



FAMILY PLANNING VICTORIA

REVIEW OF SEXUAL HEALTH CLINICAL SERVICES IN VICTORIA

A report by Family Planning Victoria

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Full details of the review participants and members of the reference group are listed in Appendices 1 and 5 respectively.

ACRONYMS

| | |
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| ACSHP | Australasian College of Sexual Health Physicians |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ASHM | Australasian Society of HIV Medicine |
| ASHNA | Australian Sexual Health Nurses Association |
| ATSI | Aboriginal and Torres Strait Islanders (abbreviation used interchangeably with 'indigenous communities') |
| BBVs | Blood-borne viruses |
| CALD | Culturally and linguistically diverse |
| CME | Continuing medical education |
| DHS | Department of Human Services |
| FPV | Family Planning Victoria |
| GPs | General practitioners |
| GPDV | General Practice Divisions Victoria |
| HCC | Health Care Card |
| HIC | Health Insurance Commission |
| HIV | Human Immuno-Deficiency Virus |
| IDUs | Injecting drug users |
| MOU | Memorandum of Understanding |
| MSHC | Melbourne Sexual Health Centre |
| MSM | Men who have sex with men |
| NPs | Nurse practitioners |
| NPS | National Prescribing Service |
| PCP | Primary Care Partnership |
| RACGP | Royal Australian College of General Practitioners |
| RhED | Resourcing health & Education in the Sex Industry |
| STIs | Sexually transmitted infections |
| VACCHO | Victorian Aboriginal Community-Controlled Health Organisation |

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EXECUTIVE SUMMARY

This report comprises the findings of a state-wide review of sexual health clinical services in Victoria that Family Planning Victoria (FPV) has undertaken on behalf of the Department of Human Services (DHS). For the purpose of this review, sexual health clinical services are defined as those involved in the prevention, diagnosis and treatment of sexually transmitted infections (STIs) and the prevention and diagnosis of human immunodeficiency virus (HIV) and other blood-borne viruses (BBVs). It does not include the treatment of HIV and BBVs, or other related services such as reproductive health services.

There are three main strategies for the control of STI. The first is to reduce the risk of transmission during sexual contact. Safer sexual practices are likely to have an effect on reducing this risk. The second is to reduce the number of new sexual partners through effective behaviour change initiatives. The third is to reduce the period of infectiousness. Available strategies to achieve this include accessible sexual health clinical services, screening and treatment of asymptomatic at-risk individuals and effective contact tracing of cases. This review examines the last of these strategies in the control of STIs.

The overall control of STIs in Victoria and Australia compares favourably to other developed countries as reflected by the low rates of gonorrhoea in the heterosexual community. However, there is increasing concern about the rising rates of *Chlamydia trachomatis* infection amongst young women and the rise in notifications of gonorrhoea amongst men who have sex with men (MSM). In addition, indigenous communities appear to have higher than average rates of STIs. These increasing rates appear to be compounded by difficulties accessing mainstream services. Young people, injecting drug users (IDUs) and sex workers working illegally may also have difficulty accessing sexual health clinical services. The increasing awareness of the rising rates of STI in some communities, in addition to recently published evidence suggesting young people may have poor knowledge of STIs, resulted in this review being commissioned. A further motivation was the recent transfer of management of the metropolitan state-funded sexual health clinical service, Melbourne Sexual Health Centre (MSHC), from DHS to Bayside Health.

The major providers of sexual health clinical services in Victoria are general practitioners (GPs). They receive no funding from DHS to provide these services. There are also six state-funded sexual health clinical services scattered throughout

Victoria. MSHC is located in Melbourne and there are five other funded services, one in each non-metropolitan DHS region. The Hume region has a clinic in Wodonga, the Gippsland region has a clinic in Traralgon, the Barwon-South Western region has a service in Geelong, the Loddon Mallee region has a service in Bendigo and the Grampians region provides a service in Ballarat.

This review used qualitative research methods to collect data from three groups of participants. The first group included the state-funded sexual health clinical services. A semi-structured questionnaire was used to obtain data from service representatives. Data on clinical standards, facilities, staffing and characteristics of clients was collected. Semi-structured interviews were used with the second group of participants, key informants, who were identified by the researchers as possessing knowledge about or expertise in sexual health clinical service delivery to the general community or to special needs groups or communities. Representatives from professional associations for sexual health clinical service providers were also included in this group. The third group included service providers identified as being involved in the prevention, diagnosis and treatment of STIs and/or the prevention and diagnosis of HIV and BBVs. Focus groups were used to gather data from these participants, although written contributions were made by service providers unable to participate in a focus group.

Findings suggested the metropolitan state-funded sexual health clinical service is accessible to those most at-risk, provides best practice care, and collaborates with organisations to increase accessibility to their services by marginalised groups. Clients can be seen within 24 hours if symptomatic or at high risk and are triaged by a nurse to access the clinic. No Medicare card is needed to access the service and treatment is free and dispensed at the clinic. The clinic is open five days a week with evening hours available once a week. MSM comprise 25% of clients. The premises are purpose-built with their own microbiology facilities. There are good public transport links and disabled access is available. The clinicians comprise GPs, sexual health physicians, infectious diseases physicians and other specialists. The clinician in charge of clinical standards completes continuing medical education (CME) according to specialist college requirements. The centre's link with the University of Melbourne provides an opportunity to offer postgraduate courses in sexual health to GPs and other interested health professionals. In addition, collaborative partnerships with Aboriginal community-controlled health organisations have ensured easier access for those from indigenous communities. Overall, the service fulfils its stated objective to reduce STIs

in the community by working effectively to provide accessible and appropriate services to those most at risk.

Non-metropolitan state-funded sexual health clinical services opening hours vary from two hours a week to two full days a week. The facilities and infrastructure are often substandard. In many cases, the clinics are situated in public hospitals or community health centres with poor access by public transport and inadequate signage. Without exception they have no collaborative working partnerships. The funding of both clinicians and pathology investigations depends on Medicare billing, which decreases access to these services for those without a Medicare card. In addition, treatment is not free. Recruiting appropriately trained doctors is problematic, with one service being without a doctor for the last few months and there are no foreseeable potential candidates. Nurses in some of these clinics have little sexual health training and often work across other specialties. These findings alone suggest there are likely to be difficulties for marginalised groups in accessing these services. Performance indicators and data to accurately assess these services are not reliably recorded by most of these clinics so assessment is difficult. However, it is clear that with the limited funding allocated to these regional services it is unlikely that they will be able to deliver an accessible, best practice, collaborative sexual health clinical service to their communities. It appears this situation has led to many motivated and enthusiastic medical, nursing, and administrative staff feeling isolated and unsupported.

Seventeen key informant interviews with 18 individuals were conducted. Representatives from different types of services participated in the focus groups or submitted a written contribution. In total, 57 service providers participated. Findings from the interviews and focus groups suggested that most participants believed that sexual health clinical services in inner metropolitan Melbourne were adequate and accessible. However, outside this area, services were thought to be less than adequate and inaccessible. Chlamydia in young people and gonorrhoea in MSM were considered the most pressing sexual health issues in Victoria and access issues were highlighted for certain population groups such as young people, IDUs, culturally and linguistically diverse (CALD) communities, indigenous communities, MSM, and sex workers.

Apart from clinical services, strategies that were implemented to address sexual health issues included education, outreach, and intersectoral collaboration. However, social, structural, financial, informational, geographic, attitudinal, and knowledge-related barriers to service access were cited, including stigma and embarrassment, cost, transport, distance to travel, concerns about confidentiality, lack of information

about sexual health and available services, and lack of knowledge about STIs and available services. Participants also considered existing sexual health education in schools to be inconsistent and inadequate in many areas of Victoria, negatively impacting on young people's STI knowledge and utilisation of services. A number of barriers to service delivery were also highlighted. These barriers included negative attitudes towards sexual health, a lack of political commitment to sexual health, Health Insurance Commission (HIC) rules for STI screening, workload, time, and lack of support.

Intersectoral collaboration was felt to be poor and ad hoc and there appeared to be no concerted efforts on a state-wide basis to encourage services to work together. There were no set performance indicators in place. Professional development for staff was difficult to attend, only occurred when self-motivated and was costly, particularly for rural-based service providers.

Suggestions to improve sexual health clinical service delivery included prioritisation of sexual health at a political level and within general practice. Formal and informal networks for debriefing and ongoing education of staff needed to be improved to help confidence and knowledge in this area. The development of quantitative and qualitative performance indicators that provided demographic data as well as information about access, STI incidence, service provision, patient satisfaction, and patient level of knowledge was recommended. The development of youth-specific performance indicators was also suggested. Participants also emphasised the importance of implementing consistently-delivered and appropriate sexual health education from an early age to empower young people with the skills necessary for accessing sexual health services. Educational initiatives for the general community were also considered necessary to increase community awareness of sexual health and to improve service access by those at high risk of STIs.

Supporting GPs with an interest in sexual health to deliver clinical services and integrating nurse practitioners into sexual health clinical service delivery were felt to be necessary in improving service access. It was thought the role of nurses in the delivery of sexual health clinical services in Victoria had not been fully exploited. Nurse practitioners were considered vital to service delivery, particularly in rural and remote areas where there were fewer GPs. Other nurses who already provided sexual health clinical services and whose role could be enhanced, such as practice nurses and community health nurses, needed more support, training, and recognition of the difficulties experienced in the provision of these services. Structural barriers,

particularly for practice nurses, such as management of their time being controlled by the priorities of their practice, which often did not include sexual health, and no nurse-specific Medicare item number for Chlamydia testing needed to be addressed to make these solutions viable.

Confidentiality and location of state-funded sexual health clinical services in rural regions was highlighted and it was thought placement in generic health services with appropriately-trained staff might be a solution to this. State-funded sexual health clinical services could be improved by being located in community health centres whenever possible. Other recommended solutions included a liaison position to co-ordinate services and to provide a link to DHS, outreach, and Chlamydia screening of sexually active young women under 25. As a result of the structure of the current health care system, patterns of health-seeking behaviour and the geography of Victoria it is unlikely that state-funded services alone will be able to provide sexual health clinical services for all Victorians and thus achieve adequate STI control. In order to provide best practice in sexual health clinical service delivery throughout Victoria, DHS needs to continue to provide and enhance its state-funded sexual health clinical services, but also acknowledge the role of GPs in the provision of these services. This acknowledgment needs to be accompanied by financial, educational, and structural support for the delivery of sexual health clinical services within general practice. The important role of nurses should be acknowledged with the support and appointment of nurse practitioners in sexual health, additional training and support for practice nurses in the delivery of sexual health clinical services, and increased support and sexual health training for community health nurses. General practice, community health, state-funded sexual health clinical services, and other specialised providers need to work collaboratively to control STIs effectively in Victoria.

Review findings are consistent with the published literature in this area. GPs remain the major providers of sexual health clinical services in Victoria, a role the findings suggest are appropriate. However, to have a positive impact on the control of STI in the community and to provide accessible services, GPs need educational, financial, structural and community support. In order for GPs to provide Chlamydia screening, there will need to be structural changes to the Medicare system as well as educational and financial incentives with ongoing support. Practice nurses, if supported to be more involved in sexual health clinical services, may be able to have an impact on the accessibility of these services in general practice. In addition, other nurses in the community working in sexual health (community health nurses, secondary school nurses and potentially nurse practitioners) could help create much-needed networks

and links between services. Community health centres may be best placed to offer sexual health clinical services in many communities. However, they too will need similar support in order to be effective in controlling the spread of STIs. Furthermore, for sexual health clinical service delivery to become a priority for GPs, there needs to be greater involvement and more support from bodies such as the Royal Australian College of General Practitioners (RACGP), General Practice Divisions Victoria (GPDV), Health Insurance Commission (HIC), and the Federal Government. The current lack of relationship between GPs and the State Government is an obstacle that needs to be overcome.

To be effective in the control of STI, state-funded non-metropolitan services need to be more accessible, with standardised performance indicators and strong networks and collaborations in the community. These services need more funding if they are expected to provide best practice standards and accessible services. Support for these services and their staff is also needed. This could be provided by organisations in Victoria already involved in the provision of sexual health education to health professionals, but would need formalising and co-ordination. A liaison role in the DHS to create support for and oversee state-wide sexual health clinical services to enable them to offer best practice standards could help address this.

CHAPTER 1: INTRODUCTION

1.1 Background

Family Planning Victoria (FPV) was contracted by the Department of Human Services (DHS) to undertake a state-wide review of sexual health clinical services in Victoria. The World Health Organisation (WHO) defines sexual health to be more than just the absence of a sexually transmitted infection or unplanned pregnancy, but also includes freedom from the attitudinal, cultural and societal influences in their definition.¹ However, for the purposes of this review sexual health clinical services were defined as those involved in the prevention, diagnosis, and treatment of sexually transmitted infections (STIs) and the prevention and diagnosis of Human Immuno-Deficiency Virus (HIV) and other blood-borne viruses (BBVs). It did not include the treatment of HIV and BBVs, or other related services such as reproductive health services.

The spread of STIs in a community can be controlled by three main strategies: reducing the risk of transmission during sexual contact, reducing the rate of partner acquisition and reducing the period of infectiousness.²⁻³ Safer sexual practices are likely to have an effect on reducing transmission during contact and effective behaviour change initiatives may help to reduce the acquisition of new partners. Accessible sexual health services, the availability of screening and treatment for asymptomatic individuals at risk and effective contact tracing strategies are vital in order to reduce the period of infectiousness.² Reducing the period of infectiousness is the STI control strategy that this review aimed to examine.

Whilst Australia's HIV control strategies are considered amongst the most successful in the world,⁴ there is little evidence to demonstrate the success of STI control strategies in Australia particularly sexual health services. Australian research has found that whilst sexual health services in Australia have increased, it is difficult to ascertain whether existing facilities meet community sexual health needs.⁵ This review aimed to determine whether existing facilities and services in Victoria were meeting local needs.

1.2 Rationale

There were three main reasons for this review being commissioned.

STI notification rates in Victoria

Increasing rates of many notifiable STIs, primarily Chlamydia, gonorrhoea, infectious syphilis, and BBVs such as HIV have been reported in Victoria in the last few years.⁶

The public health consequences of STIs are well-documented.⁷ STIs are often asymptomatic and can remain undetected for a significant period of time. Many people who are seropositive for herpes simplex virus (HSV) 2 are unaware that they are infected.⁸ Likewise, Chlamydia is asymptomatic in up to 90% of infected women⁷ and up to 40% of those infected develop pelvic inflammatory disease (PID). This can result in infertility, ectopic pregnancy, and chronic pelvic pain. These conditions result in significant reproductive morbidity and mortality for the individual and the community as a whole with major economic implications. In addition to these direct 'costs', many STIs have been shown to increase the transmission of HIV.⁸⁻⁹ In Australia, the cost of the sequelae of Chlamydia alone was estimated to be \$90-160 million a year over a decade ago when rates were significantly lower.¹⁰

The burden of disease caused by STIs is not equitably distributed in the community. Women under the age of 25 years have the highest rates of notification of Chlamydia in Victoria.⁶ Most of the notifications of gonorrhoea are in men in Victoria, the majority being from those men who give a history of having sex with other men.¹¹ The international literature also reflects that the incidence of some STIs is associated with socio-economic status, social capital and income inequality.¹²⁻¹³ In Australia, disproportionately high rates of STIs are reported from isolated indigenous communities.¹⁴ Increased rates of STIs are also reported amongst drug misusers.¹⁵

Research indicating low levels of knowledge about STI transmission

Recent Australian research has highlighted gaps in STI knowledge levels of men, women and school students.¹⁶⁻¹⁷ Whilst knowledge is not the only factor influencing behaviour, it is acknowledged to be an important prerequisite for the successful implementation of effective sexual health promotion strategies.¹²

Sexual health clinical service provision

There are six state-funded sexual health clinical services in Victoria. These are provided by Bayside Health (Melbourne Sexual Health Centre), Ballarat Community Health Centre, Barwon Health, La Trobe Regional Hospital, Bendigo Community Health Services Incorporated and Wodonga Regional Health Service. There are no clearly and consistently understood outcomes or performance indicators for these clinics. Funding is based on historical outdated factors and is not necessarily related to the needs of today's local community. The largest of these services is Melbourne Sexual Health Centre (MSHC) which is situated in metropolitan Melbourne. The management of this clinic was recently transferred from DHS to the Alfred Hospital. The other main providers of sexual health clinical services in the Victorian community include general

practitioners (GPs), community health centres, youth health services, drug and alcohol services, Family Planning and Reproductive Health services, emergency departments of public hospitals and indigenous-specific health services.

As highlighted previously, the distribution of STIs is not equally distributed in the community. Currently, there is no evidence that the state-funded sexual health clinical services are accessible to those most at risk of STIs. A review of sexual health clinical services has never been undertaken in Victoria before, so the findings will make a significant contribution to the current level of understanding about sexual health clinical service delivery in this state.

1.3 Aim and objectives

The aim of the review was to determine the range and scope of sexual health clinical services in each of the eight DHS regions in Victoria (Eastern Metropolitan, Southern Metropolitan, North and West Metropolitan, Loddon Mallee, Grampians, Barwon-South Western, Gippsland, Hume) in order to identify gaps in service provision and to determine if the current services were adequate to meet the needs of clients in the most cost-effective and efficient manner.

More specifically, the review objectives were to:

- Determine the range and scope of sexual health clinical services provided by the six state-funded sexual health clinical services in Victoria;
- Review issues of equity and access to sexual health clinical services by those from special needs groups or specific communities including young people, sex workers, injecting drug users (IDUs), culturally and linguistically diverse (CALD) communities, indigenous communities, men who have sex with men (MSM), individuals who are socioeconomically disadvantaged, rural and remote communities and people with a disability;
- Review the level of training and support available to the practitioners providing sexual health clinical services;
- Explore the potential role of nurse practitioners in the future delivery of sexual health clinical services;
- Explore the possible output measures and performance targets for the state-funded sexual health clinical services;
- Identify new models of care in the provision of sexual health clinical services which may improve the quality of care to those most at risk of STIs.

2. LITERATURE REVIEW

This literature review extends on the information presented in Chapter 1.

2.1 Definition of sexual health

Sexual health can be defined in many ways. The importance of sexual health as part of physical and mental health is illustrated by the United Kingdom Government's 2001 National Strategy for Sexual Health and HIV.¹⁸ This report defined sexual health as a key part of an individual's identity together with the fundamental human rights to privacy, family life and a life free from discrimination. The definition also highlights that essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease. This is based on the WHO definition of sexual health.¹⁹ There is currently no national sexual health strategy in Australia despite the call for one from experts.²⁰ However, the Victorian State Government has a Ministerial Advisory Committee currently in the process of producing a draft state-wide sexual health strategy that will be presented to the Victorian Minister for Health in 2005.

2.2 Review of sexual health clinical services in Victoria

This review of sexual health clinical services in Victoria defines sexual health as the prevention, diagnosis and management of STIs, and the prevention and diagnosis (but not treatment) of HIV and BBVs. This is acknowledged to be a limited definition that excludes reproductive health and sexual dysfunction issues. The authors of this report acknowledge the significant body of literature suggesting that these issues should not be addressed in isolation when considering service provision. However, a WHO report from 2000 suggested that although many experts advocated for the integration of reproductive health services with STI prevention services, this was mainly for idealistic reasons and that currently there was scant evidence that integration led to better outcomes in STI prevention.²¹ In contrast, for certain core groups, in particular adolescents, there appears to be consensus agreement that not only should STI prevention services and reproductive health services be commissioned together, but that best practice dictates these services should also provide general health care for young people in an accessible form.²²⁻²⁶

2.3 The importance of STIs

It has long been established that STIs are responsible for significant costs, both in terms of health and economics to the individual and the community.²⁷ For example

Chlamydia, the most common notifiable bacterial STI in Australia, commonly causes pelvic infection with resulting tubal damage, infertility and ectopic pregnancy in spite of its asymptomatic nature.⁷ In addition to these direct costs, many STIs have been shown to increase the transmission of HIV.⁹

2.4 Epidemiology of STIs

In many developed countries STI rates have been increasing since the mid 1990s.³ In the UK, rates of gonorrhoea, genital Chlamydia and syphilis have risen substantially over the past 5 years. This rise is greater than any seen since the 1970s.²⁸ This is thought to be the result of sexual behaviour changes²⁹ in addition to increased detection techniques and deteriorating access to services.³ As a result of this substantial rise in the rates of many STIs, the United Kingdom Government launched its National Strategy for Sexual Health and HIV in 2001.¹⁸ In Western Europe, rates of STIs have also been increasing rapidly owing in part to deteriorating infrastructure of health care services.³ The USA has also suffered from similar rises in STI rates for similar reasons combined with the additional burden of increasing socio-economic deprivation in many inner city areas.¹³

In Australia, there have also been documented rises in many STIs over the past 5 to 10 years. Rates of gonorrhoea and syphilis have risen annually since 1991.³⁰ Syphilis and HIV notifications have also risen.³¹ Increasing rates of many notifiable STIs have also been reported in Victoria in the last few years.⁶ Of particular concern are the rising rates of Chlamydia, especially amongst young women. There has been an increase in the notification rates of Chlamydia in Victoria every year for the last 5 years. The reasons for this include the widespread use of more sensitive diagnostic tests, increased awareness and testing in addition to a possible true rise in the prevalence of the disease in the community.³²⁻³³ In addition to this, recent work in Australia shows that the age of initiation of sexual intercourse continues to decline, knowledge of STIs could be better and condom usage, though better than it was 10 years ago, is still inconsistent.¹⁶ Despite the recent rise in notification rates for Chlamydia, gonorrhoea and HIV, STI rates in Australia and Victoria for the most part remain much lower than rates in comparable countries such as UK and USA. However, it is important that this does not lead to complacency and that interventions proven to be of benefit in the control of STIs are adopted and improved in Victoria. Victoria and Australia should aim for much lower rates of STIs.

2.5 Models of sexual health clinical service delivery in Victoria

There are eight DHS regions in Victoria. Three of these are in metropolitan Melbourne (Southern Metropolitan, Eastern Metropolitan and North and West Metropolitan) and five in non-metropolitan Victoria: Hume, Grampians, Loddon Mallee, Gippsland and Barwon-South Western. There is one state-funded sexual health clinical service in metropolitan Melbourne, namely Melbourne Sexual Health Centre. In non-metropolitan Victoria, each of the five regions has one state-funded sexual clinical health service. The Hume region has a service in Wodonga, the Gippsland region has a service in Traralgon, the Barwon-South Western region has a service in Geelong, the Loddon Mallee region has a service in Bendigo and the Grampians region has a service in Ballarat. Funding allocations, staffing levels and hours of operation vary across the services. The amount of funding available to these services means that they are severely limited in the direct clinical services they can provide to their community.

Metropolitan Melbourne is serviced by MSHC. This centre offers accessible services to those most at-risk of STIs. A recent publication showed that the change to a 'Walk in Triage System' (WITS) has been associated with attendance by a higher proportion of younger clients and those not using condoms. In addition, more investigations were performed and more genital herpes detected in men and women and Chlamydia in men.³⁴ In metropolitan Melbourne, in addition to this state-funded sexual health clinical service, there are also a number of GPs who work in 'high HIV caseload' practices. These practices, staffed by GPs, some of whom have postgraduate qualifications in sexual health as well as general practice, deal mainly with sexual health issues and HIV, primarily in men who have sex with men. Other organisations, such as FPV and Centre for Adolescent Health Young People's Health Service, also provide sexual health clinical services in the metropolitan region. In metropolitan Melbourne, in contrast to non-metropolitan areas, accessible services appear to be adequate.

Outside metropolitan Melbourne, current sexual health clinical services appear to struggle with providing access to those most at risk of STIs. These services are working in isolation, feel unsupported and under-funded. Most sexual clinical health services in Australia (and probably Victoria) are provided by GPs, as shown by a study published in 2003 reporting that more than 80% of Australians diagnosed with Chlamydia are treated by their GP.³⁵ However, general practice is not always accessible to those individuals most at risk of STIs. Decreasing numbers of GPs in Victoria are free (bulk billing) to the consumer at the time of presentation and this is likely to reduce access for those with a low income. Socio-economic factors and social

capital have been shown to be related to STI prevalence with those from more deprived areas being at higher risk than those who are less disadvantaged.¹²⁻¹³ Core groups in Victoria who carry the highest burden of disease of STIs include young people under 25, MSM, indigenous communities, IDUs and sex workers who work illegally. In addition to ensuring access to services for these important groups, in order to control the spread of STIs, services must also be accessible to those from CALD communities. These communities may not necessarily have very high prevalence rates of STIs but may need help in accessing services which they find culturally unfamiliar. Adolescents often experience difficulty accessing mainstream services and there are many factors likely to decrease access for IDUs and MSM to general practice.³⁶⁻³⁹ Services funded to reduce the spread of STIs should be providing services to these core groups and be able to demonstrate this with data. In addition, in order to reduce the infectious period of STIs, these services should be able to offer prompt (within 24-48 hours) assessment to symptomatic individuals and those at high risk. Information on access to these services needs to be publicised specifically to these important target groups with a co-ordinated approach in the local community. Effective treatment and care including reliable partner notification needs to be based on accepted best practice guidelines. Monitoring the efficacy of state-funded sexual health clinical services needs to involve consideration of the above.

As GPs offer a large amount of sexual health clinical care, it is important that they feel confident and competent to do so. General practice also needs to be more accessible to these high-risk groups and GPs needs to be better supported in order to offer appropriate sexual health care to all.⁴⁰⁻⁴² Sexual health constitutes only a small proportion of general practice.⁴³ It is therefore not often seen as a priority with an overwhelming workload of clinical situations seemingly more urgent and important. However, as Victorian GPs see 70% of all those under 25 every 12 months,⁴⁴ they remain in an ideal position to opportunistically provide sexual health care, especially with regards to prevention and screening of asymptomatic individuals.

2.6 Specific examples of existing models of sexual health clinical service delivery in Victoria

Currently, there are excellent models of sexual health clinical service delivery in Victoria which are truly accessible to individuals most at need.

In Geelong in the Barwon-South Western Region, Clockwork Young People's Health Service, is a youth service run by GPs.⁴⁵ It is a general youth health service, but youth sexual health needs are commonly addressed. This model supports the adolescent

health literature which suggests one-stop services of a multidisciplinary nature are the best way to engage young people.^{22,24}

In the Melbourne central business district (CBD), the FPV Action Centre works on a social model of health, offering a free drop-in service to young people under 25 for sexual and reproductive health issues.⁴⁶ This service was recently relocated and redesigned in consultation with youth groups to eradicate the barriers identified in the literature that make youth access to health services difficult.²⁴

The Centre for Adolescent Health Young Peoples Health Service, also known as Front Yard, is an outreach nurse-led primary health care service working from a social model of health in the CBD that targets homeless youth who have difficulty accessing mainstream services and so consequently have poor health outcomes, including sexual health outcomes.⁴⁷ This service is co-located with other services for young people, such as legal aid, social services and counselling. This model enables those young people most at risk to have sexual health issues addressed as well as being linked in with other services at the same time at no cost.

Outreach services have also been run successfully in Victoria by MSHC and FPV.^{46,48} MSHC provides an evening outreach sexual health service operating through Resourcing health & Education in the Sex Industry (RhED), a service specifically for sex workers working illegally and who have difficulty accessing mainstream services.⁴⁹ Establishing outreach services as accessible sexual health services for marginalised groups such as street sex workers is an accepted model of care well established over the last decade.⁵⁰ However, despite these services often seeing their priority as sexual health screening and reproductive health services, the demand is commonly for more basic health care such as wound dressings, infected access sites and trauma. It is important to recognise that street sex workers who may live very chaotic lives and often use illicit drugs may not see sexual health as their priority.⁵⁰ A sexual health service working alongside a primary health care service, or a health professional who can manage both may be more ideal in these situations.

FPV provides an outreach service in Shepparton after a local needs assessment identified that the large Iraqi community had difficulty accessing female GPs offering sexual health services. Furthermore, few GPs in Shepparton are bulk-billing. FPV also operates an outreach service for young people in the Cities of Casey and Wyndham. These services were recently established as a result of an identified need for youth-friendly accessible sexual health services. These services are modelled on a social

model of health and are aimed at making sexual health services truly accessible to those most at need.

School-based clinics have been shown to help eliminate some of the barriers such as cost and access for adolescents and so can be an important part of sexual health clinical service provision.⁵¹ A school-based clinical service has been established in a secondary school in the Yarra Valley in Melbourne's outer eastern suburbs. The service is run by a nurse and a GP, providing sexual and reproductive health services, education, and health promotion initiatives to enrolled students one lunchtime a week. This service was developed after the school nurse identified students were experiencing transport difficulties when trying to access local services after school.

In other parts of Victoria, where specific models may not exist, initiatives have taken place to raise the profile of sexual health in the local community. In Bendigo, a Sexual Health TaskForce has been developed from a Primary Care Partnership (PCP) Diversity Branch to raise the profile of the sexual health needs of the local community. Membership of this task force covers many disciplines, with the exception of general practice, although not through lack of trying. This may highlight that for many GPs sexual health is not a pressing priority given their daily workload of other urgent clinical issues. However, the presence of this task force has highlighted and championed the sexual health agenda in the region.

Providing services that are accessible to indigenous communities in Victoria is important as the Well Person Health Check demonstrated high STI prevalence in this group.⁵² This program, undertaken between 1999 and 2001 and involving 11 Koori communities in Victoria, screened for a number of health risk factors shown to be of local concern. Recommendations from the program suggested that better Aboriginal and Torres Strait Islander (ATSI) status data be recorded and amongst other things that indigenous workers be trained in sexual health and supported by the Victorian Aboriginal Community-Controlled Health Organisation Sexual Health Program. In addition, educational programs for indigenous youth in the juvenile justice system were recommended. These recommendations support previous Australian studies suggesting the optimal way to improve indigenous access to sexual health services is by the training and education of grassroots indigenous health workers with good links with mainstream services.⁵³ Other research has shown many individuals from different ethnic backgrounds may experience difficulties in accessing mainstream services. Suggestions to improve this have included better partnerships between services and the communities and culturally sensitive training for all staff, including administrative

staff as well as health professionals.⁵⁴ Training for staff providing sexual health services in Victoria needs to include clinical-based learning as well as issues of culture and ethnicity.

Outreach clinical sessions in sex-on-premises venues aimed at offering testing and treatment to clients in male-only saunas in Melbourne have demonstrated a high prevalence rate of STIs in this clientele.⁵⁵ However, screening participation rates have been lower than anticipated, so although such venues may be an ideal setting for outreach testing to control STIs, further work needs to be done to encourage client participation to make it more worthwhile.

All of these examples of accessible and appropriate sexual health clinical services in Victoria appear to be working well on an individual level. However, they work in isolation, are disparate and many of them are unaware of others operating with the same aims. Greater networking, liaison and shared funding arrangements together with formal memorandums of understanding may help with these issues. A liaison position in each region overseeing the focus of these services and ensuring they are working towards the same goals is likely to improve local networks and address some of the inequalities of care that currently exist.

2.7 The role of nurse practitioners in the provision of sexual health clinical services in Victoria

The nurse practitioner role extends current advanced nursing practice, and includes extensions to practice, such as prescribing medications, initiating diagnostic imaging and laboratory testing, approving absence from work certificates, referring to specialists, and admitting and discharging clients. The title of nurse practitioner (NP) can only be used by those endorsed by the Nurses Board of Victoria as a NP as a result of an amendment to the *Nurses Act 1993*.⁵⁶ Currently, there are four NPs working in different areas of clinical practice endorsed in Victoria. There are other nurses in Victoria currently working towards this endorsement. However, there are no NPs or nurses working towards this endorsement in the sexual health specialty of clinical practice. Other states in Australia have more NPs integrated into clinical service provision. An evaluation of NPs working from a primary health care facility in NSW involved mainly in the prevention, treatment and care of HIV/AIDS and other BBVs and STIs in a population of at risk clients in central Sydney demonstrated that NPs perform well with regards to effectiveness, professional appropriateness and acceptability in this setting.⁵⁷

Outside Australia, NPs have been integrated into routine clinical practice for many years. In one American study, NPs were compared to primary care physicians working in an outpatient setting, with the results demonstrating that there were no significant differences in health status or health service utilisation of patients seen by NPs compared to primary care physicians at 6 months and 12 months.⁵⁸ In many circumstances, NPs have been employed as a result of medical workforce deficiencies.⁴⁸ This is particularly relevant in countries with geographically isolated regions, such as Australia and Canada, and in specialties where low remuneration for and status of doctors (such as public health) may have an impact on recruitment of medical officers. The advantage of NPs, over other highly skilled nurses, is that although the aim of their role is not to be a doctor-substitute, they can provide very high quality and economical professional health care completely independently. In Australia, this may be a motivating force in areas where recruitment of doctors is difficult.

Within the specialty of sexual health, there are many examples of nurses working effectively and independently.^{34, 59} An English study compared the sexual health care of women presenting to a specialised sexual health service provided by nurses as opposed to that provided by junior doctors.⁶⁰ The care offered by nurses within this setting was as good as that offered by junior doctors, there were no serious clinical errors, and in many cases documentation in patient records by nurses was more complete than that from the junior doctors. Other studies have shown that patients often experience greater satisfaction when roles traditionally performed by doctors are performed by nurses trained in these procedures.⁶¹ In Victoria, there are currently many nurses involved in the delivery of sexual health clinical services outside of specialist sexual health services. Table 1 summarises the strengths and weaknesses of each nursing role, including that of the potential nurse practitioner, in the delivery of sexual health clinical services (outside specialist services) in the community:

Table 1: Strengths and weaknesses of nurses in sexual health clinical service delivery

| | Strengths | Weaknesses | Comments |
|--------------------------------|--|---|---|
| Nurse practitioners | <ul style="list-style-type: none"> • Independent • Proven effective & appropriate care in sexual health • Able to prescribe medication • More cost-effective than medical staff | <ul style="list-style-type: none"> • Expensive to employ (compared to other nurses) • Time in Victoria needed before an established significant workforce of sexual health NPs will be available | It is ideal for NPs to provide sexual health clinical services either situated within community health services, specialised sexual health services, or other allied specialised centres, such as youth centres or centres aimed at the care of IDUs. |
| Practice nurses | <ul style="list-style-type: none"> • Rapidly increasing workforce • Cost-benefits in general practice | <ul style="list-style-type: none"> • Employed by GPs and workload controlled by GPs and practice staff • busy with limited involvement in sexual health • Bulk-billing capacity of practice and clientele not controlled by nurses • Poor community networks and no real possibilities of having time to build on these | Practice nurses should ideally have a role in sexual health service delivery, especially if GPs they work with identify themselves as having a special interest in sexual health. Ongoing training and support could be combined with that offered to practice to keep the practitioners skilled and up to date in sexual health issues. There is also a possibility of advocating for a Medicare item number for Chlamydia testing as immunisation and wound management to enable nurses to see clients independently. |
| Community health nurses | <ul style="list-style-type: none"> • Situated in community health centres, which are probably ideal for sexual health clinical services for those most at risk and for those in the community most marginalised (indigenous and CALD communities) • Good community networks • Accessible through generic service • Well-established health promotion role as well as clinical service delivery | <ul style="list-style-type: none"> • May not have a doctor employed, so unless nurses can work independently or are nurse practitioners then they will have limited role | Community health centres are ideal locations for sexual health clinical service provision, especially in outer metropolitan, rural and remote areas of Victoria. |
| Secondary school nurses | <ul style="list-style-type: none"> • Good networks in community • Important liaison role | <ul style="list-style-type: none"> • No direct clinical service provision instead provide health promotion | Secondary school nurses need close links with clinical service providers. |

In summary, there is clear evidence that sexual health is a specialty where nurses can work independently, safely and effectively and with good patient satisfaction levels. The role of NPs in sexual health is likely to enhance the availability of effective and appropriate clinical services especially in those areas in Victoria where medical workforce issues are prevalent.

2.8 Professional development of sexual health clinical service providers in Victoria

Specialist services

Sexual health physicians and other specialists working within specialist centres for sexual health have CME requirements for their postgraduate affiliations that have to be maintained through appropriate educational updates.⁶² In addition, performance indicators for the specialist centres to some extent can monitor clinical standards and practice.

General practitioners in primary care

GPs provide sexual health services in general practice, but also within specialist sexual health centres. As GPs working within general practice are less likely to identify sexual health as a priority, it is this group who prove the most challenging with regards to the provision of education in sexual health.

There are many identified barriers for primary care staff in providing sexual health clinical services in general practice. As many of these are specific to the unique structure and system of primary care that exists in Australia, the Australian literature is most relevant.

Structural barriers

A study in Sydney highlighted many structural barriers that GPs face when testing for STIs in primary care. These GPs were practitioners involved in the care of HIV patients in the community and so were well aware and familiar with sexual health issues.⁶³ These barriers include anxiety about investigation by the Health Insurance Commission (HIC) and the Medicare 'three-test rule'. The HIC may investigate any practitioner whose practice and billings seem unreasonable. This may result in a fine, but even the investigation itself is enough of a deterrent to interfere with clinical practice. 'Screening' is not funded by Medicare and the confusion around what the definition of 'screening' covers adds to uncertainty around what can be funded in the Medicare system. The 'three-test rule' means if more than three tests are performed on the same day, the laboratory can only get reimbursed for a maximum of three of them. This means that

practitioners may have to confine their investigations to three tests or the laboratory has to agree to only get reimbursed for three, and accept the loss, even if more tests are done. The Australasian College of Sexual Health Physicians (ACSHP) recommends between four and seven investigations on MSM who are at risk of a sexually transmitted infection.⁶⁴ This mismatch between acknowledged best practice management and funding from Medicare creates a barrier to providing optimal sexual health care in general practice. This same study identified confidentiality of notifications and clinical time pressure as perceived barriers in providing sexual health to those presenting to general practice.⁶³ However, solutions to these difficulties were also identified in the study, including community education strategies to encourage MSM at risk of STIs to request testing in general practice, relaxation of the 'three-test rule', anonymity in notification of STIs, and a review of the HIC policy on screening. In addition, these GPs who were already working with high caseloads of HIV patients suggested that additional training in STI testing would be of benefit. An increased identification and treatment of gonorrhoea in this core group of men attending general practice is likely to have a positive effect on the prevalence of gonorrhoea and as a result potentially reduce the spread of HIV as well.⁹

Knowledge, attitudes and skills as factors influencing service provision

A study of 242 Victorian GPs who received an educational package on the identification and management of STIs in general practice and completed pre and post questionnaires demonstrated that the educational package produced an improvement in knowledge and self-reported practice of STI management. This type of initiative may therefore have the potential to help improve the control of STIs in Victoria.⁶⁵

Another study identified that female GPs were less likely than male GPs to report perceived embarrassment of the patient as a barrier to taking a sexual history in a related consultation such as performing a pap smear.⁴¹ This study also demonstrated that opportunistic sexual history taking was minimal in general practice. The lack of confidence in this area of clinical practice identified in this study is thought to be due in part to the small number of cases of STIs GPs see and the infrequent occasions when they feel they are able to raise the issues of sexual health opportunistically. This study supports a previous study which highlights that GPs feel their training and education is a barrier to sexual history taking.⁶⁶ Undergraduate medical training in sexual health is inconsistent and ongoing professional development in sexual health is not prioritised by GPs as many feel their practice does not include many patients who are at risk of STIs.⁴⁰ In addition, many GPs will never feel comfortable embracing sexual health as part of their core business.⁴¹ This means that it seems most likely that some GPs who have an

interest are likely to provide the majority of sexual health clinical services in primary care. These GPs need to be supported in a formalised manner if they are to provide evidence-based accessible services which will have a favourable impact on the control of STIs in Victoria.

A study which provided an educational package to a group of GPs in Sydney found that when this initiative was evaluated positive outcomes in self-reported confidence in dealing with sexual health issues and improved skills in the management of STIs were reported.⁶⁷ Earlier papers have also called for more education and training packages for undergraduates and postgraduate GPs in the field of sexual health.⁴² Patient acceptance of opportunistic sexual history taking in general practice may not necessarily confer with GPs perceptions. Certain inner-city practices in urban Australia may be seeing significant numbers of people from core groups who are at risk of STIs and BBVs and HIV.⁶⁸ This may not confer with GP perceptions that very few of their patients are at risk of STIs and HIV. This misperception is often cited as a barrier to opportunistic risk assessment in general practice.⁴⁰⁻⁴¹

In summary, there is much literature supporting the need for greater undergraduate and ongoing postgraduate education in sexual health for general practitioners. How this education is most effectively delivered and packaged within the current system of general practice in Australia has not yet been fully defined, but current evidence suggests there is a need for basic STI training if GPs are to be effective in offering clinical sexual health services in primary care. In addition to basic clinical skills training, education around who is at risk, how to make services accessible to these groups and how to be sensitive to cultural differences in this clinical area are also important in educational initiatives. Staff trained in issues specific to indigenous health may help improve access for ATSI's.⁵²

Other educational initiatives: an international overview

In the United Kingdom, it is acknowledged that if primary care physicians are to opportunistically screen for Chlamydia, training on whom, when and how to test as well as the possible consequences of Chlamydia infection is needed.⁶⁹ The success of the National Strategy for Sexual Health and HIV in the United Kingdom, which aims at improving sexual health with specific targets to reduce rates of STIs and unplanned pregnancies, is acknowledged to depend heavily on education and training in sexual health for those practitioners involved in the delivery of clinical services.⁷⁰ This strategy acknowledges that not all GPs will feel comfortable offering a complete range of sexual health services. Practitioners can therefore offer different levels of service. Level 1 is the most basic level of sexual health care and attendance at a nationally co-ordinated course

for two days, which covers knowledge, skills and attitudes to the management of STIs in general practice, is available for practice staff to attend. GPs that have a special interest in sexual health may opt to provide more in-depth services to their patients (Level 2). More in-depth training and continuing medical education for these practitioners is available through specialist sexual health services.⁶⁵

Models of GP education in other specialties

There are many successful models of GP education in Australia already in existence around other areas of clinical practice. The National Prescribing Service (NPS) is regarded as being one of the better models.⁷¹ The vision of this organisation is to be the most trusted source of independent information about medicines for Australians. The organisation works with many health professionals and allied health professionals as well as the general community. Good working relationships with local Divisions of General Practice enable local contact and education with primary care staff throughout Australia. NPS provides an easily negotiated website, downloadable fact sheets and a telephone helpline on all issues related to prescribing. Importantly, it is independent of the pharmaceutical industry and government. An evaluation of NPS has been ongoing since 1998 and demonstrates a high level of GP awareness of the program (>90%). Two-thirds of GPs who responded felt NPS was of moderate or great value in their clinical work. Evaluation concerning the behaviour of health professionals is not yet complete but is currently ongoing. It is a highly regarded and reliable educational initiative for GPs.

Sexual health support for GPs could be run through a similar model. A website, downloadable fact sheets and educational initiatives with a free phone number could be promoted. However, it is important this is well-respected, consistently promoted and easily used by GPs. One of the major issues is too much information and not knowing where to go for reliable, independent advice. A website similar to that of NPS, perhaps named SHV (Sexual Health Victoria), could provide such education. Simple support such as this would be enough to meet basic GP education needs. However, those GPs with a special interest in sexual health may use this site to access other educational initiatives such as courses, notification data and contacting partner notification officers. Websites of MSHC, ACSHP and FPV could provide such a service. However, a new website with close links to the others may be the most credible and could be launched and consistently promoted to enable GPs to provide best practice sexual health clinical services. This could be done with support from RACGP, ACSHP and Divisions of General Practice. A 1800 number for advice, educational activities, local visits from experts and fact sheets could all be linked through and provided by this website.

2.9 Performance indicators for sexual health clinical services

In order to reduce the period of infectiousness and so reduce the spread of STIs, prompt and easy access to appropriate services is vital.²⁻³ Other factors which will also reduce this period of infectiousness include effective partner notification, improved compliance with medication, screening and treatment of symptomatic STIs and possibly long-term antiviral treatment to reduce the spread of HIV and herpes simplex virus (HSV).⁷² If state-funded sexual health clinical services aim for the public health control of STIs, then they should be able to demonstrate they are providing a prompt and appropriate service to those most at risk of STIs.

Performance indicators for state-funded sexual health clinical services

Performance indicators that could be used in state-funded sexual health clinical services:

1. Length of time to be seen for an urgent problem (24-48 hours if symptomatic, high risk or contact of someone with a known STI);
2. Flexible appointment/drop-in/triage system demonstrating accessibility by those in the community who are most in need of the service;
3. Demonstration that core groups are accessing the service. This means data must reflect a significant proportion of clients are <25 years of age, ATSI, CALD communities, MSM, IDUs, Health Care Card holders and others with limited economic means such as travellers. This data must be a reliable record of ATSI status, in line with the standard of the Australian Institute of Health and Welfare and the Australian Bureau of Statistics;
4. Demonstration that those who currently have an STI are able to be seen in the clinic (Are those really at risk being seen or is the service only really accessible to those who are at low risk of STIs?);
5. Consumer satisfaction (Percentage of patients satisfied with the service and ability to feedback on areas for improvement in the clinic);
6. Partner notification;
7. Incorporation of best practice guidelines into clinical service provision;
8. Ongoing professional education on a regular basis for all staff to include local networking and case discussion.

Performance indicators for sexual health clinical services delivered in general practice

Performance indicators for sexual health clinical services delivered in general practice could include:

1. Patient demographics including ATSI status. This data should be collected according to those standards set out by Australian Institute of Health and Welfare and the Australian Bureau of Statistics;
2. Time waiting to get an appointment for those with an STI or contacts of an STI-infected person;
3. Percentage of notification forms with complete data;
4. Partner notification;
5. Consumer satisfaction in accessing general practice for sexual health clinical services.

International performance indicators

This review is concerned with the role and accessibility of services in the control of STIs in Victoria and so this literature is concentrating on performance indicators and outcomes for these services. In the United Kingdom, as part of the National Strategy for Sexual Health and HIV, standards and targets have been set for sexual health clinics to work towards.¹⁸ These include reducing the rates of many STIs and the number of unplanned pregnancies in at risk groups. The idea of using targets as performance indicators is controversial as it may be too crude an instrument to identify difficulty in access to services, which is a key component of optimal sexually transmissible disease control.

The literature supporting this review of sexual health clinical services in Victoria highlights the importance of access for the core groups of individuals most at risk of STIs. Education for all practitioners involved in the delivery of services is important not only in clinical standards but in addition around access issues and ethnicity and cultural issues of those groups most at risk. Nurses play an important role in the delivery of sexual health clinical services. However, in Victoria this role has not been fully exploited. General practitioners provide the majority of sexual health clinical services and need ongoing support and education in order to provide best practice care. In addition, structural support and changes are needed to enable GPs to offer accessible appropriate services especially in more isolated regions. Performance indicators for state-funded sexual health clinical services need to be consistent and reflect, amongst other things, ease of access to services for those core groups most at risk of STIs. Although overall access to services is good in Victoria, rising rates of Chlamydia, particularly in young women, and gonorrhoea in MSM indicates there is room for improvement. Where and how this improvement should occur is addressed in the review.

CHAPTER 3: METHODODOLOGY

In order to obtain a complete understanding of sexual health clinical service delivery in Victoria, the review methodology was predominantly qualitative in nature. Qualitative research methods are often used in research where little is known about the issue being explored⁷³ and so were more appropriate for this review given it was the first of its kind in Victoria. Interviews and focus groups were the methods used to collect data from three groups of participants: The first group consisted of representatives from the six state-funded sexual health services, whilst the second group, key informants, included health professionals, academics and sexual health experts. The third group included representatives from general practice, youth health services, community health centres, drug and alcohol services, indigenous health services, secondary school nursing program, and university health services. All review participants are listed in Appendix 1.

3.1 State-funded sexual health services

Currently, there are six services or clinics located across Victoria that are specifically funded by DHS to provide sexual health clinical services to the community. A representative from each service initially completed a structured survey containing open and closed-ended questions about service dynamics such as facilities, performance indicators, clinic opening hours, waiting lists, workload, number of staff employed and their qualifications, and staff roles and responsibilities (see Appendix 2). Subsequent to the completion of the survey, representatives participated in an interview to discuss professional and infrastructure support, treatments provided, populations treated, and policies on screening and confidentiality.

3.2 Key informants

Semi-structured interviews were conducted to obtain expert or specialised perspectives from key informants identified using established selection criteria. The selection criteria were:

- A health professional for whom sexual health clinical service delivery is a significant or major part of their business;
- A health professional recognised by consumers, other health professionals or the key informant as a provider of sexual health clinical services;
- A sexual health expert or academic with a professional interest in the delivery of sexual health clinical services;

- A representative from a professional association for service providers or health professionals involved in or perceived to be involved in the delivery of sexual health clinical services;
- A health or community professional with expertise or knowledge about the delivery of sexual health clinical services to special needs groups or communities.

A total of 17 key informant interviews were conducted with 18 key informants. An interview schedule was devised, covering the following themes: the state of sexual health clinical service delivery in Victoria, access to sexual health services, intersectoral collaboration, performance indicators/outcome measures, professional development, and suggested improvements (see Appendix 3).

3.3 Service providers

Focus groups were conducted with service providers from each DHS region, either face-to-face or by telephone. Only service providers who were identified as playing a role in the prevention, diagnosis or treatment of STIs and/or the prevention and diagnosis of BBVs were invited to participate. The following service providers participated: GPs (through Divisions of General Practice), secondary school nurses, and representatives from community health centres, youth health services, indigenous health services, women's health organisations, drug and alcohol services, university health services, pregnancy termination clinics, and hospital clinics. Ten focus groups were held with 46 service providers.

Service providers unable to participate in the focus groups were invited to complete a written submission based on the same questions asked in the focus groups. A total of 11 written submissions were completed. The same themes discussed with the key informants were also raised with the service providers (see Appendix 4). In total, 57 service providers from across Victoria contributed to the review. Table 2 provides a breakdown of service providers by region, type of service, and profession.

Table 2: Service provider overview

| Service provider characteristics | N (n=57) |
|---|-----------------|
| Region: | |
| North and West Metropolitan | 15 |
| Southern Metropolitan | 8 |
| Loddon Mallee | 8 |
| Barwon-South Western | 7 |
| Grampians | 6 |
| Gippsland | 6 |
| Eastern Metropolitan | 5 |
| Hume | 2 |
| Type of service: | |
| Community health centre | 21 |
| Secondary school nursing program | 11 |
| Sexual health service | 6 |
| Drug and alcohol service | 4 |
| Other* | 4 |
| University health service | 3 |
| General practice | 3 |
| Indigenous health service | 2 |
| Youth-specific health service | 2 |
| Hospital | 1 |
| Profession: | |
| Medical practitioner | 7 |
| Nurses | 46 |
| Other** | 4 |

* Includes pregnancy termination clinics and women's health organisations

** Includes administrative and managerial personnel

3.4 Statistical or other analyses

The small number of surveys completed by representatives from the state-funded sexual health services (n=6) meant that the quantitative data collected was not significant. Instead, discourse analysis was used to examine the completed surveys and interview data. Key informant interviews and service provider focus groups were recorded and transcribed. QSR NVivo, a software package designed to assist in the organisation and coding of qualitative data, was used to determine the key issues under each theme emerging from the data.

3.5 Reference group

In order to ensure the independence of recommendations found in this report, a reference group was established. The reference group consisted of health professionals, medical, nursing or allied health, from various types of services currently involved in the delivery of sexual health clinical services in Victoria, and representatives from relevant professional associations or committees (see Appendix 5). The purpose of this reference group was to assist in the analysis of review findings and contribute to the development of recommendations.

3.6 Limitations

The review has a few limitations that need to be considered when interpreting the results. First, consumers who used sexual health clinical services were not consulted during the review. Consumer input was considered when developing the review's methodology, but the scope of the review did not allow for it nor did the time and funds available. Further exploration of consumers' experiences in accessing sexual health services in Victoria is needed.

Integral to the review process was involvement of the six state-funded sexual health services; however, difficulties were experienced in contacting representatives from several of the services. The limited opening hours and availability of these services, with most open for only one session a week, could explain the difficulty in making contact with a service representative, but there also seemed to be service disinterest in the review. The data collection process was complicated further by the lack of information provided by service representatives.

Attempts were made to ensure an equal representation from service providers across all Victorian regions. However, some regions were better represented than others, with the North and West metropolitan region best represented and Hume region the least. More research, including a service mapping exercise in each region to determine which individuals and agencies provided sexual health clinical services, would be beneficial.

Efforts were also made to ensure that GPs were involved in the review given that the majority of STI notifications come from GPs. However, the majority of service providers were nurses, possibly skewing the results. Further research exploring the GP perspective on their role in sexual health clinical service delivery may contribute to the review's findings.

CHAPTER 4: FINDINGS FROM STATE-FUNDED SEXUAL HEALTH CLINICAL SERVICES

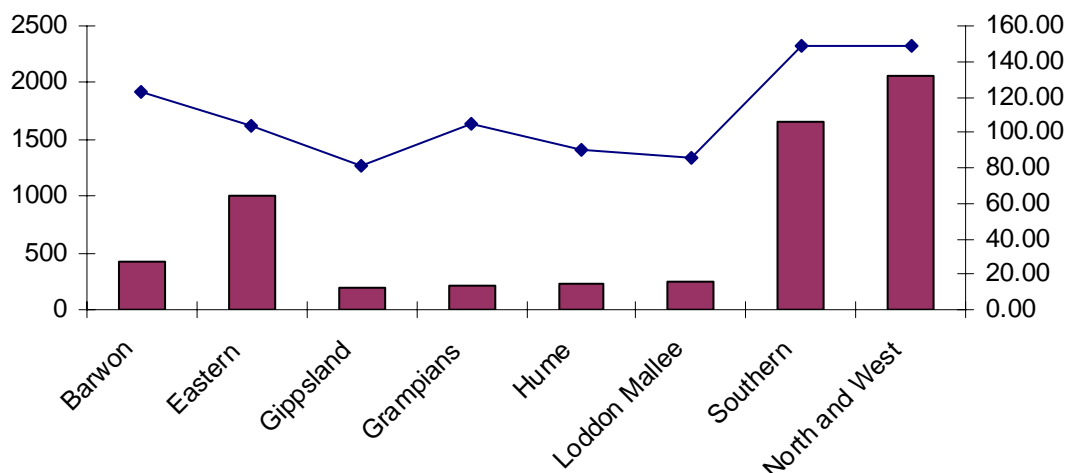
This chapter provides a comprehensive overview of the six state-funded sexual health clinical services in Victoria.

4.1 State-funded sexual health clinical services in Victoria

There are eight DHS regions in Victoria. Three of these are in metropolitan Melbourne (Southern, Eastern, North and West) and five are in non-metropolitan Victoria: Hume, Grampians, Loddon Mallee, Gippsland and Barwon-South Western. There is one state-funded sexual health clinical service in metropolitan Melbourne, MSHC. In non-metropolitan Victoria each of the five regions has a state-funded sexual clinical health service. The Hume region has a service in Wodonga, the Gippsland region has a service in Traralgon, the Barwon-South Western region has a service in Geelong, the Loddon Mallee region has a service in Bendigo and the Grampians region provides a service in Ballarat.

STI notification rates vary greatly for each region. The majority of notifications are from the metropolitan regions particularly the Southern and North and West regions (see Figure 1). The sexual health clinical services provided in these regions also differ with regards to the amount of funding received, the hours of service provided, level of accessibility to the local population, and the focus of the clinical service provided. There appears to be little relationship between the amount of DHS funding each clinic receives and local prevalence rates or other indicators of need. However, despite these differences, there is some commonality to the themes that have come out of this review, looking at the reported clients that clinics provide services to and the barriers faced in providing these services.

Figure 1 Notifications of *Chlamydia Trachomatis* in each region of Victoria for 2003



Metropolitan Melbourne (North and West, Southern, and Eastern regions)

The 2003 estimated resident population for the three metropolitan regions of Victoria was 3,560,157 persons. The state-funded sexual health clinical service for the three metropolitan regions is Melbourne Sexual Health Centre (MSHC) and receives base funding from DHS of \$4,993,000 (funded exclusively by DHS for clinical STI services) on a recurrent basis. This centre provides a sexual health clinical service five days a week (four mornings and five afternoons) with after hours availability (one evening a week). Both doctor and nurse sessions are offered, with nurses working in an extended role and able to perform some investigations and some treatments autonomously.

The centre also operates a telephone information service and is accessible to those most at risk of STIs through the provision of a drop-in service triaged by nurses prioritising those at highest risk. Outreach services to those at particularly high risk such as MSM attending sex-on-premise venues and street sex workers are also provided. These services are advertised in the local press and via other media outlets. Contact tracing is assisted by the centre through the index case contacting their contacts, or by the use of the DHS contact tracers. Services are free to users, so a Medicare card is not required for consultations or pathology services, and medication is free of charge to clients. Medication is dispensed by the centre’s pharmacy. Most microbiology tests are performed on the premises and are paid for in-house. Interpreters are available and used during consultations at no cost to the user, for those clients from CALD backgrounds. The centre is housed in its own building, clearly sign-posted and local parking is available. It is also easily accessed by public transport with additional access for those with a disability. A patient with an urgent problem can be seen within 24 hours.

The centre has a website specifically directed towards supporting GPs in the management of STIs and a freecall 1800 number for GPs that is manned by a sexual health physician. Courses in sexual health are also provided by the centre, courtesy of its link with the School of Population Health at the University of Melbourne. These courses are attended by many health professionals from medical and allied health disciplines working in sexual health. A memorandum of understanding (MOU) exists between MSHC and the Victorian Aboriginal Community-Controlled Health Organisation (VACCHO). This MOU has successfully promoted effective collaboration between the two organisations, increasing accessibility to MSHC for those from indigenous communities (personal communication VACCHO). Data from MSHC is collated and provided to DHS reflecting patient numbers attending (including number of visits), notifications of STIs and patient satisfaction figures. Data is current and easily accessed.

In order to direct funding exclusively to those in the community most at risk of STIs, the centre moved to a drop-in rather than an appointment system in August 2001. This was an attempt to increase access for those clients who were symptomatic, contacts of known STIs or others assessed on the day to be at high risk of an STI. Prior to this date, new clients had to wait 2-3 weeks for an appointment. From August 2001, with the new 'drop-in' system clients were triaged by a trained sexual health nurse according to a symptom-based triage protocol and either referred into the clinic to be seen on the day or referred on to a more appropriate service if not assessed to be in need of a sexual health clinical service. Clients now are seen on the day they present, reducing the period of infectiousness and so hopefully the spread of STIs. Since this change to the appointment system, the centre has seen an increase in the number of men with Chlamydia, the number of men and women with herpes, the number of investigations for bacterial STIs and an increase in the proportion of clients who are younger and less likely to report condom usage. Although in addition to the changes in the appointment system, other factors may have influenced these differences observed in rates of STIs and demographics of the clientele, it seems likely that this improvement in access via 'drop-in' has played an important role in enabling those who need treatment to access the service. DHS funding to this metropolitan service seems to be directed to those most in need.

In the last 12 months, 5958 new clients accessed the centre, out of 9930 clients in total, with 23,567 visits in the last twelve months. Ninety to ninety-five percent of clients self-referred, with the remainder of the clients referred by GPs.

Barwon-South Western Region

Of the non-metropolitan regions, Barwon-South Western region has the highest rate of Chlamydia notifications, with 122 notifications per 100,000 persons. The estimated resident population in 2003 for Barwon-South Western was 347,289 persons. Barwon Health provides the state-funded sexual health clinical service in this region through an outpatient clinic at Geelong Hospital. Barwon Health receives \$72,057.50 per annum from DHS for the provision of sexual health clinical services. However, this funding only covers the rental for premises and for some pathology services while the hospital and Medicare pay the salary of the nurse and medical practitioner respectively. The service provided operates for approximately six hours a week and all of the clinical time is spent performing clinical duties, with no time allowed for research, administration teaching or support for local GPs. There is no facility for after hours consultation nor is there an emergency contact number. The clinic itself operates on a drop-in basis, as there is no infrastructure support for making bookings. Clients are bulk-billed for attending the clinic. Clients therefore need a Medicare card to access the clinic.

The clinic itself is located in a rundown and cramped facility within the hospital grounds, but the hospital itself is situated in the heart of Geelong and well-served in terms of parking and transport options. Other health practitioners are needed for the service, but the lack of space would not accommodate extra staff. The clinic facilities are shared by the pain clinic and social work services, so there may be a mixture of different clients in the waiting areas which potentially compromises confidentiality. There are issues with anonymity as this part of the hospital is old and dilapidated and privacy during the consultation cannot be assured. In the last 12 months, 500 clients attended the clinic, of which 230 were new clients. Ninety-eight percent of clients self-referred to the service. There is no current infrastructure to support any development of the service.

Hume Region

In 2003, the Chlamydia notification rate for Hume was 89 notifications per 100,000 persons and the estimated resident population was 256,727 persons. Wodonga Regional Health Service provides the state-funded sexual health clinical service for the Hume region. It receives \$58,271.25 per annum from DHS which only covers clinic rental and some secretarial support. The clinic itself, which is open 9am-5pm Tuesdays and Thursdays, is staffed by one medical practitioner and receives additional funding from other sources for nursing support, as the DHS finding is insufficient to cover nursing costs. No money is available for the provision of sexual health clinical services, pathology or pharmacy and there are no resources for STI screening. There is no provision for after

hours information or telephone consultations. Contact tracing is provided, and usually carried out by either the index case, or the clinic with permission from the index case. DHS contact tracers are rarely used by the service. There is an acknowledged difficulty in providing an adequate service.

The medical practitioner providing the service feels professionally isolated, with very few links between the clinic, other local services or metropolitan services, although the service is promoted through secondary school nurses as a place young people can access for sexual health issues. The medical practitioner feels that she is not able to meet the sexual health needs of the community, in that at times people seeking sexual health clinical services are turned away due to the lack of resources. There are no facilities for expansion of the service or the capacity to do large scale screening.

In the last 12 months, 480 clients accessed the clinic, with 379 of these new clients. Eighty-two percent of clients self-referred with the remainder being referred by GPs. The majority of clients (96%) were female, with approximately 45% of clients aged under 25. Approximately 2% of clients seen identified as ATSI. No information was available about the numbers of MSM, IDUs or sex workers accessing the clinic.

Grampians Region

In 2003, the Grampians region had a Chlamydia notification rate of 104 notifications per 100,000 people and the estimated resident population was 211,165 persons. Ballarat Community Health Centre receives \$55,869 per annum from DHS, providing the only state-funded sexual health clinical service for the region. The service operates two days a week, offering both drop in facilities and appointments. Local GPs are employed to provide clinical services, with a total of 3-4 sessions available a week. Two nurses are also available to take phone calls or provide consultations. However, the staff feel that the role of the nurse could be extended to nurse practitioner level in order to perform screening of asymptomatic clients, treat warts, and prescribe under protocol direction, thereby improving service delivery.

In the last 12 months, 3500 clients accessed the centre, of which 900 were new clients. The majority of clients seen were females (88%), and approximately 65% of clients were under 25. Approximately 10% of clients were MSM. Very few clients were identified as IDUs or ATSI, although 75% of clients were Health Care Card (HCC) holders. About 90% of clients self-referred to the clinic.

Loddon Mallee Region

In 2003, Loddon Mallee had a Chlamydia notification rate of 85 notifications per 100,000 persons, and an estimated resident population of 298,903 persons. Bendigo Community Health Centre receives \$49,577.49 per annum from DHS for the provision of sexual health clinical services. The centre is the only provider of such services for the region. Only one half-day session a week is available. Bendigo Community Health Centre is housed in its own building, which is well-signed, close to public transport and easily accessible for clients with a disability.

In the last 12 months, 292 clients visited the centre, of which 140 were new clients. At least 90% of clients attending self-referred and more than 90% of clients were female with 70% of clients under 25. Very few clients (less than 5%) were identified as ATSI or IDUs, although about 80% of clients are HCC holders. It is felt that there is a role for the nurse practitioner within the centre, specifically with the screening of asymptomatic clients, treatment of warts and prescribing under protocol direction. Responsible staff at Bendigo Community Health Centre was unable to provide detailed clinical information for the review as they have no physician in post. The post has been vacant for more than two months and there is no immediate prospect of filling it.

Gippsland Region

In 2003, the estimated resident population for the Gippsland region was 242,980 persons, and the region had a Chlamydia notification rate of 80 notifications per 100,000 persons. La Trobe Regional Hospital, situated outside of Traralgon, provides the only regional state-funded sexual health service, attracting \$26,861 from DHS. The service is provided in the form of an outpatient clinic from 5-7pm on Tuesday afternoons. One medical practitioner and one nurse staff this service. Given the location of the service in the regional hospital, there are issues around accessibility, especially for clients who have limited or no access to their own transport. Confidentiality is another issue.

Over the last 12 months, 80 clients accessed the service, although it is unknown how many of these were new clients. There have been approximately 160 total visits and all of these clients self-referred. Fifty percent of clients were male and fifty percent female. Approximately 50% of clients seen were under 25, with about 25% of clients identified as MSM, 10% IDUs and 5% commercial sex workers. It is unknown how many clients were identified as ATSI.

Table 3 summarises the characteristics of all state-funded sexual health clinical services. Figure 2 displays how regional Victoria is divided by DHS into five areas, with three

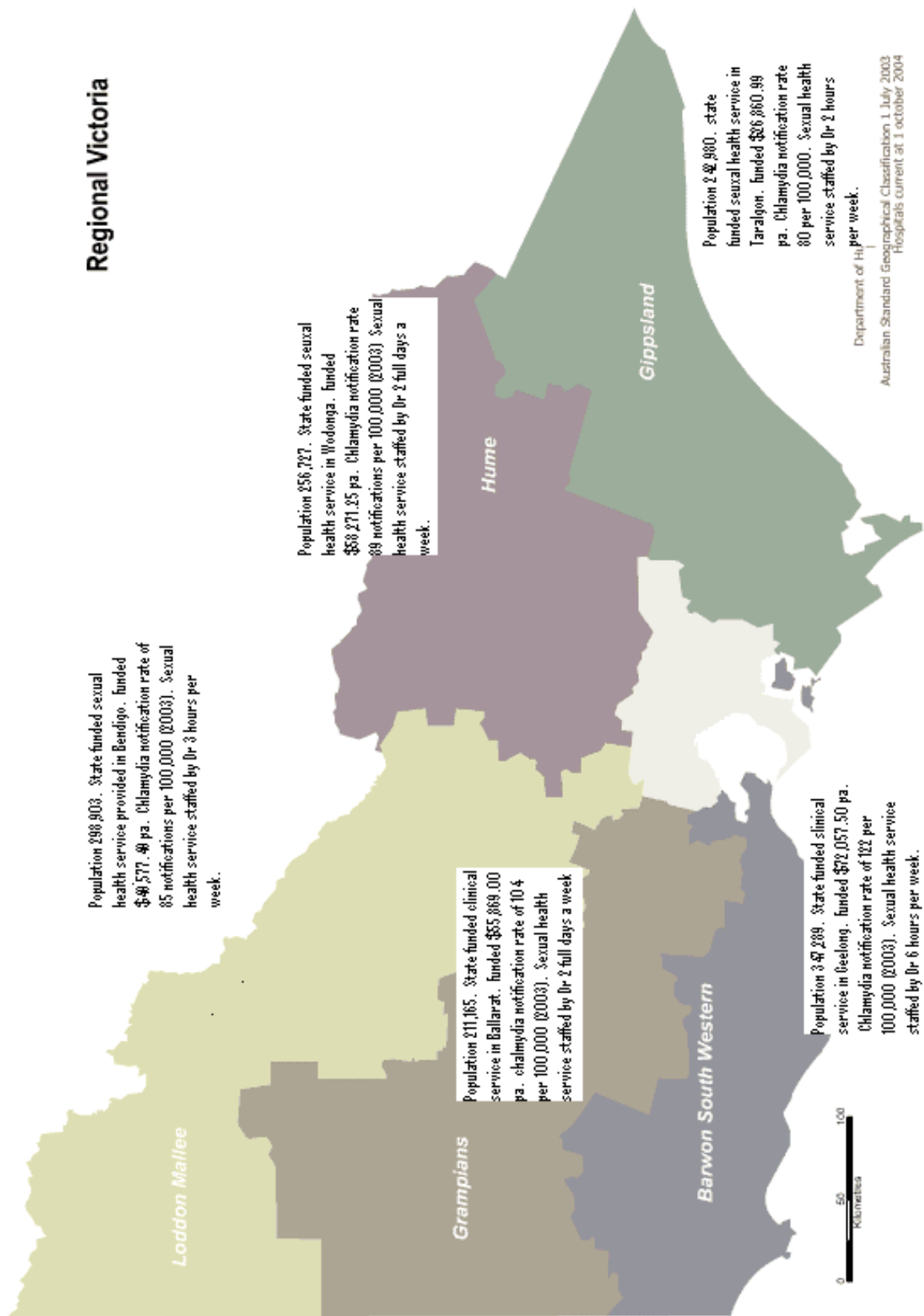
additional areas falling within the boundaries of metropolitan Melbourne. The map provides a brief summary of sexual health clinical service delivery in each region, including population, allocated funding and the Chlamydia notification rate for 2003.

Table 3: Characteristics of state-funded sexual health clinical services

| | MSHC (metro) | Gippsland | Grampians | Barwon-South Western | Loddon Mallee | Hume |
|--|---|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| Funding from DHS per year (\$) | 4,993,000 | 26,861 | 55,869 | 72,057.50 | 49,577.50 | 58,271.25 |
| Population of region (2003) | 3,560,157 | 242,980 | 211,165 | 347,289 | 298,903 | 256,727 |
| Chlamydia notification rates per year per 100,000 by post code of residence (2003) | 131 | 80 | 104 | 122 | 85 | 89 |
| Opening hours staffed by Drs a week | 5 full days and 1 evening | 2 hours a week | 2 full days a week | 6 hours a week | 3 hours a week | 2 full days a week |
| New pts seen each year | 5,958 | 80 | 900 | 230 | 140 | 379 |
| Total pts seen each year | 9,930 | 80 | 3500 | 500 | 292 | 480 |
| Total no visits in year | 23,567 | 160 | Unknown | Unknown | Unknown | 2160 |
| Appointments or drop in | Drop in & appointment | Drop in | Drop in | Drop in | Appointment | Appointment |
| Medicare Card required | Free at point of access and no need for Medicare card | Medicare card needed: bulk-billed | Medicare card needed: bulk-billed | Medicare card needed: bulk-billed | Medicare card needed: bulk-billed | Medicare card needed: bulk-billed |
| Free investigations (bulk billed or not charged) | Free | Bulk-billed | Bulk-billed | Bulk-billed | Bulk-billed | Bulk-billed |
| Free treatment | Yes | No | No | No | No | No |
| Waiting time to be seen if urgent | 24 hours | Unknown | Unknown | Unknown | 2 days to 1 wk | <48 hours |
| Qualifications/ specialisation of Drs in the clinic (SHPs, ID physicians, GPs) * | SHPs, ID physicians, GPs Visiting specialists | GP | GP but no one in post | GP | GP | GP |
| Collaboration with other services | VACCHO formally | No | No | No | No | No |
| % clients who self-refer | 90-95 | Unknown | 90 | 98 | 90 | 82 |
| % of clients < 25 | Unknown | 50 | 65 | Unknown | 70 | 45 |
| % of clients MSM | 20 | 25 | 10 | Unknown | Unknown | Unknown |
| % of clients ATSI | Unknown | Unknown | Unknown | Unknown | < 5 | 2 |
| % of clients IDUs | Unknown | 10 | Unknown | Unknown | < 5 | Unknown |
| % of clients HCC | Unknown | Unknown | 75 | Unknown | 80 | Unknown |

* SHPs = sexual health physician; ID physician = infectious disease physician; GPs = general practitioners

Figure 2: Sexual health clinical service delivery in regional Victoria



4.2 Discussion

There is a marked distinction between metropolitan and non-metropolitan state-funded sexual health clinical services. Whilst it is acknowledged that there is a large difference in funding between metropolitan and non-metropolitan services, it is also evident that metropolitan services have made vast efforts to make their services accessible and appropriate for those most at risk of STIs. There is little evidence that these initiatives have taken place outside Melbourne. However, the general impression from these non-metropolitan services is that their funding does not allow them to do this, with the amount of funding varying across regions (\$26,861 p.a for Gippland to \$72,057.50 p.a). There is generally a feeling of isolation and acknowledgement that they do not receive enough support to provide an appropriate service to those most at risk.

As a result of funding discrepancies across the non-metropolitan regions, the range of services provided varies. The service provided in the Gippsland region (with a Chlamydia notification rate of 80 per 100,000), which receives the least amount of funding of all the regions, is run out of Latrobe Regional Hospital, providing only two hours of direct services per week. It is staffed by one doctor and one nurse. As the infrastructure for the service is provided by the hospital and the doctor bulk-bills Medicare for a salary, it is unclear as to where the money is being spent. By comparison, the non-metropolitan region that receives the most amount of DHS funding for sexual health clinical services (Barwon-South Western, \$72, 057.50) also only provides up to six hours of clinical service per week on a drop in basis while also being supported by infrastructure within the Geelong Hospital. However, the rate of notification in this region is highest of all non-metropolitan regions (122 per 100,000).

All regions provide a sexual health clinical service. However, they provide one point of service that is unable to provide comprehensive services to the entire region. In the case of Barwon-South Western, Grampians and Loddon Mallee regions, the services are located on the Melbourne side. In contrast, in the Hume region the service is located in Wodonga on the New South Wales side. In the Gippsland region, the service is located centrally in Traralgon.

Interviews with representatives from the non-metropolitan state-funded sexual health clinical services revealed that the services are stretched and often unable to provide a comprehensive sexual health service to their local communities. There is little opportunity to extend their services beyond their immediate community, leaving large parts of each region with no local service. There is little evidence that at risk groups are being appropriately targeted in these regions. There also appears to be an almost

universal problem of staffing the clinics with appropriately trained doctors in regional areas. Clinical staff currently employed also report a lack of ongoing support and professional development. However, a professional task force has been established in the Loddon Mallee region and has been proactive in placing sexual health on the public health agenda and assessing local needs with regards to sexual health services. This has evolved due to the commitment of health professionals with an interest in sexual health. The participation and acknowledgement of the wider community appears to be vital in this initiative.

There are particular difficulties with infrastructure support for those clinics unable to work within a community health centre setting. All centres reported that they provide contact tracing for all STIs but use DHS-funded contact tracers very little. No regional centre is able to provide a telephone line for information or an out of hours telephone advice service of any kind. Only MSHC is able to provide an after hours telephone service or a within hours telephone consultation service, although the service in the Grampians region (Ballarat) does have some provision for nurses providing counselling and advice over the phone during working hours. All services that completed the questionnaire supported the idea of a nurse practitioner becoming part of their clinical service delivery team.

STI notification rates are highest in metropolitan regions as demonstrated by the place of residence of those infected. However, many individuals treated in metropolitan services may live outside metropolitan areas. Central services rather than local may be used for many reasons including the perception of services being better in a larger centre, anonymity, concerns around confidentiality, and also ease of access owing to better public transport links and longer opening hours in Melbourne. Consumer input was not possible for this review, so the reasons why people choose to use which service is an important consideration when making decisions about service provision. Notification data kept by DHS is recorded by place of residence. However, data also on 'where notified' should be available through laboratory notifications. Analysis of these two data sets may help assess the differences between place of residence and the region of notification, though this is outside the scope of this review. This analysis may help assess the number of people travelling from their local area to another region to access a sexual health clinical service and hence clarify consumer opinion about services.

The purpose of state-funded sexual health clinical services does not seem to be apparent to those providing services nor to other providers in the community. Their specific purpose and role is not well understood. Whilst the control of STIs is an ultimate goal, this will not be achieved unless these services enable those most at risk of STIs to access

their services. Metropolitan services have addressed these issues and have a well-established model of service delivery which appears to enable those most at risk to access clinical care. The fact that regional centres have not necessarily addressed these issues is reflected in the lack of data from many services which should indicate those individuals most at risk have used the service. This data is either not readily available or not actually recorded, so in some services, the figures reported are approximate.

There were difficulties for many of the services in providing the basic data requested for the review. This was sometimes thought to be due to lack of data and other times thought to be due to a general lack of interest and commitment of the services in providing this information. There did not appear to be a strong working relationship between the services and DHS. This was felt to be due to a feeling of a lack of support and involvement from DHS.

It seems unlikely that state-funded sexual health clinical services can effectively be the sole providers of sexual health clinical services in Victoria. DHS needs to acknowledge GP involvement in the provision of services and provide support for collaborative partnerships between GPs and state-funded sexual health clinical services. One solution to this is to create a GP liaison position at DHS to be responsible for the co-ordination of state-wide sexual health clinical services. This position could create networks within each region, establish training and support for all GPs and their staff, and act as a link between all state-funded sexual health clinical services and DHS. In addition, support to GPs via nurse-led clinical care would need to come through DHS with support for practice nurse involvement in sexual health.

During the review and its wide consultation process it seemed that most participants (key informants and service providers) felt that GPs were the major providers of sexual health clinical services in Victoria. However, this view is not held by the vast majority of GPs themselves who often do not acknowledge sexual health as a priority for their practices. GPs feel overworked with their current workload and if GPs are requested to deliver sexual health clinical services, there is a need for incentives and support for this within the current system. There is a general feeling that state-funded sexual health clinical services need to exist and work alongside GPs (whether in private general practice or community health) in order to offer accessible services to those most at risk of STIs and those who find it difficult to access mainstream services. GPs, whilst acknowledged by most to be very important in the control of STIs, are currently disadvantaged in providing STI services as they have no professional relationship with the State Government. They see themselves as supported by Federal Government and State Government provides no

support to them to provide sexual health clinical services. This must change if GPs are expected to increase their role in the provision of sexual health clinical services. If this is to be the case, financial incentives and professional development support needs to be offered to GPs by the State Government to enable them to prioritise sexual health clinical service delivery in their practices.

DHS also needs to acknowledge the importance of nurses in sexual health clinical service delivery in Victoria by supporting and encouraging the establishment of a viable workforce of nurse practitioners in sexual health. In addition, continued training in sexual health needs to be offered and supported by DHS to practice nurses, community health nurses and secondary school nurses. A liaison nurse in each region would be important with regards to co-ordinating services and enabling nurses to work together effectively. Support for practice nurses must also involve the GP who employs the practice nurse.

Standardised performance indicators demonstrating accessibility to those most at risk of STIs also need to be established and monitored for all state-funded sexual health clinical services.

CHAPTER 5: FINDINGS FROM INTERVIEWS & FOCUS GROUPS

This chapter provides findings from key informant interviews and service provider focus groups. The following topics are presented:

- Current state of sexual health clinical services in Victoria;
- Key sexual health issues and needs;
- Strategies utilised to address sexual health issues and needs;
- Access to sexual health clinical services;
- Barriers to sexual health clinical service delivery;
- Performance indicators;
- Professional development in sexual health;
- Suggested improvements to sexual health clinical services.

Findings from key informants and service providers are presented together, collectively referred to as participants, but any differences in views are highlighted.

5.1 The current state of sexual health clinical services in Victoria

Overall, participants highlighted the inadequacies of existing sexual health clinical services, stating that these services were not resourced to cater for the population. Service delivery was considered ad hoc and fragmented, with a limited number of services, lack of funding and an insufficient sexual health workforce cited as factors contributing to less than optimal service delivery. Rural-based service providers in particular were less than satisfied with their local state-funded sexual health service, which in rural regions was open from a few hours to a couple of days a week and largely inaccessible due to poor location, geographically and physically. More specifically, some rural-based service providers agreed that one state-funded sexual health service per region was not enough given the size of the region, nor was it appropriate to locate the service at the rear of the local hospital. Service providers from the outskirts of metropolitan regions were also concerned at the lack of services available in their area, where GPs were the only choice for sexual health care.

Many participants recognised GPs as the main providers of sexual health clinical services, with some suggesting this contributed to the accessibility of STI screening and treatment. On the contrary, rural-based service providers disagreed, stating that the decline of bulk billing in rural general practice meant that sexual health care was out of

reach for many consumers. Despite suggestions that GPs were insufficiently trained or supported to manage sexual health issues, screening for STIs infrequently, many participants agreed that GPs should remain the main providers of sexual health clinical services.

The strengths of metropolitan-based sexual health clinical services were highlighted during the consultation. Some key informants and those service providers operating in inner metropolitan Melbourne agreed that this particular geographic location was well resourced with specialist services such as the state-funded Melbourne Sexual Health Centre and the Action Centre, a youth-specific sexual health centre. These services were regarded as accessible, comfortable, and non-judgemental facilities that consumers found satisfactory.

Participants also provided feedback on the state of sexual health clinical services for special needs groups, including young people, MSM, sex workers, IDUs, indigenous and CALD communities (including refugees and new arrivals), citing the lack of services specific to most of these groups as an issue. Of all the special needs groups, young people were singled out most often as having few options to access services, particularly in rural and regional areas where there were fewer GPs. On the contrary, men who have sex with men, especially those based in or near inner metropolitan Melbourne, had access to several gay-friendly practices delivering sexual health and HIV-related services. However, it was suggested that the rising notifications of gonorrhoea, syphilis and HIV in this group could be an indication that there were insufficient services to cater for this population, or that more needed to be delivered.

Whilst some key informants commended the services currently available for IDUs and sex workers, such as the needle and syringe exchange program and the Melbourne Sexual Health Centre respectively, these groups also had few choices for sexual health care. The main issue affecting service delivery to the indigenous community was the lack of workforce, with only two sexual health workers in community-controlled organisations, neither of whom serviced rural areas. Meanwhile, sexual health clinical services for CALD communities were still being developed, and although the network of services was good, only some of these were culturally aware and responsive.

5.2 Key sexual health issues and needs

Sexual health issues that had been addressed well were discussed during key informant interviews, with many agreeing that HIV/AIDS had been addressed well in Victoria and Australia, particularly with regards to prevention, service access, treatment, and

research. Of particular note, the specialist services, including high caseload general practices catering for men who have sex with men, were commended. Whilst many key informants and service providers acknowledged that sexual health was still a taboo topic in the community, HIV/AIDS was considered important in promoting awareness of sexual health and bringing much-needed funding to the area. Other sexual health issues considered well-addressed include follow-up, gay and lesbian health, and the development of the new HPV vaccine.

On the contrary, STIs in general, including screening and sexual health funding, were considered poorly addressed, particularly in light of the rising rates of notifications for Chlamydia in young women and gonorrhoea and syphilis in men who have sex with men. Gender relations, particularly as it related to sexual relationships, has been not been considered in sexual health strategies, increasing the vulnerability of young women to Chlamydia. Professional development focusing on the dynamics of sexual relationships between young people, particularly the effect of gender and power on such encounters was lacking. Professional development, particularly in regards to STI risk assessment and counselling, was also considered poorly addressed as was STI prevention and education and the sexual health of indigenous and CALD communities and people with disabilities.

Current sexual health issues that needed to be addressed were highlighted. Chlamydia in young people under 25 and gonorrhoea in men who have sex with men respectively were the most reported sexual health issues. The increasing incidence of Chlamydia in young people in recent years and the long-term consequences of the infection concerned numerous participants who attributed incidence to lack of awareness of the infection. Subsequently, the lack of consistent sexual health education in schools and the wider community was also highlighted as being severely deficient and so a sexual health issue that needed to be addressed. The inability of young people to access sexual health information, which resulted in their lack of awareness of STIs and safe sex practices, put them at greater risk, with many participants suggesting that young people be prioritised in improving sexual health clinical service delivery. Several participants also noted the increasing rates of gonorrhoea, syphilis and HIV in men who have sex with men, with attention given to men who frequented sex-on-premises venues.

5.3 Strategies

Apart from the clinical services offered by the six state-funded sexual health clinics, participants provided an overview of the additional strategies implemented to improve sexual health outcomes in Victoria. The clinical services offered through Family Planning Victoria and the Action Centre were well-documented, but other clinical services offered

throughout Victoria included well women's clinics in community health centres and women's health services, STI and BBV testing and counselling in university health services, health checks for the indigenous community, and sexual health assessments for young people through youth health services.

Education

Most education efforts appeared to be implemented in schools courtesy of secondary school nurses and community health nurses. The secondary school nursing program was well represented in the service provider focus groups, highlighting that nurses played an important role in adolescent sexual health. However, instead of providing clinical services, nurses were more involved in education and linking adolescents with appropriate health services. Secondary school nurses highlighted a variety of strategies implemented in the school setting, including Health Days, excursions to youth health services such as the Action Centre, and workshops or information sessions for students across all year levels. Participating community health nurses also engaged in education in schools, implementing similar strategies, sometimes in conjunction with secondary school nurses. These nurses were also involved in the community, providing education and support to a diverse range of groups, including young people, low income earners, and refugees and new arrivals.

Outreach

Outreach services were also utilised with groups whose access to health services was poor, including indigenous communities and sex workers. With indigenous communities, outreach included the provision of health checks with an STI screening component and peer education for indigenous youth living in rural Victoria while an outreach bus was used to access sex workers in inner metropolitan Melbourne.

Intersectoral Collaboration

Intersectoral collaboration in sexual health involving a network of services was another strategy employed by the majority of participants. However, the process itself appeared to be ad hoc, informal, fragmented and without Memorandums of Understanding indicating the nature of relationships, or providing guidance on relationship directions. Many participants, service providers in particular, reported collaborating with the Family Planning Victoria and Melbourne Sexual Health Centre. Some service providers were committed to collaborating with the latter because of its commitment to addressing the sexual health needs of special needs groups such as injecting drug users, sex workers and indigenous communities. On the next level, considerable collaboration occurred with GPs either directly, or via Divisions of General Practice, because of their key role in

sexual health clinical service delivery, especially in rural and remote locations. For participating nurses who offered STI screening through their service, collaboration with GPs was mandatory in order to obtain GP approval for Chlamydia tests.

Collaboration also occurred amongst nurses, with community health nurses and secondary school nurses working closely particularly in school education. Youth health services were also a magnet for other service providers working with young people, primarily schools, community health nurses and drug and alcohol services. However, collaboration was not without its difficulties. There appeared to be no formal mechanism to facilitate networking, so some service providers indicated they were unaware of all the services addressing sexual health. Others reported the current level of networking was insufficient, hindered by a lack of time and money to establish and maintain working relationships with other services. Many service providers indicated the barriers to collaborating with GPs, including GP lack of knowledge of services, lack of GP interest in managing sexual health issues, or the lack of GP services in the local area, with the latter being most pertinent for rural-based service providers.

5.4 Access to sexual health clinical services

Access to sexual health services was discussed with key informants and service providers, with participants identifying barriers for the general population and specific groups. The barriers were categorised as follows:

- Social
- Structural
- Financial
- Informational
- Geographic
- Attitudinal and knowledge-related.

The most commonly highlighted barrier by participants was the lack of knowledge about STIs and the available services. This was most pertinent for young people, possibly due to the lack of consistent sexual health education in schools, which was also mentioned frequently. Other commonly reported barriers included cost, especially with the falling numbers of bulk-billing GPs, transport, and the lack of priority given to sexual health by politicians, GPs and the general public.

Commonly reported barriers are listed in Table 4 while Table 5 lists commonly reported barriers for specific groups.

Table 4: Barriers to accessing sexual health clinical services

| Social | Structural | Financial | Informational | Geographic | Attitudinal & Knowledge-related |
|---|--|--|--|--|---|
| <ul style="list-style-type: none"> • Negative or conservative community attitudes towards sexual health • Stigma & embarrassment • Discrimination and alienation | <ul style="list-style-type: none"> • Lack of services • Services poor located (rear of local hospital) • Lack of transport • Long waiting lists/difficulty getting appointments • Stand-alone sexual health services identifies attendees as having an STI • Decline in number of bulk-billing GPs • Health services are culturally insensitive • Opening hours are limited • Poor access to interpreter services | <ul style="list-style-type: none"> • Cost of transport • Cost of medical consultations • Cost of medication | <ul style="list-style-type: none"> • Lack of information about STIs and available services • Lack of consistent sex education in schools | <ul style="list-style-type: none"> • Distance to travel to services • Rural-based sexual health services located in regional centres | <ul style="list-style-type: none"> • Sexual health is not a priority • Lack of knowledge about STIs and sexual health services • Discriminatory attitudes of health professionals towards certain groups (IDUs, MSM, sex workers) • Confidentiality |

Table 5: Barriers to accessing sexual health clinical services for specific groups

| | |
|-------------------------------------|--|
| Young people | <ul style="list-style-type: none"> • Lack of knowledge about STIs and available sexual health services • Transport • Cost (lack of bulk-billing GPs) • Confidentiality • Poor access to sex education in schools • Opening hours of services are limited |
| Low income earners | <ul style="list-style-type: none"> • Transport • Cost (lack of bulk-billing GPs) |
| Indigenous communities | <ul style="list-style-type: none"> • Transport • Cost (lack of bulk-billing GPs) • Discomfort in accessing non-indigenous health services • Stigma and embarrassment • Lack of information about STIs |
| Rural and remote communities | <ul style="list-style-type: none"> • Lack of services • Transport • Distance to travel to services located in regional centres • Cost (lack of bulk-billing GPs) • Stigma and embarrassment • Confidentiality |
| Injecting drug users | <ul style="list-style-type: none"> • Sexual health is not a priority • Lack of awareness of sexual health services • Discrimination • Cost |
| Men who have sex with men | <ul style="list-style-type: none"> • Conservatism of local community • Discrimination • Stigma • Confidentiality |
| Heterosexual men | <ul style="list-style-type: none"> • Sexual health is not a priority • Lack of awareness of sexual health services • Stigma and embarrassment • Opening hours of services are limited |
| Sex workers | <ul style="list-style-type: none"> • Lifestyle issues may make sexual health less of a priority • Lack of awareness of sexual health services • Cost of consultation and regular STI screening • Stigma |
| CALD communities | <ul style="list-style-type: none"> • Lack of awareness of services • Stigma associated with attending a stand-alone sexual health service • Poor access to interpreter services |
| People with disabilities | <ul style="list-style-type: none"> • Sexual health is not prioritised by disability workers • Lack of awareness of sexual health services • Lack of transport • Cost (lack of bulk-billing GPs) |

5.5 Barriers to sexual health clinical service delivery

Key informants and service providers identified a number of barriers to the delivery of sexual health clinical services, all of which were inextricably linked. These barriers were categorised as follows: social, political, structural, professional and geographical.

Social

Several participants suggested that current societal attitudes towards sexual health, an issue that was still very much taboo, filtered into government and general practice, both of whom appeared too embarrassed to properly address sexual health. Key informant views suggested that the community did not view sexual health as a component of overall health, resulting in negative community attitudes towards sexual health, discrimination of people infected with an STI and associating STI infection with promiscuity. Furthermore, this resulted in individuals afraid to seek sexual health care for fear of discrimination.

Political

The lack of political commitment to addressing sexual health also emerged during discussions about barriers to service delivery. Several participants were annoyed that insufficient attention had been given to sexual health with regards to health policy, health program planning, and sexual health education in schools.

Structural

Many participants reported that HIC rules about sexual health screening was a barrier to GPs and nurses delivering sexual health services. More specifically, the three test rule for Chlamydia fuelled GP reluctance to screen for this infection for fear of being investigated by the HIC. In contrast, nurses could not screen for Chlamydia as no nurse-specific Medicare item number was available. Several service providers were in this latter predicament, constantly seeking GP signature for Chlamydia testing through their service. This was most difficult for service providers not working alongside a GP or where access to a GP was poor. Another GP-related structural barrier that was highlighted included the decline of bulk-billing surgeries, which put pressure on those GPs who continued to bulk bill.

Professional

Several participants recognised the dynamics of general practice as a barrier to service delivery, imposing limitations on how GPs practised sexual health medicine. GPs were wary of time and a busy waiting room, with the heavy workload possibly impacting on whether GPs engaged in preventative work. Furthermore, a lack of GP interest in sexual

health was also identified. Some GPs did not view sexual health as part of their core business, possibly contributing to their lack of knowledge of sexual health services, yet another barrier raised by participants.

As nurses made up a significant proportion of service providers, a number of barriers specific to community health nurses and secondary school nurses, the most represented of all nurses in the review were reported. The role of community health nurses varied from region to region, with some involved in clinical work, such as running well women's clinics, and others only engaged in community education. In many cases, community health nurses were responsible for an extensive portfolio, covering numerous health issues, such as diabetes and cardiac rehabilitation, and in which sexual and reproductive health made up a small portion. In addition to these numerous responsibilities, community health nurses also covered a large area geographically.

Barriers for secondary school nurses differed to that of their community health counterparts. Whilst the secondary school nursing program has been in existence for a number of years, some nurses reported difficulties in establishing rapport with teachers. More specifically, as these nurses were responsible for two schools each, gaining teacher support was further complicated by the limited time spent in each school. However, others reported that teachers were threatened by secondary school nurses, believing their authority was being usurped. Consequently, these nurses were concerned that the lack of teacher support could affect referral of young people.

Geographical

As with community health nurses, rural-based service providers located in remote areas reported difficulties in delivering services to communities over a large geographical area.

5.6 Performance Indicators

Due to the lack of uniform performance indicators in sexual health clinical service delivery, the majority of participants, service providers in particular, implemented their own mechanisms to measure sexual health outcomes. Process evaluation rather than outcome or impact evaluation was the norm, with many service providers collecting data about consumer satisfaction or feedback about how to improve service delivery. Of all the service providers, secondary school nurses were the only providers required to regularly complete reporting requirements for DHS against set criteria. Few service providers appeared to use quantitative indicators, but those that did collected information about:

- Number of people accessing service by age group and gender;
- Number of STI screenings;
- Opportunistic STI screening;
- Rate of return to obtain test results;
- Ability to contact patients about test results;
- Number of patients being treated;
- Clients following through with referral.

Access to STI statistics from DHS for local areas was considered imperative in the evaluation process, but some participants expressed concern at their inability to access this data.

5.7 Professional Development

Sexual health clinical service delivery is dependent on an upskilled workforce and there were a number of opportunities available, albeit metropolitan-based, for participants to increase their knowledge and skill base in sexual health. Such opportunities included those offered through Family Planning Victoria, such as Sexual and Reproductive Health Certificates 1 and 2 and other regular updates, Melbourne Sexual Health Centre, Australasian Society for HIV Medicine, PapScreen, Victorian Cytology Service, Centre for Adolescent Health, and Divisions of General Practice. Nurses associations, such as the Australian Sexual Health Nurses Association and Women's Health Network, also provided professional development opportunities, but locally-based nurse networks were also established in rural areas to compensate for the lack of training available locally.

However, the availability of opportunities did not always result in uptake. Financial, geographical and professional barriers impeded the ability of many participants to engage in education and training, with cost being the most reported barrier. Whilst this primarily related to the exorbitant cost of education itself, many rural-based service providers were hindered by the cost of travelling to and staying in Melbourne, where most education was held, whilst for GPs there was a cost to the practice if time was spent pursuing education during regular practice hours. However, it was noted that GPs were reticent to attend professional development during practice hours because of a heavy workload. Nurses also indicated that a heavy workload, lack of time, especially if employed part-time, and their inability to find a temporary replacement factored into decisions to engage in further training. Community health nurses were very particular about training to be undertaken because of the limited funding allocated to further professional development, often on a pro rata basis. Professionally, the lack of

commitment to sexual health training in the undergraduate medical curriculum and the lack of GP registrar positions were also raised as barriers to GP service delivery.

5.8 Suggested Improvements to Sexual Health Clinical Services

Participants recommended numerous ways of improving sexual health clinical services.

Advocacy

Some key informants and service providers highlighted the need for sexual health to be placed on the political agenda and prioritised as an important public health issue, suggesting that sexual health professionals, particularly GPs with an interest in the issue, drive the process. The involvement of a GP-specific body such as GPDV was considered important in putting sexual health on the general practice agenda and demonstrating to GPs that sexual health was a core part of GP business. Furthermore, enlisting interested GPs to advocate to other GPs in their Division was suggested as one way of creating GP interest in sexual health.

Models of care

Participants highlighted the components that needed to be included in a model of care for sexual health, advocating for the need to develop the current and future sexual health workforce. Strengthening general practice emerged as the most reported improvement to sexual health clinical service delivery. Several key informants suggested that GPs across Victoria with an interest in sexual health, including those that were bilingual, be identified and supported in providing sexual health services. Support could be provided in the form of financial incentives to screen for STIs, access to state-funded sexual health clinical services for secondary consultations, education and training, information about specialist sexual health services, and referral protocols.

However, there were participants that highlighted the need for a multi-disciplinary approach to sexual health clinical service delivery that went beyond general practice and included nurses and counsellors. In particular, the role of the nurse emerged as an important theme, with suggestions made about how to best incorporate nurses in service delivery. Participants recognised the expertise of nurses, particularly those in community health, which included skills outside the realm of medicine such as health promotion and community liaison. Given the recommendation to strengthen general practice, it was suggested that practice nurses be located with identified GPs and supported in their role by state-funded sexual health clinical services. There was also strong support from many service providers for the introduction of a nurse-specific Medicare item number for Chlamydia screening, especially for nurses who were accredited Pap test providers.

The integration of the nurse practitioner in the delivery of sexual health clinical services was raised in discussions with participants. Overall, participants supported nurse practitioners, recognising the benefits of these professionals in sexual health. They were seen as vital in a field where health professionals were not being replaced, so were seen as important in filling a void where clinical services were lacking particularly in rural and remote or outer metropolitan areas. However, encouraging nurses to assume this greater responsibility, providing support during the accreditation process which involved completion of a Masters, recognising prior learning and experience, and providing support in the role with access to training and secondary consultations was considered by some participants as important to the integration of nurse practitioners in sexual health clinical service delivery. But despite the support for nurse practitioners, some participants suggested the role and funding issues needed clarification.

Another recurring theme that emerged during discussions about models of care was the location of existing state-funded sexual health clinical services particularly in rural regions. Stand-alone services were considered inappropriate as they encouraged labelling of consumers accessing such services. The recommendation was made to locate services, including those specifically for indigenous communities, in generic services such as community health centres that were centrally located and accessible. In addition, satellite services or outreach could be provided particularly for young people.

Intersectoral Collaboration

Participants recognised the need for more collaboration between service providers delivering sexual health services. Much emphasis was placed on the need for GPs to develop partnerships with schools, community health centres, and sexual health services. Other partnerships suggested included indigenous-controlled health services and sexual health services especially in rural regions, DHS and high caseload general practices catering for men who have sex with men, and state-funded sexual health services with each other. Memorandums of understanding were recommended to facilitate collaborative ventures.

Professional Development

Several suggestions were offered about enhancing the knowledge and skill base of the future and existing sexual health workforce. Participants strongly recommended that medical and nursing curricula include a sexual health component as a means of encouraging more health professionals to work in the field. One way of achieving this was through increasing the number of GP registrars working in sexual health and adolescent health.

For the existing workforce, participants made a number of recommendations. Regular structured updates on the following topics were recommended: changes in sexual health medicine, including diagnosis, treatments, available sexual health services, referral protocols, and statistics; maintaining confidentiality; counselling; taking a sexual history; psychological aspects of sexual health. Some service providers suggested such professional development needed to be mandatory for all sexual health professionals to ensure all were working on the same level.

Specific recommendations were also made by rural-based service providers who suggested ongoing professional development be offered locally and at low cost whilst some nurses expressed an interest in developing their clinical skills through attendance at a specialist clinic. Professional development on adolescent sexual health specifically for non-clinical professionals working with this group, such as youth workers was also needed.

Some key informants highlighted the need for education about addressing sexual health needs in specific groups, with particular reference given to young people and indigenous and CALD communities. Education about the dynamics of sexual encounters between young people, such as gender and power, as well as the factors contributing to STI transmission in this group was required. Cross-cultural training focusing on indigenous and CALD communities was also suggested.

Education formats suggested included a website specifically for sexual health practitioners, updates sent electronically to rural-based service providers, CD ROMs, peer review for GPs, and GP access to knowledgeable professionals who could provide information and assist with secondary consultations.

Performance Indicators

Quantitative and qualitative performance indicators to measure sexual health clinical service delivery were recommended. The categories that were considered important to measure include demographics of service users that increase risk, STI incidence, access, service provision, patient satisfaction, and knowledge. More specifically, indicators suggested included:

Demographics that increase risk:

- Gender, age, number of sexual partners

STI incidence:

- Number of sexual health issues identified locally vs state vs national

Access:

- Number of service providers delivering sexual health services
- Referral pathways
- Number of people accessing service by age
- Reasons for accessing service
- Ease of access to service

Service provision:

- Number of client phone consultations
- Number of follow-up appointments met
- Number of people treated successfully
- Screening rates
- Location of screenings (GPs, clinics)

Patient satisfaction:

- Patient satisfaction with service delivery
- Patient satisfaction with specific services provided (treatment, counselling)
- Aspects of service delivery that were satisfactory and unsatisfactory

Knowledge:

- Level of knowledge

Youth-specific performance indicators were also suggested including:

- Number of young people accessing services
- Number of young people who do not access services
- Youth satisfaction with services
- Number of young people screened for STIs
- Discussion about contraception
- Identification of young people at risk of STIs
- Occurrence of youth-specific health promotion
- Levels of knowledge

The quality of STI notifications was the only performance indicator recommended for use in general practice.

Participants also suggested that performance indicators be simple to allow information to be recorded easily. Readily-accessible data by region from one central source was also requested as current statistics were collated by a number of sources, such as the HIC and DHS, making data access difficult.

Community education (including school education)

Several participants agreed that community education about sexual health was needed to normalise sexual health and to demonstrate that it was a part of general health. Information about STIs, screening and available services, including GPs trained in sexual health, was required. CALD communities could also be informed of bilingual GPs providing sexual health services.

Many participants highlighted the importance of providing sexual health education in schools, starting as young as Grade 6 and Years 7–8 to capture early school leavers, and providing education to every year level to reinforce sexual health knowledge. Community health nurses providing school education stated that sexual health education needed to empower young people and provide the skills necessary for health service access. Responsibility for health also needed to be encouraged.

Screening

Screening for Chlamydia in sexually active young women under 25 and gonorrhoea in men who have sex with men was also suggested.

In summary, the consultation with service providers raised issues that were consistent across the regions. Overall, sexual health clinical service delivery was considered inadequate outside metropolitan Melbourne. Chlamydia was the most pertinent sexual health issue and young people an important target group. Professional development in sexual health was available, but cost and time impeded the ability to participate in any education. Intersectoral collaboration was ad hoc and lacking. Strengthening general practice, advocacy, intersectoral collaboration, professional development, and community education were recommended improvements to service delivery. There was also a great deal of support for the integration of nurse practitioners in the delivery of sexual health clinical services.

CHAPTER 6: RECOMMENDATIONS

The following recommendations are based on review findings and contributions from the reference group.

1. Improve the existing model of sexual health clinical service delivery especially in non-metropolitan regions

To achieve this:

- Non-metropolitan state-funded sexual health clinical services need more support to offer accessible services to those most at risk;
- GPs need support (financial, structural, educational) from DHS to offer best practice sexual health clinical services in a collaborative manner with state-funded sexual health clinical services;
- DHS needs to actively promote collaboration between GPs and state-funded sexual health clinical services in providing best practice clinical sexual health care to all Victorians;
- Nurse-led services need to be promoted and encouraged by DHS. DHS should aim for a viable nurse practitioner workforce in sexual health in the next five years as well as provide training and support for practice nurses, community health nurses and secondary school nurses who all need to be acknowledged for their role in the provision of sexual health clinical services in Victoria;
- Standardised performance indicators demonstrating accessibility for those most at risk of STIs need to be established and monitored for all state-funded sexual health clinical services.

2. Identify and acknowledge target groups for STIs

This review has identified the following as being important core groups who must be ensured access to sexual health clinical services throughout Victoria (metropolitan and regional):

| Groups with a high prevalence of STIs | Groups who may not have high rates of STIs, but have difficulty accessing mainstream services |
|--|--|
| Men who have sex with men | Travellers (such as overseas visitors) |
| Young people under 25 | CALD communities |
| Intravenous drug users | Gay, lesbian and transgender individuals |
| Aboriginal and Torres Strait Islanders | Sex workers working in brothels |
| Sex workers who work illegally | |

To achieve this:

- Health professional education needs to be provided with information targeted at GPs and other service providers about these 'core groups' and the importance of enabling them to have access to sexual health clinical services;
- Public health campaigns need to be developed specifically for those individuals within these groups to promote accessible sexual health clinical services for them and inform them about the need to protect themselves from STIs. The report acknowledges that a Chlamydia campaign has been undertaken by Department of Human Services (DHS), but the data suggests there is still a need for increased awareness amongst high risk individuals about protection from STIs, the possible consequences of STIs, and how to access services.

3. Annually screen sexually active young women under 25 for Chlamydia

To achieve this:

- Public health education campaigns about where to go to get tested need to be developed and implemented;
- GPs and their staff need to be educated around what Chlamydia is, how to test, who to test, how to treat and how to contact trace;
- Structural barriers in general practice which currently prevent testing of asymptomatic individuals from being performed need to be addressed. These include Medicare funding for screening and bulk billing.

4. Develop and implement targeted public health education campaigns that aim to increase community awareness of STIs, the consequences of STIs, and how to protect oneself from STIs

To achieve this:

- Public health education campaigns need to target those most at risk and should aim to improve knowledge in specific communities about sexual health issues, such as where and how men who have sex with men can be tested regularly, how young people can access Chlamydia screening, and what GPs can offer in regards to sexual health;
- Promote the positive aspects of sexuality and being sexually healthy.

5. Ensure all those individuals with symptoms suggestive of an STI can be seen at a sexual health clinical service (specialist centre or GP with the appropriate skills and knowledge) within 24–48 hours and be managed appropriately at low cost to the individual

To achieve this:

- All GPs need to have a basic level of skills and knowledge to provide basic clinical management of the common STIs or awareness of appropriate services in order to refer as required;
- The state of sexual health clinical service delivery in non-metropolitan regions needs to be addressed. Within metropolitan Melbourne, access to appropriate and free sexual health clinical services is good. In outer regions of Melbourne and geographically isolated regions, access is less than optimal. Regional state-funded sexual health clinical services will need to be able to show they provide a service to those most in need. This means that access is crucial to groups most at risk. If only two hours a week of direct clinical service is provided, then the service providers may need to make evidence-based decisions on how best to spend this money. This may in fact mean they provide their service as an outreach clinic at the local community health centre, such as when a needle exchange program is running or a youth clinic is in progress. It may mean that the money is spent on a liaison nursing position rather than direct clinical service provision. The liaison nurse could work alongside other providers and assist individuals most in need access already existing services.

6. Ensure all GPs possess necessary skills and a level of knowledge that will enable them to provide basic (best practice) clinical management of the common STIs or to refer patients to an appropriate service as required

To achieve this:

- A higher profile needs to be given to sexual health in the undergraduate medical curriculum;
- Rural skills training for GPs needs to include compulsory sexual health training for GP registrars in a specialist sexual health centre;
- Subsidies for GPs and organisations who train GP registrars in undertaking sexual health training positions needs to be provided;
- Ongoing basic sexual health training for all GPs needs to be provided, ideally linked as a compulsory part of CME accreditation via a credible education program such as a website with fact sheets, courses advertised, 1800 number for advice and visits by sexual health specialists to give talks to local practice staff on common sexual health issues that can be managed in general practice. The NPS initiative could be used as a model for this training.

7. Ensure a core group of interested GPs are upskilled in sexual health medicine to provide a more extensive (best practice) level of care for individuals with sexual health concerns

To achieve this:

- GPs who would like to assume a more active role in STI management need to be identified and provided with training plus additional support and incentives. These may include structural support around bulk billing, use of Medicare, training of practice nurses, close links with and visits to or from sexual health physicians at sexual health clinical services, support for GPs and practice staff to attend courses to achieve relevant qualifications such as the Sexual and Reproductive Health Certificate;
- Support needs to be provided to these practices which enable them to be accessible to those individuals most at risk of STIs.

8. Support the involvement of nurse-led sexual health services

To achieve this:

- The provision of a sexual health nurse practitioner in each region of Victoria should be considered. However, scholarships will need to be offered to encourage nurses to work towards this and DHS will need to encourage organisations to support interested nursing staff to pursue this goal;
- Nurses working in general practice, community health and secondary schools need to be offered more training and support so that they are able to provide consistent care and work closely together with better networks and collaborations. This includes addressing the barriers specifically highlighted in the review such as advocacy for a Medicare item number for nurses to test for Chlamydia (as has been created for immunisation and wound dressings) which would create financial support for GPs who encourage their nurses to become more involved in the delivery of sexual health clinical services. In addition, the ability for practice nurses to liaise and form good community networks with other service providers should be considered. Currently, their role is totally consumed with service provision and this may mean that some part of the position of practice nurses needs to be funded by DHS to specifically address sexual health.

9. Establish formal networks and promotion of collaborative partnerships between providers of sexual health clinical services

To achieve this:

- At least one sexual health liaison officer (possibly with a background in community health nursing) in each region needs to be appointed to work closely with all providers of sexual health clinical services to help achieve consistency of standards and common goals in controlling STI transmission;
- All providers of sexual health clinical services need to be linked to a local support network and DHS;
- A DHS GP liaison officer needs to be appointed to set up networks, co-ordinate training for GPs and help establish the provision of collaborative accessible services throughout Victoria.

10. Ensure uniform performance indicators are monitored for all state-funded sexual health clinical services while establishing relevant performance indicators for those providers of sexual health clinical services not directed funded by DHS

Performance indicators need to demonstrate:

- Demographics including age, sexuality, risk factors, ethnicity, and ATSI status. The latter needs to be recorded according to best practice guidelines established by the Australian Bureau of Statistics, Australian Institute of Health and Welfare, and Federal and State Governments;
- Consistency of clinical standards with best practice guidelines;
- Service accessibility for at risk groups, such as IDUs, MSM, and ATSI's;
- Ability (if symptomatic or STI contact) to be seen within 48 hours and clients triaged appropriately ie access to health professional trained in sexual health;
- Percentage of positive STI tests (proof clients with STIs accessing service);
- Percentage of patients satisfied with service delivery;
- Reasons for patient satisfaction and dissatisfaction and how to improve service delivery.

Performance indicators specifically for general practice should demonstrate:

- Ease of access (cost, youth friendliness, waiting times);
- Percentage of patients satisfied with service delivery;
- Number of Chlamydia tests in young people under 25.

11. Prioritise sexual health clinical services in general practice and advocate to remove the barriers that currently prevent this from happening

To achieve this:

- Professional bodies such as RACGP, ACSHP and GPDV need to accept and acknowledge sexual health as important in general practice;
- A DHS GP liaison officer needs to be appointed to set up networks, co-ordinate training for GPs and help establish the provision of collaborative accessible services throughout Victoria. Ideally, this position should be able to work well with Divisions of General Practice as well as GPs and co-ordinate and instigate appropriate sexual health training through the Divisions. In addition, this position should examine how

the barriers to sexual health clinical service delivery in general practice can be addressed;

- A sexual health working party needs to be established, including representatives from RACGP, GPDV, DHS, state-funded sexual health clinical services, other specialist sexual health clinical services such as FPV, youth health services, nurse practitioners, community health nurses, secondary school nurses, and practice nurses. The working party needs to establish a common agenda and support mechanisms for the provision of services within Victoria. This working party could work alongside the STI Ministerial Advisory Committee and with the GP liaison officer.

REFERENCES

1. World Health Organisation (2000) *Gender and reproductive rights: Considerations for formulating reproductive health laws Ref. WHO/RHR/00.1*. Geneva: World Health Organisation.
2. Anderson, R. (1999) 'Transmission dynamics of sexually transmitted infections' in Holmes KK, Sparling PF, Mardh P, et al. (eds) *Sexually transmitted diseases. 3rd ed.* McGraw-Hill.
3. Catchpole, M. (2001) 'Sexually transmitted infections: control strategies.' *British Medical Journal*; 12:322(7295):1135-1136.
4. Fairley, C.K. (1997) 'Sexual health: reaching out.' *Medical Journal of Australia*; 166(7): 341.
5. Marks, C., Tideman, R.L. & Mindel, A. (1997) 'Evaluation of sexual health services within Australia and New Zealand.' *Medical Journal of Australia*; 166(7): 348-352.
6. Department of Human Services Public Health Division (2001) *Chlamydia Strategy for Victoria 2001-2004*.
7. Stamm, W.E. (1999) 'Chlamydia trachomatis infections: progress and problems.' *Journal of Infectious Diseases*; 179 (Suppl 2):S380-383.
8. Fleming, D.T., McQuillan, G.M., Johnson, R.E., Nahmias, A.J., Aral, S.O., Lee, F.K., St Louis, M.E. (1997) 'Herpes simplex virus type 2 in the United States, 1976 to 1994.' *New England Journal of Medicine*; 337(16): 1105-1111.
9. Laga, M., Manoka, A., Kivuvu, M., Malele, B., Tuliza, M., Nzila, N., Goeman, J., Behets, F., Batter, V., Alary M., et al. (1993) 'Non-ulcerative sexually transmitted diseases as risk factors for HIV-1 transmission in women: results from a cohort study.' *AIDS*; 7(1): 95-102.
10. Philpot, C.R. (1986) 'Impact of chlamydia and herpes infections on the community.' *Australian Microbiologist*; 7:11-17.
11. Victorian Infectious Diseases Bulletin (1999-2003) Amalgamated data

12. Aral, S.O. & Holmes, K.K. (1999) 'Social and behavioral determinants of the epidemiology of STDs: industrialized and developing countries.' In: Holmes, K.K., Sparling, P.F., Mardh P, et al. (eds) *Sexually transmitted diseases. 3rd Ed*: McGraw-Hill.
13. Holtgrave D.R. & Crosby, R.A. (2003) 'Social capital, poverty, and income inequality as predictors of gonorrhoea, syphilis, chlamydia and AIDS case rates in the United States.' *Sexually Transmitted Infections*; 79(1): 62-64.
14. Bowden, F.J., Paterson, B.A., Mein, J., Savage, J., Fairley, C.K., Garland, S.M., et al. (1999) 'Estimating the prevalence of *Trichomonas vaginalis*, *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, and human papillomavirus infection in indigenous women in northern Australia.' *Sexually Transmitted Infections*; 75(6): 431-434.
15. Ross, M.W., Hwang, L.Y., Zack, C., Bull, L. & Williams, M.L. (2002) 'Sexual risk behaviours and STIs in drug abuse treatment populations whose drug of choice is crack cocaine.' *International Journal of STDs & AIDS*; 13(11): 769-774.
16. Grulich, A.E., de Visser, R.O., Smith, A.M.A., Rissel, C.E. & Richters, J. (2003) 'Knowledge about sexually transmissible infections and blood borne viruses in a representative sample of adults.' *Australian & New Zealand Journal of Public Health*; 27(2): 230-233.
17. Smith, A., Aguis, P., Dyson, S., Mitchell, A. & Pitts, M. (2002) *Secondary students & sexual health: Results of the 3rd national survey of Australian secondary students, HIV/AIDS and sexual health*. Melbourne: La Trobe University.
18. Department of Health (2001) *The National Strategy for Sexual Health and HIV (United Kingdom)*.
19. World Health Organisation (1998) *The second decade: improving adolescent health and development*. Geneva: World Health Organisation.
20. Chan, D.J., Bradford, D.L. (2004) 'A sexual health strategy for Australia - time for action.' *Sexual Health*; 1(4): 197-199.

21. Dehne, K.L., Snow, R., O'Reilly, K.R. (2000) 'Integration of prevention and care of STIs with family planning services: what is the evidence for public health benefits.' *Bulletin of the World Health Organisation*; 78(5): 628-639.
22. Royal College of Paediatrics and Child Health (2003) *Bridging the Gaps: Health Care for Adolescents*. United Kingdom.
23. Department of Health Teenage Pregnancy Unit (2000) *Best practice guidance on the provision of effective contraception and advice services for young people*. United Kingdom. http://www.dfes.gov.uk/teenagepregnancy/dsp_Content.cfm?PageID=85,
24. Skinner, S.R. & Hickey, M. (2003) 'Current priorities for adolescent sexual and reproductive health in Australia.' *Medical Journal of Australia*; 179(3): 158-161.
25. Williams, H. & Davidson, S. (2004) 'Improving adolescent sexual and reproductive health. A view from Australia: learning from world's best practice.' *Sexual Health*; 1(2):95-105.
26. Rogstad, K.E., Ahmed-Jushuf, I.H. & Robinson, A.J. MSSVD Adolescent Sexual Health Group. (2002) 'Standards for comprehensive sexual health services for young people under 25 years.' *International Journal of STDs & AIDS*; 13(6):420-424.
27. Mead, O. (1999) 'Socioeconomic impact of sexually transmitted diseases/HIV.' In: Holmes, K.K., Sparling, P.F., Mardh P, et al. (eds) *Sexually transmitted diseases. 3rd ed*: McGraw-Hill.
28. Nicoll, A., Hughes, G., Donnelly, M., Livingstone, S., De Angelis, D., Fenton, K., Evans, B., Gill, O.N & Catchpole, M. (2001) 'Assessing the impact of national anti-HIV sexual health campaigns: trends in the transmission of HIV and other sexually transmitted infections in England.' *Sexually Transmitted Infections*; 77(4):242-247.
29. Aral, S.O. (2004) 'Sexual risk behaviour and infection: epidemiological considerations.' *Sexually Transmitted Infections*; 80 (Suppl 2): ii8 - 12.
30. Blumer, C., Roche, P., Spencer, J., Lin, M., Milton, A., Bunn, C., Gidding, H., Kaldor, J., Kirk, M., Hall, R., Della-Porta, T., Leader, R. & Wright P. et al. (2003) 'Australia's notifiable diseases status 2001: Annual Report of the National Notifiable Diseases Surveillance System. *Communicable Diseases Intelligence*; 27(1):1-78.

31. Communicable Diseases Australia: National notifiable diseases surveillance system: <http://www.health.gov.au/cda/Source/CDA-index.cfm>.
32. Hocking, J., Fairley, C., Counahan, M. & Crofts N. (2003) 'The pattern of notification and testing for genital Chlamydia trachomatis infection in Victoria, 1998-2000: an ecological analysis. *Australian & New Zealand Journal of Public Health*; 27(4):405-408.
33. Donovan B. (2002) 'Rising prevalence of genital Chlamydia trachomatis infection in heterosexual patients at the Sydney Sexual Health Centre, 1994 to 2000.' *Communicable Diseases Intelligence*; 26(1):51-54.
34. Tideman, R.L., Pitts, M.K. & Fairley, C.K. (2003) 'Effects of a change from an appointment service to a walk-in triage service at a sexual health centre.' *International Journal of STDs and AIDS*; 14(12): 793-795.
35. Grulich, A.E., de Visser, R.O., Smith, A.M., Rissel, C.E. & Richters, J. (2003) 'Sexually transmissible disease and blood borne virus history in a representative sample of adults.' *Australian & New Zealand Journal of Public Health*; 27(2):234-241.
36. Veit, F.C., Sanci, L.A., Coffey, C.M., Young, D.Y. & Bowes, G. (1996) 'Barriers to effective primary health care for adolescents.' *Medical Journal of Australia*; 165(3):131-133.
37. Burack, R. (2000) 'Young teenagers' attitudes towards general practitioners and their provision of sexual health care.' *British Journal of General Practice*; 50(456):550-554.
38. Wartenberg, A.A. (1991) 'HIV disease in the intravenous drug user: role of the primary care physician.' *Journal of General Internal Medicine*; 6(1 Suppl):S35-40.
39. Cooper-Patrick, L., Gallo, J.J., Gonzales, J.J., Vu, H.T., Powe N.R., Nelson, C. & Ford, D.E. (1999) 'Race, gender, and partnership in the patient-physician relationship.' *Journal of American Medical Association*; 282(6):583-589.
40. Temple-Smith, M., Hammond, J., Pyett, P. & Presswell, N. (1996) 'Barriers to sexual history taking in general practice.' *Australian Family Physician*; 25(9 Suppl 2):S71-74.

41. Temple-Smith, M.J., Mulvey, G. & Keogh L. (1999) 'Attitudes to taking a sexual history in general practice in Victoria, Australia.' *Sexually Transmitted Infections*; 75(1):41-44.
42. Mulvey, G., Temple-Smith, M.J. & Keogh, L.A. (1997) 'Sexually transmissible diseases--knowledge and practices of general practitioners in Victoria, Australia; *Genitourinary Medicine*; 73(6):533-537.
43. Johnston, V.J., Britt, H., Pan, Y. & Mindel, A. (2004) 'The management of sexually transmitted infections by Australian general practitioners.' *Sexually Transmitted Infections*; 80(4):212-215.
44. Health Insurance Commission data. 2002.
45. <http://www.clockhealth.com.au>.
46. <http://www.fpv.org.au>
47. <http://www.frontyard.org.au>.
48. <http://www.mshc.org.au>.
49. <http://www.sexworker.org.au>
50. Carr, S., Goldberg, D.J., Elliott, L., Green, S., Mackie, C. & Gruer, L. (1996) 'A primary health care service for Glasgow street sex workers - 6 years experience of the 'Drop-in Centre,' 1989-1994.' *AIDS Care*; 8 (4): 498-497.
51. Chavasse, M., North, D. & McAvoy, B. (1995) 'Adolescent Health-a descriptive study of a school doctor clinic.' *New Zealand Medical Journal*; 108 (1003): 271-273.
52. Draft Victorian Koori STI/BBV Information for an evidence base. August 2004.
53. Plummer, D. & Forrest, B. (1999) 'Factors affecting Indigenous Australians' access to sexual health clinical services.' *Venereology*; 12 (2): 47-51.
54. Fenton, K.A. (2001) 'Strategies for improving sexual health in ethnic minorities.' *Current Opinion in Infectious Diseases*; 14(1):63-69.

55. Lister, N.A., Smith, A., Tabrizi, S., Hayes, P., Medland, N.A., Garland, S. & Fairley, C.K. (2003) 'Screening for Neisseria gonorrhoeae and Chlamydia trachomatis in men who have sex with men at male-only saunas.' *Sexually Transmitted Diseases*; 30(12): 886-889.
56. <http://www.nursing.vic.gov.au/furthering/practitioner.htm>.
57. Hooke, E., Bennett, L., Dwyer, R., van Beek, I. & Martin, C. (2001) 'Nurse practitioners: an evaluation of the extended role.' *Australian Journal of Advanced Nursing*; 18(3): 20-28.
58. Munding, M.O. (2000) 'Primary care outcomes in patients treated by nurse practitioners or physicians: a RCT.' *Journal of American Medical Association*; 283(1): 59-68.
59. Handy, P. (2002) 'Nurse-directed services in genitourinary medicine.' *Nursing standard* 17(11): 33-38.
60. Miles, K., Penny, N., Mercey, D. & Power, R. (2002) 'Sexual health clinics for women led by specialist nurses or senior house officer in a central London GUM service: a randomised trial.' *Sexually Transmitted Infections*; 78(2): 93-97.
61. Hill, J. (1994) 'An evaluation of the effectiveness, safety and acceptability of a nurse practitioner in a rheumatology outpatient clinic.' *British Journal of Rheumatology*; 33(3): 283-288.
62. Australasian College of Sexual Health Physicians: <http://www.acshp.org.au/>.
63. Donovan, B., Knight, V., McNulty, A.M., Wynne-Markham, V. & Kidd, M.R. (2001) 'Gonorrhoea screening in general practice: perceived barriers and strategies to improve screening rates.' *Medical Journal of Australia*; 175(8): 412-414.
64. Australian College of Sexual Health Physicians. *Guidelines for men who have sex with men*.
http://www.acshp.org.au/sexual_health/guidelines/MSMSTItestingguidelines.pdf

65. Mulvey, G., Keogh, L. & Temple-Smith, M.J. (2000) 'Outcomes of an educational activity with Victorian GPs aimed at improving knowledge and practices in relation to sexually transmissible diseases.' *Australian and New Zealand Journal of Public Health*; 24(1): 76-79.
66. Mindel, A. & Tenant-Flowers, M. (1998) 'Services for sexual health: where should they be provided?' *Medical Journal of Australia*; 168(8):373-374.
67. Wray, L., Law, C. & Barrie, S.C. (1998) 'A general practitioner STD training programme: meeting education and service provision needs.' *International Journal of STDs & AIDS*; 9(12):731-735.
68. Ward, J. & Sanson-Fisher, R. (1995) 'Prevalence and detection of HIV risk behaviour in primary care: implications for clinical preventive services.' *American Journal of Preventive Medicine*; 11(4):224-230.
69. McNulty, C.A. (2004) 'Diagnosis of genital Chlamydia in primary care: an explanation of reasons for variation in Chlamydia testing.' *Sexually Transmitted Infections*; 80(3):207-211.
70. Sherrard, J. & Robinson, A. (2003) 'The MSSVD, the National Sexual Health and HIV strategy for England and genitourinary medicine education.' *Sexually Transmitted Infections*; 79(2):166-167.
71. National Prescribing Service: <http://www.nps.org.au/>
72. Quinn, T.C., Wawer, M.J., Sewankambo, N., Serwadda, D., Li, C., Wabwire-Mangen, F. Meehan, M.O., Lutalo, T. & Gray, R.H. (2000) 'Viral load and heterosexual transmission of human immunodeficiency virus type 1. Rakai Project Study Group.' *New England Journal of Medicine*; 342(13): 921-929.
73. Minichiello, V., Fulton, G. & Sullivan, S. (1999) 'Posing qualitative research questions' in Minichiello, V., Sullivan, G., Greenwood, K. & Axford, R. (eds) *Handbook for research methods in health sciences*. Sydney: Addison Wesley Longman.

APPENDICES

APPENDIX 1: PARTICIPANTS

The following individuals participated in the review:

Catherine Ashford, La Trobe Community Health Service

Alison Bean-Hodges, Gynaecology Assessment Clinic, Royal Women's Hospital

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Mary Burns, Secondary School Nursing Program, Department of Human Services

Belinda Caldwell, General Practice Divisions Victoria

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Dianne Gibbs, Bairnsdale Regional Health Service

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Kerryn O'Rourke, Secondary School Nursing Program, Department of Human Services
Julie Parker, La Trobe Community Health Service
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Karin Stanzel, Yarra Valley Community Health Service
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Helen Sullivan, Secondary School Nursing Program, Department of Human Services
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Inga Tribe, nurse
Bernadette Tucker, Secondary School Nursing Program, Department of Human Services
Dr Lerma Ung, Australasian Society for HIV Medicine
Bernadette Unmack, Barwon Health

Lynne Walker, Australian Practice Nurses Association

Sue Watt, Western District Health Service

Anne Watts, Sunraysia Community Health Services

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Dr Keith Wing-Shing, GP

Vanessa Wood, Melbourne Sexual Health Centre

Judy Woods, La Trobe Community Health Service

Leanne Wynne, Mildura Aboriginal Health Service

Dr Desiree Yap, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Victorian Regional Committee)

Representatives from state-funded sexual health clinical services in Bendigo, Traralgon and Wodonga also participated.

APPENDIX 2: STATE-FUNDED SEXUAL HEALTH CLINICAL SERVICE QUESTIONNAIRE

Facilities

1. What does DHS fund the centre or service to do?
 - a. Provide clinical services only
 - b. Provide a combination of clinical services and education
 - c. Not sure

2. What performance indicators are used?

| | | | |
|------------------------------------|-----|----|----------|
| a. Patient demographics | Yes | No | Not sure |
| b. Patient information and consent | Yes | No | Not sure |
| c. Patient history reviewed | Yes | No | Not sure |
| d. Physical examination performed | Yes | No | Not sure |
| e. Lab exams performed | Yes | No | Not sure |
| f. Diagnosis recorded | Yes | No | Not sure |
| g. Treatment provided | Yes | No | Not sure |
| h. Follow up performed | Yes | No | Not sure |
| i. Other (please identify) | Yes | No | Not sure |

3. Do you routinely collect the following information?

| | | | |
|--|-----|----|----------|
| a. Country of birth | Yes | No | Not sure |
| b. Main language other than English spoken at home | Yes | No | Not sure |
| c. Proficiency in spoken English | Yes | No | Not sure |

4. What are the main outcomes or outputs? Please comment.

5. Is this clinic funded exclusively by DHS for clinical STI services?

Yes No

If no, what other sources of funding are there for clinical STI services?
(Prompts: drug companies, private billing of patients?)

6. Is the facility well sign-posted and in good view from the outside or roadside?

Yes No Not sure

7. Is the centre housed in its own building?

Yes No Not sure

8. Is there easy access for patients with a disability?

Yes No Not sure

9. Is your facility well-served by public transport?

Yes No Not sure

If so, where is such professional development undertaken?
 (Prompts: local meetings, meetings in Melbourne, meetings at Family Planning Victoria, meetings at Melbourne Sexual Health Centre)

19. Do you think there is a role in your clinic for a nurse practitioner ie extended nurse role?

Yes No

If yes, what is that role?

(Prompts: screening asymptomatic patients, offering treatment of warts, limited prescribing under protocol direction, other – please state)

Clinic opening hours

20. What times are the clinics open on:

Monday

| | 7am | 8 | 9 | 10 | 11 | 12 | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--------------------|-----|---|---|----|----|----|-----|---|---|---|---|---|---|---|---|----|
| Dr | | | | | | | | | | | | | | | | |
| Nurse | | | | | | | | | | | | | | | | |
| Male only clinic | | | | | | | | | | | | | | | | |
| Female only clinic | | | | | | | | | | | | | | | | |
| Appt | | | | | | | | | | | | | | | | |
| Drop in | | | | | | | | | | | | | | | | |

Tuesday

| | 7am | 8 | 9 | 10 | 11 | 12 | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--------------------|-----|---|---|----|----|----|-----|---|---|---|---|---|---|---|---|----|
| Dr | | | | | | | | | | | | | | | | |
| Nurse | | | | | | | | | | | | | | | | |
| Male only clinic | | | | | | | | | | | | | | | | |
| Female only clinic | | | | | | | | | | | | | | | | |
| Appt | | | | | | | | | | | | | | | | |
| Drop in | | | | | | | | | | | | | | | | |

Wednesday

| | 7am | 8 | 9 | 10 | 11 | 12 | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--------------------|-----|---|---|----|----|----|-----|---|---|---|---|---|---|---|---|----|
| Dr | | | | | | | | | | | | | | | | |
| Nurse | | | | | | | | | | | | | | | | |
| Male only clinic | | | | | | | | | | | | | | | | |
| Female only clinic | | | | | | | | | | | | | | | | |
| Appt | | | | | | | | | | | | | | | | |
| Drop in | | | | | | | | | | | | | | | | |

Thursday

| | 7am | 8 | 9 | 10 | 11 | 12 | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--------------------|-----|---|---|----|----|----|-----|---|---|---|---|---|---|---|---|----|
| Dr | | | | | | | | | | | | | | | | |
| Nurse | | | | | | | | | | | | | | | | |
| Male only clinic | | | | | | | | | | | | | | | | |
| Female only clinic | | | | | | | | | | | | | | | | |
| Appt | | | | | | | | | | | | | | | | |
| Drop in | | | | | | | | | | | | | | | | |

Friday

| | 7am | 8 | 9 | 10 | 11 | 12 | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--------------------|-----|---|---|----|----|----|-----|---|---|---|---|---|---|---|---|----|
| Dr | | | | | | | | | | | | | | | | |
| Nurse | | | | | | | | | | | | | | | | |
| Male only clinic | | | | | | | | | | | | | | | | |
| Female only clinic | | | | | | | | | | | | | | | | |
| Appt | | | | | | | | | | | | | | | | |
| Drop in | | | | | | | | | | | | | | | | |

Saturday

| | 7am | 8 | 9 | 10 | 11 | 12 | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--------------------|-----|---|---|----|----|----|-----|---|---|---|---|---|---|---|---|----|
| Dr | | | | | | | | | | | | | | | | |
| Nurse | | | | | | | | | | | | | | | | |
| Male only clinic | | | | | | | | | | | | | | | | |
| Female only clinic | | | | | | | | | | | | | | | | |
| Appt | | | | | | | | | | | | | | | | |
| Drop in | | | | | | | | | | | | | | | | |

Sunday

| | 7am | 8 | 9 | 10 | 11 | 12 | 1pm | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--------------------|-----|---|---|----|----|----|-----|---|---|---|---|---|---|---|---|----|
| Dr | | | | | | | | | | | | | | | | |
| Nurse | | | | | | | | | | | | | | | | |
| Male only clinic | | | | | | | | | | | | | | | | |
| Female only clinic | | | | | | | | | | | | | | | | |
| Appt | | | | | | | | | | | | | | | | |
| Drop in | | | | | | | | | | | | | | | | |

Prompts:

Need to record drop in vs. appointments, male and female vs. male only or female only

Male/female

Dr/nurse

Appt/drop in

21. How long is the wait for a routine appointment?

<1 week <2weeks < 3 weeks < 4 weeks 4 or more weeks

22. How long is the wait for an urgent appointment?

< 24hrs < 48 hrs 2 days-1 week >1 week >2 weeks

Clinic work load

23. How many patients have visited the centre in the last twelve months?

24. How many new patients have visited the centre in the last 12 months?

25. How many visits have there been in the last 12 months?

26. What % of patients seen in the clinic self refer?

27. What % of patients seen in the clinic are referred from GPs?

28. Please provide the following information for patients visiting the clinic.
(Indicate if an approximate figure or if data has been collected to verify this)

- % male:
- % female:
- % transgender:
- % < 25 yrs:
- % MSM:
- % who identify as ATISs:
- % who identify as IDU:
- % who identify as sex workers:
- % who have HCC:

29. What is the number of newly diagnosed cases of the following STIs in your clinic in 2002 and 2003? (Indicate if an approximate figure or if data has been collected to verify this)

| Disease | GC | Syphilis | Chlamydia | Genital Herpes | Trich | Candida | NSU | Warts | BV | HIV |
|----------------------|----|----------|-----------|----------------|-------|---------|-----|-------|----|-----|
| No of new cases 2002 | | | | | | | | | | |
| No of new cases 2003 | | | | | | | | | | |

30. How do you classify a case?

APPENDIX 2: STATE-FUNDED SEXUAL HEALTH CLINICAL SERVICE INTERVIEW

Clinician in Charge

1. What year did you qualify as a medical practitioner?
2. What is your gender? M F
3. Which of the following post graduate qualifications do you have?

| | Tick here if you hold this qualification | Tick here if you hold an equivalent recognised qualification from overseas (state the qualification) | Tick here if you follow the CME requirements for this college/body |
|----------------------------|--|--|--|
| FACSHP | | | |
| FRACP | | | |
| FRACGP | | | |
| FRACS | | | |
| FFMPH | | | |
| FRACOG | | | |
| MD | | | |
| PhD | | | |
| Masters in related subject | | | |

4. If you don't have any of the above qualifications, do you have other requirements for continuing medical education you have to follow?

Yes No

If yes, who makes these requirements of you?

5. Of these professional development opportunities, which is most frequently used to fulfil your CME requirements? (Please tick the 3 most commonly attended, marking 1 as the most commonly attended, and 3 as the least commonly attended)

- International conferences
- National Conferences
- Local educational meetings
- Educational meetings in Melbourne
- Educational meetings throughout Victoria and Australia
- Other (Please state)

6. Do you have enough opportunities for continuing medical education?

Yes No Not sure

If not or not sure, do you have any ideas how this could be improved? (Prompts: more local meetings of high standard, paid study leave to attend other courses)

7. How many hours each week are you employed by the service?

- a. Full time equivalent
- b. Full time plus on call
- c. < half time
- d. > half time

8. What % of your employed hours are spent on

- Clinical duties:
- Administrative duties:
- Management duties:
- Research duties:
- Teaching duties:
- Other (Please state):

9. Do you do paid work elsewhere?

Yes No

Please give details:

10. Do you have responsibility for clinical standards in the service?

Yes No

If not, who does? (Prompt: another doctor employed in the clinic, another doctor not employed in the clinic, local hospital doctors)

11. From whom do you most commonly seek advice and support for advice about specific difficult clinical issues? (Prompt: telephone advice with local specialists/experts, telephone advice specialists in Melbourne, telephone advice from Melbourne Sexual Health Centre, professional email discussion lists, discussion with colleagues in the clinic)

12. To what extent do you feel supported on a professional level particularly in regards to communication with other experts?

Not at all Hardly Somewhat Mostly Totally

13. Are there other forms of professional support you access?

Yes No

If yes, please indicate (Prompt: email communication, case discussions with other health professionals)

Telephone consultations

14. Do you have an after hours emergency contact number with medical advice?

Yes No

If yes, who takes these calls? (Prompt: yourself, rostered medical staff, phone message referring to a local emergency department, other)

15. Do you have a telephone information line?

Yes No

If yes:

When is it available? (Prompt: working hours 9-5 5 days a week, less than this, 24 hours 7 days a week)

| | | | |
|-------------------|----------------------|---------------|-------|
| Who staffs this? | Doctor | Nurse | Other |
| Who is it for? | Health professionals | Lay community | Both |
| Is it advertised? | Yes | No | |

Where is it advertised? (Prompt: local press, GP surgeries, local health services)

Partner notification

(Contacting partners of patients with an STI to ensure testing and appropriate treatment)

16. Does your centre contact trace for cases of:

| | | |
|--------------|-----|----|
| Gonorrhoea: | Yes | No |
| Chlamydia: | Yes | No |
| HIV: | Yes | No |
| Trichomonas: | Yes | No |

17. How does this contact tracing most commonly occur? Please tick all appropriate and mark the method that is used most frequently with a **1**

- a. The centre interviews contacts by phone with permission from index case
- b. Advises index case to advise their contacts to attend a sexual health clinic and gives index case a letter to give to contacts advising testing and treatment
- c. Advises index case to advise their contacts to attend a sexual health clinic but does not give them a letter
- d. Asks index case to advise contacts to attend their GP and gives index case a letter for contact to take to GP advising testing and treatment
- e. Asks index case to advise contacts to attend their GP but does not give index case a letter for contact to take to GP
- f. DHS contact tracers asked to contact the contacts (with index case permission)
- g. Sends a script for contact via index case
- h. Other (please state)

Individual STI management

18. What services do you provide? For each, indicate if diagnosis is on or off site.

Chlamydia

| | | |
|-------------------|-----|----|
| Prevention advice | Yes | No |
| Diagnosis | Yes | No |
| Treatment | Yes | No |
| Contact tracing | Yes | No |

| | | |
|--------------------|-----|----|
| Gonorrhoea | | |
| Prevention advice | Yes | No |
| Diagnosis | Yes | No |
| Treatment | Yes | No |
| Contact tracing | Yes | No |
| Trichomonas | | |
| Prevention advice | Yes | No |
| Diagnosis | Yes | No |
| Treatment | Yes | No |
| Contact tracing | Yes | No |
| Syphilis | | |
| Prevention advice | Yes | No |
| Diagnosis | Yes | No |
| Treatment | Yes | No |
| Contact tracing | Yes | No |
| HIV | | |
| Prevention advice | Yes | No |
| Diagnosis | Yes | No |
| Screening | Yes | No |
| Contact tracing | Yes | No |
| Hepatitis A | | |
| Prevention advice | Yes | No |
| Diagnosis | Yes | No |
| Contact tracing | Yes | No |
| Immunisation | Yes | No |
| Hepatitis B | | |
| Prevention advice | Yes | No |
| Diagnosis | Yes | No |
| Contact tracing | Yes | No |
| Immunisation | Yes | No |
| Hepatitis C | | |
| Prevention advice | Yes | No |
| Diagnosis | Yes | No |
| Screening | Yes | No |
| Contact tracing | Yes | No |
| Warts | | |
| Diagnosis | Yes | No |
| Treatment | Yes | No |
| Contact tracing | Yes | No |
| HSV | | |
| Diagnosis | Yes | No |
| Treatment | Yes | No |
| Contact tracing | Yes | No |
| Screening | Yes | No |

19. What methods do you use to diagnose Chlamydia? Please rank in order of frequency i.e. 1 for most frequently used test, X if never used

| Test | Most commonly used | Occasionally used | Never used |
|---------------------------|--------------------|-------------------|------------|
| PCR or other NAAT on swab | | | |
| PCR or other NAAT on FVU | | | |
| Culture | | | |
| EIA | | | |
| Other eg IF | | | |

What treatment do you prescribe for Chlamydia? Please tick each box as appropriate

| Treatment | Most commonly used | Occasionally used | Never used |
|--------------------|--------------------|-------------------|------------|
| Doxycycline 7 days | | | |
| Oxytetracycline | | | |
| Azithromycin | | | |
| Erythromycin | | | |
| Other (specify) | | | |

Do you prescribe empirically? Yes No

Does your clinic offer contact tracing for Chlamydia?

Always Mostly Sometimes Rarely Never

Is it the clinic policy to offer all attendees a Chlamydia test on their first visit?

Yes No

If no, what criteria do you use? (Prompt: only if patient asks, all women under 25, all men and women under 25, depends on sexual history, only is symptomatic, Victorian Chlamydia Strategy recommendations, other)

After treatment for Chlamydia do you recommend a test of cure? Yes No

If yes, when do you do this?

2 weeks 6 weeks 3 months 6 months annually

After treatment for Chlamydia do you recommend testing again for reinfection?

Yes No

If yes, when do you do this?

2 weeks 6 weeks 3 months 6 months annually

20. Which method do you use to diagnose gonorrhoea?

| Test | Most commonly used | Occasionally used | Never used |
|------------|--------------------|-------------------|------------|
| Gram stain | | | |
| Culture | | | |
| PCR | | | |

Do you treat empirically? Yes No

Do you treat on the basis of the gram stain before the culture result is available?

Yes No

Does your clinic provide contact tracing for gonorrhoea?

Always Mostly Sometimes Rarely Never

| Treatment | Most commonly used | Occasionally used | Never used |
|----------------------------|--------------------|-------------------|------------|
| Amoxicillin and probenecid | | | |
| Ciprofloxacin | | | |
| Ceftriaxone | | | |
| Spectinomycin | | | |
| other | | | |

21. Do you perform dark ground examination on site in the diagnosis of syphilis if indicated?

Yes No Sometimes Depends on staff availability

If not, how do you diagnose infectious syphilis?

22. Who do you offer Hepatitis B immunisation to?

| | Always | Sometimes | Never |
|------------------------------------|--------|-----------|-------|
| Anyone attending who is non-immune | | | |
| Heterosexuals | | | |
| Sex workers | | | |
| Injecting drug users | | | |
| Health care workers | | | |
| Men who have sex with men | | | |
| Other criteria (please state) | | | |

Who do you offer Hepatitis A immunisation to?

| | Always | Sometimes | Never |
|------------------------------------|--------|-----------|-------|
| Anyone attending who is non-immune | | | |
| Heterosexuals | | | |
| Sex workers | | | |
| Injecting drug users | | | |
| Health care workers | | | |
| Men who have sex with men | | | |
| Other criteria (please state) | | | |

Is there a cost to the patient for Hep B and Hep A immunisation?

No Yes Only for some clients (please give details)

Who do you offer HIV screening to?

- All those who attend
- Only if they are at risk as identified by a sexual history
- Only if they ask

Where do HIV positive individuals identified through your clinic go for treatment? Please rank in order of likelihood AND please tick all appropriate and mark the one that is used most frequently with a **1**

- a. Treated at this centre
- b. Local hospital specialist (public)
- c. Local hospital specialist (private)
- d. Melbourne specialist (private)
- e. Melbourne specialist (public)
- f. Melbourne Sexual Health Clinic
- g. GP with an interest

Where do Hepatitis B patients go for treatment? Please tick all appropriate and mark the one that is used most frequently with a **1**

- a. Treated at this centre
- b. Local hospital specialist (public)
- c. Local hospital specialist (private)
- d. Melbourne specialist (private)
- e. Melbourne specialist (public)
- f. Melbourne Sexual Health Clinic
- g. GP with an interest

Where do Hepatitis C patients go for treatment? Please tick all appropriate and mark the one that is used most frequently with a **1**

- a. Treated at this centre
- b. Local hospital specialist (public)
- c. Local hospital specialist (private)
- d. Melbourne specialist (private)
- e. Melbourne specialist (public)
- f. Melbourne Sexual Health Clinic
- g. GP with an interest

STI Screening

23. Do you promote your centre as a place to drop in for STI screening for those who are at risk and asymptomatic?

Yes No

If yes, who do you include as being at risk or what criteria do you use to assess 'risk'. Please tick as many as you like and add any others

| | | |
|-------------------------|-----|----|
| MSM: | Yes | No |
| Young people under 25 | Yes | No |
| Sex workers | Yes | No |
| IDUs | Yes | No |
| ATSI's | Yes | No |
| HCC holders | Yes | No |
| Others (please specify) | Yes | No |

If yes, how do you promote this service? (Prompt: word of mouth to other health care providers, flyers or advertising to local community, advertising via GPs, website, leaflets, no promotion, other)

If no promotion, why not? (Prompt: workload too big, not the role of the clinic, not funded for this service, other services more appropriate, no funding to advertise)

24. Which of the following screening tests do you offer MSM who present to the clinic?

| | Always | Sometimes | Never |
|------------------------------|---------------|------------------|--------------|
| Throat swab for gonorrhoea | | | |
| Urethral swab for gonorrhoea | | | |
| FVU Chlamydia | | | |
| Rectal swab for gonorrhoea | | | |
| Rectal swab for Chlamydia | | | |
| HIV and BBVs | | | |

Young People (< 25 yrs)

25. Do you have a confidentiality policy for young people? Yes No
 If yes, is this visible to all those who attend (on walls or handed to those who attend as a brochure)? Yes No
26. Is it promoted/distributed in the local community? Yes No
27. Do you have an age limit under which you will not see clients without parents/guardians? Yes No
 If yes, what age is this?
28. Is your service promoted through secondary school nurses? Yes No

Cost to individuals

29. Is there any fee for those attending this centre? Yes No
30. Do attendees need a Medicare card? Yes No
31. Is this made known in the local community and actively promoted? Yes No
32. How are investigations funded?
 a. Need a Medicare card but bulk billed
 b. Need a Medicare card but not bulk billed (have to pay up front, but can claim most back)
 c. Funded by the service (no Medicare card needed)
33. How is treatment funded?
 a. All treatment free
 b. All treatment free with exceptions (Please specify)
 c. All treatment provided by script

Community links and other providers

34. Do you hold any outreach services? Yes No
 If yes where are they held? Tick as many as appropriate
- Youth centres Yes No

| | | |
|--------------------------|-----|----|
| Prisons | Yes | No |
| Schools | Yes | No |
| General practice | Yes | No |
| Women's health services | Yes | No |
| MSM venues | Yes | No |
| Brothels | Yes | No |
| Services for sex workers | Yes | No |
| Other (Please specify): | Yes | No |

35. Are any of this formal MOUs or formal collaborative working arrangements?

Yes No

If yes, which service/organisation?

35. Does the clinic have any of the following special clinical services?

| | | |
|--------------------------------|-----|----|
| Colposcopy | Yes | No |
| Contraception | Yes | No |
| HIV management clinics | Yes | No |
| Young people's clinics | Yes | No |
| Women's health clinics | Yes | No |
| Drug and alcohol organisations | Yes | No |
| Others (Please specify) | Yes | No |

General

36. To what extent do you believe the service is accessible to those in the community most at risk?

Not at all Hardly Somewhat Mostly Totally

37. What would improve access for those most at risk?

38. Do you believe your centre is adequately staffed to meet the needs of the local community? If not, what could be done to address this?

39. How do you feel the centre could be improved?

40. Is there an unmet sexual health need in the local community? Can you specify this and your reasons for thinking this is the case?

41. What could be done locally to improve this? (Prompt: GPs able to bulk-bill, increased awareness of Chlamydia, telephone information line for community, increased training and awareness of STI to other health professionals in the community)

APPENDIX 3: KEY INFORMANT INTERVIEW SCHEDULE (GENERAL)

What are your thoughts on the current state of sexual health clinical service delivery in Victoria?

What would you consider to be the most important sexual health issues in the community?

Which of these issues is best addressed? Which of these is least addressed?

Which population groups are most affected? Which population groups are most at risk?

Can you comment on the current level of collaboration between sexual health service providers?

What do you perceive are the barriers to collaboration between sexual health service providers?

What do you perceive are the barriers for service providers in addressing community sexual health needs?

What professional development opportunities need to be available in order to ensure optimal delivery of sexual health clinical services?

What are the main access issues for consumers wanting to improve sexual health? (transport, cost, anonymity, availability of appointments, lack of knowledge about or concern for sexual health, lack of knowledge about services)

What are the main access issues for the specific groups wanting to access sexual health services? (Prompt: young people, IDUs, MSM, socioeconomically disadvantaged, ATSI, rural and remote communities, CALD communities, rural and remote communities, sex workers, people with a disability, men)

What needs to be done to improve access to sexual health clinical services?

How can existing models of sexual health service delivery be improved? OR

What strategies are needed to:

- Improve community access to sexual health services;
- Improve sexual health service delivery to the community.

What should be the key components of a sexual health service delivery model or framework? (strategies, target groups, tiers or levels, key players, outcomes)

What outcome measures or performance indicators are currently in place to measure sexual health clinical service delivery? What works? What doesn't?

What outcome measures or performance indicators need to be in place to measure sexual health clinical delivery?

APPENDIX 3: KEY INFORMANT INTERVIEW SCHEDULE (SPECIAL NEEDS GROUPS)

What are your thoughts on the current state of sexual health clinical service delivery in Victoria for (insert special needs group here – adolescents, youth at risk, same sex attracted youth, MSM, IDU, rural, CALD communities, low SES, ATSI)?

What would you consider to be the most important sexual health issues in this group?

Which of these issues is best addressed? Which of these is least addressed?

Can you comment on the current level of collaboration between sexual health service providers in the delivery of services to _____?

What do you perceive are the barriers to collaboration between sexual health service providers?

What do you perceive are the barriers for service providers in addressing the sexual health needs of _____?

What professional development opportunities need to be available in order to ensure optimal delivery of sexual health clinical services to _____?

What are the main access issues for _____ wanting to improve sexual health? (transport, cost, anonymity, availability of appointments, lack of knowledge about or concern for sexual health, lack of knowledge about services)

How can existing models of sexual health service delivery be improved? OR

What strategies are needed to:

- Improve community access to sexual health services;
- Improve sexual health service delivery to _____.

What should be the key components of a sexual health service delivery model or framework? (strategies, target groups, tiers or levels, key players, outcomes)

What outcome measures or performance indicators are currently in place to measure sexual health clinical service delivery to _____? What works? What doesn't?

What outcome measures or performance indicators need to be in place to measure sexual health clinical delivery to _____?

APPENDIX 4: SERVICE PROVIDER FOCUS GROUP SCHEDULE & WRITTEN SUBMISSION QUESTIONS

What are your thoughts on the current state of sexual health clinical service delivery?

What would you consider to be the most important sexual health needs in the local community as experienced through your service?

Which population groups are most affected? Which population groups are most at risk?

How are these needs currently being addressed? (Prompt: What strategies are in place to address these needs in your local area? Are there any unmet needs?)

How do you collaborate with other service providers to address these needs?

What are the barriers to collaborating with other service providers in addressing local sexual health needs?

What other barriers exist for service providers in addressing community sexual health needs?

What opportunities in professional development focusing on sexual health are available to you AND do you access?

To what extent do these professional development opportunities enable you to deliver sexual health clinical services? OR What professional development opportunities should be available to service providers?

What are the main access issues for consumers wanting to improve sexual health? (transport, cost, anonymity, availability of appointments, lack of knowledge about or concern for sexual health, lack of knowledge about services)

What are the main access issues for the specific groups wanting to access sexual health services? (Prompt: young people, IDUs, MSM, socioeconomically disadvantaged, ATSI, rural and remote communities, CALD communities, rural and remote communities, sex workers, people with a disability, men)

What needs to be done to improve access to sexual health clinical services?

How can existing models of sexual health service delivery be improved? OR

What strategies are needed to:

- Improve community access to sexual health services;
- Improve sexual health service delivery to the community.

What should be the key components of a sexual health service delivery model or framework? (strategies, target groups, tiers or levels, key players, outcomes)

What outcome measures or performance indicators are currently in place to measure sexual health clinical service delivery? What works? What doesn't?

What outcome measures or performance indicators need to be in place to measure sexual health clinical delivery?

APPENDIX 5: REFERENCE GROUP MEMBERS

The following individuals were members of the reference group established to assist with the development of recommendations:

Denise Brown, Isis Primary Care

Ruby Callanan, Secondary School Nursing Program, Department of Human Services

Rosie Cummings, Melbourne Sexual Health Centre

Professor Christopher (Kit) Fairley, Melbourne Sexual Health Centre

Bev Greet, Victorian Aboriginal Community-Controlled Health Organisations

Dot Henning, Young People's Health Service, Centre for Adolescent Health

Demos Krouskos, Centre for Culture, Ethnicity and Health

Sarah Lord, VIVAIDS

Dr Kathy McNamee, Family Planning Victoria

Dr Nick Medland, Victorian AIDS Council

Dr Sonya Morrissey, GP

Jenny Morrison, Ballarat Community Health Centre

Sharon O'Reilly, Resourcing Health and Education in the Sex Industry

Marie Wintle, Communicable Diseases Section, Department of Human Services

Dr Henrietta Williams (Chair), Family Planning Victoria

Vanessa Wood, Melbourne Sexual Health Centre

Lynne Walker from the Australian Practice Nurses Association and Alison Bean-Hodges from the Royal Women's Hospital Gynaecology Assessment Clinic were also consulted during the development of the recommendations.