



Aboriginal Health Council
of South Australia Ltd.

SEXUALLY TRANSMISSIBLE INFECTIONS & BLOOD-BORNE VIRUSES

Handbook for South Australian Aboriginal Community Controlled Health Services

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Aboriginal Health Council
of South Australia Ltd.

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'Our health, our choice, our way'

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Abbreviations

Abbreviation	Explanation
ACCHS	Aboriginal Community Controlled Health Service
AHCSA	Aboriginal Health Council of South Australia
AHP	Aboriginal Health Practitioner
AHW	Aboriginal Health Worker
BBV	Blood-Borne Virus
CARPA STM	Central Australian Rural Practitioners Association Standard Treatment Manual
CARPA WBM	Central Australian Rural Practitioners Association Women's Business Manual
CDCB	Communicable Disease Control Branch
GP	General Practitioner
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
MBS	Medicare Benefits Schedule
PEP	Post Exposure Prophylaxis
PrEP	Pre Exposure Prophylaxis
RN	Registered Nurse
SDO	Standing Drug Order
STI	Sexually Transmissible Infection



Background

The Aboriginal Health Council of South Australia (AHCSA) is a membership-based peak body with a leadership, advocacy and sector support role, and a commitment to Aboriginal* self-determination. AHCSA is the health voice for Aboriginal people across South Australia, representing the 11 Aboriginal Community Controlled Health Services (ACCHSs) and 1 Substance Misuse Service at a State and National level.

The AHCSA Sexual Health Program began in 2009 with the aim of strengthening capacity of ACCHSs to provide comprehensive sexual health services for Aboriginal communities across SA. This includes supporting an 'enhanced' six week sexually transmissible infection (STI) screening period annually for people aged 16 to 35 years as well as opportunistic STI screening throughout the year. The AHCSA Blood-Borne Virus (BBV) Program aims to strengthen the capacity of ACCHSs to identify and manage chronic hepatitis B and C. The programs are supported by a small but dedicated team consisting of a Sexual Health Program Coordinator, Clinical Support Officer, BBV Program Coordinator and Public Health Medical Officer.

This Handbook has been developed by AHCSA to facilitate a standardised evidence-based approach to control programs for STIs and BBVs at the comprehensive primary health care level within ACCHSs in SA. The contents have been drawn from various resources aimed at clinicians and community which are listed in a separate section. The Handbook is not intended to replace other resources used by the sector, but rather as a quick reference guide primarily focussing on the standard STI check and screening of asymptomatic members of the community.

*The use of the term Aboriginal in this Handbook is inclusive of Aboriginal and Torres Strait Islander people.

Clinical features & risk factors

Common STIs

Clinical Features

CHLAMYDIA & GONORRHOEA

Chlamydia and gonorrhoea are equally common in women and men. Infection is often asymptomatic (no symptoms).

When symptoms are present they commonly include abnormal vaginal discharge, abnormal vaginal bleeding, lower abdominal pain and, less commonly, pain on passing urine in females, and pain on passing urine, discharge from penis and scrotal pain in males. They can also cause eye infections in both men and women, and gonococcal conjunctivitis (red eyes with discharge) can lead to blindness.

Pelvic inflammatory disease (PID) is an important condition that may occur as a consequence of untreated chlamydia and gonorrhoea infections in women. PID may cause infertility (difficulties in becoming pregnant), ectopic pregnancy and chronic pelvic pain. Symptoms of PID include lower abdominal pain, vaginal discharge, deep dyspareunia (pelvic pain during sex) and abnormal vaginal bleeding – bleeding in between periods, or after sex. For more information about PID please refer to the [CARPA WBM 6th edition, pp. 260-263](#).

Epididymo-orchitis (painful, red swollen testicle/s) may occur as a consequence of infection in males. Very rarely, infection in men may also cause prostatitis (infection of the prostate gland).

Disseminated (widespread) gonococcal disease may also occur, characterised by septic arthritis and macular rash that may include necrotic pustules. Rare consequences include meningitis (infection of the lining of the central nervous system) and endocarditis (infection of the inner layer of the heart, involving the heart valves). Disseminated gonococcal infection is an emergency and requires urgent treatment.

Chlamydia can cause Sexually Acquired Reactive Arthritis (SARA). This is manifested by urethritis (pain on passing urine), conjunctivitis (red eyes) and arthritis (joint pain/swelling).

TRICHOMONIASIS

Trichomoniasis is more common in women than men because the protozoal parasite, *trichomonas vaginalis*, which causes the trichomoniasis infection lasts much longer in women (up to 5 years if untreated) than in men (up to 4 months).

Infection in women may be asymptomatic. If symptoms occur, these include vaginal discharge, vulval itch or soreness, dysuria (pain on passing urine) and cervicitis (on speculum exam). Infection with trichomonas is usually asymptomatic in men. If present, symptoms of trichomoniasis in men include dysuria and urethral discharge.

Trichomoniasis is associated with complications in pregnancy such as premature rupture of membranes, pre-term delivery and low birth weight of the baby. In men, it is uncommonly associated with prostatitis.

Infection with any STI, including chlamydia, gonorrhoea or trichomoniasis may increase the risk of transmission of human immunodeficiency virus (HIV).

GENITAL HERPES & VIRAL WARTS

Genital herpes and genital wart virus infections are common in all populations. However, rates of genital warts and Human Papillomavirus (HPV)-related pre-malignant lesions have reduced significantly in Australia since the national HPV vaccination program commenced in 2007. In 2013, the national HPV vaccination program was expanded to include boys aged 12-13 years. See [CARPA STM 7th edition, p. 288](#) and [CARPA WBM 6th edition, p. 256](#) for more details of diagnosis and treatment. Although the rate of cervical cancer and mortality from cervical cancer have improved for Aboriginal populations, these are still experienced at disproportionately higher rates compared to the general Australian population. The reasons for this include reduced access to cervical screening programs and treatment services for pre-cancerous cervical changes and cervical cancer as well as higher rates of cigarette smoking.

Risk factors

- Living in a community with high STI rates
- Rural and remote area of residence
- Age:
 - High risk – sexually active under 35 years
 - Highest risk – sexually active under 19 years
- STI in the past 12 months
- New sexual partner in previous three months; more than one partner in previous six months
- Drug or alcohol use increases high risk behaviours (e.g. multiple sexual partners, unsafe sex)
- Recent travel
- Intercourse without condoms / low rates of condom use

Other STIs/BBVs

SYPHILIS

An outbreak of infectious syphilis was declared in the Eyre, West and Far North regions of South Australia (SA) in early 2017. The outbreak area extended to include Adelaide in November 2018. This is part of a larger multi-jurisdictional outbreak of syphilis in Aboriginal and Torres Strait Islander people living in Northern and Central Australia which began in 2011 and has been associated with a number of deaths from congenital syphilis (present from birth).

Transmission of syphilis is via sexual contact or vertical transmission from mother to child in utero (during pregnancy). Syphilis is highly infectious through sexual contact in the first two years of infection during the primary, secondary and early latent stages (early infection).

For infectious syphilis in pregnancy, the risk of transmission to the foetus (baby) is very high (70-100%) with up to 40% of pregnancies resulting in perinatal death, high rates of premature delivery and congenital abnormalities in surviving infants.

The public health significance of syphilis lies in its impact on the developing foetus in utero as well as enhancing both the transmission and acquisition of **Human Immunodeficiency Virus (HIV)**.

Symptoms depend on the stage of infection. The genital lesion of **primary** syphilis (chancre) appears 9 to 90 days after contact. The lesion is usually firm (“indurated”), round and painless and may go unnoticed. It is highly infectious at this stage. The sore lasts 3 to 6 weeks and heals regardless of whether treatment is given. The **secondary** stage produces a maculo-papular rash (raised, rough, red or brown rash), typically on the palms of the hands and/or the soles of the feet. Secondary syphilis lesions appear 4 to 10 weeks after the chancre first appears. Other secondary stage symptoms include condylomata lata (wart-like lesions) in the genital or perianal area, fevers, lymphadenopathy (swollen lymph glands), sore throat, patchy hair loss, headaches, visual disturbances, weight loss, muscle aches and fatigue. The mucous membrane lesions of the secondary stage are also highly infectious. Symptoms in this stage will also resolve regardless of treatment. However, one third of those who are not treated will go on to develop tertiary syphilis after a period of 10-30 years, characterised by potentially serious cardiac and neurological complications.

HIV

Since the beginning of the HIV epidemic in Australia in the 1980s, there have been concerns about the potential for the rapid spread of HIV in Aboriginal communities. For many years, the rates in Aboriginal and non-Aboriginal populations in Australia remained the same. In the past five years however, the rates for Aboriginal people have increased while they have decreased in the general population. The rate of HIV for Aboriginal people in Australia is now double the non-Aboriginal rate. There are many reasons for this difference, including a different risk factor profile – Aboriginal people are far more likely to have acquired HIV through heterosexual sex as well as sharing injecting drug use equipment. There is also likely to be less access to newer medication prevention strategies - Post Exposure Prophylaxis (PEP) and Pre Exposure Prophylaxis (PrEP) - and treatment services.

Other risk factors for HIV include if the person or their partner is a man who has sex with men (MSM), transgender/sistergirls, migrants/refugees living in Australia from high prevalence countries and people who inject drugs.

Infection with HIV affects the immune system, causing chronic immune deficiency. Symptoms may include oral thrush, weight loss, skin infections. If left untreated, infected persons develop Acquired Immunodeficiency Syndrome (AIDS) which is characterised by several kinds of infections (opportunistic infections) and some types of cancers.

Early identification of HIV is important to enable all infected people to go on treatment as quickly as possible. If people with HIV are on treatment and have no detectable virus in their blood there is very good evidence that they cannot transmit HIV to another person, even through unprotected sex (Treatment as Prevention – TasP). Further, early treatment keeps people well and improves the long-term health of people living with HIV.

See the [Australian STI Management Guidelines](#) and other resources listed at the back of this manual for more information.

HEPATITIS B

Hepatitis B is a blood-borne and sexually transmitted viral infection. Chronic hepatitis B occurs more commonly in Aboriginal people compared to non-Aboriginal people, particularly those who grew up in remote Aboriginal communities. Hepatitis B is thought to have been endemic in these communities for many generations. With childhood vaccination programs incorporating a hepatitis B vaccine since the 1990s, it is hoped that hepatitis B eradication is a realistic possibility within a generation. However, there are still a significant number of adults from remote Aboriginal communities who have chronic hepatitis B. For Aboriginal people, the majority of hepatitis B infection is acquired at birth or in early childhood. As a result, many Aboriginal people acquired infection at a young age where the risk of developing chronic infection, and the complications of cirrhosis (permanent scar tissue on the liver) followed by liver failure and liver cancer or Hepatocellular Carcinoma (HCC), is much higher than if infection is acquired as an adult. Other potential routes of transmission include sexual contact, sharing of razors/toothbrushes and the use of non-sterile equipment for procedures involving skin piercing, such as injections, tattooing and ceremony.

Asymptomatic infection with chronic hepatitis B is common. If symptoms occur, these could be in the context of a new acute infection, a flare of chronic hepatitis or progression to advanced liver disease. Symptoms include feeling unwell, loss of appetite, jaundice, nausea and vomiting, upper abdominal pain, confusion or drowsiness, dark urine and pale faeces.

It is important to determine the chronic hepatitis B status of all Aboriginal people to ensure people without immunity are offered vaccination and people living with chronic hepatitis B are identified and engaged in care. Treatment options have greatly improved in recent years with the availability of antiviral medication. The goal of treatment for hepatitis B is to suppress viral replication thereby reducing the risk of progression to advanced liver disease and subsequent complications. Although many people with chronic hepatitis B do not need treatment with antiviral medication, it is estimated that only a small proportion of Aboriginal people who do require treatment are accessing it. People living with hepatitis B should have a clinical review every six to twelve months. This clinical review can identify which clients require antiviral treatment and support the early detection of HCC.

HEPATITIS C

Hepatitis C is predominantly a blood-borne viral infection and the majority of new and existing infections are the result of unsafe sharing of injecting equipment. There is evidence that Aboriginal people have higher rates of injecting drug use as a result of being a younger, mobile and marginalised population who are more likely to participate in risk-taking behaviour; are more likely to be exposed to unsafe injecting practices and are less likely to access needle and syringe programs. Other important routes of transmission are listed in Box 1.

Chronic hepatitis C, if left untreated, can cause similar complications as chronic hepatitis B. Additionally, excessive alcohol consumption, obesity and diabetes can all increase liver damage.

Asymptomatic infection with chronic hepatitis C is also common. The most common symptoms for chronic hepatitis C include nausea, low energy, depression, brain fog and pain in the abdomen. Like hepatitis B, symptoms from chronic hepatitis C infection are more likely with advanced disease.

With the availability of the new Direct-Acting Antiviral (DAA) agents, all people identified with chronic hepatitis C should be offered treatment. See management section for additional information.

Box 1. Risk factors for hepatitis C transmission

- Prison incarceration (due to high prevalence in prisons)
- Blood transfusion prior to 1990
- Mother to child transmission (low risk)
- Any blood to blood contact or sharing of equipment which cuts the skin including:
 - o Sharing drug injecting equipment
 - o Unsterile tattoos or piercings
 - o Cultural practices
 - o Fighting
 - o Playing sport
 - o Sharing items such as shaving razors
- Sexual transmission may occur (uncommonly), especially in HIV positive men who have sex with men (MSM)

HUMAN T-CELL LYMPHOTROPIC VIRUS TYPE-1 (HTLV-1)

HTLV-1 is a virus that occurs in many communities around the world and has been present among Aboriginal people in Central Australia for thousands of years. The type of virus found in Central Australia, type C, is unique to this region. The true burden of HTLV-1 disease in Aboriginal communities is not currently known. Preliminary data suggests high rates of this virus in some communities in Central Australia.

Current evidence shows that infection with this virus is not likely to cause disease in the majority of people. In a small proportion of people after many decades however, HTLV-1 causes a rare form of leukaemia and/or spinal cord disease. Studies have suggested associations with other diseases, such as bronchiectasis and arthropathy, but it is not yet known whether it causes those diseases or not.

HTLV-1 can be prevented in adolescents and adults through safe sex and by not sharing needles. The significant health benefits of breastfeeding are well established and, whilst transmission through breastfeeding can occur, current evidence does not yet warrant restricting breastfeeding in HTLV-1 positive women.

Once acquired, HTLV-1 is present for life, but there are management options for most of the diseases that may arise from it. Further treatment options specifically for HTLV-1 are being investigated.

A forum held in Alice Springs in August 2018 attended by Aboriginal leaders, community and patient representatives, researchers, representatives from ACCHSs, clinicians, public health officials, and representatives from Commonwealth and State and Territory health departments concluded that there needs to be a major long-term study, developed in partnership with the affected communities, to work out exactly what impact HTLV-1 is having on people in Central Australia. The forum attendees also

concluded that more research needs to be done to understand where the virus occurs and that there is a need for better access to effective testing options, together with clinical guidelines for HTLV-1 associated conditions. However, **the forum did not recommend population-wide HTLV-1 testing at this stage.**

DONOVANOSIS

While previously more common especially in remote communities, donovanosis is now a rare condition. It causes a pinkish-red ulcer, usually in the genital area, which might be raised and beefy, and might emit a foul odour. Take a swab for nucleic acid amplification testing (NAAT) for herpes, syphilis and donovanosis when any ulcerated lesion around the genital area is found. Treatment is with azithromycin (see [CARPA STM, 7th edition, p. 280](#) and [CARPA WBM, 6th edition, p. 247](#)).

MYCOPLASMA GENITALIUM

Infection with *Mycoplasma genitalium* is often asymptomatic. If symptoms occur these may include pain in passing urine, urethral discharge and prostatitis in males; and vaginal discharge, pelvic pain, bleeding in between periods, bleeding after sex and pain on passing urine in females.

Asymptomatic screening for *Mycoplasma genitalium* is not recommended. Testing is only recommended in males with urethral symptoms, females diagnosed with PID whose tests for chlamydia and gonorrhoea are negative, and regular partners of diagnosed cases. Regular partners should only be treated if test result is positive.

See the [Australian STI Management Guidelines](#) for more information.

SCREENING PROGRAMS

Screening Programs

ACCHS Community Screening Program

Common STIs are ideal conditions for screening in Aboriginal communities for the following reasons:

- They are often asymptomatic, which means that the person does not know they have the infection unless they have a test
- There are high rates of chlamydia, gonorrhoea, trichomoniasis
- They can have a significant health impact if left untreated
- Simple reliable and acceptable screening tests are available
- Effective and simple treatments are available

There are two main ways STI screening may be undertaken:

- Opportunistic screening - offering a test to people when they present to the clinic for other reasons
- Community screening - attempting to test all people in the target age group over a short period of time

Opportunistic screening is important and should be encouraged. However, community screening is likely to have a much greater impact on reducing the rates of STIs, for the following reasons:

- Some people in the target age-group may not present to the clinic for other reasons and will not be offered an STI test if only opportunistic screening is relied upon
- By “blitzing” the whole target group with screening and treating all positive cases at around the same time, there is a greater likelihood that transmission of the infections will be interrupted
- Having a period of a few weeks every year where there is an emphasis on STI screening can help to remind everybody concerned about the importance of STIs as a health issue and be an opportunity to up-skill health service staff in STI control activities

Comprehensive community STI screening program components

All services are encouraged to participate in the annual STI community screening program, although the decision to participate lies with each health service. Staff from the AHCSA Sexual Health Program team will be available to provide support and advice. Nganampa Health Council has its own program and protocols.

1. Determine dates for the six-week community STI screening period early in the year. Ideally, this should fall between **April and June**. Individual health services may adjust these dates if they wish, although given high population mobility, effectiveness of the program is enhanced if health services all screen roughly at the same time.

2. It is recommended that STIs routinely screened for include **chlamydia, gonorrhoea and trichomonas**. Screening for **syphilis and HIV** are also routinely recommended given the current syphilis outbreak in SA (as well as Northern/Central Australia) and concerns about recent increased rates of HIV diagnosis in Aboriginal communities nationally also warrant regular screening.
3. The recommended target age-group is those **aged 16-35 years**. It is important to have informed consent from people who provide specimens. They should be aware of why the specimens are being requested, that the specimens will be sent away to a laboratory to test for chlamydia, gonorrhoea, trichomonas, syphilis and HIV, and what it will mean if any are detected. While written, signed consent is no longer required for HIV, aspects of consent such as normalising testing, confidentiality, the 12 week window period and having a plan for sharing results are particularly important when obtaining consent for HIV testing (See [SA Health HIV testing and pre- test discussion guidelines](#)).
4. Screening of younger children (e.g. those aged 14 or 15) where there is thought to be a reasonable likelihood of sexual activity is encouraged. Written consent (see Appendix 1 for consent form template) from parent/carer is required if under the age of 16 years, unless they are assessed as a **competent minor** (see Box 2 below).

Box 2. Obtaining consent for testing from a minor

The Consent to Medical Treatment and Palliative Care Act 1995 (SA)

Section 12 – Administration of medical treatment to a child:

A medical practitioner may administer medical treatment to a child if –

- a. The parent or guardian consents; or
- b. The child consents and:
 - i. The medical practitioner who is to administer the treatment is of the opinion that the child **is capable of understanding the nature, consequences and risks of the treatment and that the treatment is in the best interest of the child's health and well-being**; and
 - ii. That opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced.

There can be difficulties in satisfying s12(b)(ii), especially in rural or remote Aboriginal health services where there may be only one medical practitioner available. Therefore in this event, either a secondary doctor performs a consult by phone or a registered Health Professional is utilised to give a secondary opinion.

5. The aim should be to test everybody from the health service client database in the target age group and to treat every person with a positive test as soon as possible after the diagnosis has been made.
6. This program may provide ideal opportunities for full health assessments and where possible this should be offered. It also provides an opportunity to administer seasonal flu vaccinations. However, the priority over this six-week period is to try and get as many people in the target age group screened for STIs.

7. To ensure maximum coverage, it is important, where possible, to go out of the health centre to various places within the community (including people's homes) to locate people on the list and to offer testing. While this is more feasible when screening geographically discrete communities it should still be the aim of the program regardless of the community being screened.

Preparations & community engagement

1. The ACCHS Board and all health service staff should be fully aware of the activities involved in the program.
2. A person, or small team, should be appointed to coordinate the screening program in each health service. However, as many staff as possible should be encouraged to help with the screening program.
3. Staffing rosters should be arranged to ensure that appropriate staff have specific times allocated to the screening program throughout the screening period. AHCSA may be able to assist with extra staff at various times.
4. A list of all people aged 16 – 35 years should be obtained from the health service's Communicare database. Each health service should ensure a system is in place to keep track of who has been screened, whether results have been received, and whether the appropriate follow-up has occurred.
5. Testing equipment and medical supplies need to be obtained (see Appendix 2 for checklist).
6. The recall "**Check up; sexually transmitted infections**" in Communicare should be set for all people aged 16-35 years to be activated on the first day of the screening period.
7. All staff involved in the screening program should know how to:
 - Use the STI screening clinical items in Communicare (see Appendix 3)
 - Generate pathology request forms (preferably this should be printed from Communicare but in some cases pre-printed pathology request forms may be used). Communicare can be enabled so that non-medical clinical staff can generate pathology request forms for STI screening without a General Practitioner's (GP) signature but linked to a GP's provider number. ACCHSs using this function should have clear protocols in place to ensure results are followed up in a timely manner. Contact the Patient Information Management Systems Project Officer at AHCSA for assistance if necessary
8. Promotion of the event should occur for several weeks leading up to the screening period to raise awareness among community members.
9. Organise special events, e.g. men's health evenings and use the occasion for health promotion as well as screening.
10. Consider arranging visits with sporting clubs, schools, etc for screening purposes.

If people on your list, or named contacts, are away from your community, find out where they are if possible and contact the appropriate health service to ask them to do the screening and to let you know when it has occurred. The AHCSA Sexual Health Program team can help if necessary.

Asymptomatic STI testing

It is recommended that the Standard STI Check ([CARPA STM, 7th edition, p. 272](#) and [CARPA WBM, 6th edition, p. 238](#)) is followed when offering asymptomatic STI testing. This avoids the need for obtaining a detailed sexual history which is often an impediment to staff undertaking STI testing. Ideally, an opt-out approach for testing should be used. The Standard STI Check includes the following steps:

1. Ask if experiencing symptoms – discharge, pain on passing urine or genital sores/ulcers, no detailed sexual history and physical examination.
 - If symptoms present – refer to CARPA STM or CARPA WBM for relevant protocols for each symptom
2. Collect samples (please refer to the chart on page 17 to assist selection of the appropriate specimen collection container).

Chlamydia, gonorrhoea & trichomonas

- Females: self-obtained low vaginal swab (SOLVS) using 1 x Swab Aptima Transfer Tube OR First-catch urine using Aptima Urine Transfer Tube (or yellow top sterile container)
- Males: First catch urine using Aptima Urine Transfer Tube (or yellow top sterile container)

HIV & syphilis (+/- hepatitis B)

- Blood – test for HIV and syphilis serology. If hepatitis B status is unknown or not immune (no evidence of previous infection or immunisation on record) ADD HepBsAg, HepBsAb and HepBcAb to blood test request form
3. Arrange follow up for results.
 4. If any positive results – do full STI check (see [CARPA STM, 7th edition, p.273](#) and [CARPA WBM, 6th edition, p. 239](#)). Provide results of STI check – be clear about what was tested for and what conditions the results relate to.

Box 3. Asymptomatic STI screening

Routinely offer chlamydia, gonorrhoea, trichomonas and HIV/syphilis serology +/- hepatitis B status to all people aged **16 to 35 years**, at least annually.

*If **symptomatic** – do a full STI check as per CARPA STM and WBM (see point 4 above).

Box 4. Swabbing other sites

If information is disclosed during the consultation indicating sexual involvement of other sites (e.g. anal, oral), offer additional swabs accordingly, e.g. self-collected anorectal swab, throat swab, skin lesion swab.

Additional notes on specimen collection

When people are asked to provide a urine specimen remember that there are sensitivities around urine. Any talk about urine, and the handling of the specimen, should be as discreet as possible, with gender separation maintained as much as possible.

A first-catch specimen (not a mid-stream specimen) is required – approximately the first 20ml of the urine stream. Once the container is one-third filled, pass the rest of the urine in the toilet.

Preferably, female clients should provide self-collected low vaginal swabs (white-top swabs for PCR chlamydia, gonorrhoea and trichomonas; and a charcoal swab for gonorrhoea M/C/S). A **charcoal swab** is preferred for gonorrhoea testing to maintain the viability of live organisms, and should therefore be used when available. If charcoal swabs are not available, a blue-top swab can be used. From a practical view it is difficult to culture specimens from remote areas as the long transit time renders poor organism survival upon arrival at the lab. Any woman who is reluctant to provide swabs should be asked to provide a urine specimen.

Urine specimens should be refrigerated as soon as possible after collection.

All specimens should be sent to SA Pathology.

Figure 1. SA Pathology guide to specimen collection

INFECTIOUS DISEASE TESTS		SA PATHOLOGY	
Urine / Genital / Skin			
To order consumables please go to www.sapathology.sa.gov.au and click on Supplies/Ordering. Also available Blood/Respiratory/Enteric Test Guide, PUB-0064.			
TEST	COLLECT WITH	WHAT TO COLLECT	
URINE	 Yellow top	First pass urine Store specimen at 4°C prior to transport	
	 Aptima Urine Transport tube and Yellow top	Urine - First 20mls Transfer 2mL to Aptima transport container NOT suitable for bacterial culture	
GENITAL	 Aptima swab	Swab NOT suitable for bacterial culture	
	 Amies Liquid swab	Swab State site, e.g. vaginal, cervical, penile	
	 LIM Broth swab	Swab Low vaginal/rectal or vaginal Indicate if patient has a Penicillin allergy NOT suitable for micro, culture & sensitivity for other bacterial pathogens	
SKIN / WOUND	 Amies Liquid swab	Swab State site, e.g. wound, skin, throat	
	 Viral Transport Media swab	NOT suitable for bacterial culture	
	 Fungal Scrapings kit	Skin scraping See kit instructions	

*Polymerase Chain Reaction (PCR), Nucleic Acid Testing (NAT).

Pathology
Collection
Guide



Enquiries 8222 3000

For our patients and our population

www.sapathology.sa.gov.au

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Further information for viral hepatitis, HIV & syphilis testing

Asymptomatic STI testing offers a good opportunity to undertake HIV, viral hepatitis and syphilis testing. However, testing should be offered to other people, and at other times, as detailed below.

HEPATITIS B

All Aboriginal and Torres Strait Islander adults should be tested at least once in adulthood for hepatitis B to establish whether they have an existing chronic infection, are immune from past infection or previous immunisation, or are susceptible to infection. Vaccination should be discussed with those without immunity who remain at high risk (National HBV Testing Policy, 2016). Testing can be opportunistically added during blood testing for other reasons and during adult health checks (e.g. MBS item 715).

Testing for hepatitis B should include the following panel:

- Hepatitis B surface antigen (HepBsAg - the marker of current infection)
- Hepatitis B surface antibody (HepBsAb - the marker for immunity) and
- Hepatitis B core antibody (HepBcAb - the marker of current or past infection)

Interpretation of hepatitis B testing is outlined in Table 1 (see page 20). Isolated core antibody positive may occur and indicates several possibilities, one of which is occult HBV infection. This can be verified by HBV DNA testing, however the test is not Medicare-rebatable in the absence of HBsAg. Further investigation for occult HBV infection should be part of the workup for people planned for significant immune suppression (e.g. cancer therapy, organ transplant) which can precipitate viral reactivation with associated hepatitis flares which can be fatal.

HEPATITIS C

Testing should be offered to all Aboriginal people with the risks listed in Box 5. There are barriers to offering risk factor-based assessment for hepatitis C and it is likely that many Aboriginal people with chronic hepatitis C remain undiagnosed. Given the availability of the highly effective and well tolerated new direct acting antiviral agents, there is an argument for offering universal screening to all Aboriginal people aged 16-59 years once, in the absence of any identified risk factors listed below. Regular testing should be offered for any person who injects drugs.

Box 5. Indications for testing for hepatitis C

- Pregnant women or women contemplating pregnancy
- Evaluation of abnormal liver function tests
- People who have ever injected drugs
- Men who have sex with men
- Unsterile tattooing and body piercing
- Received a blood transfusion or blood products before 1990 in Australia
- People who are a sexual partner of someone with hepatitis C
- Unsterile medical and dental procedure and blood transfusion in high prevalence countries
- People in custodial settings or who have ever been in custodial settings
- People with another blood-borne virus
- Patients undergoing dialysis
- Sex workers
- Healthcare workers who perform, or are expected to perform, exposure-prone procedures
- A person who requests a test in the absence of undeclared risk factors

Screening for chronic hepatitis C is undertaken with HCV antibody testing. If the anti-HCV test is positive then HCV RNA testing should be performed. Ideally, two HCV RNA results six months apart should be negative before assurance is given that the infection has been cleared.

Anti-HCV and HCV RNA tests can be ordered together by submitting 1 purple and 1 white top tube with the initial test. Indicate on the request form 'perform HCV RNA if anti-HCV positive'. Both specimen tubes from regional and remote health services should be spun prior to dispatch to the lab.

See the AHCSA Communicare Viral Hepatitis manual for further information (listed in resource section) on the identification and management of people with hepatitis B and C and how Communicare can be adapted to facilitate the provision of best practice care.

Table 1. Interpretation of hepatitis B & C serology results

Hepatitis B		
HBSAg Anti-HBc Anti-HBs	Positive Positive Negative	Chronic HBV infection
HBSAg Anti-HBc IgM Anti-HBc * Anti-HBs	Positive Positive Positive Negative	Acute HBV infection *(high titre) If acute HBV is suspected (through recent risk, presentation, or both) IgM Hepatitis B core Ab is ordered to support clinical suspicion.
HBSAg Anti-HBc Anti-HBs	Negative Negative Negative	Susceptible to infection (not immune and not infected) May be very low undetectable levels of antibodies (recommend vaccination or booster if previously vaccinated)
HBSAg Anti-HBc Anti-HBs	Negative Positive Positive	Immune due to resolved infection
HBSAg Anti-HBc Anti-HBs	Negative Negative Positive	Immune due to vaccination
HBSAg Anti-HBc Anti-HBs	Negative Positive Negative	Various possibilities <ul style="list-style-type: none"> • Waning immunity from past infection OR • Window period before anti-HBs response in acute infection OR • False positive anti-HBc OR • Occult hepatitis B Consider: <ul style="list-style-type: none"> • HBV DNA testing (Test is not Medicare-rebatable) • Repeat serology if possibility of recent infection • Single dose vaccination and retest for anti-HBs in 1 month
Hepatitis C		
Anti-HCV	Positive	Current or previous infection Order HCV RNA
Anti-HCV	Negative	No infection detected If risk factors present during window period, repeat screening after 3 months

Reproduced with adaptations from *Communicare User Manual Viral Hepatitis, ASHM & AHCSA 2015.*

HIV

Given concerns about the possibility of an increase in HIV diagnoses in Aboriginal people it is timely to offer HIV testing more broadly to those attending ACCHSs. As well as during asymptomatic STI screening, consider adding **HIV serology** opportunistically during blood testing for other reasons as well as during adult health checks (e.g. MBS item 715).

While written, signed consent is no longer required for HIV testing, aspects of consent such as normalising testing, confidentiality, the twelve week window period and having a plan for giving results are particularly important when obtaining consent for HIV testing.

SYPHILIS

Given the current syphilis outbreak in SA, screening should be considered in all men and women of sexually active ages in Aboriginal communities.

Women of reproductive age who are diagnosed with syphilis, or are contacts of individuals diagnosed with syphilis, should have pregnancy testing.

Anybody who has been diagnosed with an STI should be encouraged to have a blood test for syphilis serology (as well as HIV and hepatitis B serology).

Other people who should be tested for **syphilis serology** include:

- Pregnant women, as part of routine antenatal screening (see below for increased screening recommendations in outbreak areas)
- Sexual partners of pregnant Aboriginal women should also be offered syphilis screening
- Anybody with an ulcer in the genital area (take swab for NAAT for herpes [viral transport media – green top swab], syphilis [dry swab (preferably) OR Amies liquid swab OR viral transport media] and donovanosis [dry swab] as well as blood test)
- Anybody with a skin rash when the diagnosis is unclear (especially on palms of hands and soles of feet)
- Hair loss (including eyebrows and beard)
- Neurological symptoms with unclear diagnosis
- Opportunistically, when taking blood for other reasons

Pregnant women who live in or travel to the areas affected by the outbreak require additional syphilis screening at:

- First antenatal visit (routine for all pregnant women)
- 28 weeks
- 36 weeks
- At birth
- Six-week postnatal check

Syphilis serology results may be difficult to interpret, so if necessary contact the duty sexual health physician at Adelaide Sexual Health Centre (formerly known as Clinic 275 - Ph 7117 2800). If the SA syphilis register data is available contact SA Health Communicable Disease Control Branch (CDCB) for patient information on past testing and treatment.

MANAGEMENT

Management

Uncomplicated chlamydia, gonorrhoea & trichomoniasis

The management below relates to the treatment of **uncomplicated** asymptomatic infection in males or **non-pregnant** females or where symptoms are limited to dysuria (pain on passing urine) or discharge (vaginal or penile). If pelvic pain is present, suggesting the possibility of pelvic inflammatory disease or if the client is pregnant, refer to the CARPA WBM for management.

CHLAMYDIA

- Azithromycin 1g oral single dose (Pregnancy category B1)

GONORRHOEA

- Ceftriaxone 500mg IMI single dose (mix with 2ml lignocaine 1%) (Pregnancy category B1), and
- 1g Azithromycin oral single dose (Pregnancy category B1)

Two antibiotics are recommended due to emerging ceftriaxone resistance (www.sti.guidelines.org.au)

TRICHOMONIASIS

- Metronidazole 2g oral single dose (Pregnancy category B2)
- Tinidazole 2g oral single dose (Pregnancy category B3), or
- Metronidazole 400mg 12 hourly for 7 days (best for breast feeding), or
- If **pregnant** refer to the [CARPA WBM, 6th edition p. 249](#) for management

Additional management for all STIs

- Discuss and plan sexual partner notification and treatment
- Advise no sex for 7 days after single dose therapies, and until partner is treated
- Complete full STI check including HIV/syphilis serology if not done (see [CARPA STM, 7th edition, p. 273](#) or [CARPA WBM, 6th edition, p. 239](#))
- Encourage safer sex and offer condoms
- Complete Communicare recall for “STI Treatment”
- Offer review in one week
- Notify chlamydia and gonorrhoea infections to CDCB, SA Health
- Test for reinfection at 3 months

Legal issues when treating minors

Age of consent/legal age for having sex in SA is **17 years unless legally married** (or **18 years** if the older person is in a position of power/authority over the younger person, e.g. teacher, youth worker, step-parent, boss, sports coach, religious leader etc).

Sex is considered **non-consensual** if the person is **under the age of consent**.

It is against the law to have sexual activities with someone under the age of consent **even if they agree to the sexual activity**.

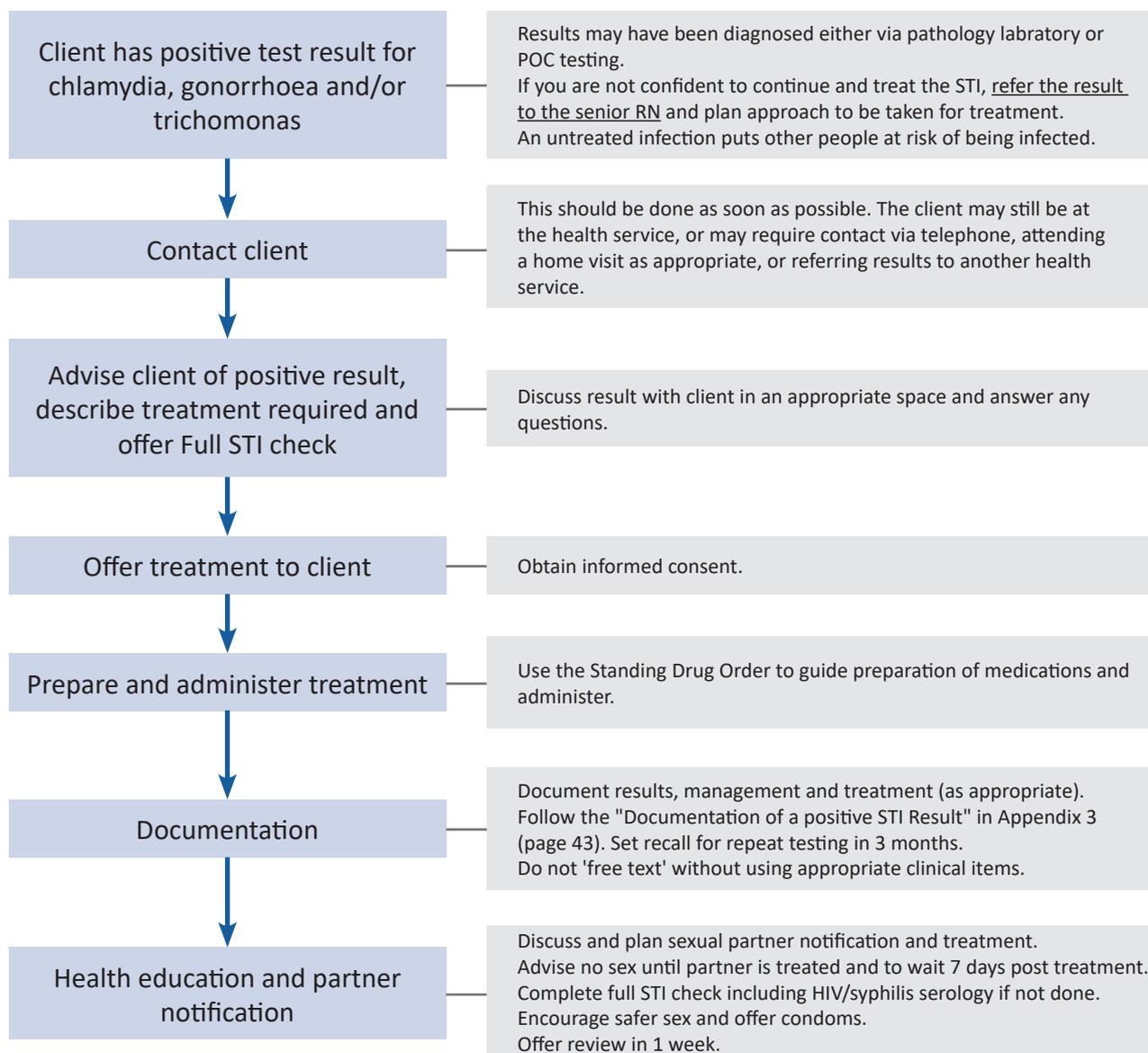
Any sexual behaviour between a young person under 18 years and a family member or a person in a position of power/authority is sexual abuse and therefore must be mandatorily reported.

Mandatory reporting

In SA **all health staff** are mandated reporters. If you suspect on reasonable grounds that a child or young person has been, or is being, sexually abused you are mandatorily required to notify the Department for Child Protection via the **Child Abuse Report Line (CARL) 13 14 78** or <https://my.families.sa.gov.au/IDMProv/landing.html>. Serious cases must be reported by phone.

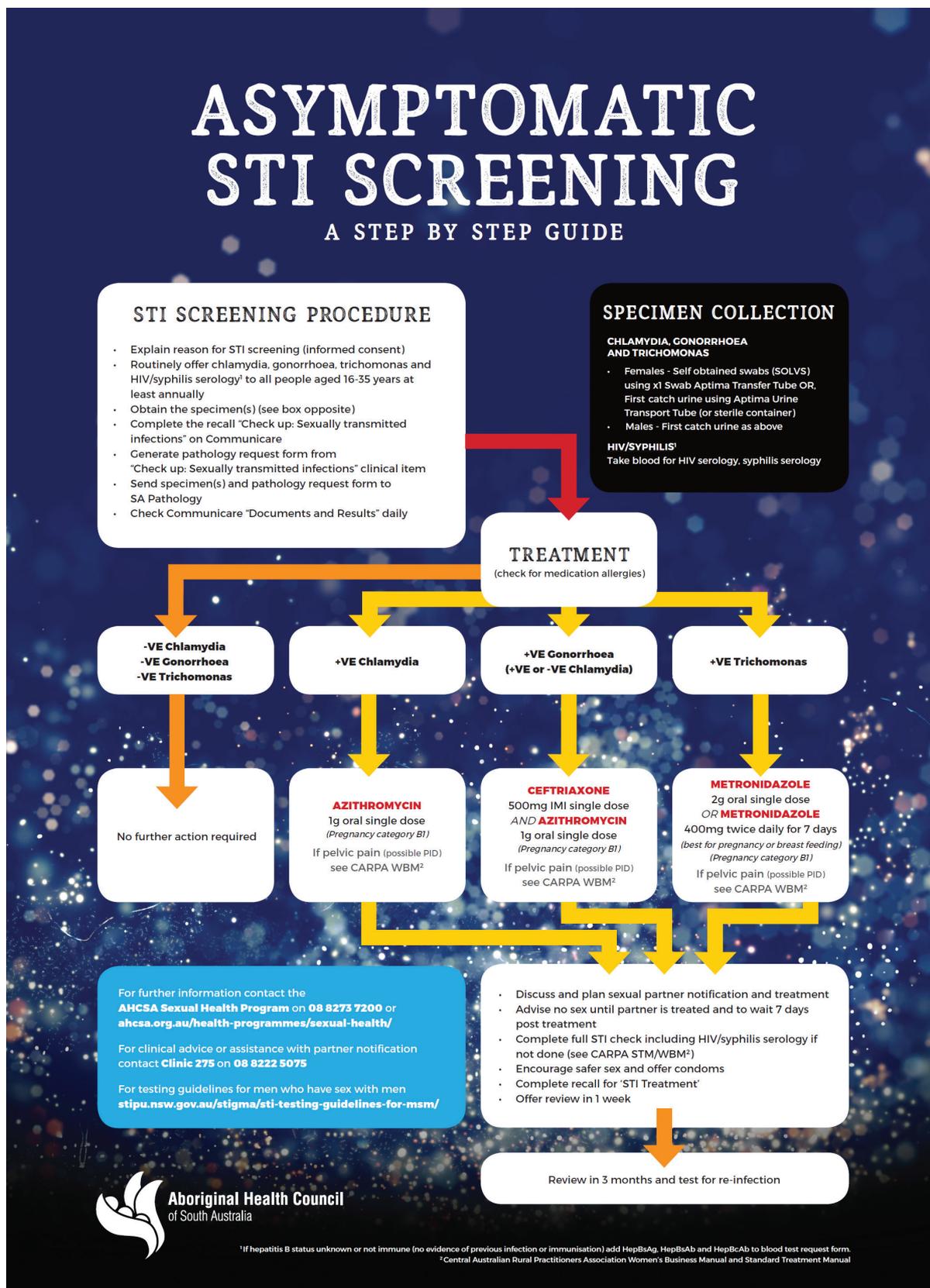
If a child under age 17 years has a positive STI test, discuss the case with a senior clinician to plan the next steps for follow up and considerations for mandatory reporting.

Figure 2. Treatment steps for a Registered Nurse (RN) for chlamydia, gonorrhoea and/or trichomoniasis in conjunction with an endorsed Standing Drug Order*



*Under current (2019) pharmacy licensing regulations in South Australia, access to pharmacy supplies within health services are restricted to doctors and RNs. This precludes independent access to pharmacy supply storage by Aboriginal Health Workers (AHW) or Aboriginal Health Practitioners (AHP). Also, under the *SA Controlled Substances Act 1984*, AHWs and AHPs can only administer medication if they have completed the Administer Medication training module, are deemed competent AND are delegated to do so by a RN. Factors to be considered when delegating tasks to AHPs and AHWs are outlined in the [Registered Nurses Standards for Practice](#) (Standard 6) and [National framework for the development of decision-making tools for nursing and midwifery practice](#) (September 2007).

Figure 3. AHCSA Asymptomatic STI Screening: a step by step guide



HIV, syphilis & viral hepatitis

HIV

Arrange a medical consult as soon as possible. Follow local procedures – contact Adelaide Sexual Health Centre (formerly Clinic 275) and the AHCSA Sexual Health Program team for further advice. Early initiation of treatment has shown to benefit the individual in terms of health outcomes. Treatment also suppresses the virus and therefore prevents the transmission of HIV to others (Treatment as Prevention – TasP, and undetectable (viral load) = untransmissible). Treatment should be conducted under the care of a specialist (shared care best) or GP specialising in HIV care (with s100 prescriber rights). HIV positive individuals should be engaged with and offered appropriate support in the community. Refer to SA Health’s guidelines for further information [here](#).

SYPHILIS

Arrange a medical consult as soon as possible. Adelaide Sexual Health Centre can give advice on management (Phone 7117 2800) but generally the following actions should be taken:

- Immediate treatment with Penicillin where there is CLINICAL SUSPICION or A POSITIVE TEST for early infection. Contacts of infectious syphilis should be offered the option of treatment while awaiting results:
 - o For infectious syphilis give benzathine penicillin 1.8g IMI as a single dose
 - o For late latent syphilis (no signs or symptoms of early or tertiary stages of syphilis, and no negative syphilis test within the past two years) give weekly benzathine penicillin 1.8g IMI, 3 doses one week apart. Refer to the [CARPA STM, 7th edition, p. 281](#) or [CARPA WBM, 6th edition, p. 248](#). Follow-up with an infectious disease or sexual health physician is recommended
- Ensure immediate partner notification – SA Health Communicable Disease Control Branch will assist (Phone 1300 232 272). Partner notification support can also be sought from Adelaide Sexual Health Centre’s Partner Notification Service on (08) 7117 2816. How far back to trace depends on the stage and onset of symptoms
- Syphilis in pregnancy – discuss treatment immediately with an infectious disease or sexual health physician (Adelaide Sexual Health Centre)
- Suspected tertiary (neuro-, ocular-, cardiovascular or gummatous) syphilis – seek advice from an Infectious Disease or Sexual Health Physician

HEPATITIS B

Once a diagnosis of chronic hepatitis B is established, further workup is required to determine the patient’s disease phase, the presence of any complications and indications for starting treatment or referral to specialist care. Figures 4 and 5 (see pages 29 and 30) below provide a guide for subsequent workup.

Figure 6 (see page 31) illustrates vaccination recommendations for those found to not be immune and not infected following hepatitis B screening.

HEPATITIS C

All people diagnosed with chronic hepatitis C should be offered treatment.

Newly available Direct-Acting Antiviral (DAA) agents are highly effective oral medications with few side effects. These medications are able to be **prescribed by GPs** in primary care as the Pharmaceutical Benefits Scheme (PBS) listing of direct acting antiviral medications for hepatitis C (HCV) under section 85 (General Schedule) means medical practitioners no longer need to be accredited under the section 100 Highly Specialised Drug program to be eligible to prescribe. Therefore, GPs are encouraged to assess and treat anyone identified with chronic hepatitis C infection.

Figure 7 (see pages 32 and 33) provides guidance on the pre-treatment assessment. Current treatment protocols are still evolving and are likely to continue to rapidly change. The most up to date treatment protocols can be found at the [Gastroenterological Society of Australia \(GESA\)](#). Support can also be provided to GPs when prescribing through the [HealthElink](#) program which is a secure online assessment, referral and treatment portal involving tertiary hospitals in South Australia, Northern Territory and Victoria in conjunction with referring GPs. Through this program, GPs can determine patient eligibility for treatment, appropriate medication protocols, detailed treatment and follow-up plans as well as access to online specialist support and links to nursing support (see below).

A team of **Viral Hepatitis Support Nurses** in SA provide advice and support to GPs on the management of patients with viral hepatitis. Viral Hepatitis Nurses are clinical practice consultants who work with patients in the community, general practice or hospital setting. They provide a link between public hospital specialist services and general practice and give specialised support to GPs to assist in the management of patients with hepatitis B or hepatitis C. Patients may also speak to the nurses directly. The Viral Hepatitis Nurses are located across the Adelaide metropolitan area and support can also be arranged for people in country areas. The nurses can be contacted directly by patients or their GP (See Box 6 for location and contact details or see [Viral Hepatitis Nursing Support](#)).

Box 6. Viral Hepatitis Nursing Support contacts

Central Adelaide Local Health Network

- Queen Elizabeth Hospital
Phone: 0423 782 415 (Margery) or 0401 717 953 (Jeff)
Fax: (08) 8240 9609
- Royal Adelaide Hospital
Phone: 0401 125 361 or (08) 7074 2194 (Anton)
Fax: (08) 8222 5883

Northern Adelaide Local Health Network

Phone: 0401 717 971 (Lucy) or 0413 285 476 (Michelle)
Fax: (08) 7485 4011

Southern Adelaide Local Health Network

Phone: 0466 777 876 (Rosalie) or 0466 777 873 (Emma)
Office: (08) 8204 6324
Fax: (08) 8204 6420

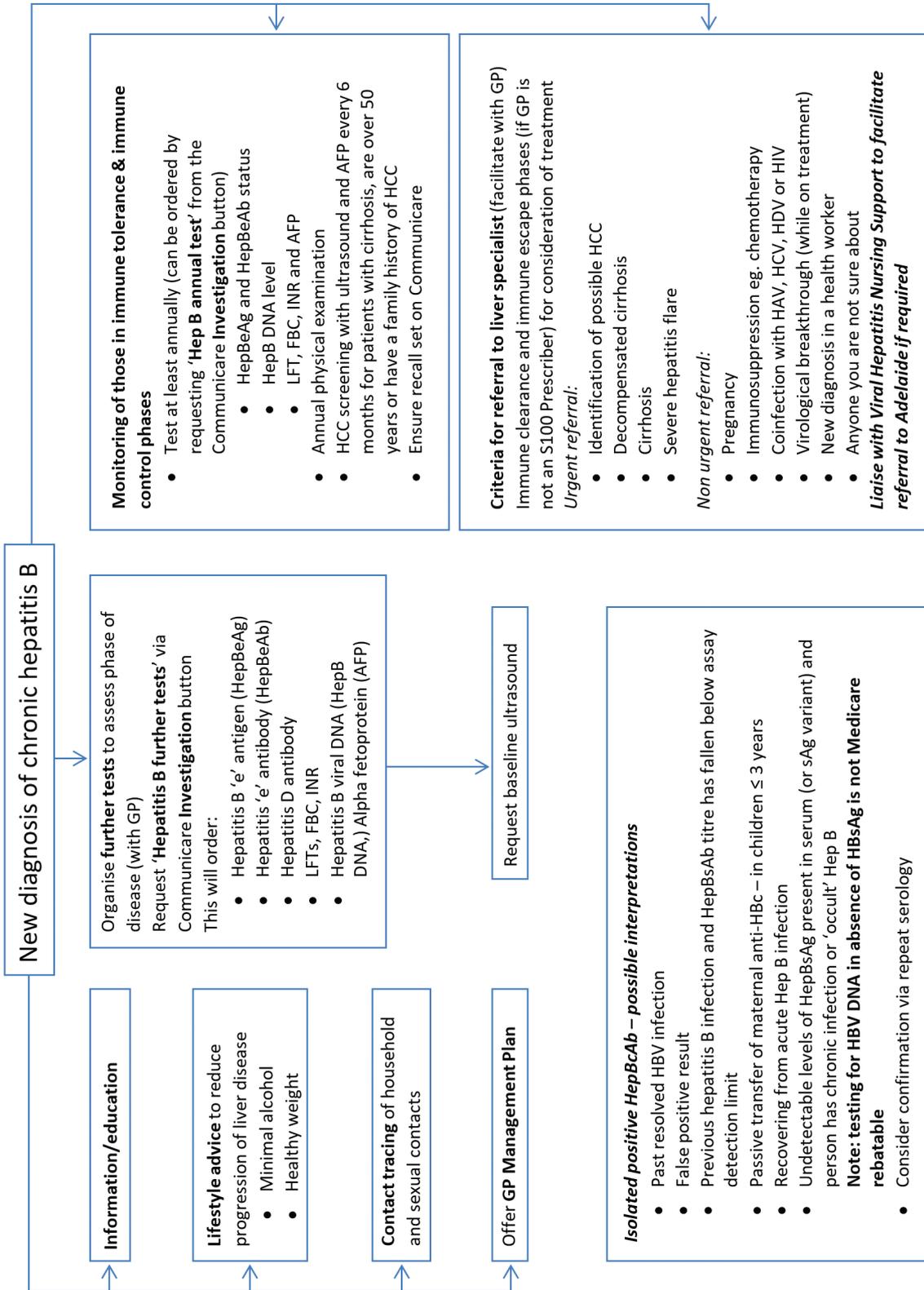
While many patients can now be treated in primary care some patients will still require specialist management. If a patient presents with co-morbidities/features outside the scope of the clinician's expertise with respect to the treatment of hepatitis C, then the clinician should:

- Seek specialist support from a gastroenterologist, hepatologist, infectious diseases physician or authorised nurse practitioner experienced in the treatment of chronic hepatitis C to assist in the management of the patient by submitting the [GESA Remote Consultation Request for Initiation of Hepatitis C Treatment form](#), or
- Refer the patient to a gastroenterologist, hepatologist, infectious diseases physician or authorised nurse practitioner (see Viral Hepatitis Nursing Support detailed above) experienced in the treatment of chronic hepatitis C for specialist management, or
- See HealthElink program above

ACCHSs are encouraged to develop their own clinical procedures on identification and management of hepatitis B and hepatitis C. Figure 4 is an example of a management protocol for chronic hepatitis B. Figure 7 outlines the management of chronic hepatitis C.

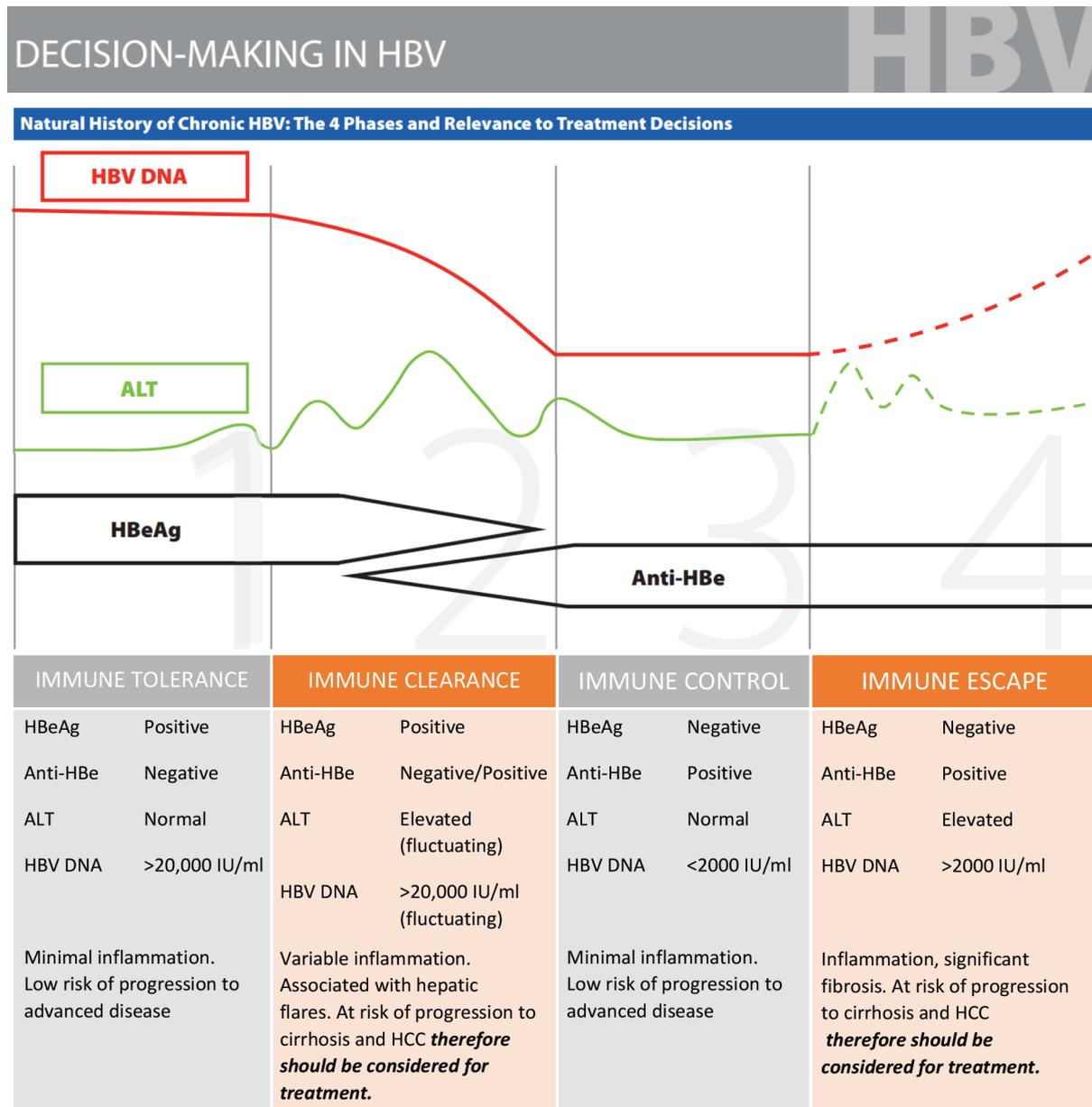
More information can be found in the AHCSA Communicare User Manual for Viral Hepatitis which was developed to guide Aboriginal Health Services in screening and managing chronic hepatitis B and C.

Figure 4. Chronic hepatitis B assessment & management



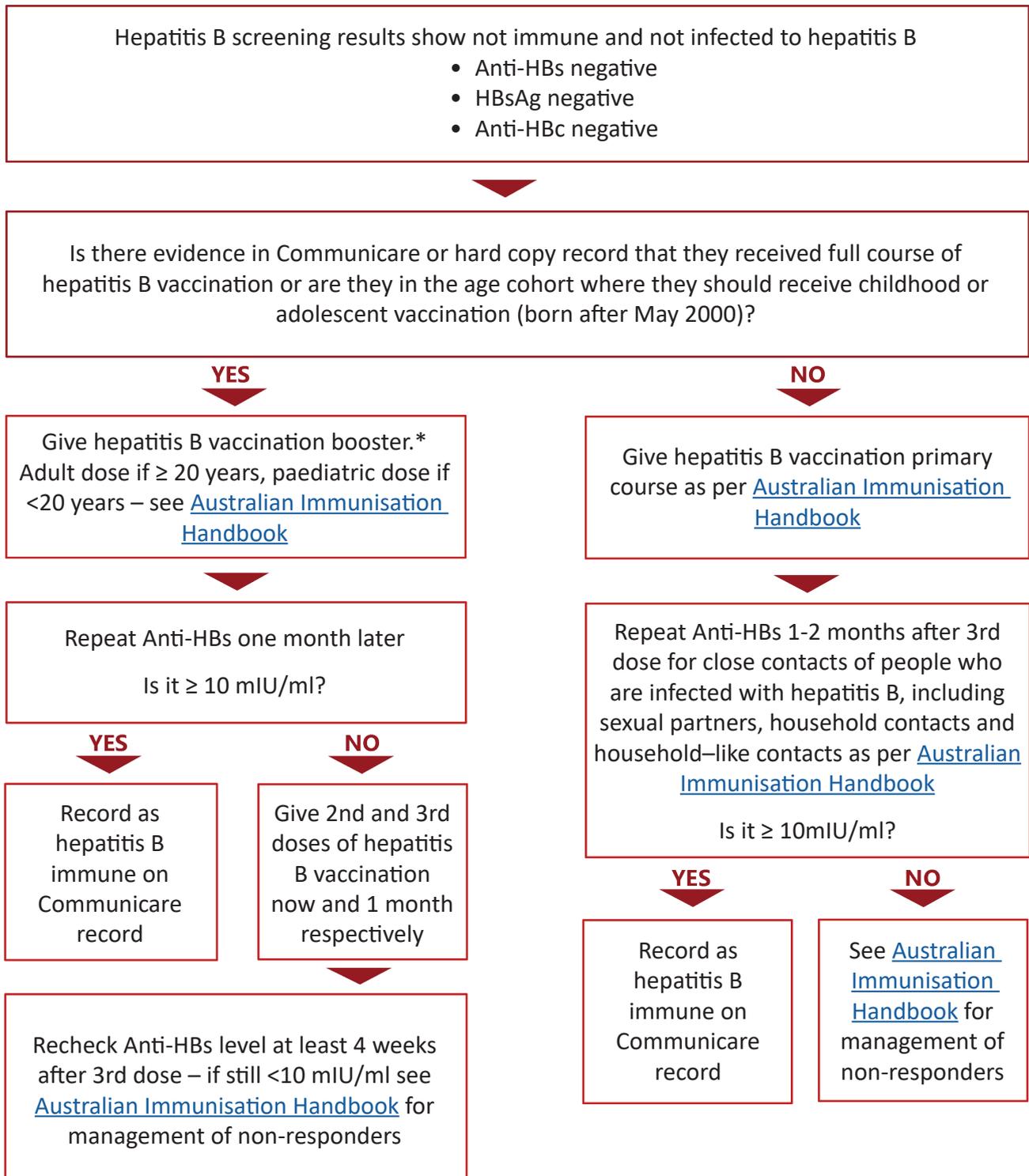
Adapted with permission from PLAHS Chronic hepatitis B management protocol.

Figure 5. Decision making in HBV



Reproduced with adaptations from *Decision-Making in HBV*, ASHM 2015.

Figure 6. Vaccination for clients not immune & not infected following hepatitis B screening



*If a person is assessed to be at low risk for exposure to hepatitis B both now and in the future then a decision whether to boost or not should be made on a case by case basis.

Adapted from *Communicare User Manual Viral Hepatitis, ASHM & AHCSA 2015.*

Figure 7. Clinical guidance for treating hepatitis C virus infection: a summary

Six key questions before commencing treatment for hepatitis C virus (HCV) infection	
<ul style="list-style-type: none"> • Is cirrhosis present? • What is the HCV genotype? • Is the patient treatment-naïve? 	<ul style="list-style-type: none"> • Is HBV–HCV or HIV–HCV coinfection present? • Are there potential drug–drug interactions? • What is the renal function (eGFR)?

Checklist for pre-treatment assessment for people with hepatitis C virus (HCV) infection	
HCV virology: <ul style="list-style-type: none"> • Anti-HCV (serology) • HCV PCR • HCV genotype, quantitative HCV RNA level* 	<ul style="list-style-type: none"> • Indicates HCV exposure • Confirms HCV infection • May influence choice and duration of treatment regimen
HCV treatment history — previous regimen and response	Determines treatment regimen and duration
Potential for non-adherence?	Consider medical and social issues that may be barriers to medication adherence
Alcohol intake history	Cofactor for cirrhosis
Check for drug–drug interactions	www.hep-druginteractions.org Includes prescribed, over-the-counter, herbal, illicit drugs
Pregnancy discussion†	
Weight and body mass index	Non-alcoholic fatty liver disease is a cofactor for cirrhosis
Signs of chronic liver disease	
FBE	<ul style="list-style-type: none"> • Baseline haemoglobin level • Low platelets — suspect portal hypertension
LFTs and INR	Low albumin, raised bilirubin, raised INR suggest advanced cirrhosis
U&Es and eGFR	<ul style="list-style-type: none"> • Sofosbuvir is not recommended if eGFR < 30 mL/min/1.73 m² • Ribavirin is renally cleared and needs dose reduction if eGFR < 50 mL/min/1.73 m²
HBV (HBsAg, anti-HBc, anti-HBs), HIV, HAV serology	Specialist referral is recommended for people with HBV or HIV coinfection If seronegative, vaccinate against HAV, HBV
Cirrhosis assessment <ul style="list-style-type: none"> • e.g. FibroScan • e.g. APRI 	Thresholds consistent with no cirrhosis: <ul style="list-style-type: none"> • Liver stiffness < 12.5 kPa • APRI < 1.0 Specialist referral is recommended for people with cirrhosis
Electrocardiogram if ribavirin therapy planned and patient is aged > 50 years OR has cardiac risk factors	Screen for ischaemic heart disease

FBE = full blood examination. LFT = liver function test. INR = international normalised ratio. U&E = urea and electrolyte. eGFR = estimated glomerular filtration rate. HBV = hepatitis B virus. HAV = hepatitis A virus. HBsAg = hepatitis B surface antigen. anti-HBc = hepatitis B core antibody. anti-HBs = hepatitis B surface antibody. APRI = aspartate aminotransferase to platelet ratio index. MELD = Model for End-Stage Liver Disease. HCC = hepatocellular carcinoma. * HCV genotype is required by the PBS criteria; it is important before prescribing elbasvir plus grazoprevir or sofosbuvir plus ledipasvir. HCV RNA level is important for determining eligibility for 8-week treatment duration with sofosbuvir plus ledipasvir. † As there are no safety data for the use of any direct-acting antiviral regimen during pregnancy, treatment of pregnant women is not recommended. Ribavirin (Category X) and peginterferon-alfa are contraindicated during pregnancy.



**AUSTRALASIAN
HEPATOLOGY
ASSOCIATION**



Support for people living with hepatitis C

People living with hepatitis C can receive information, support and referral from community services, including:

- Hepatitis Australia: <http://www.hepatitisaustralia.com>
- Hepatitis Information Line: 1800 437 222
- Australian Injecting & Illicit Drug Users League: <http://www.aivl.org.au>

On-treatment and post-treatment monitoring for virological response

Routine monitoring for a 12-week treatment regimen:

Week 0	<ul style="list-style-type: none">• Pre-treatment blood tests, including LFTs, HCV PCR
Week 12 post-treatment (SVR)	<ul style="list-style-type: none">• LFTs, HCV PCR (qualitative)

- More intensive monitoring may be required in certain populations (see *Australian recommendations for the management of hepatitis C virus infection: a consensus statement* (September 2018), <http://www.gesa.org.au>).
- People treated with elbasvir plus grazoprevir should have LFTs at Week 8 to screen for hepatotoxicity.

SVR = sustained virological response at least 12 weeks after treatment (cure). LFT = liver function test. INR = international normalised ratio. HCV = hepatitis C virus. PCR = polymerase chain reaction.

Ongoing monitoring of people after successful hepatitis C treatment outcome (SVR)

SVR, no cirrhosis and normal LFT results (males, ALT < 30 U/L; females, ALT < 19 U/L):

- People who are cured do not require clinical follow-up for hepatitis C

SVR and abnormal LFT results (males, ALT ≥ 30 U/L; females, ALT ≥ 19 U/L):

- Patients with persistently abnormal LFT results require evaluation for other liver diseases and should be referred for gastroenterology review. Investigations to consider include: fasting glucose level, fasting lipid levels, iron studies, ANA, ASMA, anti-LKM antibodies, total IgG and IgM, AMA, coeliac serology, copper level, caeruloplasmin level and α-1-antitrypsin level

SVR and cirrhosis:

- Patients with cirrhosis require long-term monitoring and should be enrolled in screening programs for:
 - ▶ hepatocellular carcinoma
 - ▶ oesophageal varices
 - ▶ osteoporosis

SVR = sustained virological response at least 12 weeks after treatment (cure). LFT = liver function test. ALT = alanine aminotransferase. ANA = anti-nuclear antibodies. ASMA = anti-smooth muscle antibodies. LKM = liver-kidney microsome. AMA = anti-mitochondrial antibody.

People who do not respond to hepatitis C treatment

- Specialist referral recommended



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Supporting the HIV, Viral Hepatitis and Sexual Health Workforce

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Reproduced from Gastroenterological Society of Australia, 2018.

CONTACT TRACING

Contact tracing

Support for contact tracing

Contact tracing for chlamydia and trichomoniasis is the responsibility of the Doctor/RN/AHP from the diagnosing health service. General advice can be obtained from Adelaide Sexual Health Centre (formerly Clinic 275) and AHCSA Sexual Health Team.

Contact tracing for gonorrhoea, syphilis and HIV is actively supported by Adelaide Sexual Health Centre.

During follow-up consultation

1. Explain to the person with the STI (index case) that contacts (sexual partner(s)) have a right to a STI check and treatment. If the contacts are not treated, the risk for re-infection of the index case is very high. It is crucial to treat contacts ASAP. Advise no sex or use condom for 7 days after index case and contact(s) treated.
2. If the index case is a male it may be useful to explain that most of the serious consequences of STIs occur in women, and to children born to mothers with STIs. An explanation along these lines may prompt the index case to name contacts.
3. Emphasise CONFIDENTIALITY. It should be stressed that the name of the index case will not be passed on to the contacts or to anybody else. Contacts are only informed that an STI check-up and treatment is advisable at that time.
4. Discuss methods and offer choice. Index case or staff can contact trace in person, by telephone, email, SMS or using contact tracing websites (listed in Resources section <https://www.bettertoknow.org.au/>). Record the name and address of the contact on a piece of paper. It should not be recorded in the index case's Communicare notes. Ask for the approximate age, nicknames, aliases and other contact details if possible.

Box 7. Managing sensitivities during a sexual health consultation

Sensitivities

- Always be mindful of client confidentiality
- Use language that is easy to understand and non-judgemental
- Whenever possible, ensure gender of practitioner is the same as that of the client
- Allow time for them to understand the implications of the diagnosis and the need and purpose of contact tracing. Do not apply too much pressure

Managing contacts

1. If the contact is a client of the same health service OR if you are advised by somebody from another area that one of your clients has been named as a contact, put in a recall on their Communicare clinical record for “STI Treatment” and document in progress notes, “named as contact by patient with chlamydia/gonorrhoea/trichomoniasis/syphilis/HIV”.
2. If the contact is not in the local community, contact the appropriate person in the Aboriginal health service where they are located. If there are difficulties locating the contact, inform the AHCSA Sexual Health Program team.
3. Notify the appropriate person in your health service that the person named as a contact needs urgent follow-up.
4. Be innovative – if conventional methods of contact tracing are proving unsuccessful, identify areas where the client frequents, e.g. parks, sporting clubs, homes of other relatives, hotels and taverns to attempt to make contact with the client. Seek support from the Partner Notification Service at Adelaide Sexual Health Centre on (08) 7117 2816.

Table 2. How far back in time to trace contacts

Infection	How far back to trace
Chlamydia	6 months
Gonorrhoea	2 months
Hepatitis B	6 months prior to onset of acute symptoms
Hepatitis C	6 months prior to onset of acute symptoms; if asymptomatic according to risk history
HIV	Start with recent sexual or needle-sharing partners; outer limit is onset of risk behaviour or last known negative HIV test result
Syphilis	Primary syphilis - 3 months plus duration of symptom Secondary syphilis - 6 months plus duration of symptom Early latent syphilis - 12 months
Trichomoniasis	Unknown - current partner notification is recommended - guided by sexual history

Reproduced from the *Australasian Contact Tracing Guidelines*, ASHM 2016.

Using Communicare for STI Screening

Communicare is the health information system used by all ACCHSs in SA. Specific clinical items are available in Communicare to facilitate the identification of clients for testing as well as appropriate treatment, follow-up and contact tracing. Listed below are the steps for optimal use of Communicare during the 6 week screen, but are relevant at any time STI testing and management is indicated (further step-by-step instructions are included in Appendix 3):

- Automated recalls for STI screen - On the first day of the screening period, a “**Check up; Sexually Transmitted Infection**” recall is generated in Communicare for each person aged 16-35 who is a current patient of your health service. This is usually organised by AHCSA prior to the Annual Screening period with permission from each participating ACCHS
- Check up STI recall - When a patient is screened, the information should be entered on that day by completing the “Check up; Sexually transmitted infection” recall. This will automatically remove that name from the recall list
- Check results daily - When the test result is electronically returned to your service it should appear as usual in the Communicare “Documents and Results”. It is important that somebody checks results **daily** during the screening period
- Positive results - Enter result as a clinical item in Communicare, but not in the summary section
- Set recall **STI Treatment** - If a positive result is received, a recall should be entered for “STI treatment” and the appropriate staff notified. Treatment should be attempted on the day that you are notified of an infection or as soon as possible thereafter, and the “STI treatment” recall completed
- When the client presents for follow-up, complete “STI Treatment” recall
- Ensure automatic **follow-up STI test** recall is set for 3 months
- Add “STI Treatment” recall to all contacts identified who attend the local health service
- Run regular reports:
 - o Daily during the screening period that lists people in the target age-group who have not been screened. It is essential to use the list of people to be screened and to go out of the clinic to look for them. If you wait for people to come to the clinic, you will miss a lot of people. Specimens can be collected at any site, not necessarily at the clinic – but they must be labelled and the information entered on Communicare when you return to the clinic
 - o At least weekly for those who require treatment and actively seek them out

STI SURVEILLANCE IN SA & CQI

In 2013, an innovative partnership was developed between AHCSA, SA Pathology and nine SA ACCHSs to allow for the automated reporting of STI testing and positivity data from SA Pathology to AHCSA for analysis (see figure 8).

This meant that not only could STI testing and positivity data be collected and analysed for the 6 week enhanced screening period, but also for all opportunistic screening completed over one year. This also allowed for positivity rates for chlamydia, gonorrhoea and trichomoniasis to be calculated given the availability of data for both the number of people with infection as well as the number of people tested – a major limitation of nationally collected notifiable STI datasets.

Following the declaration of an outbreak of infectious syphilis in 2017 in the Eyre, West and Far North regions of South Australia, SA Pathology now also provides AHCSA with automated reports of syphilis and HIV testing associated with a test for chlamydia, gonorrhoea and trichomonas (SA Pathology only provides AHCSA with data on whether a test for syphilis and/or HIV has been performed, not the results).

Protection of privacy and personal information is an important consideration and this system utilises privacy of sensitive information handling practices, including unique patient identifiers instead of patient names in data extracts from SA Pathology, secure electronic data transfer and storage and reporting at an aggregate level.

The primary functions of the AHCSA STI data program are to enable:

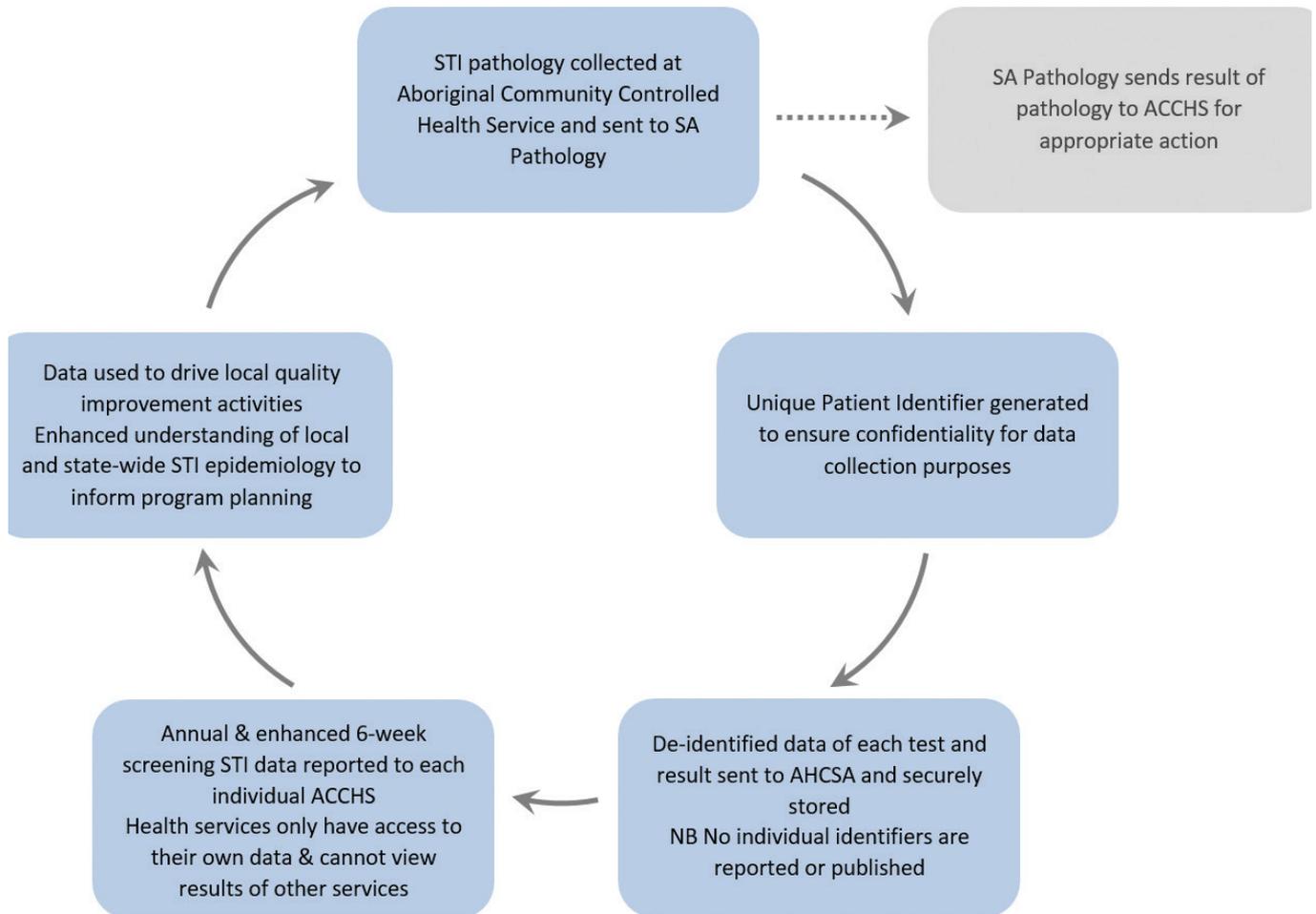
- Production of annual and enhanced 6 week screening STI reports for ACCHSs to facilitate local continuous quality improvement (CQI) activities in relation to STI testing and treatment
- Improving the understanding of the epidemiology of STIs among Aboriginal people attending ACCHSs in SA
- Evaluating the impact of AHCSA's sexual health program activities and inform future program planning

Other potential uses of the data include:

- Comparisons of STI testing between SA ACCHSs and with relevant national data
- ACCHSs use of de-identified data at a health service or aggregated level for individual advocacy purposes
- AHCSA utilising de-identified data to inform outbreak response activities, advocacy work, workforce development activities and/or funding applications

Further information on the AHCSA STI data collection program can be found in the AHCSA Sexual Health Program Data Governance Protocol available to ACCHSs in SA from AHCSA.

Figure 8. Collecting data for CQI in Sexual Health 2019



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Appendix 1. Consent form template (STI screening in young persons under the age of 16 years)

HEALTH SERVICE LETTERHEAD

I give permission for staff from Aboriginal Health Service to request my son/daughter/ward to provide a specimen for testing for chlamydia, gonorrhoea and trichomonas, HIV and syphilis.

Name of child/young person:

Date of birth:

I understand that if chlamydia, gonorrhoea, trichomonas, HIV or syphilis is detected, the child will be provided with treatment free-of-charge and will be asked to give the names of any sexual contacts.

I understand that health care workers are required by law to report suspected sexual abuse to the Department for Child Protection.

Signed:

Name:

Witness signature:

Name of witness:

Date:

Appendix 2. Checklist for equipment & medication

Table 3. Checklist for equipment and medication

General	Specimen collection
Desk/chair/bed Linen/pillow/blue sheets Desktop with Communicare access Lamp Disinfectant/hand wash General rubbish bin First aid kit Participant lists Consent forms (for under 16 years) Sticky labels, stationery	Pathology forms Pathology bags Gloves Sharps container Infectious and non-infectious wastebags Urine pots (yellow tops) Aptima Urine Transport tube Aptima swab Amies liquid swab Charcoal swabs Dry swabs Viral transport media swab Blood tubes Tourniquets Vacutainers 23 gauge needles Alcohol swab Cotton wool balls Band-aids Personal protective equipment Eskies (and tape) Ice bricks
<p style="text-align: center;">Medication</p>	
Azithromycin Ceftriaxone Metronidazole 1% Lignocaine (mix with Ceftriaxone)	
<p style="text-align: center;">Other Equipment</p>	
Needles Syringes Urine pregnancy tests Condoms Educational resources/pamphlets/videos	

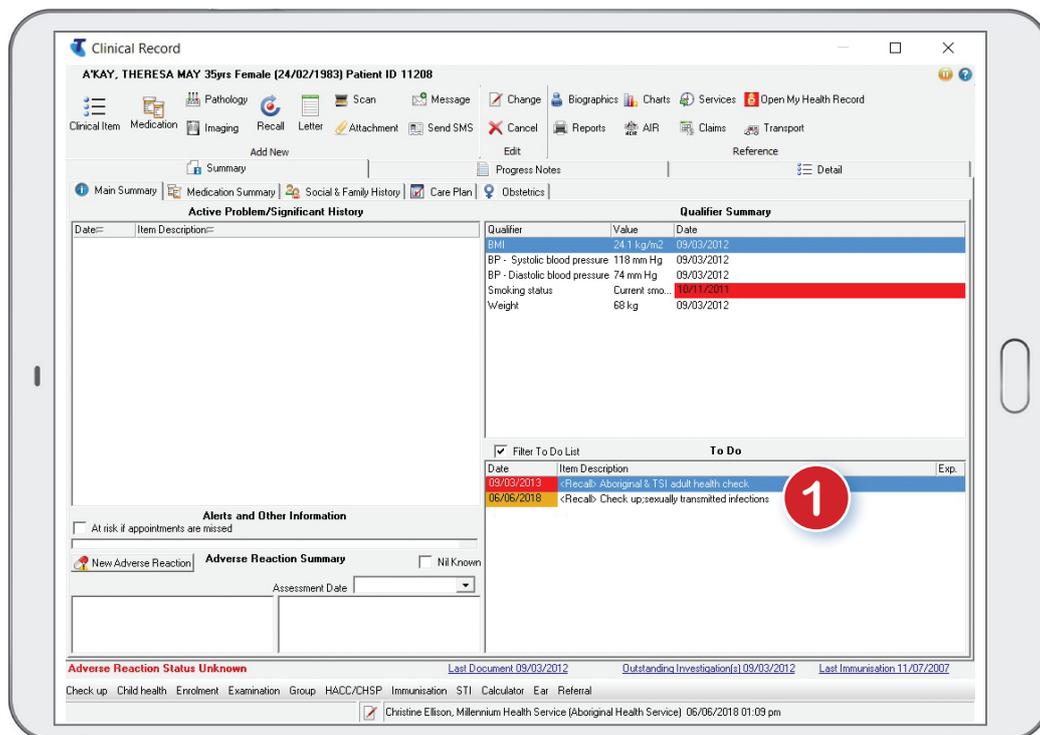
Appendix 3. Entering Information on Communicare (step-by-step screenshots)

Clinical items have been developed to enable consistent and systematic recording of information for STI screening and subsequent follow-up. **Every time a person is screened for an STI, or a diagnosis is made, or treatment given, the appropriate STI screening clinical items should be used.**

This section provides a step-by-step guide to using the STI screening clinical items for entering information on Communicare.

“Check up;sexually transmitted infections” consultation

The “Check up;sexually transmitted infections” recall will appear in the clinical records of those clients aged 16-35 years on the first day of the 6 week screening period:



1. Double click on the **recall**
2. Select **“Complete it”**



Complete Recall - A'KAY, THERESA MAY 35yrs Current Patient Female

Check up;sexually transmitted infections

Christine Ellison, Millennium Health Service (Aboriginal Health Service) 06/06/2018 01:09 pm

Comment Display on Main Summary
Display on_Qbstetric Summary

Planned date: 06/06/2018
 Expiry date:
 Responsibility:
 Performed date: 06/06/2018
 Actual duration (minutes):

STI reason for presenting: Community screen (No previous values)
 STI specimen: a. Urine and blood (No previous values)
 STI test request: **3**

Viewing right: Maternal & Sexual Health

3. Complete using the dropbox options available and click on the **“Request Investigation”** button to generate the pathology form with the required investigations

4. Select **“Print & Save”**

Add Investigation Request

A'KAY, THERESA MAY 35yrs

Sally Adams, Millennium Health Service (Aboriginal Health Service) 06/06/2018 02:32 pm

Investigation Provider: Sir Charles Gairdner Hospital
 You are required to pick a provider in order to make a request that can be claimed.
 Claiming Provider: Christine Ellison

Search Investigations:

- ACR, urine
- Albumin
- Albumin Creatinine Ratio
- Alpha fetoprotein, serum
- Anti DNA antibodies
- Anti Thyroid antibodies
- Anti-DNASE B titre
- Anti-streptolysin D titre
- Antinuclear antibodies
- Barmah forest IgG and IgM
- Bicarbonate

Copy To:

Investigation Reason:

Urgent Reply To:
 Critical if result outstanding

Printing Format: Std. plain paper radiology

Investigations Requested:

- Gonorrhoea, Chlamydia and Trichomonas PCR
- HIV antibodies 1/2
- Syphilis serology

 Fasting Pregnant

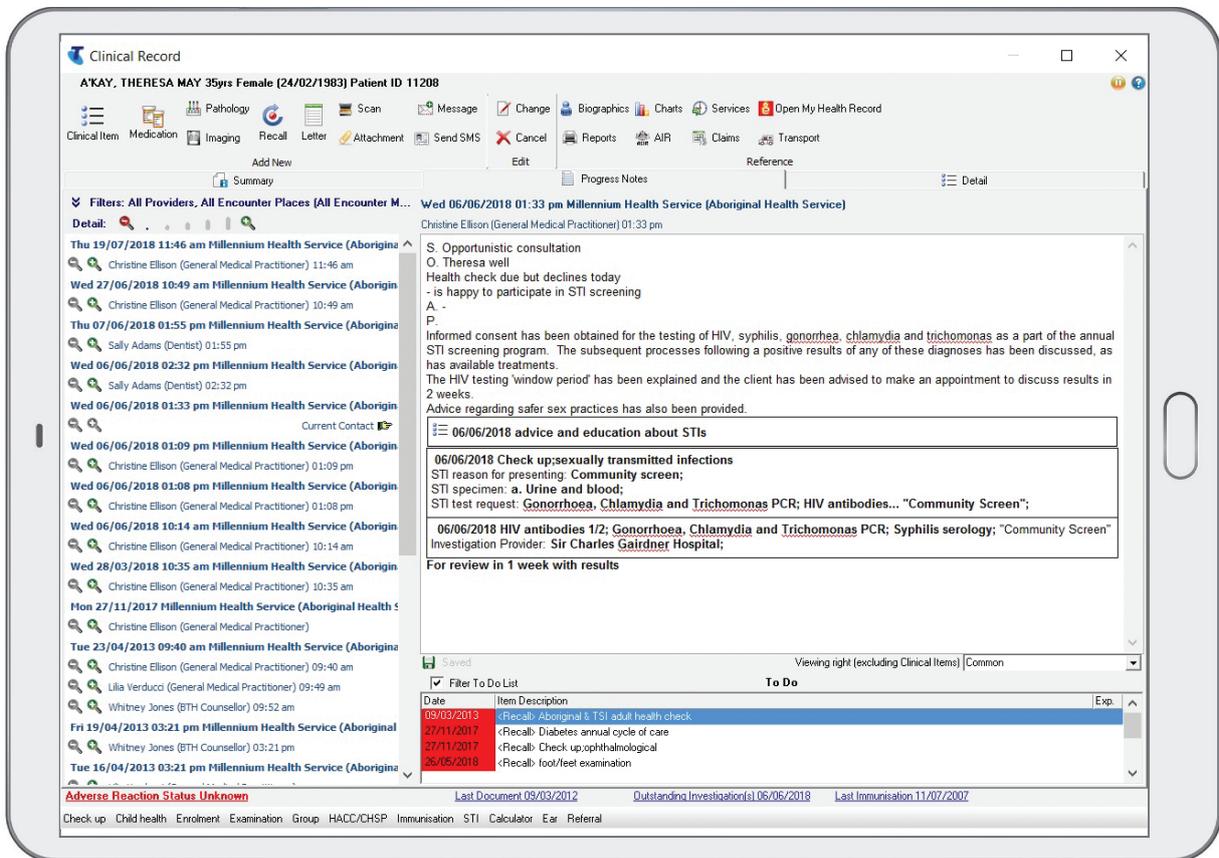
Clinical Notes:

- Community Screening

 Do not send reports to My Health Record

4

Progress Note entry of “Check up;sexually transmitted infections” STI Screening consultation:



To document that you have obtained informed consent from the client, your health service might choose to add a text shortcut. See your Communicare Administrator regarding this option.

By typing .sti for example, the following text will appear in your Progress Notes:

“Informed consent has been obtained for the testing of HIV, syphilis, gonorrhoea, chlamydia and trichomonas as a part of the annual STI screening program. The subsequent processes following a positive result of any of these diagnoses has been discussed, as has available treatments. The HIV testing ‘window period’ has been explained and the client has been advised to make an appointment to discuss results in one week. Advice regarding safer sex practices has also been provided.”

Documentation of a positive STI result

If a positive result is detected, document using a clinical item and set a “STI Treatment” recall:

Add the clinical item, e.g. “Chlamydia”

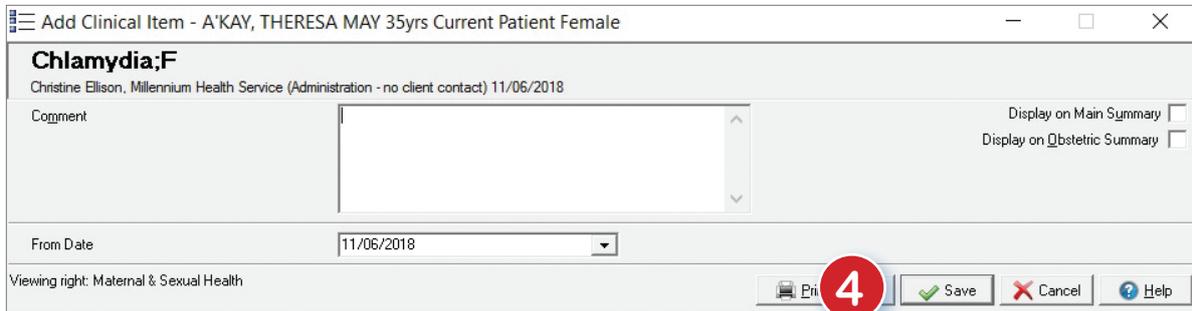
The screenshot shows a 'Clinical Record' window for a patient named AKAY, THERESA MAY (35yrs Female, Patient ID 11208). A red circle with the number '1' highlights the 'Clinical Item' button in the top navigation bar. The main content area shows a list of encounters on the left and a detailed view of a consultation on the right. The consultation notes include: 'S. Opportunistic consultation', 'O. Theresa well', 'Health check due but declines today - is happy to participate in STI screening', 'A. - P.', 'Informed consent has been obtained for the testing of HIV, syphilis, gonorrhoea, chlamydia and trichomonas as a part of the annual STI screening program. The subsequent processes following a positive results of any of these diagnoses has been discussed, as has available treatments. The HIV testing 'window period' has been explained and the client has been advised to make an appointment to discuss results in 2 weeks. Advice regarding safer sex practices has also been provided.', and '06/06/2018 advice and education about STIs'. Below the notes, there is a section for '06/06/2018 Check up:sexually transmitted infections' with details on STI test requests and results. A 'To Do' list at the bottom shows a recall for '06/05/2018' for a 'foet/feet examination'.

1. Click “Clinical Item”
2. Within the “Keyword” tab, enter “CHLA” in the ‘Search-words:’ field
3. Click “Select”

The screenshot shows the 'Clinical Terms Browser' window. The 'Keyword' tab is selected, and the search field contains 'CHLA'. The search results are displayed in a table with columns for 'Keyword', 'Clinical Item Type', 'Class', and 'Definition'. A red circle with the number '2' highlights the search field. A red circle with the number '3' highlights the 'Select' button at the bottom of the window.

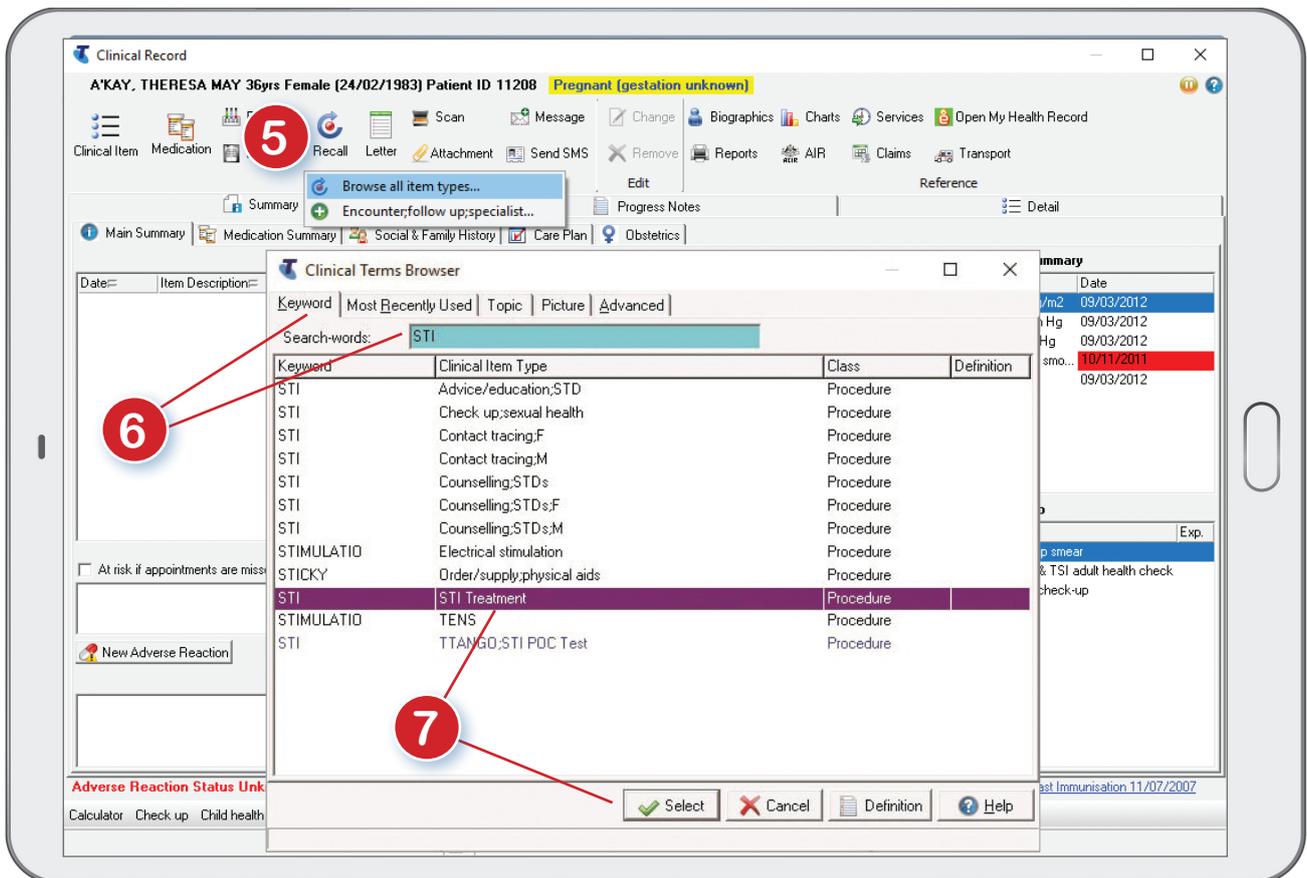
Keyword	Clinical Item Type	Class	Definition
CHLAMYDIA	Chlamydia,cervical	Condition	
CHLAMYDIA	Chlamydia,F	Condition	
CHLAMYDIA	Chlamydia,M	Condition	
CHLAMYDIA	Chlamydia,non-genital	Condition	
CHLAMYDIA	Conjunctivitis,chlamydia	Condition	
CHLAMYDIA	Disease,pelvic inflammatory	Condition	
CHLAMYDIA	TTANGO,STI POC Test	Procedure	
CHLAMYDIA	Urethritis,chlamydial	Condition	
CHLAMYDIA	Urethritis,non specific,M	Condition	

4. To add the clinical item, click **“Save”**



To add the recall **“STI Treatment”**;

5. Click **“Recall”** and then **“Browse all item types”** if the **STI Treatment** recall doesn't appear in the list



Within the **Clinical Terms Browser** window;

6. Under the **“Keyword”** tab, enter the search term **“STI”** in the **“Search-words”** field

7. Select **“STI Treatment”** from the list and click **“Select”**

The Add Recall “STI Treatment” window will now open;

8. Click “Save”

Add Recall - A'KAY, THERESA MAY 35yrs Current Patient Female

STI Treatment

Christine Ellison, Millennium Health Service (Administration - no client contact) 11/06/2018

Comment

Planned date: 11/06/2018

Expiry date

Responsibility

Viewing right: Maternal & Sexual Health

8 Save Cancel Help

Progress note entry of “STI Treatment” for positive STI result:

Clinical Record

A'KAY, THERESA MAY 35yrs Female (24/02/1983) Patient ID 11208

Christine Ellison (General Medical Practitioner)

Review of pathology

11/06/2018 chlamydia

+ve result

Needs treatment and contact tracing

11/06/2018 <Recall> STI Treatment

Viewing right (excluding Clinical Items) | Common

Filter To Do List

Date	Item Description	Exp.
27/11/2017	<Recall> Check up, ophthalmological	
26/05/2018	<Recall> foot/feet examination	
11/06/2018	<Recall> STI Treatment	
23/11/2018	<Recall> HbA1c test	

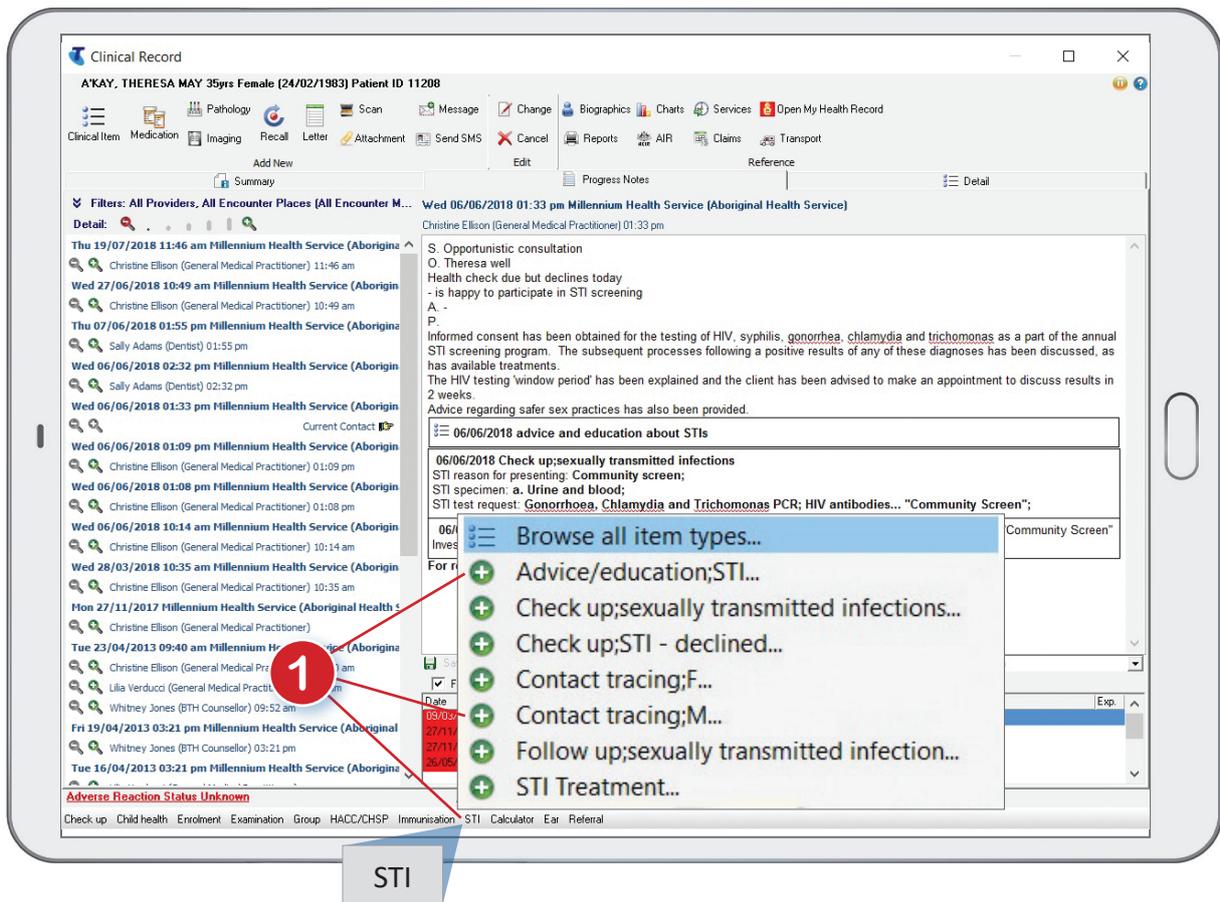
Adverse Reaction Status Unknown

Last Document 09/03/2012 Outstanding Investigation(s) 06/06/2018 Last Immunisation 11/07/2007

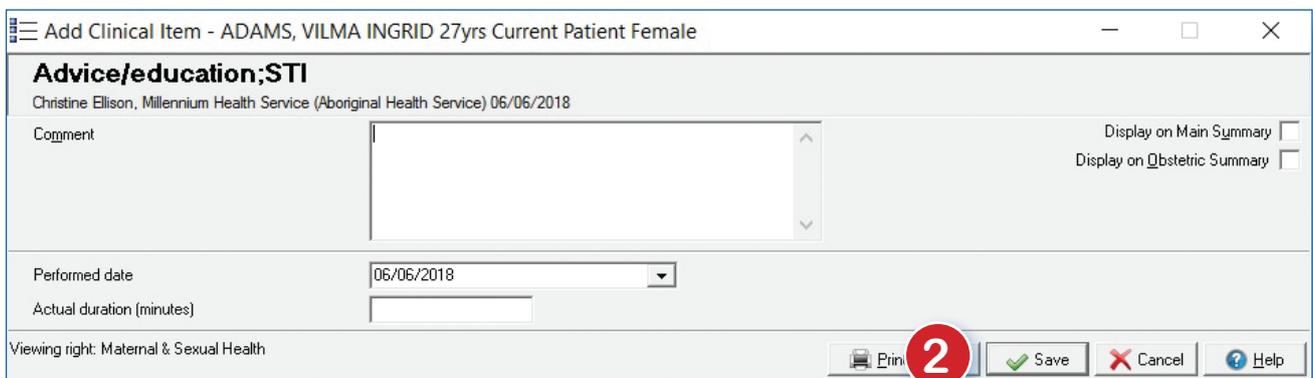
Check up Child health Enrolment Examination Group HACC/CHSP Immunisation STI Calculator Ear Referral

Documentation of a client presentation for STI treatment

1. Click the “STI” quick tab at the bottom of the screen and select to add clinical items: “Advice/education;STI” and “Contact tracing;M”



2. Click “Save”



3. Click "Save"

The screenshot shows a window titled "Add Clinical Item - A'KAY, THERESA MAY 35yrs Current Patient Female". The main heading is "Contact tracing;M" with a sub-heading "Christine Ellison, Millennium Health Service (Aboriginal Health Service) 06/06/2018 01:09 pm". There is a large text area for "Comment" and two checkboxes on the right: "Display on Main Summary" and "Display on Obstetric Summary". Below the comment area are fields for "Performed date" (set to 06/06/2018) and "Actual duration (minutes)". At the bottom, there is a "Viewing right: Maternal & Sexual Health" label and a toolbar with "Print", "Save", "Cancel", and "Help" buttons. A red circle with the number "3" is overlaid on the "Save" button.

4. Click the recall "<Recall> STI Treatment" in the 'To Do' list and choose to "Complete it"

The screenshot shows a tablet interface for a "Clinical Record" of "A'KAY, THERESA MAY 35yrs Female (24/02/1983) Patient ID 11208". The interface includes a top navigation bar with various icons and a main content area showing a list of encounters. A "Manage Recall" dialog box is open, asking "What do you wish to do with this STI Treatment recall?". The dialog has four buttons: "Complete it", "Modify it", "Cancel it", and "Do nothing". A red circle with the number "4" is overlaid on the "Complete it" button. Below the dialog, there is a "To Do" list with columns for "Date", "Item Description", and "Exp.". The list contains several items, with the one dated "11/06/2018" and description "<Recall> STI Treatment" highlighted in blue.

Date	Item Description	Exp.
27/11/2017	<Recall> Check up,ophthalmological	
26/05/2018	<Recall> foot/feet examination	
11/06/2018	<Recall> STI Treatment	
23/11/2018	<Recall> HbA1c test	

5. Complete the “STI Treatment” recall and click “Save”

STI Treatment
Christine Ellison, Millennium Health Service (Aboriginal Health Service) 06/06/2018

Comment: [Empty text area]

Planned date: 06/06/2018
Expiry date: [Empty]
Responsibility: [Empty]
Performed date: 06/06/2018
Actual duration (minutes): [Empty]

Gonorrhoea result abnormal	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Blank	(06/06/2018 No)
Chlamydia result abnormal	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Blank	(06/06/2018 Yes)
Trichomonas result abnormal	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Blank	(06/06/2018 No)
Syphilis result abnormal	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Blank	(06/06/2018 No)
HIV result abnormal	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Blank	(06/06/2018 No)
Azithromycin treatment	<input checked="" type="checkbox"/>	(06/06/2018 Yes)
Benzathine Penicillin treatment	<input type="checkbox"/>	(No previous values)
Ceftriaxone treatment	<input type="checkbox"/>	(No previous values)
Metronidazole treatment	<input type="checkbox"/>	(No previous values)
Tinidazole treatment	<input type="checkbox"/>	(No previous values)
Number of named sexual contacts reported	2 contacts	(06/06/2018 2 contacts)

Viewing right: Maternal & Sexual Health

5 Save Cancel Help

6. A “Follow up;sexually transmitted infections” Automatic Recall will be triggered by the completion of the “STI Treatment” recall. Click “Save”

Progress Notes | Detail

Wed 13/06/2018 Millennium Health Service (Aboriginal Health Service)
Christine Ellison (General Medical Practitioner)

S. Client presents for treatment of Chlamydia
O. Asymptomatic
A.
P.

13/06/2018 advice and education about STIs

Discussed safer sex practices

13/06/2018 contact tracing

Recalls for STI testing documented in contact's clinical records

13/06/2018 STI Treatment
Gonorrhoea result abnormal: No;
Chlamydia result abnormal: Yes;
Trichomonas result abnormal: No;
Syphilis result abnormal: No;
HIV result abnormal: No;
Azithromycin treatment: Yes;
Number of named sexual contacts reported: 2 contacts;

Confirm Automatic Recall

Recalls triggered by: STI Treatment

Recall for Follow up;sexually transmitted infection

Comment: [Empty text area]

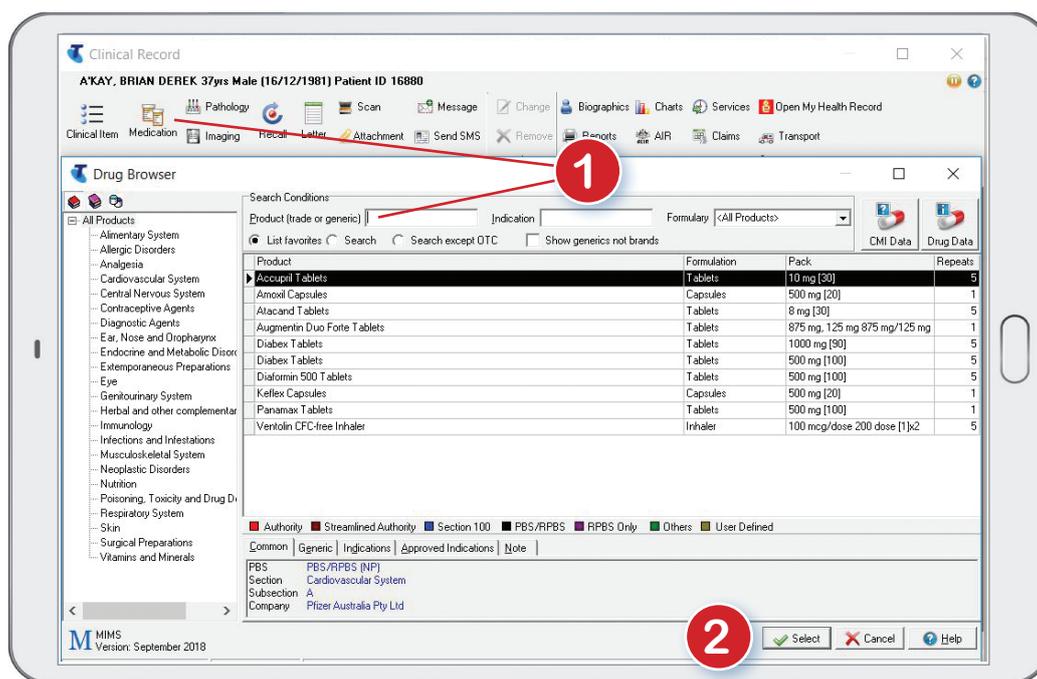
Recall interval: 3 months Responsibility: [Empty]
Planned date: 11/09/2018 Responsibility: [Checked] Recall confirmed
Expiry date: [Empty]

6 Save Reset Cancel Help

Last Immunisation 11/07/2007

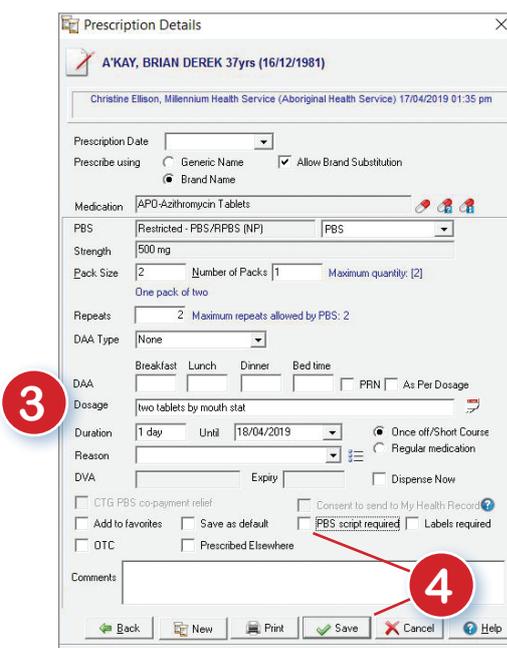
If the Medication Module is available to you, use it to document the provision of **Azithromycin** to the client. Clinicians who are not 'prescribers' are still able to document using this module. A printable prescription is not being generated and it ensures the Medication Summary reflects what medications the client has/will receive.

1. Click **"Medication"**, search for the medication in the **"Product (trade or generic)"** field
2. Click **"Select"** from the options at the bottom of the window



The Prescription Details window will now open;

3. Enter the **"Dosage"** details
4. Un-tick the **"PBS script required"** and click **"Save"**



Progress note entry for **Azithromycin**:

Clinical Record
AKAY, BRIAN DEREK 37yrs Non Patient Male [16/12/1981] Patient ID 16880

Pathology | Scan | Message | Change | Biographics | Charts | Services | Open My Health Record
 Clinical Item | Medication | Imaging | Recall | Letter | Attachment | Send SMS | Delete | Reports | AIR | Claims | Transport

Summary | Progress Notes | Detail

Filters: All Providers, All Encounter Places (All Encounter Modes), All Spe...

Detail: Exclude non-contact services

Wed 17/04/2019 10:43 am Millennium Health Service (Aboriginal Health Servi

Christine Ellison (General Medical Practitioner) 10:43 am

S. Client presents for treatment of Chlamydia
 O. Asymptomatic
 A.
 P.

17/04/2019 advice and education about STDs
 Discussed safer sex practices

17/04/2019 contact tracing

STI testing recalls in contact's clinical records

17/04/2019 STI Treatment
 Gonorrhoea result abnormal: **No**;
 Chlamydia result abnormal: **Yes**;
 Trichomonas result abnormal: **No**;
 Syphilis result abnormal: **No**;
 HIV result abnormal: **No**;
 Azithromycin treatment: **No**;
 Number of named sexual contacts reported: **2 contacts**;

17/07/2019 <Recall> Follow up;sexually transmitted infection

Nii Known Adverse Reactions

17/04/2019 APO-Azithromycin Tablets; 500 mg
 Dosage Instructions: **two oral stat**;
 Quantity: **[2]**; Repeats: **2**;

17/04/2019 medication given

17/04/2019 advice and education about medication

20/06/2005 <Referred> referral

20/06/2005 Diabex Tablets; 1000 mg
 Dosage Instructions: **one three times a day**;
 Quantity: **[90]**; Repeats: **5**;

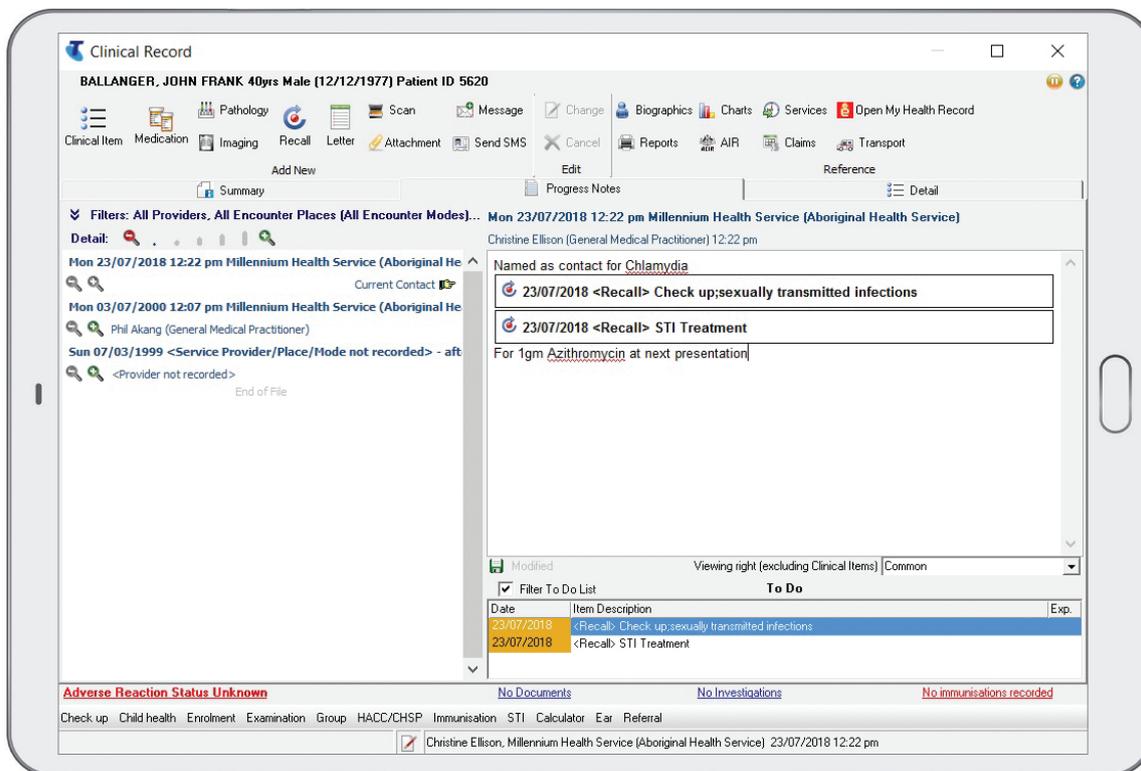
17/07/2019 <Recall> Aboriginal & TSI adult health check.

20/06/2005 <Referred> referral

17/07/2019 <Recall> Follow up;sexually transmitted infection

Contact tracing in the contact's clinical record

Set Recalls for **“Check up;sexually transmitted infections”** and **“STI Treatment”** as per steps 5 to 7 on page 46 of this section.



A list of clients requiring follow-up of a treated infection at 3 months may be generated manually or be received as a scheduled report to appear in a clinician's email in-tray.

Completion of “Follow up;sexually transmitted infections” recalls

1. Click the “**Follow up;sexually transmitted infections**” recall in the “**To Do**” list
2. Choose to “**Complete it**”

The screenshot shows a medical software interface. At the top, there's a header for 'Progress Notes' and 'Detail'. Below that, the patient information is displayed: 'Thu 19/07/2018 01:53 pm Millennium Health Service (Aboriginal Health Service)' and 'Joanne Bell (Aboriginal and TSI Health Worker) 01:53 pm'. The main text area contains notes: 'S. Opportunistic visit', 'O. Has recall for f/up STI - treated for Chlamydia 3 months ago', 'A.', and 'P.'. A 'Manage Recall' dialog box is open in the center, asking 'What do you wish to do with this Follow up;sexually transmitted infection recall?'. It has four buttons: 'Complete it' (with a green checkmark icon), 'Modify it' (with a pencil icon), 'Cancel it' (with a red X icon), and 'Do nothing' (with a green checkmark icon). A red circle with the number '2' is placed over the 'Complete it' button. Below the dialog box, there's a 'To Do' list with columns for 'Date', 'Item Description', and 'Exp.'. The list contains four items, with the last one, '19/07/2018 <Recall> Follow up;sexually transmitted infection', highlighted in blue and marked with a red circle containing the number '1'. At the bottom of the interface, there's a 'Filter To Do List' checkbox and a 'Viewing right' dropdown menu set to 'Common'.

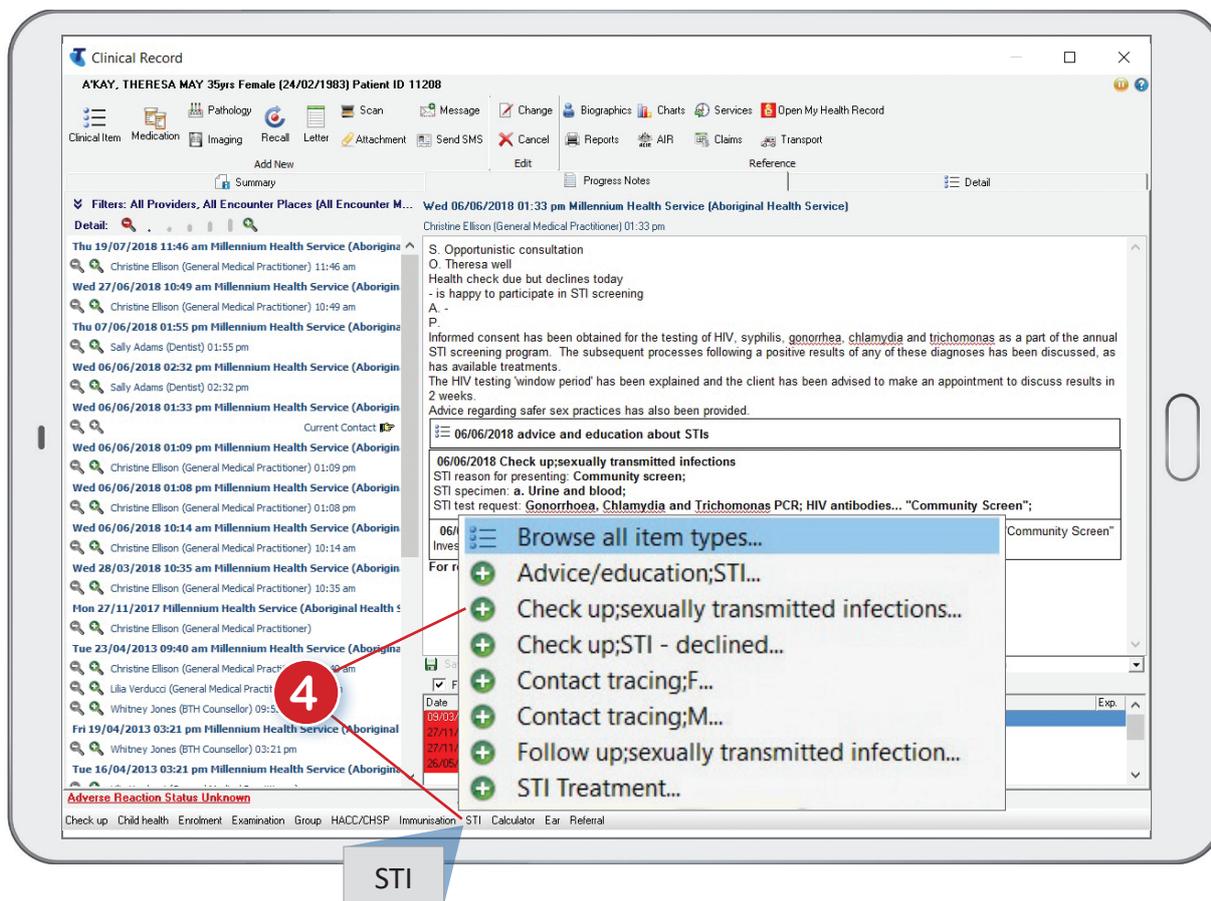
The **Complete Recall “Follow up;sexually transmitted infection”** window will now open;

3. Click “**Save**”

The screenshot shows the 'Complete Recall' window for a patient named 'AKESSON, THERESA NELLY 47yrs Current Patient Female'. The window title is 'Complete Recall - AKESSON, THERESA NELLY 47yrs Current Patient Female'. The main heading is 'Follow up;sexually transmitted infection'. Below the heading, the patient information is displayed: 'Joanne Bell, Millennium Health Service (Aboriginal Health Service) 19/07/2018 01:53 pm'. There's a 'Comment' field with a text area and a 'Display on Main Summary' checkbox (unchecked) and a 'Display on Obstetric Summary' checkbox (checked). Below that, there are several fields for scheduling: 'Planned date' (19/07/2018), 'Expiry date', 'Responsibility', 'Performed date' (19/07/2018), and 'Actual duration (minutes)'. At the bottom, there's a 'Viewing right: Maternal & Sexual Health' and a 'Save' button (with a green checkmark icon), a 'Cancel' button (with a red X icon), and a 'Help' button (with a question mark icon). A red circle with the number '3' is placed over the 'Save' button.

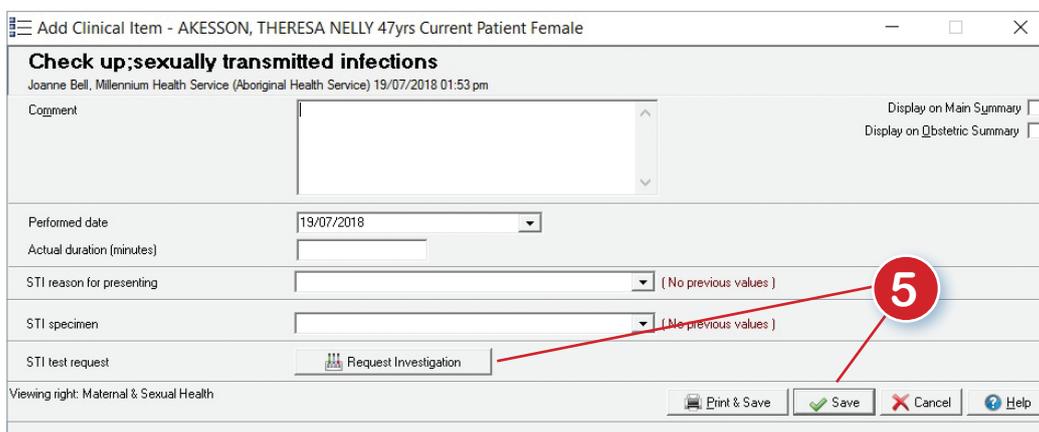
To re-test for infection;

4. Click the “STI” quick tab and select and complete the clinical item “Check up;sexually transmitted infections”



The Add Clinical Item “Check up;sexually transmitted infections” window will now open;

5. To generate the pathology form, click the “Request Investigation” button and then click “Save”



Progress note entry for “Follow up;sexually transmitted infections” recall:

Clinical Record
AKAY, THERESA MAY 36yrs Female (24/02/1983) Patient ID 11208 Pregnant (gestation unknown)

Filters: All Providers, All Encounter Places (All Encounter Modes), All Spe...
 Detail: Exclude non-contact services

Wed 17/04/2019 04:56 pm Millennium Health Service (Aboriginal Health Service)
 Christine Ellison (General Medical Practitioner) 04:56 pm

02/04/2019 <Recall> Follow up;sexually transmitted infection
 Modified by ADMINISTRATOR on Wed 17/04/2019 04:56 pm (Common).

Wed 17/04/2019 04:54 pm Millennium Health Service (Aboriginal Health Service)
 Joanne Bell (Aboriginal and TSI Health Worker) 04:54 pm

S. Opportunistic visit
 O. Has recall for f/up STI
 - treated for Chlamydia infection 3 months ago
 A.
 P.

17/04/2019 Follow up;sexually transmitted infection
 Informed consent has been obtained for the testing of HIV, syphilis, gonorrhoea, chlamydia and trichomonas as a part of follow up testing. The subsequent processes following a positive result of any of these diagnoses has been discussed, as has available treatments. The HIV testing 'window period' has been explained and the client has been advised to make an appointment to discuss results in one week.

18/04/2019 HIV serology; Gonorrhoea, Chlamydia and Trichomonas PCR; Syphilis serology;
 Request on behalf of: Christine Ellison; Investigation Provider: Sir Charles Gairdner Hospital;

17/04/2019 Check up;sexually transmitted infections
 STI reason for presenting.: Opportunistic;
 STI specimen: Urine;
 Investigations - STI: Gonorrhoea, Chlamydia and Trichomonas PCR; HIV serology: ...;

17/04/2019 advice and education about STDs
 For r/v with results in 1 week

Viewing right (excluding Clinical Items) | Common

Date	Item Description	To Do	Exp.
23/03/2012	<Recall> Results;pap smear		
09/03/2013	<Recall> Aboriginal & TSI adult health check		
21/05/2013	<Recall> antenatal check-up		

Appendix 4. Standing Drug Orders for chlamydia, gonorrhoea & trichomoniasis

Introduction

These Standing Drug Orders (SDOs) have been developed by AHCSA, for use by Nurses and AHW/Ps in ACCHSs in South Australia providing a sexual health program run by their health service (see Box 8 for guidance on administration of medication by AHW/Ps). The SDOs are consistent with the Australian Antibiotic Guidelines, the CARPA Standard Treatment Manual, and the CARPA Women's Business Manual, Minymaka Kutju Tjukurpa, with modifications as recommended by local experts to suit South Australian conditions.

SDOs provide an organisation the mechanism to enable an authorised person to autonomously handle and administer specific S4 drugs, in this case, antibiotics used in community-based STI programs without a prescribed medication order by a medical officer. These model SDOs must always be used in conjunction with the latest edition of the Australian Antibiotic Guidelines.

It is important to remember that no set of SDOs can account for every clinical situation that may occur. For further information that is not contained in the SDO, the nurse or AHW/P may speak to a medical officer from the Adelaide Sexual Health Centre (formerly Clinic 275), North Terrace, Adelaide (telephone 7117 2800), the AHCSA Public Health Medical Officer (telephone 8273 7200), or the medical officer who endorsed the SDO.

It is recommended that an SDO is in place within each ACCHS that provides an STI program. An organisation must authorise the establishment of SDOs to support their STI program. This will formalise treatment initiated by the RN or AHW where there is no authorised prescriber's (doctor's) order.

Box 8. Administration of medication by AHW/Ps

Under current (2019) pharmacy licensing regulations in South Australia, access to pharmacy supplies within health services are restricted to doctors and RNs. This precludes independent access to pharmacy supply storage by AHWs or AHPs. Also, under the *SA Controlled Substances Act 1984*, AHWs and AHPs can only administer medication if they have completed the Administer Medication training module, are deemed competent AND are delegated to do so by a RN. Factors to be considered when delegating tasks to AHPs and AHWs are outlined in the [Registered Nurses Standards for Practice](#) (Standard 6) and [National framework for the development of decision-making tools for nursing and midwifery practice](#) (September 2007).

Endorsement Committee

The endorsement committee should consist of a medical officer (who may be the AHCSA Public Health Medical Officer if there is no permanent medical officer within the service), senior nurse and member of management (usually the CEO or Unit Manager); in some circumstances a pharmacist may also be included.

Responsibilities of the endorsement committee include:

- Development (or adopting) of individual Standing Drug Orders (based on the model, Standing Drug Orders produced by AHCSA)
- Defining the criteria for accrediting nurses and/or AHW/Ps to administer treatment for STIs within their organisation
- Monitoring accreditation and quality assurance programs
- Reviewing and endorsing all Standing Drug Orders bi-annually
- Developing and monitoring of STI protocols (or endorsing the use of existing guidelines)

A valid SDO must:

- Be printed under the organisation's logo (this can be implemented by an appropriate covering letter on the organisation's letterhead that can accompany a signed copy of AHCSA's model SDOs)
- Be signed by endorsement committee members and must include the name and title of each person
- Include a recommended review date (usually every 24 months or when new recommendations are updated)
- Include a clause on each document which renders altered documents invalid unless the organisation's endorsement committee endorses the amendments (any hand-written amendments to the SDOs after the signatures have been added will invalidate the SDO)

Management

UNCOMPLICATED CHLAMYDIA, GONORRHOEA & TRICHOMONIASIS

The management below relates to the treatment of **uncomplicated** infection in males or **non-pregnant** females where symptoms are limited to dysuria (pain on passing urine) or discharge (vaginal or penile). If pelvic pain is present, suggesting the possibility of pelvic inflammatory disease or if the client is pregnant, refer to the CARPA WBM for management.

CHLAMYDIA

- Azithromycin 1g oral single dose (Pregnancy category B1)

GONORRHOEA

- Ceftriaxone 500mg IMI single dose (mix with 2ml lignocaine 1%) (Pregnancy category B1)
- AND 1g Azithromycin oral single dose (Pregnancy category B1)

Two antibiotics are recommended due to emerging ceftriaxone resistance (www.sti.guidelines.org.au).

TRICHOMONIASIS

- Metronidazole 2g oral single dose (Pregnancy category B2)
- OR Tinidazole 2g oral single dose (Pregnancy category B3)
- OR Metronidazole 400mg 12 hourly for 7 days (best for breastfeeding)
- If **pregnant** refer to the [CARPA WBM, 6th edition, p. 249](#) for management

Additional management for all STIs

- Discuss and plan sexual partner notification and treatment
- Advise no sex for 7 days after single dose therapies, and until partner is treated
- Complete full STI check including HIV/syphilis serology if not done (see [CARPA STM, 7th edition, p. 273](#) / [CARPA WBM, 6th edition, p. 239](#))
- Encourage safer sex and offer condoms
- Complete Communicare recall for “STI Treatment”
- Offer review in 1 week
- Notify chlamydia and gonorrhoea infections to CDCB
- Test for reinfection at 3 months

Legal issues when treating minors

Age of consent/legal age for having sex in SA is **17 years unless legally married** (or **18 years** if the older person is in a position of power/authority over the younger person, e.g. teacher, youth worker, step-parent, boss, sports coach, religious leader etc).

Sex is considered **non-consensual** if the person is **under the age of consent**.

It is against the law to have sexual activities with someone under the age of consent **even if they agree to the sexual activity**.

Any sexual behavior between a young person under 18 years and a family member or a person in a position of power/authority is sexual abuse and therefore must be mandatorily reported.

Mandatory reporting

In SA all health staff are mandated reporters. If you suspect on reasonable grounds that a child or young person has been, or is being, sexually abused you are mandatorily required to notify the Department for Child Protection via the **Child Abuse Report Line (CARL) 13 14 78** or <https://my.families.sa.gov.au/IDMProv/landing.html>. Serious cases must be reported by phone.

If a child under the age of 17 years has a positive STI test, discuss the case with a senior clinician to plan the next steps for follow-up and considerations for mandatory reporting.

The 6 'Rights' to Medication Administration



Aboriginal Health Council
of South Australia Inc.

Quality Systems Team

'6 rights' of medication administration



The following '6 rights' of medication administration should be adhered to by all healthcare professionals prior to the administration of any medication

Right client

*Am I giving the medication to the right client?
Ask the client to repeat their full name*

Right medication

*What medication does the client need?
Check the standard treatment order and check with another healthcare professional*

Right dose

*How much of the medication does the client need?
Check standard treatment order and have any medication calculations double checked*

Right time

*Is this the right time for the client to have the medication?
Check medication information*

Right route

*How and where does the medication need to be administered?
Check the standard treatment order and use the correct equipment*

Right documentation

*Document exactly what you have done in the client's file in Communicare
Use clinical items and do not 'free text'*

Appendix 5. Administration of Ceftriaxone

You need:

- 1 x 1000mg or 1g vial of ceftriaxone OR 1 x 500mg vial of ceftriaxone
- 1 x ampoule of 1% lignocaine (without adrenaline, 50mg in 5mL)
- 1 x 21 gauge needle
- 1 x 23 gauge needle
- 3 x 2ml syringes

Intramuscular Injection:

- Check against the '6 rights of medication administration'
- If using 500mg vial of ceftriaxone, inject 2mls of 1% lignocaine into the ceftriaxone vial, shake thoroughly, withdraw full amount, and administer to the correct patient
- If using 1g vial of ceftriaxone, inject 3.5ml of 1% lignocaine into the ceftriaxone vial, shake thoroughly, withdraw 2ml of the reconstituted medication and administer to correct patient - discard unused reconstituted medication
- Use 21 or 23 gauge needles
- Record the medication given in patient's file in Communicare (using STI Treatment template)

Appendix 6. Condoms

Condoms should be freely available to community members. It is a good idea to have them available in places where people can get them without shame (e.g. in toilets). They should also be on hand in consulting rooms when you are providing advice on safer sex to your clients so that they can be handed to them.

It is important that condoms which are held at your health service are stored correctly:

- Condoms should be stored in a **cool, dry place**. Preferably at or below room temperature
- Condoms should NOT be stored in excess of 35 degrees or below 0 degrees Celsius
- Care should be taken to protect latex and polyisoprene condoms against prolonged periods of exposure to extreme low or high temperatures, moisture, direct sunlight and fluorescent light
- Improper storage can lead to premature ageing and deterioration of the product
- Storage information is marked on every case of LifeStyles® condoms
- **Hints:**
 - o **Do not** keep condoms in the boot of a car
 - o **Do** cover the windows in your storage area so product is not exposed to direct rays of the sun
- Practice rotation of inventory: FIFO – first in, first out
- Expiration dates are clearly marked on cases and products. Discard expired or nearly expired stock

Condom suppliers:

Australian Therapeutic Supplies PTY LTD

(Four Seasons Condoms)

5/25 George Street

North Strathfield NSW 2137

Tel: 02 9743 6144

Fax: 02 9743 6244

Email: ats@australiantherapeutic.com

GLYDE Health Pty Ltd

PO Box 178

Ingleburn NSW 1890

Tel: 1300 364 811

Fax: 1300 364 855

Email: sales@glydehealth.com

SA SIN (SA Sex Industry Network)

220 South Road

Mile End SA 5031

Tel: 08 8351 7626

Email: info@sin.org.au

Appendix 7. Taboos – approach to discussing sensitive topics

STIs are associated with significant social stigma. Therefore, it is important to be **non-judgemental** and **ensure confidentiality** when discussing STIs with clients at every step of the check-up process. A violation of these principles discourages people from accessing healthcare, may damage their relationships with their families and partners, and lose trust in the health service.

When talking to the client:

- Where possible, give the client the choice of seeing a health practitioner of the same gender
- Maintain eye contact if appropriate
- Avoid body language that may be misinterpreted as passing judgement, e.g. raising eyebrows, sighing, crossing arms
- Listen actively – nodding, reflecting back what they say

Example script for initiating conversation about STI screening:

“Sexually Transmissible Infections/STIs are common among young people and they may not even know they have an STI.”

“We encourage all sexually active young people between the ages of 16-35 to get tested regularly for STIs which is why we are asking all young people if they would like an STI check-up.”

“We assure you that your results remain confidential and encourage you to contact your healthcare provider to get the results.”

“If your test is positive for an infection you will need to return for treatment and follow-up with a health professional.”

“Having a blood test means that you are also able to be tested for syphilis and HIV and like the other infections, if positive, you will be able to get treatment and the required follow-up.”

“There is a 3 month window period before HIV becomes visible in your blood test. So you may be advised to have another HIV test if you think you have been at risk of contracting HIV within the last 3 months.”

“Have you got any questions?”

“Would you like to have an STI check-up today?”

“Treatments are very effective for STIs and HIV.”

Tips on taking a sexual history

(The following 3 subsections are reproduced with consent from a presentation entitled ‘Taboo 3’ by Dr Alison Ward, Adelaide Sexual Health Centre).

While it is not necessary to take a full sexual history when offering asymptomatic STI testing, if someone presents with symptoms of a possible STI or is diagnosed with an STI then a full sexual history should be taken. Taking a sexual history aims to identify risks and inform subsequent clinical management. Questions must be asked carefully to avoid the client being shamed. Relationships and trust have to be built. People may not disclose private information or may choose to disclose over time, i.e. in subsequent visits.

A guide on taking a sexual history is available on the Adelaide Sexual Health Centre [website](#).

Here are some useful strategies for sexual history-taking:

- Offer **lists of options** whereby any answer would be acceptable, e.g:
 - With your most recent partner, did you have oral, vaginal or anal sex?
 - Was your last sexual partner a regular, casual or paid partner?
 - Are your partners male, female or both, or sistergirl or brotherboy?
- When asking how many partners the client has, **give an over-estimation**, e.g:
 - Roughly, how many partners did you have sex with in the last 3 months? Just estimate: 5, 10, 20, 50, 100?
- State generic information without directly stating that it applies to the client, e.g:
 - All young people aged between 16 to 35 years old are routinely offered STI check-ups each year
- Practice asking the questions so that it becomes routine, but emphasise that the client is not being singled out, e.g:
 - Some of these questions may seem very personal. We ask everybody the same questions.
- Explain the reason for asking:
 - I am asking these questions so that I can offer you the right tests; the treatment is different, it depends on where we find the infection. You can take your own tests in private from the vagina or the bottom
- If the situation gets awkward, acknowledge it, allow people to do it at another time, offer alternatives, reassure them of confidentiality

Table 4. Recording information – use of abbreviations

Abbreviation	Explanation
RMP/RFP	regular male partner/ regular female partner
RBF/RGF	regular boyfriend/ regular girlfriend
CMP/CFP	casual male partner/ casual female partner
CSW	commercial sex worker
VSI	vaginal sexual intercourse
ASI	anal sexual intercourse
MSM	men who have sex with men
OSI	oral sexual intercourse
IVDU	intravenous drug use

Swabbing other sites

Swabbing urethra (men), anus, throat and skin lesions/ulcers are performed if:

- Client reports symptoms
- Client requests testing
- Asymptomatic client had a positive screening test result
- Client is coming in for a check-up after having been identified as a contact
- MSM, sistergirl or brotherboy

Therefore, these additional swabs would occur in the context of a **full STI check**.

Notifying the Department of Health (CDCB)

Inform the client that a number of STIs are notifiable conditions under the *SA Public Health Act 2011*. Notifications are made to the Department of Health, and that information collected will be kept private and confidential. Example script:

“Doctors are legally obliged to notify the Department of Health of any cases of chlamydia, gonorrhoea, syphilis, HIV, hepatitis B or hepatitis C.”

“The Department of Health keeps all information collected confidential.”

“The Department may contact you for further information or to identify other people that may need treatment.”

Lesbian, Gay, Bisexual, Trans and Intersex (LGBTI) community members

LGBTI people in the Aboriginal community may experience multiple layers of discrimination – racial discrimination from the mainstream population, including discrimination within the mainstream LGBTI community and exclusion from the Aboriginal community.

Traditional roles are often defined by family relationships, therefore the non-heterosexual identity may be in conflict with the cultural identity. Loss of traditional roles, kinship and connectedness may create significant shame.

In the broader community, some specific issues that impact on Aboriginal LGBTI people may include social isolation and exclusion from community events which may put them at a higher risk of suicide, mental health disorders, drug and alcohol misuse and STIs. Social issues include homelessness and being subject to violence, poverty and isolation.

The experience is not uniform either – individuals who are gay, lesbian, brotherboy and bisexual may experience discrimination and isolation, and as a consequence, may choose to move to bigger centres to enable them to maintain dual identities – either traditional or expressing their sexuality. Sistergirls on the contrary, in some communities, may have more positive experiences and be accepted as women, and may live the female role to varying extents.

Aboriginal LGBTI people have also reported feeling excluded from the messages by mainstream LGBTI-specific organisations, hence further limiting access to services.

Men who have sex with men (MSM)

STIs are more common in the MSM population. STI testing should be offered at least once a year, and up to 4 times a year to people who are in any of the categories below (see 'NSW STI Programs Unit STI/HIV Testing Guidelines for MSM' in list of resources):

- Have unprotected anal sex
- >10 partners in 6 months
- Take part in group sex
- Use recreational drugs during sex
- Are HIV positive MSM – need STI check with every HIV monitoring test

In addition to the screening tests, it is recommended to test for hepatitis A, hepatitis C and check hepatitis B immunity status.

It is important to educate MSM on the availability of Post Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP) to prevent HIV.

Offer MSM hepatitis A vaccination.

Transgender/sistergirl/brotherboy

This refers to people whose gender identity, expression and behaviour are at odds with the sex they were assigned at birth. The terms 'sistergirl' and 'brotherboy' are often used in Aboriginal communities. They may be on cross hormonal therapy and some may have had various kinds of 'gender' surgery.

The occurrence of STIs among transgender people are no different from the non-trans population unless there are other risk factors. In addition to the screening tests, it is recommended to test for hepatitis A.

Women who have sex with women (WSW)

WSW are also at risk of STIs. Notably, bacterial vaginosis (BV) is more common in WSW. The risk of STIs depends on the specific infection and type of sexual contact.

In addition to the recommended STI screening tests previously documented, it is recommended to test for BV. WSW should follow the same cervical screening recommendations as all women.

Community members who do sex work

Sex workers can be male, female, sistergirl, brotherboy, gender diverse or same sex attracted. Anybody could be a sex worker, though they may keep their occupation private. Sex work can be opportunistic, and in exchange for goods, services or money. Sex workers experience discrimination, and this is intensified if they are also part of other disadvantaged groups. Therefore, it is important to be non-judgemental and not question why they do the work they do. Treat them the same way as you would with other community members. For sex workers, their health is important for their livelihood, therefore remember that a positive test result not only affects their physical and emotional health, it could also disrupt their earnings. The Sex Industry Network (SIN) provides support for all sex workers, including Aboriginal sex workers. Access SIN details [here](#).

Community members who inject drugs

Discrimination against people who inject drugs is widespread, and often based upon myths and stereotypes portrayed on television or in the media. People who inject drugs often feel misrepresented and discriminated against. This discrimination forms a major barrier to accessing health care services. The stigma associated with injecting drug use reduces access to services such as BBV screening, treatment, harm reduction education and social and emotion wellbeing services. This is a significant problem as people who inject drugs are at increased risk of BBV transmission. It is important to be conscious of language and personal values which may create further stigma for clients who inject drugs.

In Australia, hepatitis C transmission is heavily associated with the sharing of injecting equipment. For any clients who are currently injecting, consider discussing harm reduction strategies such as safer injecting, access to equipment and overdose prevention. It is also an opportunity to provide referral to a Hepatitis SA Peer Worker to discuss further injecting-related harm reduction strategies. Resources are available to support these conversations; for further information on safer injecting contact Hepatitis SA on (08) 8362 8443 or refer to their website [here](#). For Clean Needle Program locations, refer to the Drug and Alcohol Service of South Australia (DASSA) website [here](#).

Appendix 8. Key Sexual Health, STI & BBV resources used in the update of this handbook

1. Aboriginal Health & Medical Research Council of NSW. STI & BBV Manual Early Detection and Treatment of Sexually Transmissible Infections and Blood-Borne Viruses. 2nd ed. 2015. AHMRC NSW
2. ASHM. Aboriginal and Torres Strait Islander Health Workers and Blood- Borne Viruses. 2013 ASHM
3. ASHM & AHCSA. Communicare User Manual Viral Hepatitis. 2015. Available: <https://www.ashm.org.au/products/product/9-781921850233>
4. ASHM. Australasian Contact Tracing Guidelines, 2016 ASHM
5. ASHM. Australian STI Management Guidelines for use in primary care. Available: <http://www.sti.guidelines.org.au/>
6. ASHM. B Positive - all you wanted to know about hepatitis B - a guide for primary care providers, 2nd ed, 2014, ASHM, NSW. Available: <https://www.ashm.org.au/products/product/1976963310>
7. Australian Injecting and Illicit Drug Users League (AIVL) 2011, 'Why wouldn't I discriminate against all of them?', A report on stigma and discrimination towards the injecting drug user community, Canberra, Australia
8. Centre for Disease Control. NT Guidelines for the Management of Sexually Transmitted Infections in the Primary Health Care setting. 4th ed. 2016. Department of Health Northern Territory
9. Centre for Remote Health. CARPA Standard Treatment Manual 7th Ed, 2017. Alice Springs
10. Centre for Remote Health. CARPA Minymaku Kutju Tjukurpa Women's Business Manual. 6th Ed, 2017. Alice Springs
11. Department for Health and Wellbeing. South Australian Perinatal Practice Guideline – Syphilis in Pregnancy. June 2018. Available: http://www.sahealth.sa.gov.au/wps/wcm/connect/4f3188804eedeac1b604b76a7ac0d6e4/Syphilis+in+pregnancy_Clinical+Guideline_final_Dec14.pdf?MOD=AJPERES
12. Gastroenterological Society of Australia. Clinical guidance for treating hepatitis C virus infection: a summary. August 2017. Available: http://cart.gesa.org.au/membes/files/Resources/Hepatitis%20C/GP_wallchart_clinical_guidance_Aug_2017.pdf
13. National LGBTI Health Alliance: <https://lgbtihealth.org.au/communities/>
14. Queensland Association for Healthy Communities. States of Mind: Mental Health and Wellbeing and Alcohol, Tobacco and other Drugs use in Queensland Lesbian, Gay, Bisexual and Transgender (LGBT) communities – A Community Needs Analysis. 2010 QAHC.
15. SA SIN pamphlets. Available: <http://www.sin.org.au/SINpublications.html>
 - Sex Workers - A resource for nurses, doctors and all clinical staff who work with and for sex workers
 - By Sex Workers for Sex Workers
16. Ward, Alison. Sexually Transmitted Infections Update. Adelaide Sexual Health Centre, SA Health. [Powerpoint presentation]
17. Young Deadly Free factsheets. Available: <http://youngdeadlyfree.org.au/for-young-people/>

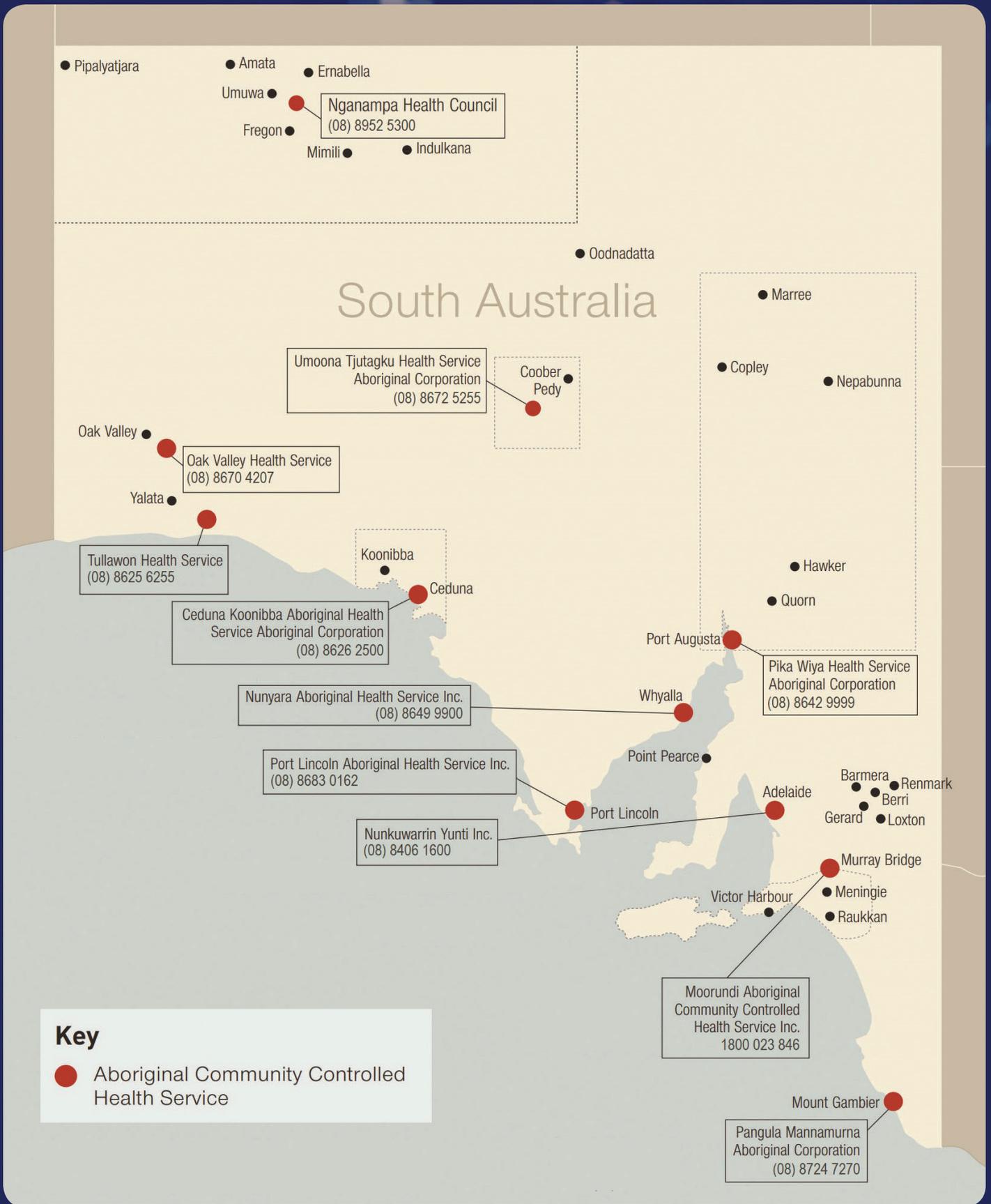
Appendix 9. Further Sexual Health, STI & BBV Resources

- AHCSA Sexual Health Program Asymptomatic STI Screening summary flowchart: https://ahcsa.org.au/app/uploads/2017/07/J010141_STI_Flowchart_A3_Poster_CLIENTFINAL.pdf
- Adelaide Sexual Health Centre (formerly Clinic 275): <http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+services/sexual+health+services/Adelaide+sexual+health+centre>
- AHCSA 'Building Safe Communities for Women Programme': <http://safecommunities.ahcsa.org.au/>
- Australian Indigenous Health InfoNet: <https://healthinfonet.ecu.edu.au/>
- Australian Injecting and Illicit Drug Users League: <http://aivl.org.au/>
- CARPA Standard Treatment Manual 7th edition (Men's Sexual Health): <https://docs.remotephcmanuals.com.au/review/g/manuals2017-manuals/d/20317.html?page=1>
- Clean Needle Program resources:
<https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/drug+and+alcohol+services/clean+needle+program>
<http://www.health.gov.au/internet/main/publishing.nsf/Content/needle-kit-ques>
<http://www.health.gov.au/internet/main/publishing.nsf/Content/needle-kit-evid>
<https://hepatitissa.asn.au/safer-injecting>
- Drug and Alcohol Services South Australia: <https://knowyouroptions.sa.gov.au/>
- Eora Action Plan on HIV 2014: <https://eoracalltoaction.wordpress.com/>
- Gastroenterological Society of Australia: Hepatitis C Treatment: <https://www.gesa.org.au/resources/hepatitis-c-treatment/>
- Gastroenterological Society of Australia: Remote Consultation Request for Initiation of Hepatitis C Treatment form: https://cart.gesa.org.au/membes/files/Resources/Hepatitis%20C/Remote_consultation_form_updated_Sep_2018.pdf
- HealthELink Hepatitis C Study: <https://healthelinkstudy.com.au/about/>
- Hepatitis SA: <https://hepatitissa.asn.au/>
- Indaba HIV – Information and resources for women living with HIV in South Australia: <https://indabahiv.com.au/>
- Legal Services Commission of South Australia – Community Legal Education: https://lsc.sa.gov.au/cb_pages/youtheducation.php
- Melbourne Sexual Health Centre: <https://www.mshc.org.au/Default.aspx?alias=www.mshc.org.au/general>
- Minymaku Kutju Tjukurpa – Women's Business Manual 6th Edition: <https://docs.remotephcmanuals.com.au/review/g/manuals2017-manuals/d/20273.html?page=1>
- Mosaic Blood Borne Viruses Support Services: <https://www.rasa.org.au/services/adult-health-wellbeing/mosaic-blood-borne-viruses-support-services/>

- NSW STI Programs Unit – STI/HIV Testing Guidelines for MSM: <https://stipu.nsw.gov.au/stigma/stihiv-testing-guidelines-for-msm/>
- SA Health ‘HIV testing and pre-test discussion guidelines’: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/sexual+health+services/adelaide+sexual+health+centre/sexually+transmitted+infections+for+health+professionals/hiv+testing+and+pre+test+discussion+guidelines>
- SA Health ‘Viral Hepatitis Nursing Support’: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public%20content/sa%20health%20internet/clinical%20resources/clinical%20programs/viral%20hepatitis%20nursing%20support/viral%20hepatitis%20nursing%20support>
- SAHMRI - U and Me Can Stop HIV: <http://www.atsihiv.org.au/>
- SAMESH – South Australia Mobilisation + Empowerment for Sexual Health: <http://www.samesh.org.au/>
- Sex Industry Network (SIN), South Australia: <http://www.sin.org.au/sindex.html>
- SHINE SA: <https://www.shinesa.org.au/>
- Test Treat and Go 2 (TTANGO2) Program: <http://www.flinders.edu.au/medicine/sites/point-of-care/research/field-programs/ttango2.cfm>
- The Aboriginal Drug & Alcohol Council (SA) Aboriginal Corporation: <http://www.adac.org.au/>
- The GOANNA Survey – survey report July 2014: <https://www.baker.edu.au/Assets/Files/Final%20Goanna%20Report%20July%202014.pdf>
- WA STI Education Project - Free STI online training program for health professionals, including specific module for nurses and AHPs: <https://sti.ecu.edu.au/>
- World Health Organisation (WHO) Consolidated guidelines on HIV testing services: <http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/>
- Yarrow Place: <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/yarrow+place+services>
- Young Deadly Free: <https://youngdeadlyfree.org.au/>
- Contact tracing websites:
 - www.bettertoknow.org.au
 - www.letthemknow.org.au
 - www.getcheckednow.com.au
 - www.thedramadownunder.info/

Non-sexual health related resources

- Australian Immunisation Handbook
<https://immunisationhandbook.health.gov.au/>
- Nursing and Midwifery Board of Australia – Registered nurse standards for practice
<https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx>



AHCSA Members Map: South Australian Aboriginal Community Controlled Health Services



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