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| Victorian sexually transmissible infections action plan2018–2020 |
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| To receive this publication in an accessible format email Prevention and Population Health <BBVSTI.Information@dhhs.vic.gov.au>.Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Australia, Department of Health and Human Services, June 2020.In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation.**ISBN** 978-1-76069-422-7 **(pdf/online/MS word)**Available at < <https://www2.health.vic.gov.au/public-health/preventive-health/sexual-health/policy-and-legislation-sexual-health>> |

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# Background

The Victorian Government is committed to improving every Victorian’s health status, healthcare outcome and experience. No matter where someone lives, their income, level of ability, gender or sexual orientation, all Victorians should have access to the health services they need, including sexual health services.

In August 2016, the Departmental Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections (the Committee) agreed to support the development of a Sexually Transmissible Infections Work Plan (the Work Plan). An initial draft was developed based on priorities identified through sector consultations in 2015-16. The sexually transmissible infections working group (the working group), a sub-group of the Committee, was established in December 2016 to oversee further development and implementation of the Work Plan.

In accordance with sustained increases in Victorian notifications of sexually transmissible infections (STI), disease burden and their role in facilitating the transmission of HIV, the Work Plan focused upon chlamydia among young people (aged 15-29) and syphilis and gonorrhoea among gay and bisexual men. The Working Group identified key short to medium term priority areas (6 -18 months) and longer term priorities (>18 months) to guide the Victorian STI response.

Following a Ministerial Roundtable on Sexually Transmissible Infections in September 2017, it was agreed that the Work Plan would be further reviewed and expanded into a two year action plan, extended beyond the initial three diseases of interest to include other existing and emerging diseases that are sexually acquired (namely shigellosis, hepatitis A and human papillomavirus in the first instance).

The Sexually Transmissible Infections Action Plan 2018-2020 (the Action Plan) has been developed based upon the original Work Plan, and through consultations with the STI Working Group and at the Roundtable. The refreshed STI Working Group, with revised membership and terms of reference, will monitor the implementation of the Action Plan.

## Goal

To reduce the transmission and impact of sexually transmissible infections in Victoria.

## Diseases of focus

The action plan focuses on:

* syphilis
* gonorrhoea
* chlamydia
* shigellosis
* hepatitis A
* human papillomavirus.

Background notification, behavioural, knowledge and testing data is in Appendix 1.

## Priority populations

Priority populations for the action plan include

* young people (15–29 years of age)
* gay and bisexual men
* Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people.

We acknowledge that The Action Plan acknowledges that many individuals may identify with multiple priority populations. Important sub-populations such as women, international students, people living with HIV, people who use drugs, people with disabilities, and people living in rural and regional areas of Victoria are not listed as distinct priority populations. Their unique needs and concerns will however be considered in the implementation of the Action Plan.

# Framework

The action plan sets out actions across four focus areas:

* **prevention** – people are supported to reduce their risk of acquiring an STI
* **testing** – people with an STI will know their status
* **treatment** – people with an STI will have access to the treatment and care services they require
* **stigma and discrimination** – people are empowered to speak about their sexual health and challenge stigma and discrimination.

The following system enablers have been identified to support work across all four focus areas:

* **workforce development** – the Victorian workforce has the skills, knowledge and attitudes to deliver best practice STI prevention, testing, treatment and care
* **surveillance, monitoring and data** – STI services and outcomes in Victoria are improved by regular surveillance and monitoring and improved quality and completeness of data
* **research and evaluation** – STI services and outcomes in Victoria are improved by supporting research and undertaking evaluation to build the evidence base for changes in policy, program and service delivery.

Actions of overlap with the Victorian HIV, hepatitis B and hepatitis C strategies are shaded and labelled, indicating that work will be implemented and monitored collaboratively across the respective working groups.

STI Action Plan 2018–2020 key priorities

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| Focus area | Objective | Priority action  |
| **Prevention** | People are supported to reduce their risk of acquiring an STI | * Build sexual health literacy, including knowledge and awareness of STIs, positive sexual health and safer sex behaviours among priority populations
* Deliver vaccination programs to priority populations
* Strengthen systems to respond to antimicrobial resistance and emerging STIs
 |
| **Testing** | People with an STI will know their status | * Strengthen systems to increase access to STI testing services across Victoria
* Improve comprehensive STI testing practices in primary care, community health and community-controlled settings
* Explore the feasibility of new and emerging testing technology
 |
| **Treatment** | People with an STI will have access to the treatment and care services they require | * Improve comprehensive STI treatment practices in primary care, community health and community-controlled settings
* Increase early diagnosis and treatment
 |
| **Stigma and discrimination**  | People are empowered to speak about their sexual health and challenge stigma and discrimination | * Normalise sexual health in priority communities and the general Victorian population
* Build and maintain inclusive primary care, community health and community-controlled settings
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| System enablers | Objective | Priority action |
| **Workforce development**  | The Victorian workforce has the skills, knowledge and attitudes to deliver best practice STI prevention, testing, treatment and care | * Build STI knowledge and enhance skills and capacity among primary care, community health and community-controlled workforces
* Improve the cultural sensitivity and integrity of the sexual health service system
* Build the capacity of an Aboriginal sexual health workforce
 |
| **Surveillance, monitoring and data**  | STI services and outcomes in Victoria are improved by regular surveillance and monitoring and improved quality and completeness of data | * Use regular monitoring and data to drive program focus and system changes to meet the needs of priority populations
* Improve data quality and completeness of data through enhancement activities
 |
| **Research and evaluation** | STI services and outcomes in Victoria are improved by supporting research and undertaking evaluation to build the evidence base for changes in policy, program and service delivery | * Support and use contemporary evidence to drive evidence-informed practice and priority setting
* Evaluate implementation of key activities across settings delivering STI services
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## Focus areas

### Prevention

People are supported to reduce their risk of acquiring an STI.

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| Strategy | Action  |
| **Build sexual health literacy, including knowledge and awareness of STIs, positive sexual health and safer sex behaviours among priority populations** | * Develop and implement communication awareness and engagement activities for priority population groups, focusing on:
	+ normalising STIs
	+ symptom and risk awareness over all sexually active age groups
	+ safer sex and risk reduction practices
	+ regular and frequent STI testing and looking after one’s sexual health and wellbeing
* Develop and implement targeted, culturally appropriate and innovative prevention and education activities and resources co-designed in partnership with priority populations, focusing on:
	+ safer sex behaviours
	+ normalising STIs and STI awareness
	+ regular testing and addressing cultural beliefs and taboos
* Develop and implement targeted communication messages about specific STIs for nominated priority populations, as needed
* Promote access to and use of condoms as part of a combination primary prevention strategy for priority populations, including increasing access to condoms
* Incorporate knowledge about STI transmission and prevention in PrEP rollout campaigns
* Strengthen partnership with the Department of Education and Training to support the delivery of comprehensive sexual health education in schools
* Improve access to STI and safer-sex education and prevention messages for school-aged young people outside of education settings
* In partnership with a tertiary and/or further education sector provider, support the delivery of a pilot initiative to improve access to sexual health information, prevention, screening and treatment for international students
* Explore establishing a partnership with mental health or alcohol and other drugs programs to integrate safer sex and regular STI testing messages in aligned services and/or settings
 |
| **Deliver vaccination programs to priority populations** | * Support the implementation of targeted prevention vaccination programs for priority populations, including communications, in consultation with community (for example, HPV, meningococcal A, hepatitis A, hepatitis B) – overlaps with the Victorian HIV, hepatitis B and hepatitis C strategies
* Support efforts to improve access to vaccination programs for school-aged young people outside of education settings – overlaps with the Victorian HIV, hepatitis B and hepatitis C strategies
 |
| **Strengthen systems to respond to antimicrobial resistance and emerging STI** | * Develop management plans for a possible gonorrhoea outbreak caused by an antibiotic resistant strain
* Develop targeted communication messages about antimicrobial resistance, risk reduction strategies and emerging STIs for nominated priority populations
* Continue to monitor antibiotic resistance for gonorrhoea and shigella
* Monitor the incidence and impact of emerging STIs and identify response options as needed
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### Testing

People with an STI will know their status.

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| Strategy | Action  |
| **Strengthen systems to increase access to STI testing services across Victoria** | * Integrate regular comprehensive STI testing and treatment into routine care for priority populations in primary care, community health, community-controlled and tertiary healthcare settings, including sexual and reproductive health hubs – overlaps with the Victorian HIV, hepatitis B and hepatitis C strategies
* Work in partnership with tertiary and further education institutions to increase access to STI testing and treatment services for young people, including subpopulations such as people ineligible to access subsidised health services
* Investigate barriers and challenges for international students accessing Victorian BBV/STI and sexual and reproductive health services, including overseas student health insurance cover
* Support innovative models of STI testing, treatment and care that increase access for priority populations including nurse-led, peer-led, mixed service models, outreach and youth-specific clinics
* Promote opportunistic STI testing among priority populations within primary care, community health and community-controlled settings and within hospital infectious diseases clinics
* Promote opt-out STI testing among priority populations within hospital infectious diseases clinics
* Promote syphilis opt-out testing along with HIV viral load tests as the standard model of care to all high case load clinics and hospitals
* Review population level disease incidence data to determine subpopulations at risk to enable logical and targeted testing initiatives
 |
| **Improve comprehensive STI testing practices in primary care, community health and community-controlled settings** | * Increase emphasis on regular testing, antenatal testing, additional testing if asymptomatic, re-testing, preventing re-infection and partner notification in primary care, community health and community-controlled settings
* Increase health professionals’ knowledge of the best modality of testing to facilitate susceptibility testing for surveillance purposes
* Work in partnership with other jurisdictions to advocate for the STIGMA guidelines to be updated to include three-monthly sexual health screening for gay and bisexual men using PrEP
* Work in partnership with other jurisdictions to advocate to the Commonwealth for inclusion of specific sexual health MBS billing items for nurse-led models of care
 |
| **Explore the feasibility of new and emerging testing technology**  | * Support in-principle innovative STI testing models and options outside of clinic settings including but not limited to self-testing, home testing, and postal testing
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### Treatment

People with an STI will have access to the treatment and care services they require.

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| Strategy | Action  |
| **Improve comprehensive STI treatment practices in primary care, community health and community-controlled settings** | * Support in-principle flexible and innovative models for treatment, care and support within usual billing systems, such as same-day STI treatment, outreach, electronic-based approaches and social media
* Promote the use of technological advances to strengthen patient recall systems in primary care, community health and community-controlled settings
* Monitor trends in gonorrhoea and shigella antimicrobial resistance and treatment recommendations through engagement with public and private laboratories and clinicians
* Improve antimicrobial stewardship by increasing the use of appropriate antibiotic treatment for gonorrhoea and shigella
* Improve the consistency of STI treatment information provided on laboratory reports to support low case load clinics
 |
| **Increase early diagnosis and treatment**  | * Promote localised STI referral pathways and clinical guidance to increase early detection and timely and appropriate treatment of cases
* Evaluate the uptake of Patient Delivered Partner Therapy in primary care for chlamydia control
* Promote and enhance partner notification, contact tracing and treatment of sexual partners, including Patient Delivered Partner Therapy for chlamydia control
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### Stigma and discrimination

People are empowered to speak about their sexual health and challenge stigma and discrimination.

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| Strategy | Action  |
| **Normalise sexual health in priority communities and the general Victorian population** | * Improve understanding and awareness of STI symptoms to promote risk reduction behaviours and support people to look after their sexual health and wellbeing
 |
| **Build and maintain inclusive primary care, community health and community-controlled settings** | * Gather information from priority populations to understand different experiences of stigma and how this might impact on barriers to accessing STI services, testing, treatment or engagement with public health campaigns
* Implement activities based on gathered information to normalise STI testing in primary care, community health and community-controlled settings
* Continue to ensure that priority populations, affected communities and people with lived experience are involved in the development of STI policy, programs and activities
* Improve the cultural safety and awareness of health professionals and STI services in primary care, community health and community-controlled settings
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## System enablers

### Workforce development

The Victorian workforce has the skills, knowledge and attitudes to deliver best practice STI prevention, testing, treatment and care.

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| Strategy | Action  |
| **Build STI knowledge and enhance skills and capacity among primary care, community health and community-controlled workforces** | * Develop, promote and deliver tailored health professionals’ STI education and training, resources and forums/workshops across Victoria, using flexible and accessible delivery modalities and suited to regional and local areas
* Promote STI education and training to allied health professionals, health service administrative staff, the education sector and translators
* Develop localised STI referral pathways and clinical guidance across the six Victorian primary health networks
* Promote the implementation of effective strategies and interventions in primary care, community health and community-controlled settings to increase STI diagnosis and improved patient treatment and care
* Strengthen linkages between primary care, community health and community controlled settings
* Support professional networks for knowledge sharing related to STIs and/or service delivery
* Support health professionals to better understand, interpret and use data (for example, epidemiological, behavioural) to inform the development and delivery of tailored community programs and activities
* Coordinate a statewide STI training and education calendar for the sexual health services sector
* Leverage and build on national and statewide programs that intersect with sexual health, to further extend the reach of workforce development initiatives
 |
| **Improve the cultural sensitivity and integrity of the sexual health service system** | * Promote Aboriginal and culturally diverse cultural safety training to health professionals through STI education and training initiatives
 |
| **Build the capacity of an Aboriginal sexual health workforce** | * Strengthen Aboriginal health worker training on STI, safer sex practices, risk reduction strategies, regular testing and treatment of cases and sexual partners
* In partnership with the Victorian Aboriginal Community-Controlled Health Organisation, support a dedicated sexual health workforce in Aboriginal community-controlled health organisations
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### Surveillance, monitoring and data

STI services and outcomes in Victoria are improved by regular surveillance and monitoring and improved quality and completeness of data.

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| Strategy | Action  |
| **Use regular monitoring and data to drive program focus and system changes to meet the needs of priority populations** | * Support and strengthen funded agency reporting using an outcomes framework approach to monitor and evaluate funded activities implemented across the STI action plan
* Support funded agency partnerships across the sector for collaboration, results sharing and continuous evaluation of activities and initiatives
* Use behavioural, testing and stigma data, including audits of clinical data, to broaden the evidence base for STI service delivery
* Improve electronic reporting of STI testing and notification data
* Monitor incidence, testing and re-infection data on STIs in real time
* Improve the monitoring of emerging STIs
 |
| **Improve data quality and completeness of data through enhancement activities** | * Implement strategies to improve the recording of Indigenous status for notifiable STI
* Improve collection, completeness and accuracy of datasets for Aboriginal and Torres Strait Islander and culturally and linguistically diverse peoples
* Increase available and accessible real-time epidemiological and laboratory surveillance data, at a granular level, to enable tailoring of community awareness and response activities
* Identify opportunities for legislative reform to improve the sexual health outcomes of priority populations in Victoria
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### Research and evaluation

STI services and outcomes in Victoria are improved by supporting research and undertaking evaluation to build the evidence base for changes in policy, program and service delivery.

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| Strategy | Action  |
| **Support and use contemporary evidence to drive evidence-informed practice and priority setting** | * Undertake to conduct a review of the Victorian sexual health service model and system
* Support in-principle social, behavioural, epidemiological and clinical research efforts
* Support in-principle innovative data linkage projects to further address STI infections and inequities in priority populations
* Support in-principle implementation research to identify the most acceptable and effective interventions for increasing and improving STI diagnosis and management in general practice
* Support analysis of reinfection data to determine areas requiring further targeted service delivery focus
 |
| **Evaluate implementation of key activities across settings delivering STI services** | * Develop monitoring and evaluation metrics for the STI action plan
* Monitor and evaluate the STI action plan, modify activities where needed and use successful prevention strategies to inform policies and programs, determining areas of additional focus
* Develop an annual STI report summarising implementation progress using metrics framework and other data
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# Appendix 1: Background data

## Notification data 2017

Notifications of infectious syphilis, gonorrhoea and chlamydia continued to increase, reaching record highs in 2017. This is consistent with national trends.

The Aboriginal and Torres Strait Islander population accounted for a disproportionate level of STIs notified in 2017. The rate of notification in the Aboriginal and/or Torres Strait Islander population was higher than that of the non-Aboriginal and/or Torres Strait Islander population for gonorrhoea (1.5 times higher) and infectious syphilis (2.4 times higher).

Aboriginal and Torres Strait Islander status data completion improved for gonorrhoea and syphilis notifications, to 74 per cent and 93 per cent respectively, due to enhanced surveillance programs.

## Syphilis

### Syphilis – congenital

Two cases of congenital syphilis were reported in 2017. These are the first cases reported in Victoria since 2004.

### Syphilis – infectious, less than two years duration

A total of 1,335 cases of infectious syphilis were notified in 2017, representing an 18 per cent increase compared to 2016.

Notifications are most commonly reported in men (88 per cent, n = 1,181) and continue to occur primarily among men who have sex with men (MSM) in urban settings, with 74 per cent of the males reported as MSM in 2017. The median age of males was 35 years.

The number of cases in women continued to increase in 2017, with 145 cases notified (11 per cent of the total), representing a 45 per cent increase compared to 2016. The median age of women was 29 years.

Eighty-three per cent of the total cases were in the 20–49 year age group. Between 2008 and 2017, the largest overall notification rate increase was in the 50– 59 year age group. For the same period, women had the largest increase in the 20–29 year age group. For men, this was in the 50–59 year age group.

Where enhanced surveillance data was available, most people acquired their infection through a casual sexual contact (69 per cent) and locally in Victoria (77 per cent). Twenty-five per cent were among people living with HIV, and 88 per cent of these were MSM. For HIV-positive MSM, infections were most common in the 30–49 year age group (62 per cent), whereas for HIV-negative MSM, cases were most common in the 20–39 year age group (67 per cent).

Thirty per cent of the total cases reported were syphilis re-infections (n = 395), similar to the proportion seen in 2016. Of the cases reported with a syphilis re-infection, 44 per cent were HIV-positive MSM.

Twenty-five cases (2 per cent of the total) reported as being of Aboriginal and/or Torres Strait Islander origin. In the past decade, 97 cases of infectious syphilis were reported in Aboriginal and/or Torres Strait Islander people: of these, 75 per cent were males.

For infectious syphilis cases with recorded postcode data, 75 per cent lived in metropolitan regions and 8 per cent were from rural regions of Victoria. Sixty-four per cent of the infectious syphilis cases were Australian-born and 28 per cent were overseas-born.

## Gonorrhoea

Gonorrhoea notifications reached a record high in 2017 with a total of 7,289 cases. This is a 16 per cent increase compared to 2016, and a population rate of 118 cases per 100,000.

Notifications are most commonly reported in men (81 per cent), with a median age of 30 years, and continue to occur primarily among MSM in urban settings, with 70 per cent of the males reported as MSM in 2017.

A continued increase was observed in women, with 1,368 cases notified in 2017. This represents a 12 per cent increase compared to 2016. The median age of women was 26 years. Nearly all of these women reported heterosexual contact as their exposure.

In 2017, 80 per cent of the total cases were in the 15– 39 year age group. Between 2008 and 2017, the largest rate of gonorrhoea increase was in the 30– 39 year age group (from 30 cases per 100,000 population to 245 cases per 100,000). Among women, the largest increase was in the 20– 29 year age group, and among men this was the 30–39 year age group.

Sixty-nine cases (0.95 per cent) were reported as Aboriginal and/or Torres Strait Islander people.

Where enhanced surveillance data was available, 10 per cent of cases were HIV positive compared with 13 and 17 per cent in 2016 and 2015 respectively. A further 18 per cent of cases indicated they were on PrEP at the time of infection. The majority of people acquired their infection through a casual sexual contact (70 per cent) and locally in Victoria (86 per cent), which has been consistent for the past 10 years.

Seventy-five per cent of the cases reported were residents of metropolitan regions and nine per cent were from rural regions of Victoria. Seventy-one per cent of cases with country of birth data reported were Australian born and 29 per cent were overseas born.

Antimicrobial resistance for gonorrhoea is emerging, with two cases reported as having high level critical resistance to azithromycin. Victoria has not seen any high level multidrug resistant gonorrhoea to date.

## Chlamydia

Chlamydia is the most frequently notified sexually transmissible infection in Victoria and Australia. Chlamydia notifications have continued to increase in Victoria since it became notifiable in 1991. In 2017, there were 25,176 notifications, representing an 11 per cent increase compared to 2016.

Seventy-three per cent of the total cases reported were residents of metropolitan regions of Victoria and 20 per cent were from rural regions of Victoria.

Historically, women comprise more than 50 per cent of the chlamydia notifications, but for the first time in 2017, notifications included more cases in men than women. Men were slightly older than women (median age 27 years and 23 years respectively).

In 2017, 71 per cent of the total cases were in the 15– 29 year age group, with the rate highest for the 20–29 year age group for both sexes. Between 2008 and 2017, the largest increase was observed in the 50–59 year old age group in both men and women (from 29 cases per 100,000 population to 90 cases per 100,000).

Due to the high volume of chlamydia notifications, demographic information such as Aboriginal and Torres Strait Islander status and country of birth is not available for reporting.

## Shigellosis

Increase in notifications of shigellosis have been reported in Victoria in the past four years, with 539 cases of shigella infection notified in 2017. This is an increase of 56 per cent on the five-year average (2012–-2016). Risk factor data indicates the majority (60 per cent) of people acquired their infection overseas, with male-to-male sex the second major risk factor (19 per cent).

Of particular concern is the increase in the proportion of shigellosis cases that have resistance to antimicrobials that are recommended for treatment for shigellosis. Higher resistance was detected among MSM compared with people who acquired their infection through travel outside of Australia.

A Chief Health Officer Advisory was issued in 2017 advising of the increased antibiotic resistance of shigellosis, requesting specimens are sent for culture and antibiotic sensitivity testing, together with changes to treatment based on risk factor information, in consultation with an infectious diseases physician.

Whole genome sequencing is being used to determine transmission networks between cases, and has demonstrated that ongoing transmission has been occurring in case networks in Victoria since 2016.

## Hepatitis A

There were 78 cases of hepatitis A notified in Victoria in 2017, an increase of 73 per cent on the number of notifications received in 2016.

From March 2017, there has been an increase in the number of reported cases of locally acquired hepatitis A infection in Victoria, linked predominantly to MSM, and also due to other overlapping exposure risk factors. This increase in notifications and the outbreak has continued into 2018. Two emerging risk groups, people who inject drugs and the rough sleeper population, have been identified.

In response to this outbreak, and to stop the spread of this disease, the department has introduced a free, two-dose hepatitis A vaccination program in Victoria until 31 December 2018 for all MSM, people who have injected drugs in the past 12 months, homeless rough sleepers and adult prisoners at Victorian correctional institutions.

Additional control measures include a public health communications campaign, Chief Health Officer alerts, immunisation provider communications and outreach immunisation at sex-on-premises venues around Melbourne to offer free hepatitis A vaccine.

Global and national outbreaks of hepatitis A infection also include high proportions of infection in MSM and people who inject drugs.

## Human papillomavirus (HPV)

Australia was the first country in the world to implement a nationally funded HPV vaccination program in 2007. Initially offered to females only, the program was extended to include males in 2013. From 2018, the nanovalent Gardasil vaccine is being used in the national program, which extends the protection provided against HPV-related cancers and diseases. Currently, the incidence of cervical cancer in Aboriginal and Torres Strait Islander women is more than twice that of non- Aboriginal and Torres Strait Islander women, and the mortality nearly four times higher.

HPV vaccination coverage in Australia has steadily improved since the program began. In 2016, coverage reached an estimated 79 per cent and 73 per cent for females and males turning 15 years respectively, exceeding the previous target of 70 per cent coverage nationally. Victoria’s coverage rates are consistently in the three top-performing jurisdictions, and above national average.

Since the program started, there have been marked declines in HPV infection, genital warts and cervical pre-cancers in the general population and among Aboriginal and Torres Strait Islander people. Among Australian-born women and heterosexual men under 21 years attending sexual health clinics, the proportion diagnosed with genital warts fell to less than 1 per cent for both groups in 2016, and there has been a fall in the rate of detection of high-grade cervical histological abnormalities in women aged under 25 years. The incidence of genital warts has declined by 88 per cent in Aboriginal and Torres Strait Islander men and 100 per cent in Aboriginal and Torres Strait Islander women at their first visit to a sexual health clinic.

Improved adolescent vaccination coverage, particularly in males and among Aboriginal and Torres Strait Islander people, is needed to improve outcomes and meet targets. The HPV vaccination is also recommended for MSM, with a national catch-up program providing access to individuals up to the age of 19, along with humanitarian entrants. Victoria has implemented a time-limited HPV vaccination catch-up program for MSM until the end of 2018. Increasing HPV vaccination awareness and education is critical in populations at greater risk of STI for preventing transmission.

## Behavioural, knowledge and testing data

### 2018 Melbourne Gay Community Periodic Survey

This survey is the national benchmark for understanding trends in risk behaviours, knowledge and awareness of key issues affecting HIV/STI testing and prevention for gay men and men who have sex with men. Conducted in January 2018, a total of 2,742 men completed the survey both face-to-face and online. The majority of the respondents identified as gay/homosexual (n = 2,484, 90.6 per cent) or bisexual (n = 124, 4.5 per cent). Respondents were primarily of Anglo-Australian background, the majority lived in metropolitan Melbourne or urban Victoria, were well educated and in full-time employment.

In 2018, the most common way of meeting male sex partners was by using mobile applications such as Grindr (reported by 53 per cent of the sample), followed by the internet (32 per cent).The use of mobile apps to meet men has continued to increase from 46.4 per cent in 2014 to 53.4 per cent in 2018.

The level of condomless anal intercourse recorded in the survey is the highest observed over the past five surveys. The proportion of men with regular and casual partners reporting any condomless anal intercourse with partners has increased over time to 68 per cent and 55 per cent respectively. This increase is attributable to the rapid increase in the number of HIV-negative men using PrEP.

In 2018, a higher proportion of HIV-positive men (92.1 per cent) reported having had any sexual health test (including a blood test for syphilis) in the 12 months prior to the survey, compared with HIV-negative men (77.3 per cent). From 2014–2018, the proportion of respondents who reported a blood test for syphilis has increased for both HIV-positive and HIV-negative men (by 7.3 per cent and 6.9 per cent respectively).

STI diagnosis varied by HIV status, PrEP use and sexual behaviour. In 2018, 40.6 per cent of HIV-positive men, 55.1 per cent of HIV-negative men on PrEP and 14.6 per cent of HIV-negative and untested men not on PrEP reported a diagnosis with any STI other than HIV. Furthermore, in 2018, 45.1% of men who engaged in condomless anal intercourse in the six months prior to the survey reported an STI diagnosis, compared with 11.5 per cent of men who had not engaged in condomless anal intercourse. STI diagnoses remain concentrated among HIV-negative men on PrEP (who typically engage in higher frequency STI testing) and men who engage in condomless sex with casual partners (a higher risk practice for STI transmission).

Changes in risk reduction and risk compensation practices will require a refocus prevention messaging, including around regular and frequent testing and condom use.

### Sexually transmissible infections testing – ACCESS, Burnet Institute (2012 to 2016)

The ACCESS clinical network includes 14 Victorian clinics: community health (four), general practice (six), gay and bisexual men general practice (three) and sexual health clinic (one).

From 2012 to 2016, significant increases were observed in syphilis, gonorrhoea and chlamydia testing rates, particularly in the gay and bisexual men general practice clinics. Increases were most pronounced between 2015 and 2016.

In the context of this increase in testing, the proportion of gonorrhoea and chlamydia tests that were positive increased among HIV-negative and HIV-positive gay and bisexual men between 2012 and 2016.

Chlamydia testing among young people (excluding gay and bisexual men) did not occur for a large majority who presented to clinics and has decreased significantly over time. In 2016, 13 per cent of young people aged 15–29 years who attended an ACCESS participating GP or community health clinic were tested at least once for chlamydia.

### Sexually transmissible infections testing at PRONTO!

Established in 2013, PRONTO! is a community-based peer-led rapid point-of-care testing service for gay men and other men who have sex with men (MSM) at higher risk of HIV.

Testing for STIs (syphilis, gonorrhoea and chlamydia) has increased at PRONTO! from 2015–16 to 2017–18 by 156 per cent for peer STI testing and 275 per cent for the PrEP STI testing program.

### 5th National Survey of Australian Secondary Students and Sexual Health 2013 – Australian Research Centre in Sex, Health and Society

The 2013 Australian Research Centre in Sex, Health and Society surveyed high school students in years 10, 11 and 12.

It found only 43.4 per cent of sexually active respondents reported always using a condom when they had sex the previous year, whereas 39 per cent reported using condoms sometimes, and 13 per cent reported never using them.

In this survey, sexually active young women were less likely than sexually active young men to have used a condom the previous year.