Submission on the next Victorian STI Strategy

Getting on top of STI rates

21 October 2020

Thorne Harbour Health

Thorne Harbour Health is one of Australia's largest community-controlled health service providers for people living with HIV, and the lesbian, gay, bisexual, trans and gender diverse, and intersex (LGBTI) communities. Thorne Harbour Health primarily services Victoria and South Australia, but also leads national projects. Thorne Harbour Health works to protect and promote the health and human rights of LGBTI people and all people living with HIV.

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1. Introduction

Thorne Harbour Health welcomes the opportunity to contribute to the next Victorian STI Strategy. With increasing STI rates and their high social and economic cost on the community, the Victorian Government's STI strategy needs to both address critical weaknesses in the current approach and pre-empt future potential problems.

A significant expansion of sexual health testing and the infrastructure and workforce needed to support it will improve Victoria's response to STIs. If this expansion is expedited, the effect of increased testing and treatment would be combined the effect of restrictions on movement due to the COVID-19 pandemic, which could see significant reductions in STI rates, allowing us to get on top of currently increasing notifications.

Thorne Harbour Health provides STI testing and treatment services to LGBTI communities through the Centre Clinic, Equinox and PRONTO! services.[1] Whilst gay and bisexual men carry the significant burden of STIs among these populations, other groups including trans and gender diverse people, bisexual women, Medicare-ineligible people, and heterosexual-identifying men who have sex with men, are also impacted by a paucity of targeted, culturally relevant information, support and services. This submission makes recommendations designed to improve STI testing, treatment and prevention among these populations.

No strategy accompanied the current *Victorian STI Action Plan 2018-2020*. Ensuring that an action plan accompanies this strategy, or that the strategy includes detailed actions and measurable outcomes, such as those recommended in this submission, will be fundamental to achieving the goals set out by the strategy.

[1] Thorne Harbour Health, *Centre Clinic* (Webpage, 2020) <https://thorneharbour.org/lgbti-health/centre-clinic/>; Equinox Gender Diverse Health Centre, *About* (Webpage, 2020) <https://equinox.org.au/>; Thorne Harbour Health, *PRONTO!* (Webpage, 2020) <https://thorneharbour.org/lgbti-health/pronto/>

2. Summary of recommendations

Priority outcomes

1. The objective for prevention should be an overall reduction in STIs. Two priority outcomes should accompany this: people knowing how to reduce their risk of STIs and acting on that knowledge, and year-on-year decreases in notifications for each notifiable STI despite year-on-year increases in testing.

2. The objective for testing should be for people with an STI to know their status. This should be accompanied by two priority outcomes: a year-on-year increase in testing numbers, and the removal of barriers to testing.

3. The objective for treatment should be for people with an STI to have access to the treatment and care services they need. This should be accompanied by two priority outcomes: a removal of barriers to treatment, and strengthened systems to respond to increasing antimicrobial resistance and research into new vaccines and therapeutics for STIs.

4. The objective for stigma and discrimination should be the elimination of stigma and discrimination in services that provide sexual health testing. Two priority outcomes should accompany this: the empowerment of people to challenge stigma and discrimination, and people being able to access a more inclusive service system without fear of stigma and discrimination.

New opportunities

5. Invest in the decentralisation of Victoria's sexual health services, such as through the expansion of the Melbourne Sexual Health Centre service.

6. Align the STI notification forms with the HIV notification forms, so they include a 3-step data collection methodology (sex assigned birth, gender identity, intersex status).

7. Make annual LGBTI training in cultural affirmative practice a requirement under funding agreements for all sexual health services funded by the Victorian Government.

8. Expand nurse practitioner and peer-led approaches to STI testing and treatment across the sexual health service system.

9. Increase the utilisation of digital platforms for STI awareness, prevention and testing.

10. Develop guidelines on prophylaxis for bacterial STIs and fund research to improve the evidence base.

Reducing transmission of STIs

11. Invest in community-controlled health promotion and peer education to improve health literacy, particularly among priority populations.

12. Fund research into the development of peer education and health promotion strategies directly addressing the complex navigation of sexual health and wellbeing, AOD use and sexual consent.

13. Fund research to determine how to better target sexual health promotion campaigns to heterosexual-identifying men who have sex with men.

14. Reinstate Victoria's HPV catch up program for men who have sex with men and expand it to include people living with HIV regardless of age.

Improving access to STI testing

15. Consider thresholds for a decrease in testing or increase in notifications among priority populations that would act as triggers for funding of responsive health promotion campaigns and activities targeted to these populations.

16. Boost the capacity of community-controlled LGBTI sexual health services.

17. Fund pathology STI testing for people ineligible for Medicare.

18. Fund peer support and navigation workers to deliver peer-driven health promotion to at-risk communities and connect people with services.

19. Boost outreach testing for priority populations, including gay and bisexual men and trans and gender diverse people, by investing in a mobile testing van for Victoria's community-controlled LGBTI sexual health service, PRONTO!.

Improving access to STI treatment

20. Invest in roles that create employment pathways for nurse practitioners.

21. Encourage the use of nurse practitioners in services by prioritising funding to services investing in the development of, and working with, this under-utilised workforce.

22. Invest in GP sexual health training with a test and treat component.

23. Consider ways Victoria can promote investment in new vaccines and therapeutics, including for STIs, such as by establishing a medical research acceleration fund for novel vaccines and therapeutics, setting aside a proportion of funding in Victoria's existing Medical Research Acceleration Fund for novel vaccines or therapeutics, or working with other Australian governments to establish a joint fund for this purpose.

Reducing stigma and discrimination

24. Invest in LGBTI training of mainstream sexual health services to reduce fear and experiences of stigma, which act as barriers to service access for people from LGBTI communities.

25. Invest in alcohol and other drug (AOD) training of sexual health services and develop pathways between the AOD and sexual health services.

26. Fund health promotion resources and activities targeted to culturally and linguistically diverse communities, including campaigns that target people belonging to both LGBTI and culturally and linguistically diverse communities.

Investing in sexual health services

27. Funding for sexual health services in Victoria should be increased.

3. Priority outcomes

The *STI Action Plan 2018-2020* outlines four priority areas, namely prevention, testing, treatment, and stigma and discrimination. Each of these areas has objectives (or goals). The goal for prevention is to support people to reduce their risk of STIs; the goal for testing is that people with an STI know their status; the goal for treatment is that people with an STI have access to treatment and care; and the goal for stigma and discrimination is to empower people to challenge it. In addition to priority areas and goals, more focused priority outcomes and their associated actions are recommended.

3.1. Prevention

The goal for prevention should be an overall reduction in STIs. The first step towards this goal requires people knowing how to reduce their risk of STIs and acting on that knowledge. Priority actions to achieve this outcome should include the development of community co-designed sexual health resources that target priority populations, and the expansion of peer support frameworks to engage, support and educate priority populations. Research is also needed to determine how to better target heterosexual-identifying men who have sex with men.

However, prevention should also be viewed through the lens of public health, not just reducing an individual's risk of acquiring an infection. As such, a second priority outcome for prevention should be year-on-year reductions in notifications for each notifiable STI despite year-on-year increases in testing. This would indicate real gains in suppressing STI incidence. Prevention-specific actions to achieve this outcome should include improved delivery of vaccination programs to priority populations (e.g. HPV vaccination targeted to men who have sex with men), as well as actions taken to improve testing and treatment as they also contribute to a reduction in STIs.

The number and rates of STI tests should be published on the 'Local Government areas surveillance report' website to increase accountability,[2] and data breakdowns by age, location, sexual orientation, gender identity, sex characteristics, and Australian or overseas-born status including years since having arrived in Australia, should be provided to sexual health services.

Recommendation 1

The objective for prevention should be an overall reduction in STIs. Two priority outcomes should accompany this: people knowing how to reduce their risk of STIs and acting on that knowledge, and year-on-year decreases in notifications for each notifiable STI despite year-on-year increases in testing.

[2] Department of Health & Human Services, 'Local Government areas surveillance report' (Website, 2020) <https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/interactive-infectious-disease-reports/local-government-areas-surveillance-report>

3.2. Testing

If the goal is for people with an STI to know their status, a priority outcome for testing must be an increase in year-on-year testing numbers. An increase in STI testing that keeps pace with the rate of population growth should be expected at a minimum. Any reduction in testing represents a failure of the system to meet and encourage demand. Actions to achieve this outcome include increasing investment in sexual health infrastructure and testing capacity.

To ensure people are not discouraged from testing, a further priority outcome should be the removal of barriers to testing. Actions to achieve this include the availability of more free sexual health services for people ineligible for Medicare, greater investment in community-controlled sexual health services that are trusted by the communities they serve, training of mainstream services so they are culturally affirmative and inclusive, and peer navigation to increase STI testing among priority populations including gay and bisexual men, trans and gender diverse people, and culturally and linguistically diverse people. As barriers to testing disproportionately impact priority populations, a further action for this outcome should be to measure annual testing and notification rates among priority populations. If testing rates decrease, or notifications increase beyond a certain threshold, this should act as a trigger for responsive health promotion campaigns and activities targeted to these populations that bolster existing health promotion.

Recommendation 2

The objective for testing should be for people with an STI to know their status. This should be accompanied by two priority outcomes: a year-on-year increase in testing numbers, and the removal of barriers to testing.

3.3. Treatment

If the goal is to ensure people with an STI have access to the treatment and care services they require, then a priority outcome should be the removal of barriers to treatment. As these barriers are similar to those for testing, the actions to achieve this outcome are largely the same, namely increased availability of free sexual health services, greater investment in community-controlled sexual health services that are trusted by the communities they serve, training of mainstream services so they are culturally affirmative and inclusive, and peer navigation to increase service use among priority populations, because people aren’t treated unless they are tested.

There is also a need for strengthened systems to respond to increasing antimicrobial resistance, including training for GPs that includes a test and treat component, and research into new vaccines and therapeutics (e.g. bacteriophage for the treatment of antibiotic-resistant bacterial STIs).

Recommendation 3

The objective for treatment should be for people with an STI to have access to the treatment and care services they need. This should be accompanied by two priority outcomes: a removal of barriers to treatment, and strengthened systems to respond to increasing antimicrobial resistance and research into new vaccines and therapeutics for STIs.

3.4. Stigma and discrimination

A more appropriate goal would be the elimination of stigma and discrimination in services that provide sexual health testing. One priority outcome here is the empowerment of people to challenge stigma and discrimination, actions for which include investing in health promotion to improve sexual health literacy. However, in addition to people being empowered to challenge stigma and discrimination, they should also be able to access a service system without fear of stigma and discrimination; a relevant priority outcome for which would be a more inclusive sexual health system. Actions to achieve this outcome include greater investment in community-controlled services, and cultural competency training, including LGBTI training, for those working in primary care and mainstream sexual health services, as well as alcohol and other drug training for all sexual health services.

Recommendation 4

The objective for stigma and discrimination should be the elimination of stigma and discrimination in services that provide sexual health testing. Two priority outcomes should accompany this: the empowerment of people to challenge stigma and discrimination, and people being able to access a more inclusive service system without fear of stigma and discrimination.

4. New opportunities

4.1. Decentralisation of Victoria's sexual health services

The STI strategy should prioritise the decentralisation of Victoria's sexual health infrastructure because all of the goals outlined in the previous section are, to a lesser or greater degree, dependent on this happening. Without testing services in outer metropolitan, suburban and regional areas, people from those areas are less likely to get tested, and therefore less likely to be treated and more likely to pass on an STI.

At present, many people have to travel long distances to get tested, which is a geographical barrier to testing. The availability of sexual health services in a local community can also have a normalising effect on testing that reduces the stigma associated with it. As Victoria's sexual health infrastructure is decentralised, it will be important to keep in mind that sexual and reproductive health are overlapping but distinct areas of health. As such, just as it is appropriate for reproductive health funding to be directed to family planning services, sexual health funding should be directed to dedicated sexual health services.

Recommendation 5

Invest in the decentralisation of Victoria's sexual health services, such as through the expansion of the Melbourne Sexual Health Centre service.

4.2. Improve LGBTI data collection

There is a need to improve the maturity, agility and reach of our surveillance and data systems, including the collection of broader epidemiological data, as this is necessary to assist with better understanding and reaching priority populations. When people of diverse sexual orientations, gender identities and sex characteristics are not included in data collection, they are invisible to policymakers.[3] In Australia, the inclusion of all trans and gender diverse people in a single third gender category has hindered the analysis of relevant data.[4] While almost nothing is known about STI rates in trans men,[5] the epidemiology of STIs differs between trans and gender diverse and cisgender populations; a fact which underpins the need for service providers to

[3] Canberra LGBTIQ Community Consortium, 'A Guide to LGBTIQ Inclusive Data Collection' (Report, 2017) <https://aidsaction.org.au/images/resource-library/LGBTIQ%20Inclusive%20Data%20Collection%20-%20a%20Guide.pdf>

[4] Denton Callander et al, 'Sexually Transmissible Infections among Transgender Men and Women Attending Australian Sexual Health Clinics' (2019) 211(9) *Medical Journal of Australia* 406

[5] Ibid 406

better capture LGBTI data, and report it in a timely fashion, in order to facilitate the delivery of sexual health care to people from LGBTI communities.[6]

Recommendation 6

Align the STI notification forms with the HIV notification forms, so they include a 3-step data collection methodology (sex assigned birth, gender identity, intersex status).

4.3. LGBTI training and workforce development

Key actions specific to men who have sex with men and LGBTI communities outlined in the *STI Action Plan 2018-2020* include workforce development, such that the Victorian workforce has the skills, knowledge and attitudes to deliver best practice STI prevention, testing, treatment and care. The consultation paper notes that "continuing to invest in and improve the capability and capacity of the primary care workforce and services and improving referral pathways to specialist support, where necessary, will be critical to building a successful STI strategy. Integral to this capacity building is the expansion of an STI workforce, increasing nurses, nurse practitioners, general practitioners and pharmacists' knowledge and skills in sexual health." A plan needs to be developed to action these critical areas of workforce development.

Annual LGBTI cultural affirmative practice training should be a mandatory requirement in funding agreements. This would ensure that all funded service providers meet minimum standards, which could be demonstrated through achieving Rainbow Tick Accreditation standards,[7] or through ongoing and regular staff training and development provided by community-controlled LGBTI organisations.

Recommendation 7

Make annual LGBTI training in cultural affirmative practice a requirement under funding agreements for all sexual health services funded by the Victorian Government.

[6] Pash.tm, *Data Collection*, (Position statement, March 2018) <http://www.grunt.org.au/wp-content/uploads/PASH.tm-Data-Collection_March2018.pdf>

[7] Quality Innovation Performance, Rainbow Tick Standards (Website, 2020)<https://www.qip.com.au/standards/rainbow-tick-standards/>

Nurse practitioner and peer-led approaches are feasible and acceptable STI testing approaches that also require a priority focus.[8] Currently, PRONTO! and the Centre Clinic operate on these models and have been shown to increase testing and deliver satisfactory outcomes for clients. Given this community-based and culturally responsive approach, nurse practitioner and peer-led approaches should be integrated more widely into Victoria's sexual health service system.

Recommendation 8

Expand nurse practitioner and peer-led approaches to STI testing and treatment across the sexual health service system.

4.4. Digital technology

In the digital age, the greater use of online platforms for prevention, testing and treatment services will, by necessity, be a feature of Victoria's strategic response to STIs. Social networking, text messages and websites present new opportunities to deliver health interventions.

A recent systematic review of digital interventions focusing on young people found a range of positive outcomes, but digital technologies do not in themselves guarantee success.[9] This can also be compounded by the rapid pace of change in digital platforms, where an evidence-base is difficult to consistently maintain.

Nevertheless, interventions that act in real-time, are customised to the target audience, are convenient and facilitate networking between the participant and the health provider or service, have the potential to increase sexual health literacy and rates of STI testing in Victoria. Digital technology allows for targeted and specific health promotion messaging, but this can only be fully utilised if relevant data is collected and disseminated.

Recommendation 9

Increase the utilisation of digital platforms for STI awareness, prevention and testing.

[8] Kathleen Ryan et al, 'Assessment of Service Refinement and Its Impact on Repeat HIV Testing by Client's Access to Australia's Universal Healthcare System: A Retrospective Cohort Study' (2019) 22(8) *Journal of the International AIDS Society* e25353; Kathleen Ryan et al, 'Trial and Error: Evaluating and Refining a Community Model of HIV Testing in Australia' (2017) 17(1) *BMC Health Services Research* 692

[9] Erin Wadham et al, 'New Digital Media Interventions for Sexual Health Promotion among Young People: A Systematic Review' (2019) 16(2) *Sexual Health* 101

4.5. Prophylaxis for bacterial STIs

A recent study of Melbourne-based gay and bisexual men taking PrEP found that 9.9% reported using the antibiotic doxycycline as prophylaxis for bacterial STIs in the previous month.[10] The study found that men who have sex with men who inject drugs are more likely to use doxycycline for STI prophylaxis, and that sexual practices including condom use and number of sexual partners are not related to its use.[11]

Several countries, including the United Kingdom, have guidelines against prescribing doxycycline for STI prophylaxis.[12] There is a need for guidelines on prophylaxis for bacterial STIs to inform if and how they are prescribed, as well as funding for research to improve the evidence base for their use. Currently the evidence is limited, with the greatest benefit assumed for people who experience recurrent bacterial STIs. There is also limited evidence regarding the potential harms in terms of antibiotic resistance or the physical and mental health impacts associated with changes to the gut microbiota that inevitably result from the use of broad-spectrum antibiotics.

Recommendation 10

Develop guidelines on prophylaxis for bacterial STIs and fund research to improve the evidence base.

[10] Eric P F Chow and Christopher K Fairley, 'Use of doxycycline prophylaxis among gay and bisexual men in Melbourne' (2019) 6(9) *The Lancet HIV* E568-569
[11] Ibid 568
[12] Golden MR, Handsfield HH. 'Preexposure prophylaxis to prevent bacterial sexually transmitted infections in men who have sex with men' (2015) 42 *Sexually Transmissible Diseases* 104–06; Public Health England British Association for Sexual Health and HIV Position statement on doxycycline as post-exposure prophylaxis for sexually transmitted infections (PHE Publications gateway number: 2017543) <https://www.bashhguidelines.org/media/1156/doxy_pep_statement_v5_phe_bashh.pdf>

5. Reducing STI transmission

5.1. Health promotion and education to improve sexual health literacy

Research into and the development of peer education and health promotion strategies directly addressing the complex navigation sexual health and wellbeing, AOD use and sexual consent, is needed to support vulnerable community members to understand their rights, know risks and make informed decisions. Such peer education and health promotion is particularly important for priority populations such as gay and bisexual men.

Recommendation 11

Invest in community-controlled health promotion and peer education to improve health literacy, particularly among priority populations.

Recommendation 12

Fund research into the development of peer education and health promotion strategies directly addressing the complex navigation of sexual health and wellbeing, AOD use and sexual consent.

5.2. Research to better target heterosexual-identifying men who have sex with men

A large proportion of men who have sex with both men and women only report a sexual attraction to women, so messaging that is aimed at gay men is unlikely to get through to this cohort.[13] Further research is needed to inform the development of STI health promotion that effectively targets heterosexual-identifying men who have sex with men, including those from culturally and linguistically diverse communities, who are less engaged with LGBTI communities.

Recommendation 13

Fund research to determine how to better target sexual health promotion campaigns to heterosexual-identifying men who have sex with men.

[13] Op cit. 5

5.3. HPV vaccination for high-risk groups

Men who have sex with men and people living with HIV are high-risk populations for human papillomavirus (HPV). Persistent infection with high-risk strains of HPV is associated with 80–90% of anal cancers and 40–50% of penile cancers.[14] The HPV vaccination is highly effective at preventing HPV infection and also significantly reduces the risk of high-grade anal cancer in men who have sex with men.[15]

Despite expert recommendations,[16] the National Immunisation Program Schedule does not currently include HPV vaccination for these high-risk Australian populations, and the subsequent cost is a barrier to uptake.

A stop-gap initiative that included HPV vaccination for men who have sex with men aged 26 and under in Victoria ended on 31 October 2019. In the absence of the Federal Government immediately rectifying this key gap in the National Immunisation Program Schedule, Victoria should reinstate the HPV catch-up program for men who have sex with men and extend it to include people living with HIV, with no arbitrary age limit placed on who can receive the vaccine.

Recommendation 14

Reinstate Victoria's HPV catch up program for men who have sex with men and expand it to include people living with HIV regardless of age.

[14] Fleur van Aar et al, 'Anal and penile high-risk human papillomavirus prevalence in HIV-negative and HIV-positive MSM' (2013) 27(18) *AIDS* 2921, 2922

[15] Joel M Palefsky et al, 'HPV vaccine against anal HPV infection and anal intraepithelial neoplasia' (2011) 356 (17) *New England Journal of Medicine* 1576

[16] Australian Government, Department of Health, Public consultation on changes to the recommended use of human papillomavirus (HPV) vaccines (Consultation paper, March 2018) <https://beta.health.gov.au/resources/publications/revised-use-of-human-papillomavirus-hpv-vaccines-january-2018>; National Centre for Immunisation Research and Surveillance, Fact sheet: Human papillomavirus (HPV). Human papillomavirus (HPV) vaccines for Australians: Information for immunisation providers (Fact sheet, April 2018) <http://www.ncirs.edu.au/assets/provider_resources/fact-sheets/human-papillomavirus-hpv-fact-sheet.pdf>

6. Improving access to STI testing

6.1. Ensure a data-driven response to priority populations

The response to STIs should be data-driven, with particular attention given to priority populations. If priority populations' testing rates decrease or notifications increase beyond a certain threshold, this should act as a trigger for responsive health promotion campaigns and activities targeted to these populations that bolster existing health promotion - the aim being to increase testing and decrease notifications.

Recommendation 15

Consider thresholds for a decrease in testing or increase in notifications among priority populations that would act as triggers for funding of responsive health promotion campaigns and activities targeted to these populations.

6.2. Invest in community-controlled LGBTI sexual health services

Fear and experiences of stigma and discrimination act as barriers to STI testing. This is especially true for the priority populations, including gay and bisexual men and trans and gender diverse people, that Thorne Harbour Health services. In order to improve access to STI testing, LGBTI communities need access to culturally appropriate and safe testing and treatment services across Victoria. LGBTI people trust community-controlled LGBTI sexual health services to be safe and affirming because they are operated by and for members of LGBTI communities. An example of such a service is PRONTO!, operated by Thorne Harbour Health.

Peer-led rapid HIV testing has become an integral feature of the national push to increase HIV testing. Since Victoria opened Australia's first peer-led rapid testing site in July 2013, PRONTO! has demonstrated that its peer-led model attracts a population that is at high risk for HIV and that test irregularly.[17] As of June 2020, PRONTO! has provided rapid HIV tests to 10,920 individuals.

In February 2016, PRONTO! expanded its services to include STI testing and the provision of PrEP to clients at risk of HIV. As of June 2020, 1667 individuals accessed PrEP through PRONTO! and over 5240 peer tested clients have undertaken gonorrhoea, syphilis and chlamydia testing. The service has delivered PrEP through a mix of general practitioners and nurse practitioners.

[17] Ryan, Kathleen, 'Evaluation of PRONTO!, A Peer-Led Rapid Point-of-Care HIV Testing Service in Melbourne, Australia' (Thesis, 24 September 2018) <https://bridges.monash.edu/articles/thesis/Evaluation_of_PRONTO_a_peer-led_rapid_point-of-care_HIV_testing_service_in_Melbourne_Australia/7121951>

An independent review by the Burnet Institute found that clients rated the peer testing model highly and preferred it over clinical settings. Piloted outreach and out-posted peer testing at non-fixed sites in regional areas like Bendigo have also proved popular. This successful community-controlled LGBTI sexual health service should be funded to expand its service reach.

Recommendation 16

Boost the capacity of community-controlled LGBTI sexual health services.

6.3. Removing testing barriers for those ineligible for Medicare

Rapid HIV testing has proven popular with male and trans sex workers, especially those born overseas who are working in Australia and don't have a Medicare card.[18] This cohort may not be obtaining full sexual health screens because they don't engage with services that are 'too complicated' or require payment.[19] Medicare ineligible patients are also experiencing barriers to STI testing, and this cohort has a higher prevalence of some STIs.[20]

Currently, health services are required to provide refugees and asylum seekers with unbilled testing, as well as prisoners and those being tested for tuberculosis.[21] A recent study into the upscaling of Thorne Harbour Health's PRONTO! STI testing service found an increase in testing for those eligible for Medicare, but these benefits did not extend to those ineligible for Medicare.[22] Financial barriers are significant, with Medicare ineligible patients required to pay up to $158 for STI testing.[23] This is further exacerbated by Medicare ineligible patients' uncertainty about what services are covered by their private health insurance and the requirement to navigate a foreign health care system where they pay upfront and claim back the expense.

The way the system is currently designed is hampering Victoria's test and treat prevention strategy. Victoria's STI Strategy needs to reduce financial barriers for Medicare ineligible patients and streamline STI testing such that navigation of the healthcare system is easier, timely, and culturally tailored. Access to affordable, non-judgmental sexual health services is essential in maintaining the sexual health and wellbeing of the population.

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[18] Respect Inc, 'TaMS: Factors influencing transgender and male sex worker access to sexual health care, HIV testing and support study' (Report 2018) <https://respectqld.org.au/wp-content/uploads/Documents/TaMS-Report-2018.pdf>

[19] Ibid

[20] Anysha Walia et al, 'Disparities in Characteristics in Accessing Public Australian Sexual Health Services between Medicare- eligible and Medicare- ineligible Men Who Have Sex with Men' (2020) 44(5) *Australian and New Zealand Journal of Public Health 363*

[21] Department of Human Services, 'Ineligible patients' (Website, 2020) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-fees-charges/admitted-patients/ineligible>

[22] Kathleen Ryan et al, 'Assessment of Service Refinement and Its Impact on Repeat HIV Testing by Client's Access to Australia's Universal Healthcare System: A Retrospective Cohort Study' (2019) 22(8) *Journal of the International AIDS Society* e25353

[23] Ibid

Free and easily accessible STI testing and treatment for non-Medicare eligible people will prevent the onward transmission of STIs.

Recommendation 17

Fund pathology STI testing for people ineligible for Medicare.

6.4. Culturally and linguistically diverse peer support and navigation

Recently arrived migrant communities experience barriers including upfront costs, the complexity of the health care system, a reliance on word of mouth to advertise services, and lack of trust in the privacy and confidentiality of services.[24] Groups like Gay Asian and Proud[25] provide a culturally responsive model for addressing these barriers through social connectedness and peer support. This is just one example of how programs can be tailored to address the particular social and situational factors of certain cohorts. An expansion of these services is critical as peer support has been shown to build health knowledge in trans and gender diverse and culturally and linguistically diverse communities.[26] Funding is needed to expand multicultural and LGBTI peer support and navigation networks.

Recommendation 18

Fund peer support and navigation workers to deliver peer-driven health promotion to at-risk communities and connect people with services.

6.5. Boost outreach testing through mobile units and point of care testing equipment

Victoria needs mobile sexual health testing capacity to reach men who have sex with men in community spaces, including events, beats, and sex on premises venues. This could be achieved, for example, by funding a permanent testing van for PRONTO!, Victoria's only

[24] Centre for Culture, Ethnicity & Health, 'Double Trouble? The Health Needs of Culturally Diverse MSM' (Report, 2010) <https://www.ceh.org.au/wp-content/uploads/2018/05/Double-Trouble_MHSS_Reeders.pdf>

[25] Thorne Harbour Health, Gay Asian Proud: Questioning stereotypes & assumptions, (Webpage, 2020) <https://thorneharbour.org/news-events/calendar-events/gay-asian-proud-event/>

[26] Belen Febres-Cordero et al, 'Influence of Peer Support on HIV/STI Prevention and Safety amongst International Migrant Sex Workers: A Qualitative Study at the Mexico-Guatemala Border' (2018) 13(1) *PloS one* e0190787

community-controlled LGBTI sexual health service. This would increase the service reach and access to currently underserved populations.

Along with a vehicle for mobile testing, there is a need for point of care testing (POCT) equipment. A one-off capital expense or funding for PRONTO! to lease and operate a POCT, Gene XPert testing machine would increase the service's STI testing for chlamydia and gonorrhoea by 30–40% and result in approximately 1000 additional STI screens being undertaken by the service each year. This POCT equipment provides results within 90 minutes and would allow same-day STI treatment, which would reduce onward transmission rates significantly.

The PRONTO! service has been evaluated and found to be highly acceptable to the men who have sex with men community.[27] Peer POCT for STIs using The Gene XPert machine has been favourably evaluated in a comparable setting in Queensland at the Rapid Peer Testing service.[28]

Recommendation 19

Boost outreach testing for priority populations, including gay and bisexual men and trans and gender diverse people, by investing in a mobile testing van for Victoria's community-controlled LGBTI sexual health service, PRONTO!.

[27] Kathleen Ryan, 'Evaluation of PRONTO!, A Peer-Led Rapid Point-of-Care HIV Testing Service in Melbourne, Australia' (Thesis, 24 September 2018) <https://bridges.monash.edu/articles/thesis/Evaluation_of_PRONTO_a_peer-led_rapid_point-of-care_HIV_testing_service_in_Melbourne_Australia/7121951>

[28] Amy Mullens et al, 'Point-of-Care Testing (POCT) for HIV/STI Targeting MSM in Regional Australia at Community 'Beat Locations' (2019) 19(1) *BMC Health Services Research* 93; Bell, Sara Fe et al, 'Peer-Delivered Point-of-Care Testing for Chlamydia Trachomatis and Neisseria Gonorrhoeae within an Urban Community Setting: A Cross-Sectional Analysis' (2020) 17(4) *Sexual Health* 359

7. Increasing access to STI treatment

7.1. Nurse practitioners

Sexual health nurse practitioners (NPs) present a unique opportunity to extend testing and treatment services into new settings and locations, including within peer services, sex on premises venues, and clinics in outer metropolitan, suburban, and regional areas with limited primary health care capacity.

Having skilled NPs in high caseload HIV services means that they can manage the high number of patients presenting for routine STI testing and PrEP. At the same time, general practitioners can focus on complex HIV management. Additional clinical support in the practice ensures that HIV positive patients are able to access appointments and care readily.

NPs can work independently within the scope of their training, visit regional communities and provide services in settings where people aren't comfortable seeing their regular GP for testing and treatment because of fear of stigma and discrimination. They are a cost-effective workforce option, and their ability to claim Medicare Benefits Schedule (MBS) items helps offset employment costs. NPs can also work independently as subcontractors within services on an income share basis.

Unfortunately, the lack of potential employment opportunities and career pathways can be a deterrent for nurses considering this training. This can result from several factors, including:

- Some GPs not trusting NPs to do the work;
- To our knowledge, a lack of existing employment models and research that demonstrate the effectiveness of NP models in sexual health care to encourage health services to utilise this model;
- MBS rates being half what GPs are paid for the same work. Also, sexual health NPs cannot currently bill mental health or chronic disease management items; and
- The uncertainty of employability once the training is complete.

Recommendation 20

Invest in roles that create employment pathways for nurse practitioners.

Recommendation 21

Encourage the use of nurse practitioners in services by prioritising funding to services investing in the development of, and working with, this under-utilised workforce.

7.2. Test and treat training

Experienced medical practitioners often utilise a test and treat strategy to reduce the risk of antimicrobial resistance and the negative impacts of infection, and this has the added benefit of improving service efficiency and reducing costs on the system. However, general practitioners are less experienced in sexual health and are therefore less aware of the importance of a test and treat strategy, meaning patients are more vulnerable to the development of resistant infections that could spread throughout the community. Investment in GP sexual health training with a test and treat component would help to improve the response of GPs to STIs and in turn, improve patient outcomes.

Recommendation 22

Invest in GP sexual health training with a test and treat component.

7.3. Investing in new vaccines and therapeutics

New STI vaccines are needed to address the global burden of STI disease, to which Victoria is not immune. While vaccines for hepatitis B and human papillomavirus have been game-changers, and vaccine candidates for herpes simplex virus, chlamydia and syphilis are in development,[29] further investment in vaccine development for other STIs is warranted.[30]

As the COVID-19 pandemic has highlighted, however, in addition to investment in vaccine development, it is necessary to pursue the development of new therapeutics, including for STIs. The need for new vaccines and therapies in our arsenal is becoming more urgent with the emergence of multidrug-resistant STIs, such as multidrug-resistant gonorrhoea.[31] In an era of increasing antibiotic resistance and underinvestment in antibiotic discovery, there is a clear and growing need for novel therapeutics. For example, bacteriophage (or phage) are ubiquitous viruses that infect bacteria, and phage therapy has a number of advantages to antibiotics. However, there is a significant need for more clinical research before this therapy can be utilised in humans.[32]

[29] Edwin D G McIntosh. 'Development of vaccines against the sexually transmitted infections gonorrhoea, syphilis, Chlamydia, herpes simplex virus, human immunodeficiency virus and Zika virus' (2020) 8 *Therapeutic Advances in Vaccines and Immunotherapy* 1
[30] Ibid
[31] Department of Health, Multi-drug resistant gonorrhoea detected in Australia, (Website, 17 April 2018) <https://www2.health.vic.gov.au/about/news-and-events/healthalerts/multi-drug-resistant-gonorrhoea-detected-in-australia>
[32] Squires, R.A. 'Bacteriophage therapy for management of bacterial infections in veterinary practice: what was once old is new again' 66(5) *New Zealand Veterinary Journal* 229

The *Victorian Public Health and Wellbeing Plan 2019-2023* lists decreasing the risk of drug-resistant infections in the community as one of its ten priorities.[33] However, of the four aims it lists to achieve this, none focus on encouraging investment in the development of new vaccines and therapeutics.[34] There is room for state and territory governments to champion and work with the Federal Government to ensure greater investment in the development of new vaccines and therapeutics, including for STIs, as a potential growth and export industry.

Recommendation 23

Consider ways Victoria can promote investment in new vaccines and therapeutics, including for STIs, such as by establishing a medical research acceleration fund for novel vaccines and therapeutics, setting aside a proportion of funding in Victoria's existing Medical Research Acceleration Fund for novel vaccines or therapeutics, or working with other Australian governments to establish a joint fund for this purpose.

[33] Department of Health, Victorian public health and wellbeing plan 2019–2023 (Report, 28 August 2019) <https://www2.health.vic.gov.au/Api/downloadmedia/%7BE62CA39E-380A-443F-A3B7-EB9022E9AC8F%7D>
[34] Ibid 24

8. Reducing stigma and discrimination

Normalising discussions about sexual health and wellbeing is key to addressing stigma and discrimination. Part of this involves making testing and treatment services readily available in settings that are free of judgement, culturally sensitive and with minimised barriers to access. Discrimination is a consequence of stigma, and removing stigma requires a continuum of both broad and targeted awareness-raising campaigns in the community, as well as further research into interventions that reduce stigma.

8.1. LGBTI training of mainstream sexual health services

Trans and gender diverse people commonly report negative health care experiences in sexual health service settings.[35] This deters the development of routine testing behaviours and learning about risks specific to this population. A study of trans and gender diverse people found extremely high rates of marginalisation in sexual health care based on their gender, with less than half of participants saying they had experienced inclusive sexual health care; a factor associated with lower sexual health testing rates among those who were sexually active.[36]

Due to fear of stigma, heterosexual-identifying men who have sex with men often do not disclose their sexual behaviour, and as a result, this cohort is less likely to be screened for HIV and other STIs.[37] Stigma can also affect people who are in non-heteronormative relationships, such as open, polyamorous or bisexual relationships. Bisexual women, in particular, lack safe and non-judgemental services to attend where they can openly discuss sexual risk activities without stigma.[38]

Workforce education should focus on understanding the needs of numerous cohorts within the LGBTI communities, with particular focus on identifying and engaging with heterosexual-identifying men who have sex with men, and the cultural drivers that increase their risk of STIs (experiences of isolation, institutionalisation, alcohol and other drug (AOD) use, sex work, non-western cultural understandings of sexuality etc.).[39] Teaching clinicians to stop making heteronormative assumptions and to engage openly with all men will support testing and treatment and reduce the burden of these infections on both themselves and their partners.

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[35] Denton Callander et al, 'The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings: The Kirby Institute' (Report, 2020) <https://kirby.unsw.edu.au/sites/default/files/kirby/report/ATGD-Sexual-Health-Survey-Report_2018.pdf> 12

[36] Ibid 16

[37] Ontario HIV Treatment Network, 'Sexual health of heterosexually-identified men who have sex with men' (Rapid Review 92, 2014) <http://www.ohtn.on.ca/rapid-response-92-sexual-health-of-heterosexually-identified-men-who-have-sex-with-men-2/>

[38] Stephen Neville and Mark Henrickson, 'Perceptions of Lesbian, Gay and Bisexual People of Primary Healthcare Services' (2006) 55(4) *Journal of Advanced Nursing* 407

[39] Emile Jasek et al, 'Sexually Transmitted Infections in Melbourne, Australia from 1918 to 2016: Nearly a Century of Data' (2017) 41(3) *Communicable Diseases Intelligence*; Handan Wand et al, 'Temporal Trends in Population Level Impacts of Risk Factors for Sexually Transmitted Infections Among Men Who Have Sex with Men, Heterosexual Men, and Women: Disparities by Sexual Identity (1998–2013)' (2018) 47(7) *Archives of Sexual Behavior* 1909

Recommendation 24

Invest in LGBTI training of mainstream sexual health services to reduce fear and experiences of stigma, which act as barriers to service access for people from LGBTI communities.

8.2. AOD training of sexual health services

AOD training of doctors, nurses and contact tracers is needed to prevent stigmatising clinical practices and promote non-judgmental care and referrals to appropriate care for people that engage in substance use during sexual activities (chem sex). Non-judgemental care involves acknowledging the social influence and pleasure associated with chem sex to increase patient acceptability of strategies to reduce harms associated with substance use, such as STIs and addiction.[40]

Recommendation 25

Invest in alcohol and other drug (AOD) training of sexual health services and develop pathways between the AOD and sexual health services.

8.3. Sexual health promotion targeted to culturally and linguistically diverse communities

Culturally appropriate health promotion activities and resources need to be developed in consultation with people from culturally and linguistically diverse communities, including LGBTI people from these communities, as these intersecting communities add to the complexity of barriers to care.[41] There is a need to include treatment and prevention information as well as information on how to navigate the sexual health system and STI testing. Resource development should be community co-designed, written in plain language, and accessible to those with low levels of literacy and sexual health knowledge.

Recommendation 26

Fund health promotion resources and activities targeted to culturally and linguistically diverse communities, including campaigns that target people belonging to both LGBTI and culturally and linguistically diverse communities.

[40] Ymke Evers et al, 'Attitude and Beliefs about the Social Environment Associated with Chemsex among MSM Visiting STI Clinics in the Netherlands: An Observational Study' (2020) 15(7) *PloS one* e0235467
[41] Centre for Culture, Ethnicity and Health, 'Double Trouble? The Health Needs of Culturally Diverse MSM. (Report, 2010) <https://www.ceh.org.au/wp-content/uploads/2018/05/Double-Trouble_MHSS_Reeders.pdf>

9. Investing in sexual health services

Under fiscal constraints, it is tempting to find short term cost savings in a range of areas that would not normally be considered for funding cuts. If these fiscal constraints occur during a recession, reduced government spending can result in a prolonged economic downturn - the only way out of a recession is to spend one's way out. Irrespective of the broader economic situation, it is always unwise to cut funding of essential health and support services, because this funding represents an investment that saves the government money in the long term.

People whose health is well managed, and who have the social and service support needed to ensure it remains that way, are more productive members of society. There is no circumstance in which cutting funding for sexual health and wraparound support services is sensible or acceptable.

9.1. Getting STI rates back under control

The COVID-19 pandemic has impacted access to HIV and other STI testing and treatment for many Victorians. During the past six months of lockdown restrictions, community members have continued to engage in sexual activities in both personal and professional capacities. With decreased access to testing and treatment services and the silent nature of many STIs, a surge of STIs in the community is both possible and likely.

It is difficult to see how the Victorian Government could ignore the urgent need to bolster a system that has been struggling to meet the demand for many years. Further investment in this sector was urgently needed prior to COVID-19, and this need has only increased because of it.

Recommendation 27

Funding for sexual health services in Victoria should be increased.