SEXUAL HEALTH

Fact sheet 9

Sexually transmitted infections (STIs)

National survey data show that 1 out of every 5 Australian men, and 1 in 6 women, has ever been diagnosed with an STI (1).

STIs occur with the highest frequency among marginalised populations, in particular Aboriginal people, men who have sex with men and injecting drug users (2, 3).

> STD Services, an agency of SA Health monitors and reports on rates and patterns of sexually transmitted infections in South Australia. Visit their web site at www.stdservices.on.net to get access to these detailed reports and other resources.

Community surveys have reported generally low-level knowledge among Australians about the transmission and health consequences of most common STIs (4, 5).

Less than one-third of exclusively heterosexually active men and women in Australia always use condoms. They use condoms more to prevent pregnancy than to guard against STIs (6).

Information and education about STIs are less accessible to some population groups, including people with disabilities, young people from culturally and linguistically

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diverse (CALD) backgrounds, young people who have not completed the full 12 years of education, and people living in country communities.

STIs are associated with many adverse physical, mental, emotional and social health and wellbeing outcomes.

STIs are linked to pelvic inflammatory disease (PID) and consequent infertility, cervical and other genital tract tumours, and are known to enhance the transmission of HIV (Human Immunodeficiency Virus).

GPs are a critical locus in the treatment of STIs.

People most often go to their general practitioners (GPs) for treatment. Easy access to diagnostic and treatment services is critical to effectively prevent and manage STIs. People at increased risk tend not to seek timely treatment and may continue to spread their infection (7).

There are national and internationally agreed-upon frameworks for STI prevention (16), whose key components include:

- support for human rights
- promotion of male responsibility and the empowerment of women
- access to a comprehensive and integrated sexual and reproductive health service system
- whole-of-government and community approaches

A comprehensive and integrated sexual health service system includes STI testing, diagnosis, treatment, counselling and support as well as prevention strategies, including information and education, safer sex promotion, partner notification and contact tracing (17).

Consistent and correct condom use is critical to preventing or reducing the transmission of STIs, including HIV (18). Inconsistent condom use, however, and the late application of condoms are widespread, with many young women reliant on 'trust' or 'love' for a partner as a major STI prevention strategy (19).

Keys to improving access to sexual health services

- Targeted screening programs and locations.
- Contact tracing to find groups/social networks of people at higher risk.
- Targeted information and education strategies.
- Free and confidential clinics with no-wait for appointments.
- Appropriate service providers (gender, age, culture, attitude).

Evidence-based action to prevent or reduce transmission of STIs

- Population-based screening for all women under 25 and targeted screening for males.
- Targeted interventions to population groups with multiple sexual partners and the greatest barriers to sexual health. Interventions must be specific to the lived experiences of these groups.
- Improved knowledge about sexual behaviours and sexual health through school-based programs, lifelong learning and mass communications.
- Free and local access to condoms and promoted practices of condom use that will reduce the likelihood of condom failure.
- Increased access to free and confidential STI clinics. Nurse-led, drop-in sexual health clinics in youth services.
- Population-based STI/HIV surveillance linked to targeted secondary prevention interventions, including contact tracing.
- Professional standards and competency-based programs developed to equip GPs and a range of other staff to provide sexual health services.

A snapshot of STIs in South Australia (1, 2)

Chlamydia

Chlamydia was the most frequently notified infection Australia-wide in 2005. The rate in South Australia more than doubled from 2001–2005 for both Aboriginal and non-Aboriginal populations to 937 per 100 000 Aboriginal population and 188 per 100 000 non-Aboriginal population. Increases Australia-wide in the rate of reported diagnoses of Chlamydia were highest in the 20–29 and 15–19 year age groups, probably influenced by the behavioural norm of multiple and frequent changes of sexual partners among these age groups (3).

Gonorrhoea

The rate of gonorrhoea in South Australia more than doubled from 2001–2005 in the Aboriginal population to 1005 per 100 000 compared to a very much smaller increase in the non-Aboriginal population to 9 per 100 000. The rate of diagnosis Australia-wide of gonorrhoea was highest in the age groups 15–19 and 20–29 years, and substantially lower for people aged 30 years and older.

Syphilis

The population rate of diagnosis of syphilis in the non-Aboriginal population of South Australia has remained low (around 1 per 100 000), while the Aboriginal population rate has declined from 83 per 100 000 in 2001 to 7 per 100 000 in 2005. There

was a rise in syphilis notifications in South Australia in 2006 (mainly non-Aboriginal male-to-male contact) which is of concern, as it is an indicator of unsafe sex practices; furthermore, people already infected with an STI are at greater risk of HIV infection.

Newly acquired HIV infection

The rate of diagnosis of newly acquired HIV infection in South Australia, as is the case in the rest of Australia, has increased, albeit marginally, in the past two years. South Australian data on HIV trends in Aboriginal populations are based on small numbers of diagnoses and may reflect localised occurrences rather than overall patterns.

Australia-wide transmission of HIV continues to occur primarily through sexual contact between men although, in Aboriginal populations, transmission through heterosexual contact is as common. One-third of Aboriginal cases were among women, whereas women comprised around 11 per cent of non-Aboriginal infection incidences.

Newly acquired Hepatitis B infection

The population rate of newly acquired Hepatitis B infection in South Australia from 2001–2005 substantially declined from 2.0 per 100 000 in 2000 to 0.5 per 100 000. The greatest declines in the rate of newly acquired Hepatitis B infection Australia-wide were among young people aged 15–29 years, which may be the result of adolescent vaccine coverage.

The percentage of newly acquired Hepatitis B infection in Australia attributed to injecting drug use remained stable at around 45 per cent in 2002–2005. The percentage of diagnoses attributed to sexual contact increased from around 25 per cent in 2001 to 33.7 per cent in 2005.

Herpes Simplex Virus 1 & 2 (HSV)

HSV conditions (oral and genital) are most prevalent in males and females aged 16–24 years. HSV plays an important role in HIV transmission. There is evidence that HSV-2 enhances the risk of HIV acquisition around three-fold. HSV-2 infection also may increase HIV infectiousness and effect on HIV viral load.

Human Papilloma Virus (HPV)

Acute HPV infection is the cause of most low-grade cervical abnormalities and a known cause of cervical cancer. Both the incidence and mortality of cervical cancer in Australia have been halved (4) since the adoption of a national screening policy and an Organised Approach to Preventing Cancer of the Cervix (as the program was named) for cervical cancer (1991–1992).

The Commonwealth Government has been funding since 2007 the cervical cancer vaccine, Gardasil, for females aged 12–26 years, primarily through a school-based immunisation program and through General Practices.

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