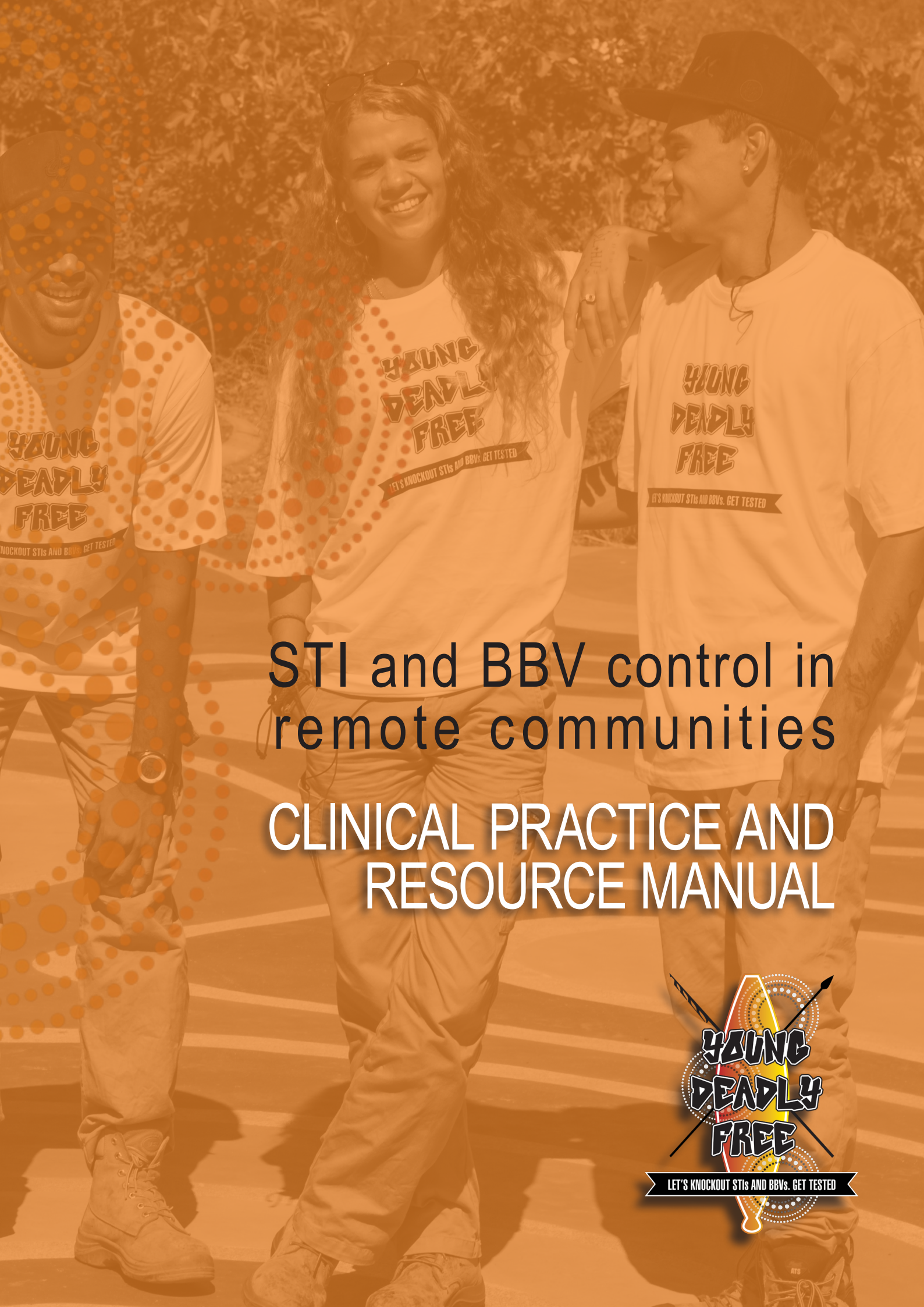

STI and BBV control in remote communities

CLINICAL PRACTICE AND RESOURCE MANUAL

YOUNG DEADLY FREE

LET'S KNOCKOUT STIs AND BBVs. GET TESTED

STI and BBV control in remote communities: Clinical practice and resource manual

Disclaimer

The information in this manual does not constitute clinical advice or guidance and should not be relied on by health practitioners in providing clinical care. Clinicians should refer to relevant clinical guidelines.

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Acknowledgment: We would like to sincerely thank the many clinicians who have generously provided feedback and advice at all levels in developing this manual. We also acknowledge the young people, Elders, community leaders — and whole communities — who have offered their time so generously to developing the *Young Deadly Free* health promotion resources catalogued in the manual.

SAHMRI acknowledges the Kaurna people as the traditional custodians of the Adelaide Plains region, where the SAHMRI building is located. We recognise the Kaurna people's cultural, spiritual, physical and emotional connection with their land. We honour and pay our respects to Kaurna elders, both past and present, and all generations of Kaurna people, now and into the future.

CONTENTS

Introduction

@youngdeadlyfree

https://youngdeadlyfree.org.au/

Rates of STIs, HIV and viral hepatitis (B and C) among Aboriginal and Torres Strait Islander people have been grossly disproportionate to rates for Australia's non-Indigenous population for over 20 years, particularly among young people in remote communities. We must turn this around.

The syphilis outbreak, first declared in 2011, is now affecting remote and rural communities across northern Queensland; the Northern Territory; the Kimberley, Pilbara and Goldfields regions of Western Australia; and the Far North, Western and Eyre regions of South Australia (and Adelaide). The persistence of the syphilis outbreak, despite concerted cross-jurisdictional efforts to encourage young people to test, highlights the urgent need for health practitioners working in remote communities to prioritise young people's sexual health.

Untreated STIs are having significant impacts, with acute as well as long-term health consequences, including: infertility in both women and men; complications in pregnancy; pre-term births; stillbirths; and congenital syphilis — with infant deaths and babies born with severe impairments. These are serious issues with major implications for the health and wellbeing of our communities.

Efforts to bring down STIs must go hand-in-hand with a stronger focus on preventing and treating viral hepatitis and HIV. There has been a disproportionate and increasing rate of new hepatitis C diagnoses among Aboriginal and Torres Strait Islander people over the past five years, particularly among 15–24 year olds. And whilst there has been a decline in newly diagnosed cases of hepatitis B due to the success of childhood and adolescent vaccination programs, chronic hepatitis B continues to disproportionately affect Aboriginal and Torres Strait Islander people.

HIV rates are also increasing among Aboriginal and Torres Strait Islander people, with a recent trend of increasing diagnoses in regional and remote Australia — despite decreasing rates for the non-Indigenous population.

Most STIs and BBVs are diagnosed in primary health care in Australia. This means that Aboriginal and Torres Strait Islander primary health care initiatives such as Adult Health Assessments provide an ideal opportunity to screen young people for STIs and BBVs. Unfortunately, this opportunity for encouraging young people to test for STIs and/or BBVs is often missed — as are opportunities to offer sexually active young people STI testing as part of unrelated consults.

ABOUT THIS MANUAL

In 2016 the Australian Government Department of Health funded the South Australian Health and Medical Research Institute (SAHMRI) to develop the Remote STI and BBV Project — *Young Deadly Free*. The project aims to substantially increase STI and BBV testing and treatment rates for Aboriginal and Torres Strait Islander young people aged 16 to 29 living in remote communities across Queensland, Northern Territory, Western Australia and South Australia. The project has involved a trial of peer educators in remote communities; and a separately funded health promotion campaign incorporating a TV, radio and social media campaign to raise community awareness of the syphilis outbreak and the need to test regularly for syphilis and other STIs and BBVs.

A key component of the *Young Deadly Free* project has been the development of resources to support doctors, nurses and health workers in remote practice — particularly new recruits and locums with limited experience of working in remote Aboriginal and Torres Strait Islander communities. We consulted with clinicians on what's needed by way of resources to support clinicians in enhancing STI and BBV testing rates, and how to better engage with young patients — especially on how to counter shame and stigma. Most clinicians pointed to the same main challenges:

- difficulty dealing with health system complexities, with onerous screening, monitoring and surveillance responsibilities covering multiple serious health conditions
- lack of familiarity with some of the STIs affecting young people in remote communities, particularly syphilis
- difficulty navigating relevant national and local STI and BBV clinical guidelines, practice manuals and online resources
- inadequate cultural orientation, and little guidance on best practice for engaging with young people in the community regarding sexual and reproductive health, and associated issues
- the need to hit the ground running, with limited orientation covering STI and BBV epidemiology, and clinical care and management.

This feedback informed the development of the *Young Deadly Free* clinician resources catalogued in this manual; and guided us in identifying online induction resources, training modules and remote practice manuals from across Queensland, Northern Territory, Western Australia and South Australia. The manual also collates the various STI and BBV clinical guidelines relevant to regional and remote communities, highlighting national guidelines for addressing the syphilis outbreak.

The focus of the manual is on supporting clinicians in efforts to boost STI and BBV testing rates for young people living in and visiting remote communities.

Acknowledgment: We would like to sincerely thank the many clinicians who have generously provided feedback and advice at all levels in developing this manual. We also acknowledge the young people, Elders, community leaders — and whole communities — who have offered their time so generously to developing the *Young Deadly Free* health promotion resources catalogued in the manual.

The context

STI AND BBV SURVEILLANCE DATA

Data collection and reporting

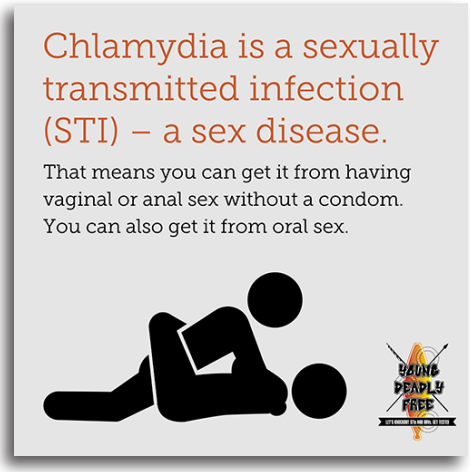
The information on all newly diagnosed cases of notifiable STIs and BBVs collected by health services and GPs is forwarded to the relevant state or territory health department by either doctors or pathology providers. This surveillance data is collated and analysed by each state/ territory department for production of reports to guide local interventions.

The data is also sent to the Kirby Institute, which produces national STI and BBV surveillance reports, including the annual *Blood-borne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: Annual surveillance report 2018.*

This report provides:

- the number of diagnoses, rates and trends for notifiable STIs and BBVs
- demographic data on diagnoses, including modes of transmission for HIV (e.g., male to male sex, heterosexual sex, sharing of injecting drug equipment).

The Multijurisdictional Syphilis Outbreak Group (MJSO) produces MJSO surveillance reports — available here — reporting on the ongoing syphilis outbreak affecting communities across Queensland, the Northern Territory, Western Australia and South Australia.



STI and BBV data snapshot

The STI and BBV surveillance data in the snapshot below is generally drawn from the *Blood-borne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: Annual Surveillance Report 2018*, highlighting divergences between STI and BBV rates for the Aboriginal and Torres Strait Islander population and the non-Indigenous population.

Throughout this manual we refer to STIs and BBVs by their common names, as per the Annual Surveillance Report and common usage among clinicians, rather than the pathogens detected in tests (which are italicised in the data snapshot below).

NB: The Annual Surveillance Report has some limitations in that some states/territories do not have accurate and/or complete Indigenous status data for all STI and BBV notifications.

Chlamydia

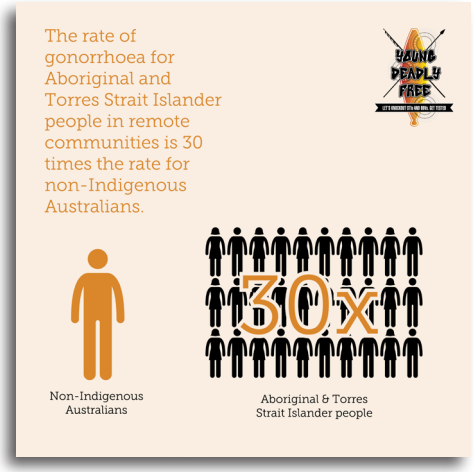
- Chlamydia (*Chlamydia trachomatis*) is the most frequently diagnosed STI in Australia. Over 100 000 cases were notified in 2017, with 7% of among Aboriginal and Torres Strait Islander people.
- The chlamydia notification rate for the Aboriginal and Torres Strait Islander population is around 3 times the rate for the non-Indigenous population, increasing to 5 times in remote/very remote areas.
- 82% of chlamydia notifications among the Aboriginal and Torres Strait Islander population in 2017 were in people aged 15–29 years, compared with 75% in that age range for the non-Indigenous population.
- It is estimated that for every diagnosis of chlamydia infection, another 1 to1.5 chlamydial infections are yet to be diagnosed.

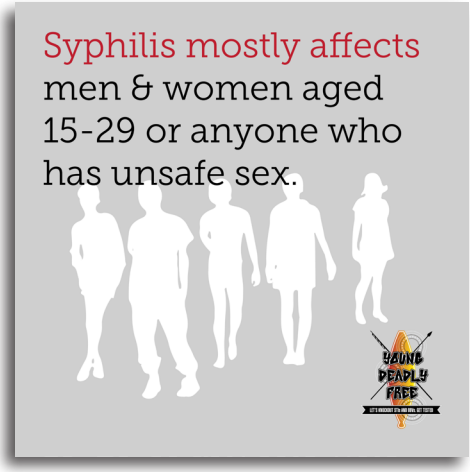
Gonorrhoea

- There were over 28 000 gonorrhoea (*Neisseria gonorrhoeae*) notifications in Australia in 2017, with approximately 15% among Aboriginal and Torres Strait Islander people.
- Gonorrhea is a major public health concern because of susceptibility to antimicrobial resistance.
- There are two distinct epidemics of gonorrhoea in Australia: one among men who have sex with men living predominantly in the large cities; the other among young heterosexual people living in regional and remote areas. There can be bridging between these two populations.
- In 2017, the gonorrhoea notification rate in the Aboriginal and Torres Strait Islander population was more than 6 times the rate for the non-Indigenous population, increasing to nearly 30 times in remote and very remote areas.
- The number of gonorrhoea notifications for Aboriginal and Torres Strait Islander men and women was nearly equal in 2017, whilst notifications for the non-Indigenous population were predominantly among men.
- In 2017 approximately 75% of gonorrhea notifications for Aboriginal and Torres Strait Islander people were among young people aged 15–29 years, compared to approximately 50% of cases in that age-group for the non-Indigenous population

Infectious syphilis

- There were almost 5 000 cases of infectious syphilis (*Treponema pallidum*) notified in 2017, with 18% of these among Aboriginal and Torres Strait Islander people.
- An outbreak of infectious syphilis in areas across northern and central Australia was declared in 2011. The outbreak is ongoing and primarily affects young Aboriginal and Torres Strait Islander people, aged between 15 and 29 years, living in northern Queensland, the Northern Territory, the Kimberley region of Western Australia and the Western, Eyre and Far North regions of South Australia.
- In 2017 the infectious syphilis notification rate for Aboriginal and Torres Strait Islander people was more than 6 times the non-Indigenous rate, increasing to 50 times in remote and very remote areas.
- In 2017 about half the infectious syphilis notifications among the Aboriginal and Torres Strait Islander population were for people aged 15–29 years, compared with 33% for that age-group among the non-Indigenous population.
- For Aboriginal and Torres Strait Islander people, the number of infectious syphilis notifications for men and women was nearly equal in 2017 (male to female ratio 1:1). In contrast, notifications for non-Indigenous people were predominantly in men (male to female ratio 13:1).
- The resurgence of infectious syphilis in regional and remote communities





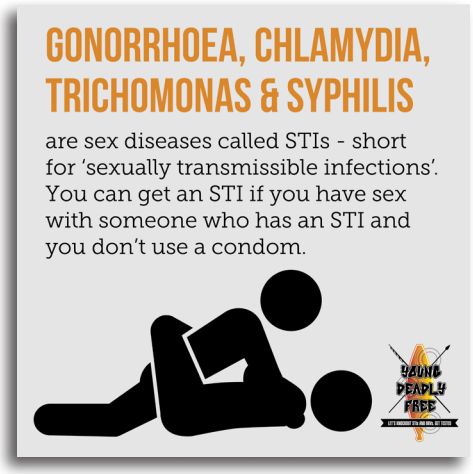
of northern and central Australia since 2011, when the syphilis outbreak was first declared, has brought cases of congenital syphilis. There were 44 cases of congenital syphilis recorded over the five year period 2013 to 2017, Australia-wide, of which 26 (59%) were in the Aboriginal and Torres Strait Islander population.
- In 2017 the congenital syphilis rate for the Aboriginal and Torres Strait Islander population was 18 times that for the non-Indigenous population.

Trichomonas

- Trichomonas (*Trichomoniasis vaginalis*) is a protozoal infection notifiable only in the Northern Territory. National data is not available.
- The prevalence of trichomonas has been estimated at 23% among Aboriginal and Torres Strait Islander people, with highest rates among women from rural and remote areas.
- Trichomonas remains detectable for years and becomes a chronic disease if left untreated in women, increasing the risk of serious complications in pregnancy, including pre-term delivery.

Chlamydia, gonorrhea, infectious syphilis, trichomonas co-infection

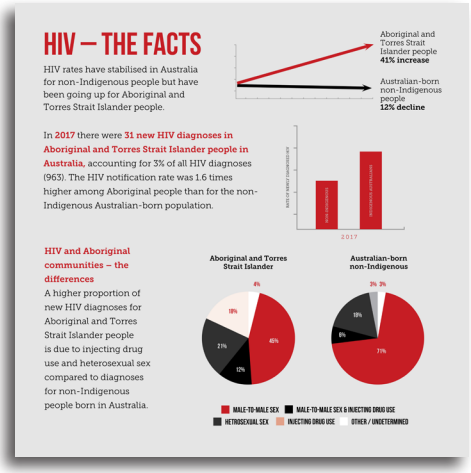
- Over recent years notification rates for chlamydia, gonorrhoea and infectious syphilis among Aboriginal and Torres Strait Islander people have been around 3 to 7 times rates for the non-Indigenous population.
- Notification rates are higher for young women, probably attributable to better engagement with health care and STI testing. Conversely, young men attend health services less regularly.
- In remote areas co-infection with chlamydia and gonorrhoea is common among young men; and coinfection with chlamydia, gonorrhoea and trichomonas is common among young women. Coinfection with syphilis is increasingly notified, particularly in areas affected by the syphilis outbreak.



HIV

- In 2017 there were 31 HIV notifications among Aboriginal and Torres Strait Islander people, accounting for 3% of all HIV notifications (963).
- In 2017 the HIV notification rate in the Aboriginal and Torres Strait Islander population was 1.6 times the rate for the non-Indigenous Australian-born population (4.6 per 100 000 vs. 2.8 per 100 000 of the population).
- The age-standardised rate of HIV notifications increased by 41% in the Aboriginal and Torres Strait Islander population between 2013 and 2016, compared with a 12% decline in the non-Indigenous population.
- Between 2013 and 2017, the male-to-female ratio of HIV notifications among Aboriginal and Torres Strait Islander people was 6:1, compared to 15:1 for the non-Indigenous population.

- There were an estimated 582 Aboriginal and Torres Strait Islander people living with HIV in Australia in 2017.
- In the period 2013–2017 a higher proportion of HIV notifications among the Aboriginal and Torres Strait Islander population was attributed to heterosexual sex (21%), and injecting drug use (18%), than for the Australian-born non-Indigenous population (18% and 3%, respectively).
- 26% of the new HIV notifications among Aboriginal and Torres Strait Islander people in 2017 were classified as late diagnoses. These notifications are likely to have been in people who acquired HIV at least four years prior to first diagnosis.
- In the five year period 2013–2017 there was a 260% increase in the HIV notification rate for the Aboriginal and Torres Strait Islander population residing in remote areas (1.5 per 100 000 to 5.4 per 100 000 of the population). (This represents a small number of cases, so caution should be taken in interpretation.)

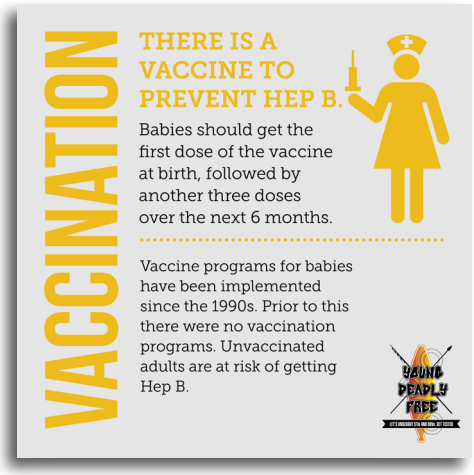


Hepatitis C

- There were 10 537 hepatitis C notifications in Australia in 2017, of which 11% were among the Aboriginal and Torres Strait Islander population, and 39% among the non-Indigenous population. Indigenous status was not reported for 49% of notifications.
- Between 2013 and 2016, the rate of hepatitis C diagnoses for Aboriginal and Torres Strait Islander people increased by 15%, whilst diagnoses in the non-Indigenous population decreased by 12%.
- In 2017 the hepatitis C notification rate in the Aboriginal and Torres Strait Islander population was 4.4 times the rate in the non-Indigenous population (168.1 per 100 000 vs 38.4 per 100 000 of the population).
- The rate of newly acquired hepatitis C (hepatitis C diagnosis with evidence of acquisition in the 24 months prior to diagnosis) in the Aboriginal and Torres Strait Islander population in 2017 was 13.7 times the rate in the non-Indigenous population (24.6 vs 1.8 per 100 000, respectively).
- In 2017, 26% of Aboriginal and Torres Strait Islander respondents to the *Australian Needle and Syringe Program Survey* reported syringe sharing, compared to 15% for non-Indigenous survey respondents (15%).
- In 2017, 37% of Aboriginal and Torres Strait Islander respondents to the Australian Needle and Syringe Program Survey who self-reported living with chronic hepatitis C, reported receiving hepatitis C treatment in their lifetime. The proportion of non-Indigenous respondents reporting any hepatitis C treatment in their lifetime was 47%.

Hepatitis B

- There were 6 102 hepatitis B notifications in 2017, of which 2% were among Aboriginal and Torres Strait Islander people. (Indigenous status was not reported for 51% of notifications, and rates are based on data from ACT, Northern Territory, South Australia, Tasmania and Western Australia only).
- In 2017, the hepatitis B notification rate for the Aboriginal and Torres Strait Islander population was 2.3 times greater than for the non-Indigenous population (45.1 per 100 000 of the population vs 19.2 per 100 000, respectively).
- In the past five years (2013–2017), hepatitis B notifications in the Aboriginal and Torres Strait Islander population decreased by 37%, with declines in all age groups. The greatest decline was among people under 40 years of age.



THE NATIONAL POLICY AGENDA

Setting policy and funding priorities

The *Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018–2022* sets out priorities for tackling the disproportionately high rates of STIs, HIV and viral hepatitis among Aboriginal and Torres Strait Islander people. The Strategy is one of five complementary national strategies on addressing STIs and BBVs — all accessible here. 2019 Federal Budget announcements and major party election commitments include funding for initiatives to enhance STI and BBV testing and treatment for young people in remote communities across Australia, framed in the context of the National Strategy.

Each state and territory develops STI/BBV strategies which include actions for implementing the national strategies:

- *Northern Territory Sexually Transmissible Infections and Blood Borne Viruses Strategic and Operational Plan 2019–2023*
- *WA Sexual Health and Blood-borne Virus Strategies 2019–2023*
- *Queensland Sexual Health Strategy 2016-2021*
- *South Australian Sexually Transmissible Infection Implementation Plan 2016–2018*

Syphilis enhanced response

The *Enhanced response to addressing STI (and BBV) in Indigenous populations* is a national Action Plan for responding to the syphilis outbreak in Queensland, Northern Territory, South Australia and Western Australia. The Australian Government is supporting the enhanced response through a phased approach, with targeted Aboriginal Community Controlled Health Services (ACCHS), employing additional sexual health staff to enable increased testing and community education. This implements the 'test and treat' model identified in the national Action Plan.

Nineteen ACCHS are funded under the phased approach:

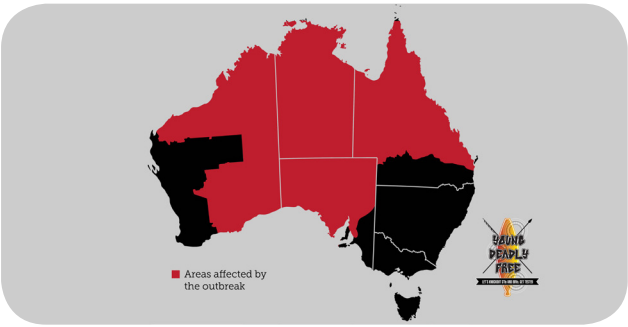
- Phase 1 commenced from 1 August 2018 at ACCHS in Townsville, Cairns and Darwin
- Phase 2 commenced from 10 October 2018 at ACCHS in East Arnhem Land (NT), the Katherine Region (NT), and in the Kimberley
- Phase 3 commenced from 4 April 2019 at ACCHS in Western Arnhem Land (NT); Western, Eyre, Far North and Adelaide regions of SA; and the Pilbara and Western Kimberley Regions of WA.

The Australian Government is supporting the use of syphilis point-of-care test kits in outbreak regions, providing kits and training to ACCHS, in consultation with jurisdictions and NACCHO.

The enhanced response also involves multi-strategy Aboriginal and Torres Strait Islander community awareness, education and testing campaigns for syphilis and other STIs, including SAHMRI's *Young Deadly Free* syphilis campaign.

Affected jurisdictions are also responding to the outbreak in accordance with the CDNA National Guidelines for Syphilis.

The Multijurisdictional Syphilis Outbreak (MJSO) Working Group includes representatives from affected jurisdictions, sexual health physicians, experts in Aboriginal and Torres Strait Islander sexual health, and the Australian Government Department of Health. The MJSO meets regularly with the objective of advising governments on co-ordinating the public health response for outbreak control.



UNDERSTANDING THE RISK FACTORS FOR YOUNG PEOPLE IN REMOTE COMMUNITIES

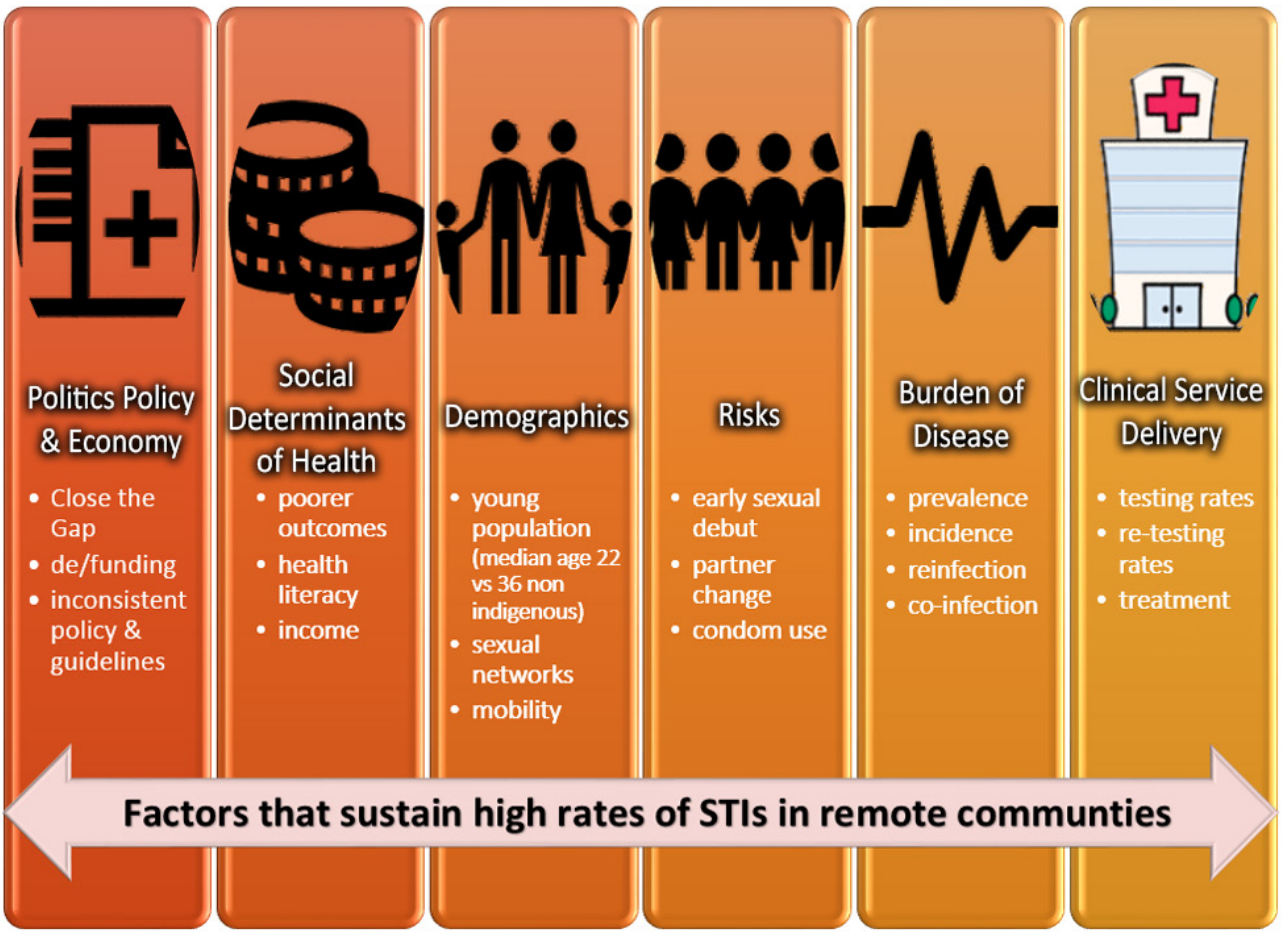
Prevalence heightens risk

Further research on the impact of prevalence on sustaining persistently high rates is ongoing, but it is clear that the prevalence of STIs in remote communities means that the risk of acquiring an STI is significantly higher for young people in these communities compared to their peers in other areas of Australia. Sexual activity is no more or less a part of Aboriginal young people's lives than for non-Indigenous people. But even when young people in remote communities are aware of STI risk, and use condoms as regularly as their regional and urban peers, high prevalence combined with limited and inter-connected sexual networks mean that risk is heightened.

This means that all sexually active young people in remote communities are at high risk of contracting STIs, as are young people in urban settings who have a sexual network connection to remote communities.

Healthy young people see no need for health checks

Unlike many other preventable health conditions disproportionately affecting Aboriginal communities, STIs are overwhelmingly affecting otherwise healthy young people, particularly in remote communities. Research has shown that young people in adolescence and early adulthood generally access health services less frequently than older people, and then only for a specific reason — especially young people in remote communities, and especially young men. Young men are also less likely to test regularly for STIs compared to young women.



Young people who are aware of STI risk are understandably unaware that STIs can be asymptomatic, or that symptoms can come and go. This means that without regular sexual health check-ups STIs can go undiagnosed for some time. This makes for rapid spread of STIs among young people in a closed sexual network, such as in a remote community; and spread from community to community when young people move between communities, such as for cultural events and festivals.

Injecting drug users — lack of access to services

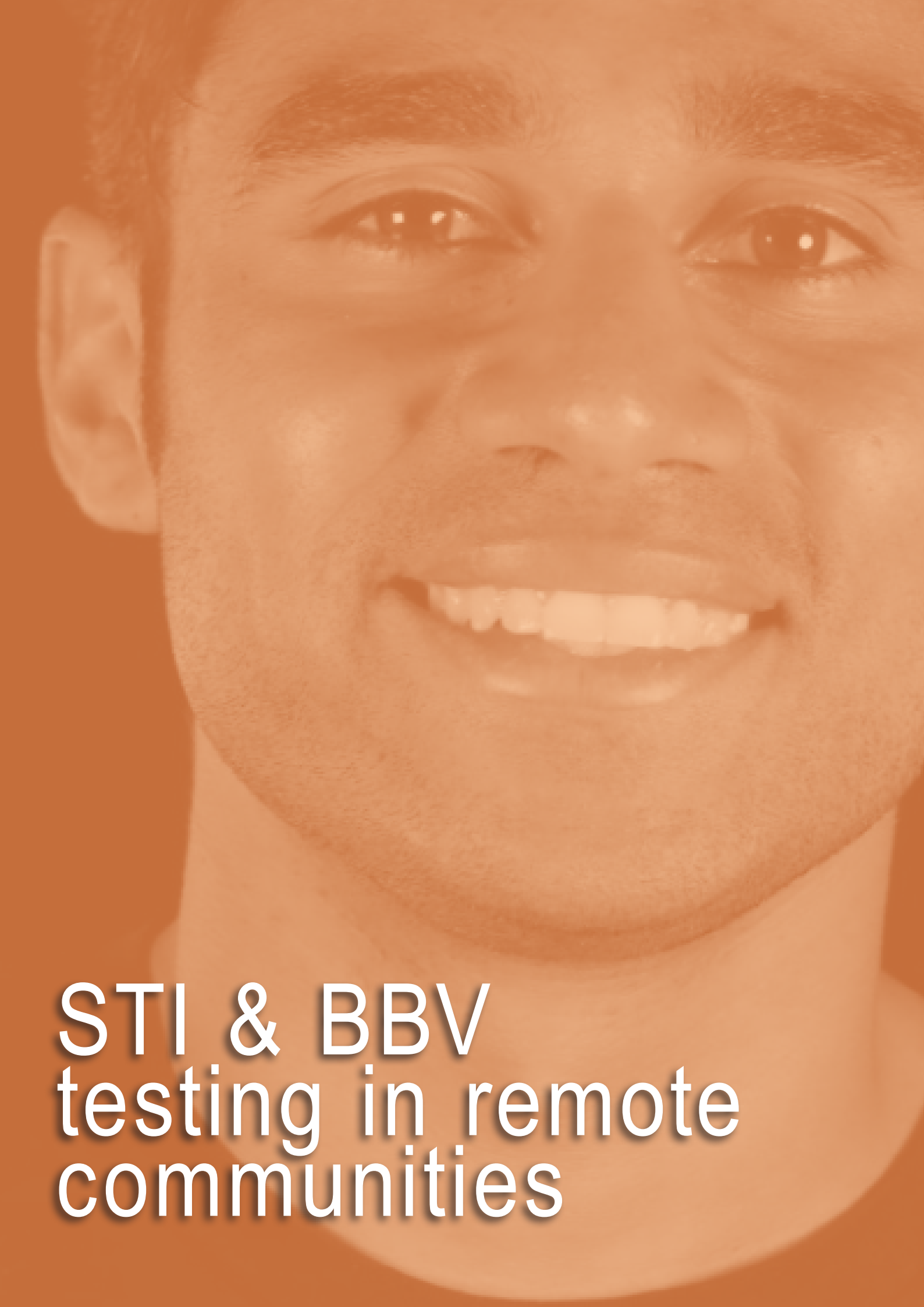
Injecting drug use is increasing among Aboriginal and Torres Strait Islander people, including among people who have been in prison, with disproportionately high rates of hepatitis C attributable to sharing injecting drug equipment, particularly among 15–24 year olds. Surveys of Aboriginal and Torres Strait Islander people attending needle and syringe programs show that rates of receptive syringe sharing are far higher than for non-Indigenous injecting drug users, and that this disparity is widening.

Until the lack of culturally appropriate, accessible Needle and Syringe Programs across regional and remote areas is addressed, there is a risk of further increases in hepatitis C and HIV rates among young Aboriginal and Torres Strait Islander injecting drug users.

Shame and stigma

Aboriginal and Torres Strait Islander cultures across Australia differ, but reluctance to openly discuss sex is common in remote communities. On top of this there is deep-seated shame and stigma associated with STIs and BBVs, with widespread misconceptions in all Australian communities about modes of transmission and the efficacy of modern treatments. STIs and BBVs continue to be often associated with what is considered to be blameworthy behaviour.

Shame and stigma can undermine clinicians' best efforts to build trust with patients in tackling yet another health issue besetting Aboriginal and Torres Strait Islander communities. Young people in remote Aboriginal communities are often under the media spotlight, with at times ill-informed and sensationalised reports conflating child sex abuse with rising STI rates. STIs among Aboriginal and Torres Strait Islander people are in fact mostly diagnosed in people over the age of 16 who are legally allowed to have sex. Issues related to sexual abuse of children need to be addressed, but should not be conflated with issues affecting the spread of STIs in the community. Such conflation fuels the shame and stigma associated with open discussion of sex and sexuality, and undermines efforts to normalise sexual health checks.



STI & BBV testing in remote communities

TESTING THOSE MOST AT RISK

Age-based STI testing

- All sexually active young people from regional and remote communities aged 15–34 years are at high risk of contracting STIs from vaginal, anal and oral sex.
- Comprehensive STI testing should be offered to sexually active young people in this age range opportunistically — whenever the opportunity arises and whatever the reason for the consult.
- Sexually active young people aged 15–34 from regional and remote communities should be advised to have a sexual health check at least every six to 12 months (three monthly if at ongoing high risk), and after any specific exposure risk.
- The upper range of age-based STI testing can depend on local epidemiology, e.g., in Far North Queensland 15–39 year olds are included in syphilis screening programs, based on local epidemiology — check your local guidelines.

Specific exposure risks

- Sex without condoms, or broken condoms
- New sexual partner(s)
- Sharing drug injecting or tattooing equipment
- Problematic drug or alcohol use (increases the risk of exposure due to high risk behaviours, e.g., multiple sexual partners, condomless sex)
- Recent travel between communities.

People at heightened risk of contracting HIV

- People with an STI
- Gay men and other men who have sex with men
- Transgender women/sistergirls and transgender men/brotherboys
- Injecting drug users who share injecting equipment
- Sexual partners of people who inject drugs
- People who have recently travelled to a country with high prevalence of HIV
- Sexual partners of people from a country with high prevalence of HIV, or who have recently travelled to a high prevalence country.

People at heightened risk of contracting hepatitis C

- People who inject drugs
- People who have been in custodial settings
- People reporting unsafe tattooing
- People living with HIV.

STIs to test for

- STIs covered in sexual health checks for young people from remote communities should include but not be limited to:
    - chlamydia
    - gonorrhea
    - syphilis
    - trichomonas
    - HIV.
- Refer to local guidelines for additional tests in the light of regional epidemiology.

Opportunistic testing of asymptomatic young people

The *Australian STI Management Guidelines* recommend offering STI testing opportunistically to all asymptomatic sexually active young people under 35 years from remote and very remote areas.

Many young people rarely visit health clinics, particularly young men, and are unaware of STI risk and possible symptoms. It is important to seize any opportunity to offer comprehensive STI/BBV testing — e.g., during a consultation for a sports injury, and as part of all *Adult Health Checks*. Given the ongoing syphilis outbreak and persistently high rates of multiple STIs in remote communities, ideally test for all STI/BBVs at the same consult, as a normalised procedure, rather than waiting until positive results of one or more STIs are returned before testing for the rest.

Testing as part of Adult Health Checks (MBS Item 715)

The *Australian STI Management Guidelines* recommend that STI testing be offered to asymptomatic young people as part of Adult Health Checks (MBS Item 715) for sexually active 15–35 year olds from remote communities.

Testing in remote communities — flexible approach

Community age-based screening programs, separately targeting young women and young men in remote and very remote communities, can significantly boost testing rates.

Use of urine samples and self-collected swabs in remote practice is more widespread than in urban/regional general practice or sexual health clinics, for practical reasons and to address patients' reluctance to undergo physical examinations. Self-collection of samples can include:

- vaginal swab
- rectal swab
- first pass urine (FPU) collection.

SYMPTOMATIC TESTING

Symptoms indicating the presence of an STI can include:

- dysuria (painful or difficult urination)
- rash
- discharge
- menstrual problems, including intermenstrual bleeding
- itch
- abdominal pain
- lumps
- hair loss
- ulcers
- enlarged groin lymph nodes
- pain or swelling in the scrotum
- post-coital bleeding
- dyspareunia (difficult or painful sexual intercourse)
- genital lesions.

Specific symptoms for each STI are outlined in the *Australian STI Management Guidelines*. There may be no clinical signs of an STI on examination during an asymptomatic phase.

TESTING ON REQUEST

Some young people can feel fairly comfortable asking to be checked for STIs, especially in response to community testing campaigns, but may not want to discuss risk behaviours such as condomless sex or injecting drug use.

The request for testing is an opportunity to reassure the patient that they are not being judged, and that the consult and test results are completely confidential. You could help the conversation by normalising the situation, reinforcing that testing is offered to their age group once or twice a year, and that asking for a test at other times is showing a sense of responsibility.

Whether or not a risk assessment is possible, conduct testing for STIs, including HIV, if requested by any sexually active young person. Similarly, conduct testing for hepatitis C on request for injecting drug users.

ANTENATAL TESTING

Barriers to antenatal STI checks

Feedback from clinicians is that one of the main barriers to offering STI testing during antenatal checks is embarrassment — not knowing how to bring up the topic, and concern that the patient will be embarrassed or offended, especially if they are in a monogamous relationship. Broaching the topic of STI risk without undermining efforts to encourage young women to return for regular antenatal checks can be challenging but it is crucial that remote health services support clinicians in efforts to retain pregnant women in care — and that STI testing is part of that care. The *Young Deadly Free* syphilis campaign on TV, radio

and social media can be a conversation starter re the importance of STI testing during pregnancy and the potential consequences of not testing.

National antenatal STI testing guidelines

The national guidelines on antenatal STI testing are available at http://www.sti.guidelines.org.au/populations-and-situations/pregnant-women#testing-advice. The Queensland specific guidelines are available at https://www.health.qld.gov.au/__data/assets/pdf_file/0035/736883/g-sip.pdf

Syphilis

Anecdotal reports from clinicians working in remote communities indicate that although pregnant women may attend the clinic to confirm pregnancy, they may not return for further antenatal checks; and if they do, they are not always actively offered STI testing — even in syphilis outbreak regions. This is despite CDNA National Guidelines for Syphilis recommending at least five STI checks during pregnancy and postpartum in outbreak areas.

Untreated syphilis during pregnancy can have severe consequences, including:

- pre-term labour, with mid-trimester spontaneous miscarriage the most common outcome of syphilis in pregnancy
- pre-term birth
- stillbirth
- neo-natal death
- congenital syphilis, with associated blindness, deafness, neurological impairment and bone deformity.

The deaths of seven Aboriginal babies have been attributed to congenital syphilis in outbreak-declared areas since 2011.

Syphilis-specific antenatal testing guidelines for outbreak areas

The National Pregnancy Care Guidelines on Syphilis, based on the Communicable Disease Network of Australia (CDNA) National Guidelines for Public Health Units on Syphilis, recommend routinely offering syphilis testing to pregnant women and new mothers at:

- the first antenatal booking visit
- 28 weeks antenatal check
- 36 weeks antenatal check
- delivery
- 6 weeks post-partum.

Hepatitis B

Despite the overall success of hepatitis B vaccination programs, there have been mother to child transmissions in some regions, with delayed diagnosis of hepatitis B in infants, because antenatal checks did not establish that mothers had not completed courses of vaccination.

RETESTING AFTER A POSITIVE STI DIAGNOSIS

There are high rates of reinfection among people who test positive for STIs — hence the emphasis on the need to retest in the national guidelines.

It is important to advise patients diagnosed with an STI about the risk of reinfection, stressing: the importance of ensuring that sexual partners are tested and treated to reduce re-infection risk; and that treating an STI will not prevent other STIs, or reinfection with the same STI.

Retesting for STIs should generally be conducted between 2–4 months after treatment to ensure reinfection has not occurred, and should be conducted in parallel with partner notification.

Note: people who test positive for *chlamydia trachomatis* (CT) *neisseria gonorrhoeae* (NG) or t*richomonas vaginalis* (TV), should be tested for syphilis and HIV within 30 days if they were not tested on the same day.

HIV TEST WINDOW PERIOD

The HIV test window period refers to the time between a person's potential exposure to HIV infection and the point when the test will give an accurate result. The window period depends on the type of test used but Australian testing guidelines set the window period at 12 weeks. (Although antibody tests can now detect HIV earlier than this, some people do not seroconvert until more than six weeks after exposure to HIV.)

To take into account the window period, HIV testing should be repeated for negative HIV test results if the person's exposure risk was within the last 12 weeks.

It is important to explain to people with negative test results within the window period that HIV is highly infectious during early infection, due to the high HIV viral loads in blood and body fluids at this time.

STI TREATMENT PENDING CONFIRMATORY TEST RESULTS

Syndromic management of STIs

In urban and regional practices STI treatment is generally delayed until test results are returned. In remote areas, waiting on return of test results can mean lengthy delays in commencing treatment, given the time taken to transport specimens to and from the reference laboratory; and issues facilitating patient recall and follow-up appointments, especially in very remote communities.

Syndromic management of STIs is an approach to identifying and treating common STIs straight away, pending laboratory test results, if the patient presents with symptoms or syndromes likely to be caused by STI, including:

- abnormal vaginal discharge
- pelvic inflammatory disease (PID)
- discharge from the penis or pain passing urine
- painful scrotum.

For symptoms associated with gonorrhea and chlamydia, check local guidelines; however, in most remote areas empirical treatment is recommended if symptoms are present, with treatment also recommended for the patient's sexual contacts.

PID is of particular concern, with research indicating that PID is common among women from remote communities but vastly underdiagnosed and poorly treated — and causing high rates of spontaneous pre-term births and still-births. Always have a low threshold for suspecting PID when working in remote areas.

For a comprehensive overview of STI syndromes, including clinical presentations, investigations and treatment, see the WA Department of Health *Silverbook* or the *CARPA Standard Treatment Manual*.

National guidelines for STI syndrome management are included in the *Australian STI Management Guidelines*.

Point of care (PoC) or rapid testing

Point-of-care (PoC) testing has the potential to improve diagnosis and management of STIs in remote areas where there are considerable delays in receiving laboratory results.

In situations where the likelihood of a patient returning for a test result and treatment is low, treatment can be initiated immediately on the basis of a PoC test result pending receipt of confirmatory laboratory test results. The benefits of potential rapid reduction in STI prevalence in a remote community can outweigh over-treatment issues associated with false positive PoC test results, especially in outbreak situations.

Syphilis PoC testing

There are limitations with current syphilis PoC testing, with potential for over-treatment if treatment is triggered on the basis of the PoC test alone; however, this is considered an acceptable risk in outbreak responses — see Appendix D of the *Communicable Disease Network of Australia National Guidelines for Public Health Units*.

A large-scale test and treat program utilising syphilis PoC test kits has been rolled out by the Australian Government Department of Health across various regions affected by the syphilis outbreak, commencing in August 2018. The kits allow on the spot diagnosis and if needed, immediate treatment. The program has been implemented in two phases, with bulk supplies of the kits sent to Aboriginal Community Controlled Health Services for use in outreach. Read more here.

Syphilis PoC test: the Determine Syphilis TP™ manufactured by Alere is a treponemal specific immunochromatographic test that can be used with whole-blood samples from either finger-prick or venepuncture

HIV PoC or rapid tests

HIV point-of-care tests (or 'rapid tests') produce results in under twenty minutes. If a test is reactive, a confirmatory laboratory test is conducted, on a full blood sample.

Although the rate of new HIV diagnoses among Aboriginal and Torres Strait Islander people has risen over recent years, the prevalence of HIV in remote communities is low. Given issues with the accuracy of HIV rapid tests for populations with generally low prevalence of HIV, use of rapid tests for people in remote communities other than for gay men is not recommended. Despite these issues, point-of-care testing can be useful in remote outreach — clinicians should refer to local guidelines.

OFFERING TESTING

Normalising, non-alarmist language

It can be hard to introduce the topic of STI and BBV testing into a consult about a broken wrist or gastro, especially if the patient is shy or uncommunicative. As outlined in the *"Young Deadly Free video resources for clinicians" on page 36*, the most seamless approach is to make it clear that the young person does not feel singled out. Each consult is different but try to be casual and non-confrontational.

A risk assessment and sexual history is generally unnecessary when offering STI testing opportunistically. More important is to focus on ensuring the young person understands that they are being offered testing because most sexually active young people in communities are at risk; and that getting tested is simple and quick. Say something along the lines: "A lot of young people across Australia have sex infections. So we're offering everyone around your age STI testing. It's just a simple wee test/swab test…"; and then explain self-collection of the sample.

If the patient does disclose condomless sex or sharing injecting drug equipment, resist being judgemental – this fuels shame and undermines efforts to get young people to engage with health services. Try saying something like, "well it's great you're here — let's do some tests to make sure you haven't picked up an STI (or BBV). We can have a yarn about condoms/using clean equipment while we're doing it."

Navigating cultural sensitivities

Cultural taboos regarding discussion of sex is common in many communities. It can be good practice to ask the patient whether they feel comfortable discussing sexual health and whether or not they would like an Aboriginal Health Worker to join the consult. Suggesting that an Aboriginal Health Worker or another clinician join you is particularly important if the patient is the opposite sex; where there is a significant age gap; in antenatal consults; or if the patient is obviously distressed or uncomfortable.

Check with the patient as to whether the Aboriginal Health Worker is a family member or an in-law and if so, establish whether this is OK with them.

Aboriginal Health Practitioners/Workers can also assist after the consultation, sitting with patients to discuss the need to return for test results, and guiding patients through STI and BBV factsheets for young people available on the *Young Deadly Free* and *All Good* websites.

Informed consent

STI and BBV tests should be conducted with the patient's informed consent — i.e., patients need to understand that it is their own decision to be tested; and that before deciding they have the right to know what is to be tested for and why, the basic testing procedure, and available treatment if they test positive.

In gaining informed consent, bear in mind the need to normalise sexual health checks. Some young patients will want lots of information but for others, overloading with information can be counter-productive to efforts to make the consult friendly and non-threatening.

Information to provide to the patient includes:

- why the test is being offered
- limitations of testing (e.g., the HIV test window period)
- when the results will be available and how the person will be informed
- confidentiality between you and the client, and that no one else in the clinic will know about your test or test result
- the implications of not being tested; that STIs can be asymptomatic but can result in adverse outcomes if not treated
- the need for recall and treatment if an STI/BBV is diagnosed.

HIV testing can be particularly confronting for patients. Specific requirements for obtaining informed consent for HIV testing are outlined in the ASHM Testing Portal.

CONTACT TRACING

Testing and treating all sex partners once someone is diagnosed with an STI is important for minimising transmission of STIs through remote community sexual networks, and for ensuring reinfection does not reoccur in a client who has been treated for STIs.

The *Australasian Contact Tracing Guidelines* provide practical support and guidance on partner notification and recommend a flexible, culturally sensitive approach for contact tracing involving Aboriginal and Torres Strait Islander communities — see here. It is crucial to emphasise to patients that contact tracing can be done anonymously.

For people from remote communities there may be issues related to kinship relationships, use of multiple identifiers, multiple addresses and mobility. The potential consequences for the patient if a partner is diagnosed with an STI or BBV, despite efforts to preserve anonymity, need to be discussed and taken into account.

The *Kimberley Contact Tracing Guidelines* provide some useful general tips on factors to take into account when talking to patients about contact tracing:

- Highlight the importance of treating others so that the community is safer.
- Be careful when contacting people, especially when using mobile phone

numbers to contact, because mobiles numbers can shared among peers.
- Don't disclose personal medical information over the phone; instead make an appointment with the person to talk about it face to face if positive.
- Named contacts should be notified and treated as soon as possible after a positive result is received and if the index case is a symptomatic male, contacts should be notified and treated straight away — without waiting for the results.

Detailed steps on conducting contact tracing are set out in the *Australasian Contact Tracing Manual* which provides guidance on how far back in time to go in tracing sexual contacts, including the guidelines below.

Table 1: Guidelines on how far back in time to trace contacts

Infection	How far back to trace
Chlamydia	6 months
Gonorrhoea	2 months
Heaptitis B	6 months prior to onset of acute symptoms
Hepatitis C	6 months prior to onseet of acute symptoms, if asymptomatic according to risk history
HIV	Start with recent sexual and/or needle-sharing partners; outer limit is onset of risk behaviour or last known negative HIV test result if known
Mycoplasma genitalium	No definite period outlined, partner notification is still recommended
Syphilis	Primary syphilis: 3 months including duration of symptoms. Secondary syphilis: 6 months including duration of symptoms. Early latent syphilis: 12 months
Trichomoniasis	No definite period outlined, partner notification is still recommended

Source: kamsc.org.au/wp-content/uploads/2016/11/Kimberley-Contact-Tracing-Guidelines-16-April-2015.pdf

State and territory contact tracing phone services

Some regions have developed contract tracing guidelines that prioritise certain STIs in some situations. Local contact tracing phone support is available:

- **Victoria**: Partner Notification Support Unit: (03) 9096 3367
- **NSW**: NSW Sexual Health Infolink: 1800 451 624
- **Queensland**: HIV Public Health Team: (07) 3328 9797
- **Northern Territory**: Clinic 34: (08) 8999 2410
- **Western Australia**: partner notification contact numbers for each WA public health unit are listed here
- **South Australia**: Adelaide Sexual Health Centre: (08) 7117 2816
- **Tasmania**: Tasmania Health: (03) 6166 0655
- **ACT**: Canberra Sexual Health Clinic: (02) 6244 2184

Better to Know — notification via anonymous SMS

Better to Know is a website developed specifically for Aboriginal and Torres Strait Islander young people, to assist with partner notification. The website can be used to notify recent sex partners by anonymous SMS or email that they need to have a sexual health check, and includes a facility to be sent a sexual health check reminder via SMS or email. The website also provides detailed, culturally appropriate information in accessible language on STIs and BBVs and getting tested — in two sections, Men's Business and Women's Business. *Better to Know* is widely used in Aboriginal health services, often with Aboriginal Health Workers sitting with patients to guide them through the site and assist them with partner notification.

MANDATORY REPORTING OF SUSPECTED CHILD SEXUAL ABUSE

It's important to note that there are STIs notified for young people who are under the legal age of consent. In many cases STI transmission has occurred between peers who are close in age; however, in a minority of cases there may have been child sexual abuse involved.

Mandatory reporting laws can apply in situations where it is known or suspected that an adult has engaged in sexual activity with a child under 16 or in some situations, a young person under the age of 18; or for young people under the age of consent, where the other party is significantly older (usually more than two years older).

Clinicians and other members of the community have mandated responsibilities under these laws to report suspected cases, with jurisdictional differences — notably regarding the relevance of the age difference between the people engaged in sexual activity.

Legal definitions of sex, sexual behaviour and sexual activity

The definition of what constitutes sex in the context of child sexual abuse laws is different for each state and territory; however, sexual behaviour or activity generally covers vaginal, anal or oral sex — including touching or penetration with fingers or objects (see the Table 2 below). Laws relating to child sexual abuse can also apply to an adult touching a child or young person in a sexual way, such as touching their penis, vagina, breast or bottom. They can apply to performing sexual acts in front of a child or young person, such as masturbating or pretending to masturbate.

Age of consent

The age of consent is the age from which a young person is considered to be legally able to freely give consent to having sex or engaging in sexual activity. Each state and territory has legislation defining the age of consent in that jurisdiction — generally 16 except for South Australia, where it is 17.

In some jurisdictions the age of consent can be 18 in situations where an adult engaging in sexual activity with a young person is in a position of power or authority, such as a parent or guardian, teacher or person in public office.

Mandatory reporting of sexual abuse

Each state and territory has laws that require particular people, including clinicians and health workers, to contact child protection authorities regarding knowledge or reasonable suspicion, gained in the course of their employment*, that an adult has engaged in sexual activity with a child or young person who is under a specified age. (*The exception is the Northern Territory — see Table 2 below.)

People such as clinicians who are legally required to report knowledge or suspicion of child sexual abuse are referred to as

mandated reporters. If a mandated reporter, fails to report suspicion or knowledge that an adult is engaging in sexual activity with a young person under the age specified in that state or territory, they may be charged with an offence.

Clinicians are mandated reporters in all states and territories. Clinicians may know or suspect a case of sexual abuse because of community connections rather than due to information gained in the course of their employment. Except in the Northern Territory (see Table 2 below), there is no legal obligation but there is an ethical obligation for clinicians to report such suspicions or knowledge to the authorities; in this situation a report can instead be made to the child protection authority voluntarily, in a private capacity.

Reporting responsibilities are complex and can change — it is important to check with practice managers/supervisors regarding clinic policies and procedures on mandatory reporting, and be aware of where to access local reporting requirements and guidelines. Seek advice if unsure.

Table 2: Mandatory reporting by jurisdiction

NB – The information in this table was correct at May 2019 but requirements are subject to change. It is important to keep up to date with changes to the legislation applying in your jurisdiction.

	Mandatory Reporting	Mandated Reporters
QLD	Reasonable grounds to suspect that a young person **under 18** is at risk of suffering significant harm caused by sexual abuse	Doctors, nurses, teachers, childcare workers, police, child advocates (Public Guardian)
NT	Reasonable suspicion that: • a child under 14 is engaged in sexual activities • A child of 14–15 is engaged in sexual activities • with someone who is more than 2 years older • a young person of 16–17 who is under special • care is engaged in sexual activities	Everyone in the community — professionals and the general public
WA	Reasonable grounds to suspect that a young person under 18 years is involved in sexual behaviour and: — is being bribed, coerced, threatened, exploited, or there is violence; or — has less power than another person involved; or - there is a significant difference developmentally, or in maturity, between the child and another person involved	Doctors, nurses, midwives, teachers, boarding supervisors
SA	Reasonable grounds to suspect that a young person under 18 years is being or has been sexually abused	Health staff (all). Pharmacists, dentists, psychologists, social workers, teachers, childcare workers, police, community corrections workers, ministers of religion and employees of religious or spiritual groups

Making a mandatory report

Mandatory reporting requires completion and submission of a form, and can involve contacting the Mandatory Reporting Hotline (see below). Actual knowledge or strong suspicion of physical/sexual assault should also be reported to the police.

In reporting suspected child abuse, provide as much information as possible, ideally including:

- the child's/young person's name and date of birth
- name/s of parent(s)/carer(s)
- addresses of all parties
- why you suspect/believe the child/young person has been sexually abused (something you saw or heard, behaviours that made you worried, something the child/young person or another credible person told you)
- any injuries or medical issues
- where the child/young person can be located
- whether you have ongoing concerns for the child's/young person's safety (or your own, or another person's)
- if the suspected/alleged perpetrator has been identified/named, as much detail as possible regarding who they are, their address and/or where they may be located.

STI testing in cases of suspected sexual abuse

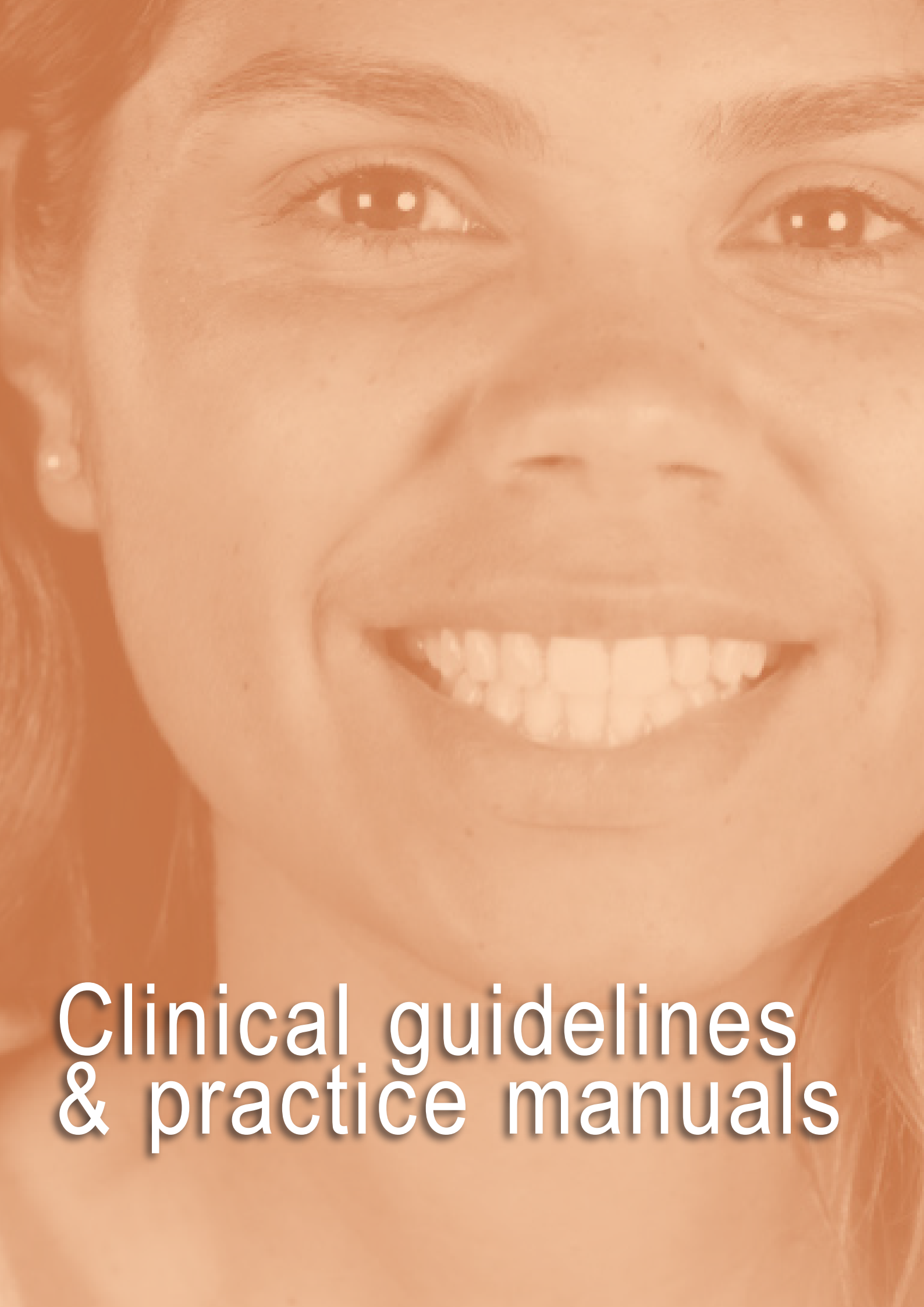
Child sexual abuse can be difficult to substantiate, and investigation of suspicions should be left to child protection authorities.

STI testing is not an appropriate way to confirm or allay suspicions of child sexual abuse. A negative STI test cannot exclude sexual abuse; and an STI may have been contracted by a young person from sexual activity with a peer of similar age.

In cases of actual knowledge or strong suspicion of child sexual abuse, it may be appropriate to conduct STI testing for diagnosis and treatment. Clinical staff should consult the child protection service before testing a child or young person who is the subject of a mandatory report for STIs.

Mandatory reporting hotlines

- **Queensland**: Regional Intake Services: Monday to Friday 9am–5pm see here Child Safety After Hours Service Centre: (07) 3235 9999 or 1800 177 135
- **NT**: 1800 700 250 (24 hours)
- **WA**: Central Intake Team:1800 273 889; After hours: (08) 9223 1111 or 1800 199 008
- **SA**: 13 14 78 (24 hours)
- **National Child Abuse Helpline**: 1800 99 10 99. Operates Monday to Friday, 9am–5pm AEST



Clinical guidelines & practice manuals

Links to national clinical guidelines on STI and BBV testing and treatment are provided below, along with jurisdictional guidelines and practice manuals relevant to remote practice in Queensland, the Northern territory, Western Australia and South Australia.

Clinical guidelines are regularly reviewed and updated in the light of surveillance data. Keep up to date by checking newsletters for alerts on guideline changes and local alerts, including on the syphilis outbreak.

NATIONAL

Australian STI Management Guidelines: maintained by ASHM, these guidelines are an easily accessible online resource for primary health care professionals to guide STI risk assessment, testing, diagnosis and management. The Guidelines are recognised as an Accepted Clinical Resource by The Royal Australian College of General Practitioners, and have been endorsed by the Australian Indigenous Doctors' Association. Guidelines specific to Aboriginal and Torres Strait Islander people are here.

Series of National Guidelines (SoNGS): developed in consultation with the Communicable Diseases Network Australia (CDNA) and endorsed by the Australian Health Protection Principal Committee (AHPPC), these guidelines provide nationally consistent advice to public health units for responding to notifiable diseases, with links to guidelines for each STI and BBV.

Australasian Contact Tracing Guidelines: this comprehensive online resource (a component of the Australian STI Management Guidelines) provides practical support and guidance on partner notification.

National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people: is intended for all healthcare providers delivering primary healthcare to the Aboriginal and Torres Strait Islander population, and makes specific recommendations aiming to prevent disease, detect early and promote health in the Aboriginal and Torres Strait Islander population.

National HIV Testing Policy: sets out principles, aims and arrangements for HIV testing in Australia.

National HCV Testing Policy: sets out requirements and guidance for hepatitis C testing.

National HBV Testing Policy: provides advice on appropriate testing pathways using currently available technologies.

CARPA Remote Primary Health Care Manuals: developed by the Central Australian Rural Practitioners Association and partners, these manuals aim to support and promote good clinical practice in primary health care in central, northern and remote Australia, except Queensland — for Queensland clinical guidelines on remote and diverse communities, see the Primary Clinical Care Manual.

Minymaku Kutju Tjukurpa Women's Business Manual: developed by the Central Australian Rural Practitioners Association and partners, this manual includes protocols for providing health care to Aboriginal and Torres Strait Islander women in remote Australia.

Conducting Medical Consultations: developed by Flinders University and Charles Darwin University, this module aims to develop the telephone consultation skills of Remote Area Nurses.

QUEENSLAND

Queensland Health website: includes current clinical guidelines on STIs and BBVs for Queensland as well as local information, with information on all aspects of contact tracing, referrals and links to national guidelines.

Queensland Clinical Primary Care Manual: principal clinical reference and policy document for clinicians in diverse and rural and remote health service settings, and supports best practice in rural and remote health care.

Aboriginal and Torres Strait Islander adolescent sexual health guidelines: produced by Queensland Health, this booklet aims to provide health professionals with a guide to delivering culturally competent sexual health care to Aboriginal and Torres Strait Islander young people.

Guide to offering Sexually Transmissible Infection (STI) testing to people aged less than 16 years attending clinical services: includes guidance on obtaining informed consent and dealing with potential emotional impacts of testing and/or a positive diagnosis.

SOUTH AUSTRALIA

SA Health website: includes current STI clinical guidelines for South Australia. Developed primarily for use by Adelaide Sexual Health Centre, which offers SA clinicians specialist advice on STIs, including HIV post-exposure prophylaxis.

HERO: Sexually Transmitted Infections & Blood-Borne Viruses Handbook for South Australian Aboriginal Community Controlled Health Services: handbook developed by the Aboriginal Health Council of South Australia to facilitate a standardised, evidence-based approach to STI and BBV control within ACCHSs in South Australia.

WESTERN AUSTRALIA

Silver book: Guidelines for managing sexually transmitted infections and blood- borne viruses, maintained by WA Department of Health. Includes clinical guidelines for all clinicians and health care providers involved in the diagnosis and/or management of STIs and BBVs in Western Australia. Provides evidence-based practice recommendations, and a range of patient and health professional resources.

Kimberley Aboriginal Medical Services Clinical Protocols / Guidelines: include sexual health guidelines that aim to standardise STI screening and management, taking extreme remoteness into consideration. Aim is to enable care to be initiated by a range of health care professionals working within their own scope of practice when direct access to specialists is limited.

WA Sexual Health Orientation Manual for Endemic Regions: a hard copy manual on common STIs and BBVs with practice scenarios to inform and enhance clinical practice. To order copies email: shbbvp@health.wa.gov.au

Quick Guide for STI Testing and Quick Guide for STI Management: hard copy resources designed to provide evidence-based practice recommendations for the treatment and management of STIs. PDF guides are available for printing on the WA Department of Health's Silver book website using the links on the right side of the home page.

NORTHERN TERRITORY

NT Guidelines for the management of STI's in a PHC setting: designed to be used as a comprehensive reference guide for sexual health service delivery for primary health care clinicians, these guidelines combine STI BBV testing, treatment and management sections of the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual (STM), 6th Edition1, and the Women's Business Manual (WBM), 5th Edition.

SYPHILIS-SPECIFIC CLINICAL GUIDELINES

GENERAL: National clinical guidelines for syphilis

Screening 2018 National Guidelines for Syphilis — pages 18 to 19

- Offer STI/syphilis testing to sexually active young people in outbreak areas:
  - as part of any consultation (opportunistically) for 15–29 year olds
  - as part of Adult Health Checks for 15–35 year olds
  - if patient asks to be tested.

Treatment 2018 National Guidelines for Syphilis — pages 16 to 17

ANTENATAL: National antenatal care guidelines for syphilis

Pregnancy Care Guidelines Routine maternal health tests: Syphilis

Key points

- In syphilis outbreak areas, to prevent cases of congenital syphilis routinely offer syphilis testing to pregnant women and new mothers at:
  - the first antenatal booking visit
  - 28 weeks antenatal check
  - 36 weeks antenatal check
  - delivery
  - 6 weeks post-partum.

  (NB: local guidelines may recommend additional checks in outbreak areas; e.g., Queensland recommends an additional test at 20 weeks)
- Seek advice from an expert in sexual health or infectious diseases regarding the care of women who test positive, and their partners.
- Ensure contact tracing (including offering testing and treatment to identified contacts) is carried out. Involve an expert in contact tracing if required or seek advice from a sexual health or other relevant expert.
- For women with newly confirmed infectious syphilis, initiate treatment as soon as possible (as per guidelines) — at least 30 days before the estimated date of birth — to ensure adequate treatment before the birth.
- In areas affected by the syphilis outbreak, where a point-of-care syphilis test is reactive, treat the woman as soon as possible without waiting for confirmatory testing, particularly if there is a risk of loss to follow-up.

Additional clinical guidelines on syphilis

National

- Remote Primary Health manuals: CARPA STM and Women's Business Manual

Northern territory

- NT Guidelines for the Management of Sexually Transmitted Infections in the Primary Health Care setting
- Congenital syphilis guidelines for the Northern Territory

Western Australia

- Silver book — Guidelines for managing sexually transmitted infections and blood-borne viruses: syphilis

South Australia

- SA Health Factsheet for Health professionals — Infectious syphilis outbreak
- SA Perinatal Practice Guidelines — Syphilis in Pregnancy

Queensland

- Syphilis in pregnancy and Guideline Supplement
- Queensland Health Communicable Disease Control Guidance — Syphilis

Clinical resource catalogue

ORIENTATION PROGRAMS AND RESOURCES

Remote Area Health Corps (RAHC) online training modules: RAHC's Introduction to Remote Health Practice Program online training was developed for Northern Territory practitioners but clinicians from anywhere in Australia can register for the training, free of charge. The eLearning modules provide an overview of health issues prevalent in the remote health context, with a suite of orientation and learning materials to better equip health professionals for working with remote Aboriginal communities. Each module has been developed to meet various colleges' and professional bodies' Continuing Professional Development criteria.

ASHM workforce development programs: The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) runs courses including:

- Training in Hepatitis B and/or Hepatitis C for Aboriginal and Islander Community Controlled Health Services (usually delivered as an in-service), Australia-wide
- Training in Hepatitis B and/or Hepatitis C for Aboriginal and Torres Strait Islander Health Workers — Australia wide
- Deadly Sex Congress — sexual health professional development conference for Aboriginal and Torres Strait Islander Health Workers — Queensland only

See available courses. ASHM can also do training by request — just send an email to education@ashm.org.au

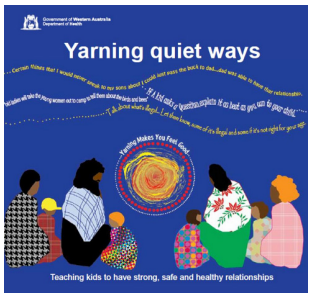
Removing Barriers: ASHM's online learning tool for reducing stigma and discrimination in providing clinical care for people affected by BBVs, including people living with HIV or hepatitis C, injecting drug users and LGBTI people.

WA Sexual Health Orientation Manual for Endemic Regions: a hard copy manual on common STIs and BBVs with practice scenarios to inform and enhance clinical practice. To order copies, email: shbbvp@health.wa.gov.au

Resources for engaging with young people

Doin' it Right is a kit for health professionals and community workers working in sexual health education with Aboriginal young people.

All Good provides basic information on BBVs and STIs, and a tool for locating testing services, in Aboriginal and Torres Strait Islander languages.



Yarning Quiet Ways is a resource developed for Aboriginal mums, dads and carers to help kids learn about strong, safe and healthy relationships.

Let's Yarn! has been developed to assist educators, parents and health professionals to talk with young Aboriginal people about ways of building strong, safe and healthy relationships. The website brings together useful resources developed by WA Health and other government and non-government agencies around Australia.

Nuts and Bolts of Sexual Health: Course (in Perth) for workers in the youth sector, including Aboriginal health workers. The course aims to develop the core knowledge, attitudes and skills required to have conversations with young people about respectful relationships and sexual health issues, and providing information and support

Healthy Conversations: An audio-visual resource to provide guidance on discussing sexual health and blood-borne viruses with Aboriginal people.

No Shame: Yarn About It: a training video that tells the story of sexual health workers in the fictitious 'Harmony Bay' clinic in Queensland and how they support the sexual health of their clients. The video includes interviews with Aboriginal and Torres Strait Islander sexual health workers, with tips on getting clients yarning about sexual health and supporting young people to feel safe about coming to a clinic.

Having the Hard Yarn in Napranum: Video developed by health workers to assist in having the hard yarn with pregnant mums and partners about STIs. Also covers smoking in pregnancy, alcohol and domestic violence. Stars members of Napranum community.

YOUNG DEADLY FREE VIDEO RESOURCES FOR CLINICIANS

As a jointly produced resource of the Remote STI and BBV Project — *Young Deadly Free*, and the *Young Deadly and Syphilis Free* Project we have produced a range of videos to support remote clinicians in STI and BBV testing and management. Watch the full suite of videos here.

Videos for clinicians that can be used in supporting clients

Creating a supportive space to talk about sexual health

Working appropriately in Aboriginal sexual health

Sexual diversity in Aboriginal sexual health

Antenatal Carers: Our role in preventing congenital syphilis

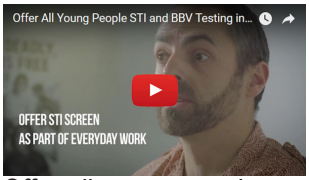
STI contact tracing in Aboriginal and Torres Strait Islander health

Working with Aboriginal and Torres Strait Islander men in sexual health

Sexual health consults with Aboriginal & Torres Strait Islander people

Listening to your community: Importance of consultation and engagement with first nations communities

Videos for clinicians regarding STI and BBV testing



Offer all young people STI and BBV testing in remote communities

Rapid syphilis testing

The basics of STI testing in remote Australia

U + ME CAN STOP HIV: Testing Aboriginal and Torres Strait Islander people for HIV

Test for syphilis and HIV with STI screen

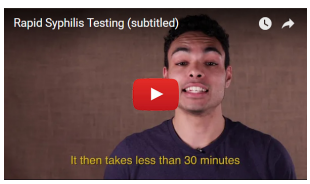
HIV testing: Don't be shame to test

Community experiences & opinions about STI testing

Clinicians sharing strategies for offering STI and BBV testing in remote communities

Videos for clinicians specific to syphilis

All abut syphilis Parts 1 & 2



Rapid syphils testing

Test for syphilis and HIV wtih STI screen

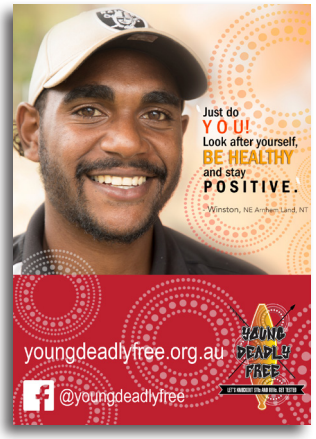
The clinician's role in stopping syphilis

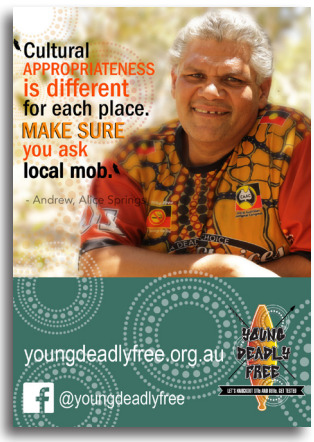
POSTERS

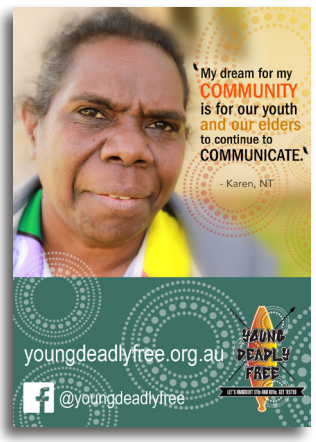
These posters, featuring people from communities across Queensland, the Northern Territory, Western Australia and South Australia, aim to get *Young Deadly Free* key messages out to young people and others in a fresh, engaging way. The posters below are grouped by state/territory, with banner colours denoting who is giving the message — red for young people, green for people of influence and yellow for clinicians. Hard copy prints of the posters can be ordered in A2 size, or you can download print friendly PDF versions to print yourself, avalable here.

Young Deadly Syphilis Free posters

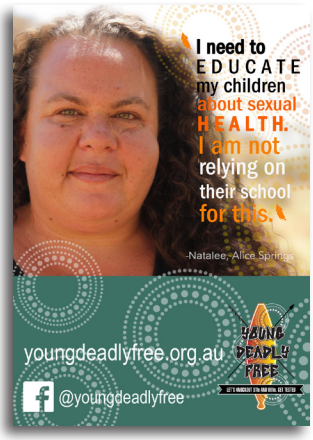
Northern Territory posters

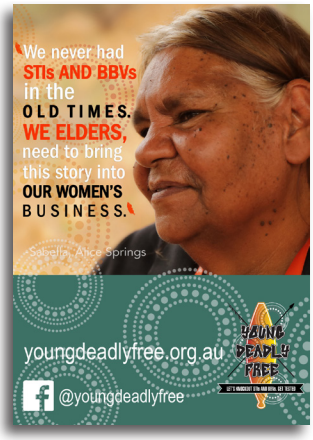


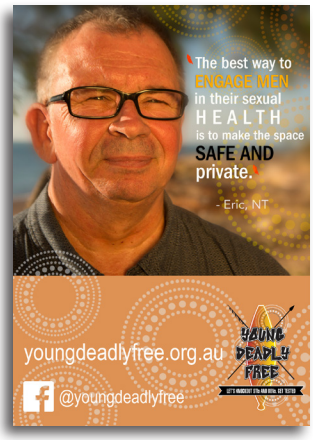


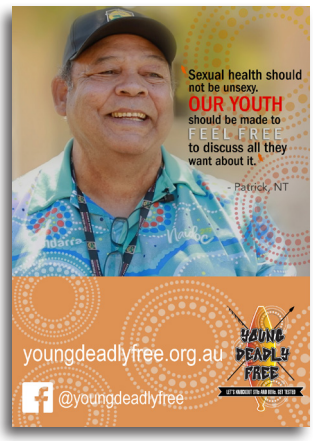


Northern Territory posters cont.

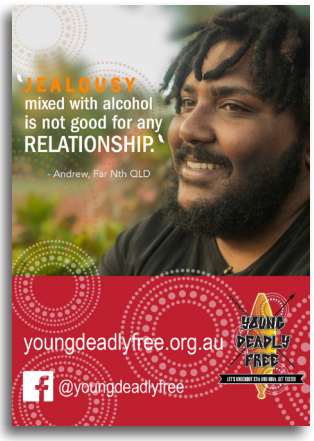


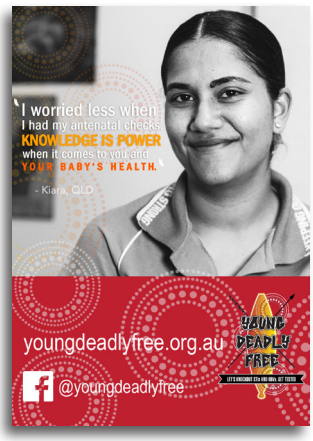


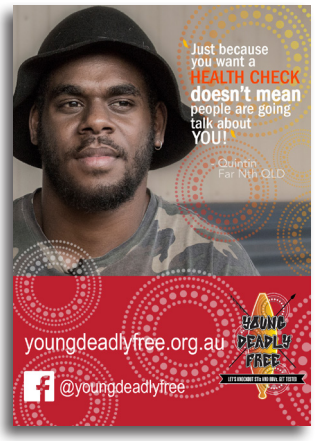


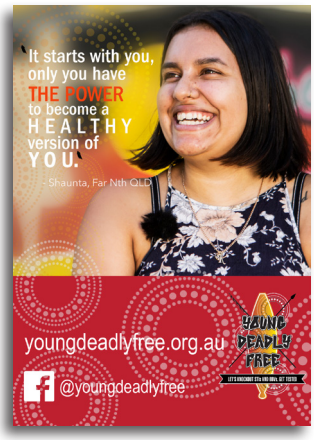


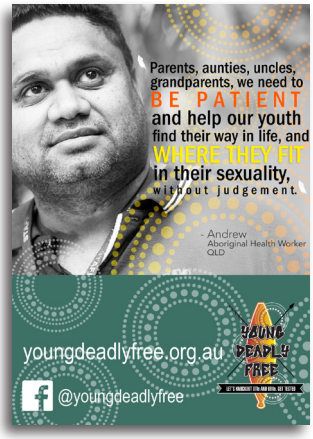
Queensland posters

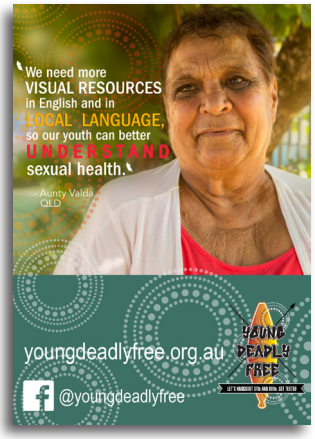


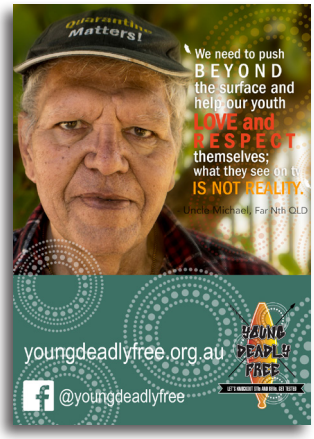


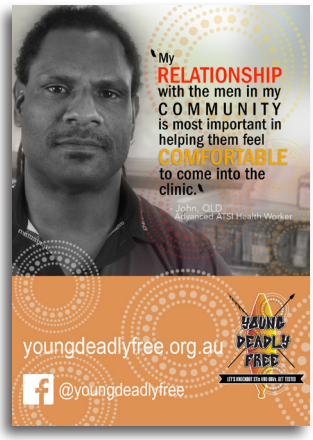


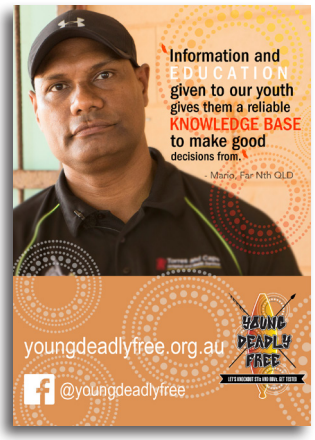




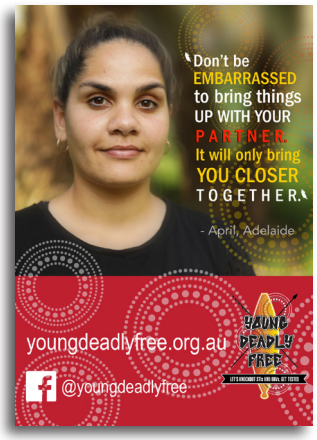


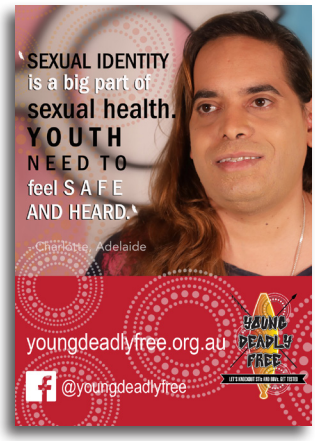


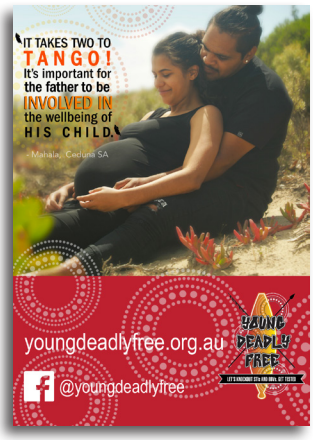


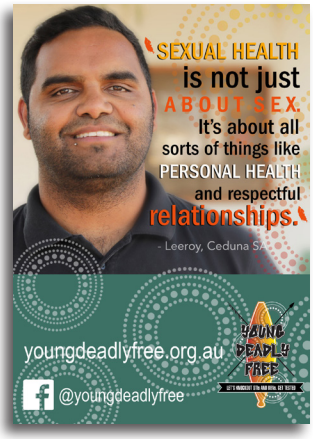


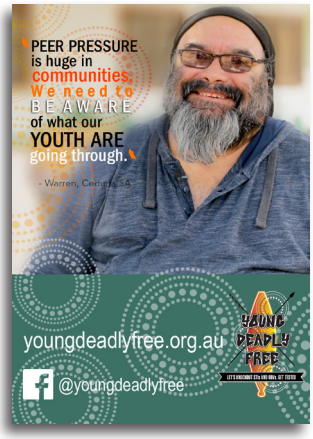
South Australia posters



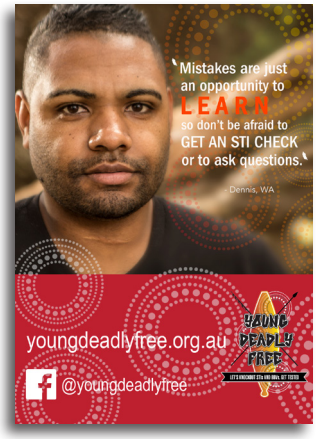


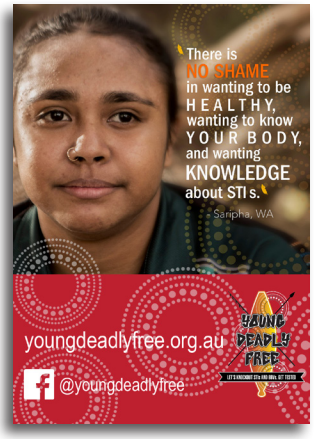


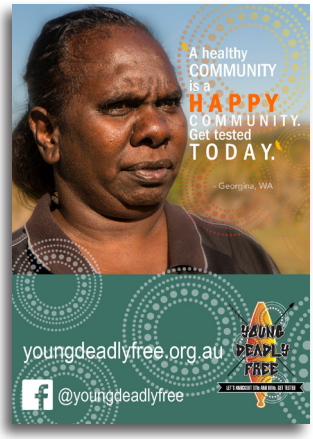


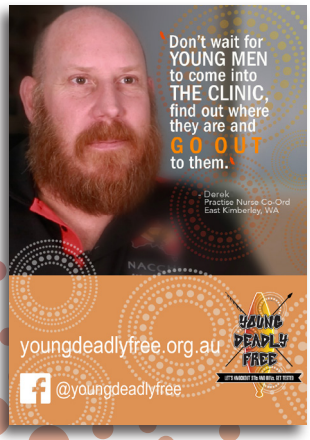


Western Australia posters





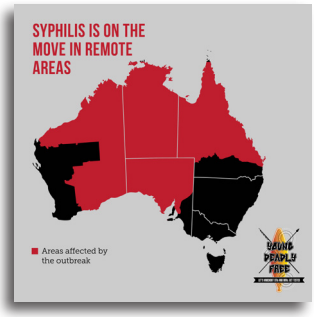


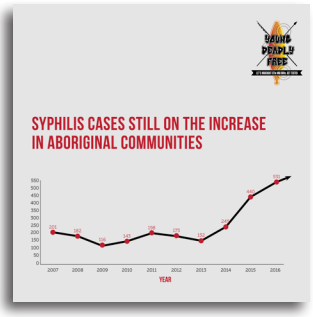


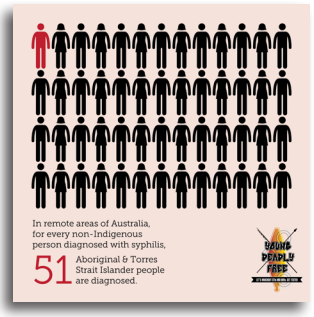
INFOGRAPHICS

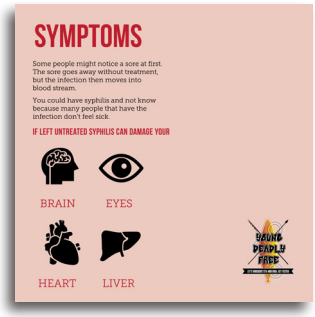
Young Deadly Free has produced infographics on STIs and BBVs. These infographics contain simple messages about STI and BBV transmission, prevention, treatment and care. View and download the infographics here.

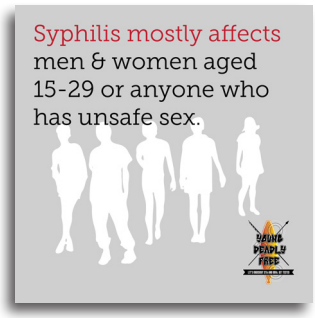
Syphilis infographics

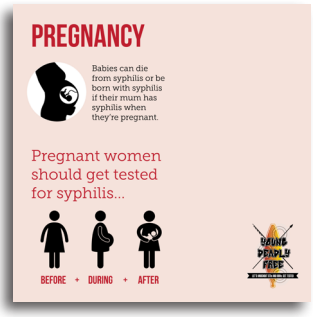




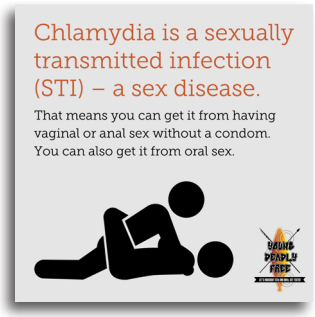


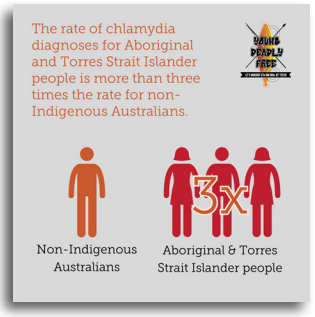


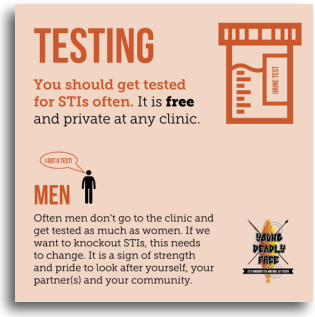


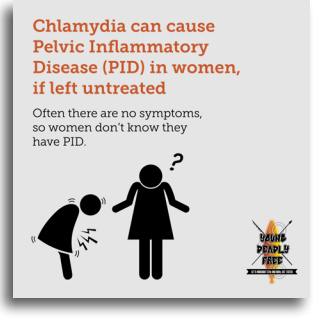


Chlamydia infographics

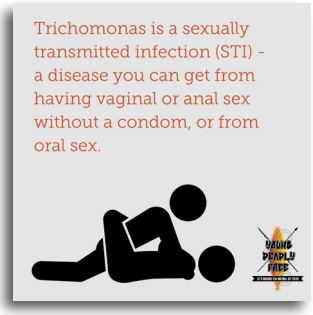


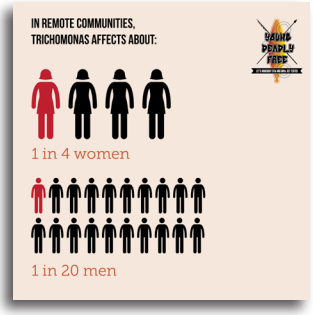


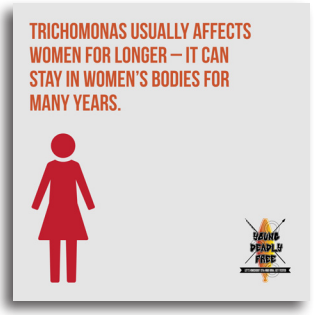


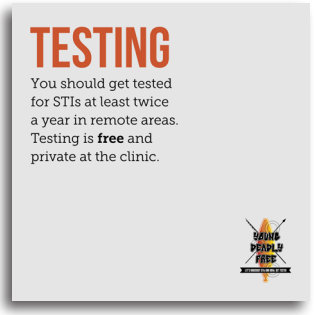


Trichomonas infographics

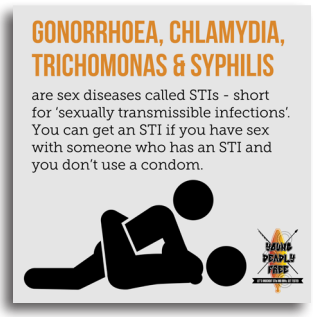


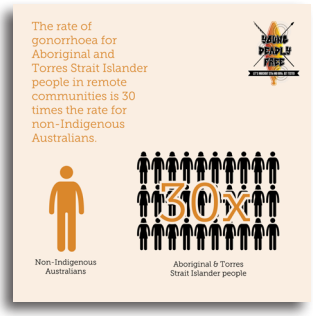




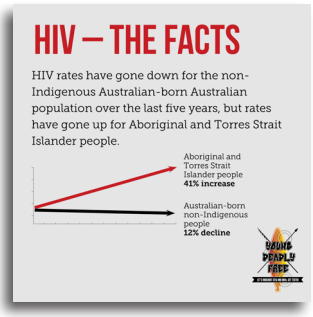


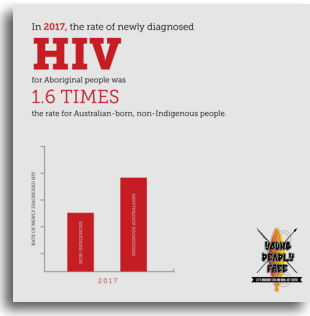
Other STIs infographics

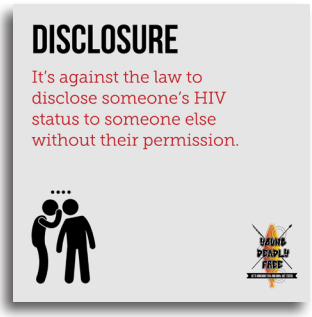


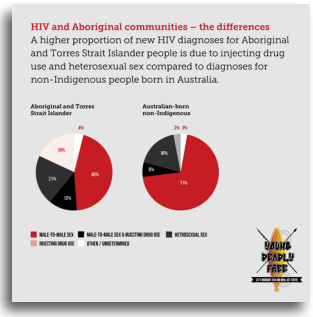


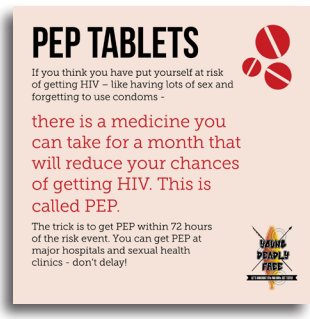
HIV infographics

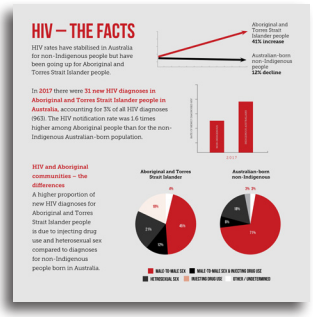


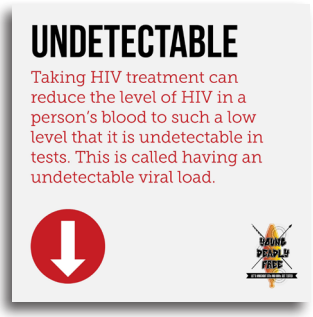




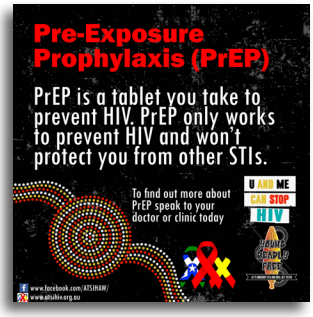


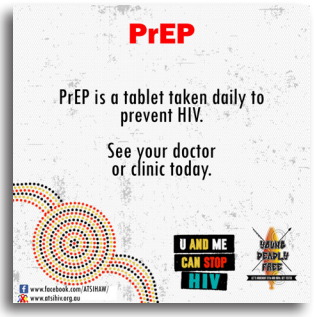


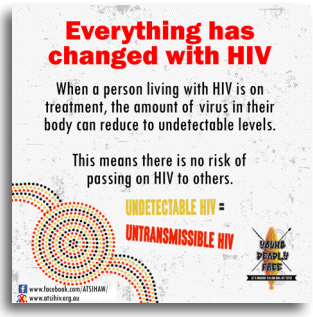


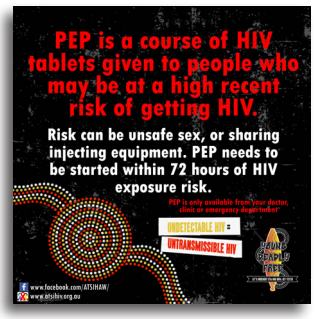


HIV infographics cont.

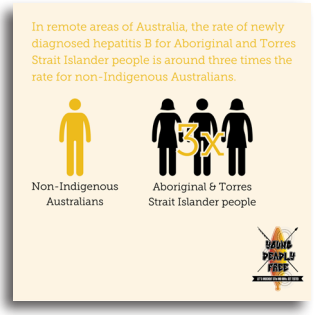


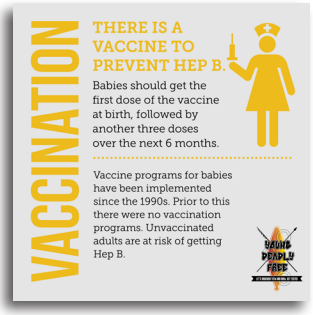


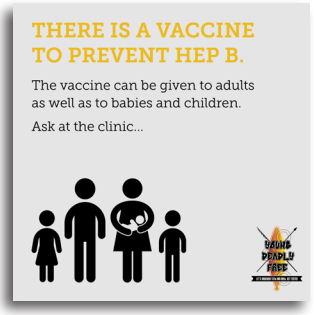




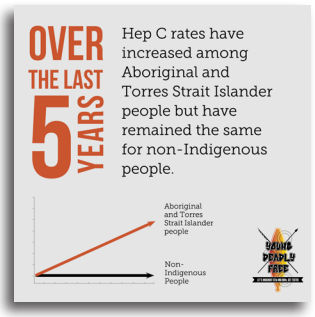
Hepatitis B infographics

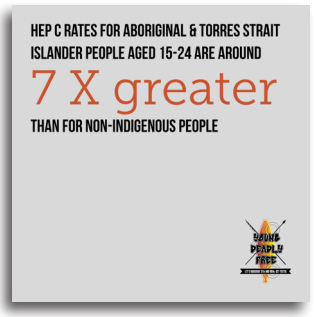


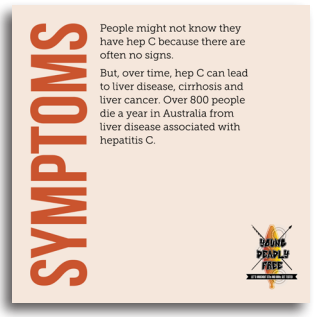




Hepatitis C infographics







FACTSHEETS AND ANIMATIONS FOR YOUNG PEOPLE

Young Deadly Free factsheets about the STIs and BBVs affecting young people in remote communities, and on sex and the law (including sexting), are available here. The factsheets on each STI and BBV are available in two forms, basic and detailed. They can be a useful clinical tool for helping young people understand STI and BBV transmission and risk, and encouraging regular testing.

Young Deadly Free animations on STIs, including HIV, can break the ice when talking to young people about STIs and BBVs — especially in community education. The animations are available here

RESEARCH PUBLICATIONS — THE EVIDENCE BASE

Here are links to a selection of peer-reviewed research publications relevant to STI and BBV prevention, testing and treatment in remote Aboriginal and Torres Strait Islander communities. See here for updates.

Incidence and prevalence of STIs/ BBVs among Aboriginal people

Changing pattern of sexually transmissible infections and HIV diagnosed in public sexual health services compared with other locations in New South Wales, 2010–14. Bourne C, Lam M, Selvey C, Guy R, Callander D. Sex Health. 2018;15(4):366–369. https://doi.org/10.1071/SH17183

An audit on the management and outcomes of infants at risk of congenital syphilis in the Top End of the Northern Territory, Australia, 2005–2013. Rode NBA, Ryder N, Su JY. Commun Dis Intell. 2018;42. pii: S2209–6051(18)00018-0.

HIV incidence in Indigenous and non-Indigenous populations in Australia: a population-level observational study. Ward J, McManus H, McGregor S, Hawke K, Giele C, Su J, McDonald A, Guy R, Donovan B, Kaldor JM. Lancet HIV. 2018;5(9):PE506–E514. https://doi.org/10.1016/S2352-3018(18)30135-8

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