

Queensland **Sexual Health Strategy**

2016-2021



Queensland
Government

Queensland Sexual Health Strategy 2016

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Contents

Foreword	4		
Introduction	5		
Why do we need a sexual health strategy?	5		
What is sexual health?	5		
How does the Sexual Health Strategy link with other strategies?	6		
Developing and implementing this Strategy	6		
About this Strategy	6		
The strategy	7		
Vision	7		
Principles	7		
Strategic directions and priority actions	7		
Success factors	11		
		1. Improving Community awareness, information and prevention across the lifespan	12
		Sexually transmissible infections (STIs)	13
		Human immunodeficiency virus (HIV)	14
		Viral hepatitis	15
		Reproductive health	16
		Healthy ageing	17
		Contraception	17
		Pregnancy	18
		Human papillomavirus (HPV) vaccination program	19
		Cervical screening	19
		Psychosexual counselling	19
		Consent to sexual activity	19
		Sexual assault	20
		2. Improving education and support for children and young people	22
		Child sexual abuse	24
		Gender dysphoria	25
		Female genital mutilation/cutting (FGM/C)	25
		3. Responding to the needs of specific population groups	26
		Aboriginal and Torres Strait Islander people	26
		Sexually transmissible infections (STIs)	27
		Culturally and linguistically diverse people	28
		People with disability	28
		Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people	29
		Risk occupation or location groups	31
		People in correctional centres	32
		4. The service system	33
		Accessibility	33
		Partnerships and collaboration	34
		Service profile	34
		Workforce profile	36
		eHealth, metrics and evidence	38
		References	40

Foreword

Queensland has a proud tradition of being the first jurisdiction in Australia to tackle challenging issues. For example, Queensland pioneered the state secondary education system in the early 1860s when the government subsidised municipalities to set up grammar schools—the first free education in Australia. In keeping with this proud tradition, Queensland is the first state in Australia to develop a comprehensive sexual and reproductive health strategy—the Queensland Sexual Health Strategy 2016–2021 (Strategy). A Strategy for all Queenslanders at all stages of life.

Good sexual and reproductive health is fundamental to our overall health and wellbeing. It is one of the foundations upon which our society relies upon to exist and is an important element in successful human relationships. There is, however, a number of challenges that we face as a community including reproductive health issues, rising rates of sexually transmissible infections, increasing numbers of people living with human immunodeficiency virus (HIV), and the discrimination and stigmatisation that is often associated with sexual health issues.

While I acknowledge these challenges, this government is committed to creating an equal and fair Queensland—a Queensland where good health outcomes are shared equally across population groups, diversity is celebrated through social cohesion and inclusiveness, individual sexuality can be expressed without fear of discrimination and stigma, and where education is empowering.

This is why the Palaszczuk Government committed to develop a statewide sexual health strategy in partnership with community organisations to ensure the mix of community education and clinical services best meets the needs of all Queenslanders including at-risk populations. This commitment includes \$18.5 million of which \$5.27 million over four years is allocated to implement the priority actions of this Strategy, and \$13.24 million to revitalising sexual health services at Biala, Metro North Hospital and Health Service.

This Strategy is another element to our vision for health in Queensland outlined in *My health, Queensland's future: Advancing health 2026*—by 2026 Queenslanders will be among the healthiest people in the world. Achieving optimal sexual and reproductive health can be realised in the everyday lives of all Queenslanders. Through working collaboratively, we can realise our vision.

The Hon Cameron Dick MP

Minister for Health and
Minister for Ambulance Services

Introduction

Why do we need a sexual health strategy?

Good sexual and reproductive health is fundamental to our overall health and wellbeing. It is one of the foundations upon which our society relies upon to exist and is an important element in successful human relationships.

Queenslanders are generally healthy compared to people in other parts of Australia and the world. However, there are still a range of sexual and reproductive health challenges that need to be addressed. The rate of sexually transmissible infections (STIs) is growing, and there are substantial inequalities in health status among specific population groups.

This Strategy aims to support healthy and safe sexual experiences and optimal reproductive health, and provide a service system that is responsive to the needs of all Queenslanders. In doing, so we will realise the vision of this Strategy: that 'all Queenslanders experience optimal sexual and reproductive health'.

This Strategy also provides an overarching framework for action in other key areas thereby providing a holistic and coordinated approach to specific challenges. The action plans under this Strategy include the North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016–2021, the Human Immunodeficiency Virus Action Plan 2016–2021, the Hepatitis B Action Plan 2016–2021 and the Hepatitis C Action Plan 2016–2021; all of which play an integral part in achieving the vision.

What is sexual health?

Sexual health is defined by the World Health Organization as 'a state of physical, emotional, mental and social wellbeing in relation to sexuality...not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.'

'Sexual health incorporates sexual development and reproductive health, as well as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own values'. Sexuality means more than the physical act—it encompasses psychological, biological and social aspects, and is influenced by individual values and attitudes.

A person's sexuality develops throughout childhood and adolescence, and is a key part of a person's identity. The way each person understands and interprets their sexuality varies significantly, and often changes over time. Healthy self-esteem and respect for self and others are important factors in developing positive sexuality.

How does the Sexual Health Strategy link with other strategies?

Queensland has an overarching vision for health: My health, Queensland's future: Advancing health 2026 (Advancing Health 2026) states that 'by 2026 Queenslanders will be among the healthiest people in the world'. This vision is supported by five principles of sustainability, compassion, inclusion, excellence and empowerment. In particular, the principle regarding inclusion requires us to respond to the needs of all Queenslanders, regardless of their circumstances, to deliver the most appropriate care and service. This not only benefits the individual but contributes to a more equitable and cohesive community.

As such, this Strategy contributes to realising the vision as well as the priority actions that respond to the four directions contained within Advancing Health 2026 of promoting wellbeing, delivering healthcare, connecting healthcare, and pursuing innovation.

The Queensland Government, through the Domestic and Family Violence Prevention Strategy 2016–2026 and the Queensland Women's Strategy 2016–2021, is committed to ensuring all Queenslanders are supported to experience safe, respectful and non-violent relationships.

This Strategy supports this commitment.

Developing and implementing this Strategy

This Strategy promotes the importance of positive relationships and optimal sexual and reproductive health across the lifespan, and focuses on raising community awareness, building the knowledge and resilience of young people, prioritising prevention of infectious disease and sexual violence, supporting healthy ageing, and providing quality, non-discriminatory healthcare at the right time and place.

To inform the development of this Strategy, baseline information on sexual and reproductive health services in Queensland was sought to identify the current range of services available, the mode of service delivery, limitations of these services and the partnerships currently in place.

The delivery of sexual and reproductive healthcare across the lifespan is underpinned by provision of comprehensive primary healthcare with the support of specialised care when required. The acquisition of sexual and reproductive health knowledge and skills by staff at every stage of the care continuum will contribute toward the delivery and place.

Public sector health services have the lead responsibility for implementing this Strategy, in partnership with other government, non-government and community sector services. The Strategy will guide services to provide appropriate and timely clinical service responses and referral to meet the needs of all Queenslanders, particularly specific population groups.

About this Strategy

A draft Strategy was developed following targeted consultation with a range of stakeholders and with the guidance of an expert reference group covering a broad range of areas including clinical care, policy, consumers, academia as well as representatives from other key government agencies. The draft Strategy was released for public consultation after which it underwent further refinement.

This Strategy includes a vision, principles, four strategic directions and a range of priority actions under each direction. The priority actions cover a range of new, expanded and existing initiatives. There are also 10 success factors which were chosen as the best indicators of the level of success in realising our vision. These success factors cover the entire Strategy and as such are not specifically linked to a particular strategic direction.

Further detail regarding each of the strategic directions and the basis for the priority actions is addressed in the section of this document relevant to each of the strategic directions.

The strategy

Vision

All Queenslanders experience optimal sexual and reproductive health.

Principles

Access, equity, person-centred care, partnership and collaboration, acceptance of diversity.

Strategic directions and priority actions

1 Improving community awareness, information and prevention across the lifespan



1.1	Continue to provide all Queenslanders with access to information about sexual and reproductive health and deliver health promotion messages that convey safe sexual practices.
1.2	Continue to provide all Queenslanders with access to information to raise awareness about sexual assault and child sexual abuse.
1.3	Establish visible and accessible care pathways for consumers to access sexual and reproductive healthcare.
1.4	Enhance community awareness and understanding of gender identity and intersex variation.
1.5	Enhance the sexual and reproductive health needs of older Queenslanders and ensure there is recognition and support in policy and programs.
1.6	Continue to provide aged care services with information about strategies to promote the sexual health, sexual safety and wellbeing of older people.
1.7	Develop health promotion messages that address the interaction between alcohol and other drug use and risky behaviours relating to the transmission of STIs, HIV and viral hepatitis.
1.8	Continue to build on current practices to improve the rates of early testing and treatment of all pregnant women for STIs, HIV and viral hepatitis.
1.9	Continue to reduce infectious syphilis and eliminate congenital syphilis in all communities.

2 Improving education and support for children and young people



2.1	Enhance the knowledge of parents and carers about the benefits of protective behaviours education for young children.
2.2	Expand implementation of the Australian Curriculum, health and physical education—relationships and sexuality education for students in Years P–10 to promote optimal sexual and reproductive health, minimise harm, reduce stigma and discrimination and highlight the importance of respectful relationships and violence prevention.
2.3	Expand current relationships and sexuality education to extend to students in Years 11 and 12 in Queensland schools.
2.4	Enhance access to school based youth health nursing (SBYHN) for Queensland secondary school communities to support the delivery of relationships and sexuality education programs and to provide enhanced sexual health services.
2.5	Develop connections for young people, who are disengaged from school, reside in out of home care, in the youth justice system or homeless to access organisations that provide sexual and reproductive health information and support.
2.6	Develop the knowledge of parents and carers, teachers, health professionals and social service agency employees to recognise normal sexual behaviour and respond to inappropriate or problem sexual behaviour and act early when children disclose sexual abuse.
2.7	Continue to provide human papillomavirus (HPV) vaccination to Aboriginal and Torres Strait Islander young people, migrant and refugee populations and young people who are disengaged from school through innovative outreach models.
2.8	Enhance multidisciplinary services for children experiencing gender dysphoria to respond to increasing demand.

3 Responding to the needs of specific population groups



3.1	Develop community led and community based, culturally appropriate sexual and reproductive health information to enhance health literacy, prevent infectious disease and unplanned pregnancy.
3.2	Enhance targeted preventative approaches to reduce transmission of HIV, STIs and viral hepatitis in priority population groups.
3.3	Enhance the availability and accessibility of post exposure prophylaxis (PEP) to those in need and expand the availability of pre-exposure prophylaxis (PrEP) as an effective treatment in the prevention of HIV to those at high risk.
3.4	Enhance the overall health, psychological wellbeing and self-fulfilment of transgender persons through access to non-discriminatory, affordable and multidisciplinary healthcare.
3.5	Develop comprehensive relationships and sexuality education and personal safety information that is adapted to individual learning needs and is available across the lifespan for people with disability, their carer's and families.
3.6	Enhance the access sex workers have to information and health services that are affordable and non-discriminatory and that collaborate with other sectors to provide a wraparound response in crisis situations.
3.7	Enhance the access prison populations have to sexual and reproductive health information through delivery of health promotion and related education programs in prisons.
3.8	Continue to work with the Australian Government to implement the National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy.
3.9	Continue to improve Indigenous identification in relation to the Notifiable Conditions System (NOCS).

4 Improving the service system



4.1	Continue to ensure sexual and reproductive health services are collaborative, available, accessible, flexible, non-judgemental and customised to local need.
4.2	Continue the use of innovative eHealth technology and explore the implementation of clinician support models that supports access for rural and remote communities.
4.3	Enhance appropriate and timely access to treatment and support services through formalisation of referral pathways between primary, secondary and tertiary healthcare services.
4.4	Continue to increase access to screening, testing and treatment for STIs, HIV and viral hepatitis through increasing point-of-care screening locations, embedding testing in primary healthcare settings and promote treatment as prevention.
4.5	Enhance the coordinated service response to all victims of sexual abuse and sexual assault.
4.6	Enhance reproductive choice through consistent implementation of the Queensland Health therapeutic termination of pregnancy guidelines across the public health system.
4.7	Enhance existing partnerships with the education sector to develop and provide graduate and undergraduate training opportunities in sexual health and continuing professional development opportunities for all clinicians including primary healthcare providers and international medical graduates.
4.8	Continue to develop sexual health workforce capacity through an increase in the number of sexual health physician training positions, S100 prescribers, advanced practice nurses and syphilis surveillance nurse positions.
4.9	Enhance support for all healthcare providers to undertake contact tracing/ partner notification and referral through educating clinicians on the importance of contact tracing in the clinical management of infectious disease and develop the promotion of Expedited Partner Therapy methods.
4.10	Continue to maintain the STI drug replacement program for eligible health services.
4.11	Continue research into scientific, social, behavioural, clinical and structural drivers for and barriers to achieving optimal sexual health and support trial evaluation and reporting of innovative prevention strategies.

Success factors

How will we measure our success

These success factors apply across all four strategic directions and the priority actions. These 10 success factors will be used to measure the success of this Strategy.

1. Information about sexual and reproductive health and sexual safety is available and accessible to all Queenslanders across their lifespan.
2. Children and young people are provided with a full range of information and support to enable good sexual health and sexual safety.
3. Implementation of the *North Queensland Aboriginal and Torres Strait Islander Sexually Transmitted Infections Action Plan 2016–2021*.
4. Implementation of the HIV and Hepatitis B and Hepatitis C action plans 2016–2021.
5. Reduced stigma and discrimination improve mental health and wellbeing in specific population groups.
6. Consumers are able to contribute to the development and design of sexual health services.
7. Consumers report that services are coordinated, collaborative and responsive to their needs and preferences.
8. Preventative equipment (e.g. condoms, clean needle and syringes) and medications are available to support a reduction in the rate of blood borne viruses and preventable STIs.
9. Increased number of trained sexual health physicians and advanced practice sexual health nurses.
10. Clinicians report increased access to education, training and professional development in evidence based sexual and reproductive health.



1. Improving Community awareness, information and prevention across the lifespan

This Strategy builds on a public health model for sexual and reproductive healthcare. The premise of the public health model is to, where possible, identify risk factors and intervene early to prevent problems from occurring.

Under a public health model, universal care and support is available for all people and includes healthcare delivered by primary care providers. More intensive or targeted care and interventions are provided to those people who need additional assistance due to vulnerability. Tertiary services are delivered by specialist providers for the most chronic or complex conditions.

Primary healthcare is socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce, supported by an integrated referral system in a way that gives priority to those most in need. It maximises community and individual self-reliance and participation, and involves collaboration with other sectors¹.

Health promotion is defined by the World Health Organization as *‘the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions’*².

Health promotion encourages people to take control of their own health to improve health outcomes and plays a pivotal role in the success of this Strategy. This can be achieved through an environment that is supportive and enables access to information and education, opportunities to develop skills and support behavioural change³.

The National Preventative Health Strategy—*Australia: the Healthiest Country by 2020* identifies the importance of effective prevention strategies to assist in the reduction of burden of disease, better use of health resources and substantial economic benefit over time. Prevention has worked in the past through well planned campaigns that have improved health outcomes including for HIV/AIDS⁴.

Community based education initiatives may incorporate broad campaigns that raise awareness of specific sexual health related issues, and have a number of benefits including promoting health, sexual rights and challenging norms or stigma and discrimination.

Alternatively, targeted initiatives may be designed in a way that specifically meets the needs of individuals or groups and are delivered through outreach models, peer education, and media including radio and telephone hotlines⁵.

Provision of information about screening, testing and the benefits of early treatment and intervention in a non-judgemental way enables individuals, groups and communities to make informed, responsible decisions about their sexual and reproductive health across the life span. This will assist to reduce the burden of disease associated with poor sexual and reproductive health.

Sexually transmissible infections (STIs)

Across Queensland, there is provision of quality prevention, testing and treatment services for STIs within the primary healthcare setting. National guidelines for general practitioners (GPs) recommend at least annual STI screening for all sexually active young people aged 15 to 29⁶.

There are numerous infections that can be transmitted via sexual contact, some of which are notifiable, and must be reported to the Chief Executive of the Queensland Department of Health in accordance with the *Public Health Act 2005* and Public Health Regulation 2005. In Queensland these include chlamydia, gonorrhoea, syphilis, HIV, hepatitis B and C, chancroid, donovanosis and lymphogranuloma venereum. Prioritising testing and early treatment of STIs is important as there are well documented links between undiagnosed and untreated STIs and long term effects on fertility and reproductive health. Currently in Queensland, chlamydia testing rates by GPs are approximately eight per cent. These rates of testing fall well below the rate required to reduce the prevalence of chlamydia⁷.

Specific population groups may require more targeted approaches to access testing for STIs. Targeted approaches include community screening, school based services for young people, testing and treatment locations at community venues, outreach to sex on premises venues, outreach to street-based sex workers and to people in correctional centres.

Barriers to testing may be twofold. Individuals need to feel empowered to request or seek testing and clinicians need to be engaged to promote testing through increased awareness of the needs of specific population groups.

Ensuring the treatment of a patient's sexual partners is an integral component of STI prevention and management. Traditional partner management where

the diagnosed patient refers partners for treatment has proven to be ineffective, with partners rarely treated⁸.

A method that has shown to be more effective is expedited partner therapy (EPT) which is where a doctor prescribes antibiotics and informative literature for the partner of someone who is diagnosed with an STI⁹. The availability, accessibility and uptake of EPT, in conjunction with rigorous contact tracing/ partner notification, may assist in the reduction of STI transmission rates within Queensland.

A key priority of this Strategy is to reduce rates of STIs through targeted best practice prevention activities, increased access to testing, retesting and early treatment for individuals diagnosed with infectious disease.

To support this priority, the Department of Health has partnered with Hospital and Health Services and community organisations to develop the *North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016–2021*.

KEY FACTS

Sexually transmissible infections (STIs)

- In 2015, there were 20,958 chlamydia diagnoses reported in Queensland. Rates are particularly high in people under 30 years of age.
- Notifications of gonorrhoea in Queensland increased from 2719 diagnoses in 2014, to 3034 diagnoses in 2015.
- There has been an upward trend in notifications of infectious syphilis, from 228 notifications in 2010, to 565 in 2015.

Human immunodeficiency virus (HIV)

HIV can affect the lives of all Queenslanders and in particular those specific population groups that have a higher prevalence of the virus.

Queensland Health has committed to the United Nations 90-90-90 HIV targets, whereby by 2020, 90 per cent of all people living with HIV will know their HIV status, 90 per cent of all people diagnosed with the HIV infection will receive sustained antiretroviral therapy, and 90 per cent of all people receiving antiretroviral therapy will have durable viral suppression.

Achievement of the first of these targets will require a combination of sustained approaches including innovative new testing options such as point-of-care and home testing as well as increasing the number of sites where peer and community based testing is offered.

Reducing infections will also require increasing availability of pre-exposure prophylaxis (PrEP), a sustained focus on education programs for those at risk and identified priority populations within this Strategy, and tackling the persistent stigma and discrimination associated with HIV.

To assist with increasing the percentage of people commencing HIV treatment, innovative models will again be required, such as increasing access for those newly diagnosed with HIV to peer support services to assist them navigate available care options, fostering individual resilience and increasing the number of s100 prescribers.

To achieve a high level of treatment compliance and undetectable viral loads in the estimated 3000 to 4000 people living with HIV in Queensland, a well-trained coordinated workforce comprising public, private and community based care teams will be required. Their roles will include supporting adherence to treatment and maintaining wellness, case managed interventions and diagnosis and treatment of the wide range of co-morbidities associated with living long term with HIV.

To outline the detail of the above tasks, the Department of Health has developed an *HIV Action Plan 2016–2021*.

KEY FACTS

Human immunodeficiency virus (HIV)

- Point-of-care testing (PoCT) is pathology screening conducted at the time of a patient consultation.
- PoCT generally provides a test result within 20 minutes and can be used to make an immediate informed clinical decision which allows for earlier treatment and intervention than laboratory based testing. For HIV, if the PoCT result is positive, a conventional blood test must be performed and sent to a laboratory for confirmation.
- PoCT is continuing to emerge as an effective way to provide initial screening for HIV and some STIs for specific population groups, particularly for those who would not normally access mainstream services for testing.

Viral hepatitis

Viral hepatitis causes inflammation of the liver. Chronic infection can result in progressive liver inflammation leading to cirrhosis (scarring of the liver) and cancer, and can be life threatening¹⁰.

Hepatitis B is largely prevented in Australia through the childhood hepatitis B immunisation program. Many people with hepatitis B don't experience symptoms and current estimates are that 40 per cent of people with chronic hepatitis B remain undiagnosed. Only 10 per cent of those diagnosed are being appropriately monitored and one third of those who should receive antiviral treatment are being treated.

Chronic hepatitis B infection is a condition which affects, amongst others, migrant communities particularly those from the Asia-Pacific region where there is a high prevalence of chronic hepatitis B infection. There are challenges associated with vaccination related to the age of migration of residents from countries where chronic hepatitis B is endemic¹². Hepatitis B notification rates and hospitalisation rates for chronic hepatitis B are at least four times higher in Aboriginal and Torres Strait Islander people than non-Indigenous people¹³.

Hepatitis C is now a curable condition for nearly everyone who is chronically infected. The listing of the first of the new Direct Acting Anti-viral (DAA) hepatitis C drugs on the Pharmaceutical Benefits Scheme (PBS) commenced on 1 March 2016. These new drugs fundamentally alter the way hepatitis C will be responded to. Treatment as prevention remains an immediate focus for specific population groups; that is people who inject drugs (PWID), people in correctional centres, people in drug treatment services, Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse (CALD) backgrounds. At the same time it will be critical that current prevention strategies, such as the Needle and Syringe Program (NSP) and Opioid Substitution Therapy (OST), are maintained.

The implementation of the *Hepatitis B Action Plan 2016–2021* and the *Hepatitis C Action Plan 2016–2021* will support the achievement of several priority actions of this Strategy.

KEY FACTS

Viral hepatitis

- The incidence of serious liver disease and cancer is linked to undiagnosed and untreated chronic hepatitis B and C.
- For every 100 people infected with the hepatitis C virus, five to 10 will die of cirrhosis or liver cancer if not treated¹¹.
- Hepatitis C is now a curable condition for nearly everyone who is chronically infected.
- One in four people with hepatitis B will die from liver cancer.

Reproductive health

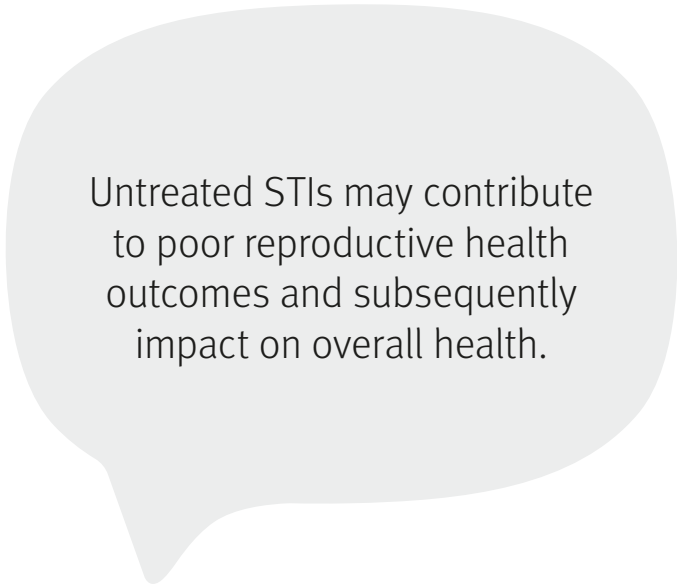
Reproductive health as defined by the World Health Organization implies 'people can have a satisfying and safe sex life, have the capacity to reproduce and the freedom to decide if, when and how often to do so.'

Achieving optimal reproductive health is contingent upon the availability of preventative health information throughout the lifespan and access to screening, testing, treatment, counselling and support services. There are many general and sexual health conditions that may impact on reproductive health.

Untreated STIs, particularly chlamydia, may contribute to poor reproductive health outcomes that affect fertility and subsequently impact on overall health, wellbeing and personal relations¹⁴.

Undetected cervical changes, breast and prostate cancers and their treatment regimes, chronic disease including cardiovascular disease, diabetes and obesity and age related issues such as menopause, may impact on sexual satisfaction and reproductive health.

The experience of child sexual abuse, sexual assault, and female genital mutilation/cutting (FGM/C) can impact a person's sexual and reproductive health, and may increase physical health risks during pregnancy and childbirth.



Untreated STIs may contribute to poor reproductive health outcomes and subsequently impact on overall health.

A statewide sexual health service mapping survey identified the following features of Queensland's reproductive health services.

Over half of the services surveyed provided contraception information and education (55.6 per cent). Provision of hormonal contraception (33.3 per cent) and long acting reversible contraception (LARC) were delivered at a lower rate of services (15.3 per cent to 29.2 per cent).

Under half of the respondents indicated delivering pregnancy testing and counselling (40.3 per cent) and indicated similar rates of referral for obstetric care (37.5 per cent) and termination of pregnancy (38.9 per cent).

Respondents also indicated the delivery of services including cervical screening and referral (37.5 per cent), referral for gynaecological care (33.3 per cent), primary menopausal care (22.2 per cent), postnatal check (20.8 per cent) and psychosexual counselling (19.4 per cent).

These survey results highlight the activity and range of reproductive health services provided by respondents. Furthermore, through establishment of formalised referral pathways, integrated service models and partnerships, the range of services that can be accessed from a specific location may be expanded.

Healthy ageing

Although sexual and reproductive health remains intrinsic, elements of health and wellbeing in older age are often overlooked in sexual and reproductive health policies and research¹⁵. Many older people remain sexually active, yet most educational campaigns designed to prevent the spread of STIs, HIV and viral hepatitis target only younger generations. Sexual and reproductive health disorders are more common as people age:

Women may experience gynaecological problems throughout their reproductive years and beyond, and are at risk from symptoms associated with hormonal changes, heart disease and stroke, gynaecological malignancies, osteoporosis, and various genitourinary conditions¹⁶.

Twenty-one percent of Australian men over 40 years of age are affected by erectile dysfunction and, despite a proliferation of products and services, important links to associated conditions such as chronic disease and diabetes are rarely made.

Post-menopausal changes in women may increase susceptibility to STIs and impact sexual function.

Contraception

All Queenslanders should have access to confidential and accurate information and counselling in relation to contraceptive options, pregnancy and reproductive health.

Contraception is predominately used to prevent pregnancy. There are many contraceptive options available; therefore, advice and information received from a reliable source is important. Correct contraceptive choice will help to reduce unplanned pregnancy.

The oral contraceptive pill is the most commonly reported method of contraception used by Australian women, followed by condom use and sterilisation. The combined oral contraceptive pill and the progesterone only contraceptive pill rely on regular and consistent daily use to be effective¹⁷.

Male and female condoms act as a physical barrier that prevents most body fluids passing between sexual partners and are highly effective against transmitting HIV and most STIs¹⁸. Condoms are also effective in reducing unplanned pregnancy and are associated with a lower rate of cervical cancer due to reduced human papillomavirus (HPV) transmission.

Long acting reversible contraception (LARCs) including intrauterine device (IUD) and implants have relatively low rates of use¹⁹. However, the effectiveness of LARCs is superior to other contraceptive methods that rely on consistent and correct use. Barriers to uptake of LARCs by young women include affordability, availability and lack of health provider knowledge and skill²⁰.

Emergency contraception reduces the risk of unplanned pregnancy for women following sex without a condom, a condom failing or inconsistent use of other contraception, or sexual assault²¹. Anecdotally, access to emergency contraception may be difficult for young women and women living in rural and remote locations with social stigma, discrimination and confidentiality issues cited as barriers.

Pregnancy

All pregnant women should have timely access to information, counselling if required, and referral to services in relation to pregnancy.

Maternity care provides an opportunity to improve the health of the pregnant woman and her unborn baby. Early and regular antenatal care provides women and their families' access to information and a range of services that will support them to make informed choices about their maternal healthcare²².

Accessing antenatal care early enables screening, detection and management of conditions that may otherwise impact on the woman and her unborn baby. Benefits include an increase in knowledge and confidence for the woman, decreases in infant mortality, and reduction in the burden of chronic disease later in life for mothers and babies²³.

Women who are vulnerable due to social or economic circumstances, and women from specific population groups may need additional support to access maternity care. Consideration should be given to service design and models of care to ensure they provide continuity of care, are flexible, woman centred, culturally appropriate and community based.

Women who are pregnant can still contract STIs and should be tested, treated and act to protect themselves against infection. STIs can complicate pregnancy and have serious effects on both the mother and developing baby²⁴.

These complications can be managed if the pregnant woman has access to antenatal care that includes testing for HIV, STIs and viral hepatitis early in the pregnancy; and testing is repeated at recommended intervals throughout the pregnancy²⁵.

For women who are living with HIV or chronic viral hepatitis, information and guidance from an appropriately skilled healthcare professional during pregnancy, labour, delivery and breastfeeding can assist to reduce the risk of transmission to the newborn²⁹.

A postnatal check is undertaken, often by a primary healthcare provider, six to eight weeks post birth and provides an opportunity to perform cervical screening, address family planning and contraceptive needs and provide health promotion and prevention messages to the woman and her family.

Women who experience unplanned pregnancy will benefit from the provision of confidential, non-judgemental support and counselling to explore available options.

KEY FACTS

Pregnancy

- Maternal syphilis infection can be passed from mother to baby during pregnancy and if not treated can result in stillbirth or infant death, prematurity and congenital disease of the newborn²⁶.
- Untreated chlamydia, gonorrhoea, bacterial vaginosis and trichomoniasis can cause preterm labour and premature rupture of membranes during pregnancy, and eye and lung infections in the newborn²⁷.
- Herpes simplex virus 1 and 2 can have serious effects on the newborn if the first episode occurs late in pregnancy²⁸.

Human papillomavirus (HPV) vaccination program

HPV is a highly contagious virus that is commonly transmitted through sexual contact. HPV infection is often asymptomatic and is linked to cancer of the cervix and genital warts. Most HPV infections will clear within one to two years. In a small percentage of cases the virus persists and it is these individuals who are at risk for developing HPV associated cancers³⁰.

In 2007, the National HPV school vaccination program commenced for females in their first year of secondary school and in 2013, was expanded to include males. Vaccination protects against a range of HPV related cancers and disease³¹.

The success of the program is indicated by reduction in the rate from 13.2 to 5.7 per 1000 of detection of highly abnormal cells among young women undergoing cervical screening³².

Cervical screening

HPV vaccination is the primary form of prevention of cancer of the cervix. Secondary prevention is available to women through a reliable screening test, the Pap smear, which can detect changes in the cervix early before cancer can develop.

Currently, regular second yearly Pap smear screening can assist in early detection which in turn can reduce the incidence of cervical cancer by up to 90 per cent. Young women should commence Pap smears within two years of becoming sexually active and continue until the age of 70 or longer if changes have been detected³³.

In 2017, a new Australian cervical cancer screening program will commence replacing the two-yearly Pap smear with HPV testing and genotyping every five years for HPV vaccinated and unvaccinated women 25–74 years of age.

Psychosexual counselling

Psychosexual counselling focuses on the experiences an individual has with sexual function/dysfunction, commonly referred to as sexual difficulties³⁴.

Psychosexual counselling can assist Queenslanders with relationship therapy, sexual orientation and identity, gender diversity, intersex variations, puberty and adolescent sexuality, sexual health and ageing, STIs including HIV, sexuality and disability, sexual and reproductive health issues³⁵ and dealing with psychosexual impacts of sexual violence.

It is important that all Queenslanders are aware of, and have access to psychosexual counselling to ensure optimal sexual outcomes are experienced.

Consent to sexual activity

Consent is where an individual has access to information of which they have the ability to understand and the competence to voluntarily authorise an action or a decision. There are a number of factors which could be a barrier to providing consent, these may include age, illness, reduced cognitive ability, language and culture³⁶.

Consensual sexual activity is any activity of a sexual nature that occurs between people over the age of 16 after mutual sexual consent has been provided by those involved, who are considered to have the capacity to consent. Consent should not be assumed and a person's silence should not be considered as consent³⁷.

The Queensland Health *Sexual Health and Sexual Safety Guidelines for Mental Health, Alcohol and other Drug services* aims to provide guidance for clinical staff to improve recognition of factors impacting on the sexual safety of clients, including those who may have impaired capacity and to identify and appropriately respond to sexual safety risks.

Sexual assault

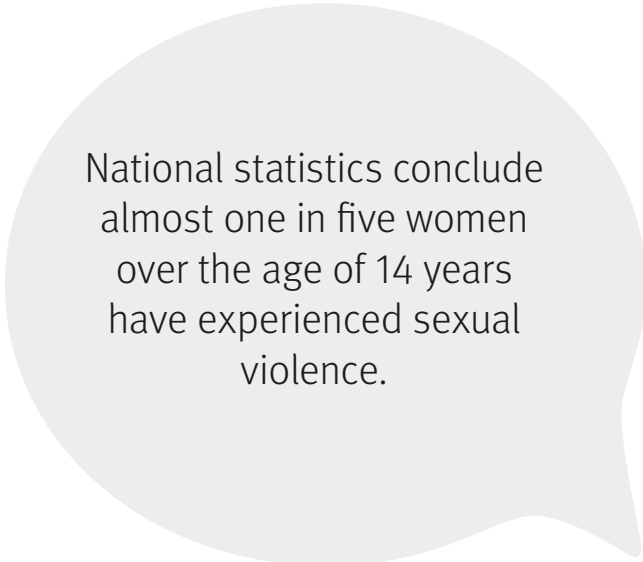
The *National Plan to Reduce Violence against Women and their Children 2010–2022* (the National Plan) and the *Queensland Domestic and Family Violence Prevention Strategy 2016–2021* (DFV Prevention Strategy) recognise two types of violence against women: domestic and family violence, and sexual assault. Both the National Plan and the DFV Prevention Strategy set outcomes, which includes respectful relationships and non-violent behaviour are embedded in our community, and in achieving this outcome conveys the importance of education in supporting children and young people to develop healthy respectful relationships.

Additionally, the DFV Prevention Strategy describes domestic and family violence as a broad issue that includes sexual violence and abuse experienced by older people. Older people are more vulnerable to abuse by partners, family members or carers and may face barriers to seeking assistance including physical and cognitive impairment, social isolation and lack of awareness that their experiences amount to abuse³⁸.

Sexual assault is any behaviour of a sexual nature that is without consent and causes feelings of intimidation. Sexual assault is a crime of violence and as such has an emotional, physical, financial and social cost for the individual and the community.

National statistics conclude almost one in five women over the age of 14 years have experienced sexual violence. Specific populations that are at increased risk include women, Aboriginal and Torres Strait Islander women from CALD backgrounds and women with disability and or impaired capacity³⁹.

The *Queensland Women's Strategy 2016–2021* reports this is a pattern repeated in Queensland where females are significantly more likely than males to be victims of sexual offences, constituting 81.8 per cent of all reported sexual offence victims.



National statistics conclude almost one in five women over the age of 14 years have experienced sexual violence.

Primary prevention strategies offering the provision of reliable evidence based relationships and sexuality education to children and young people are useful in conveying information on forming healthy sexual relationships based on respect and consent. In addition they counter inaccurate information accessible to young people through social media and internet sites.

The National Plan supports collaborative service models, information sharing protocols and risk assessment tools to strengthen systems and support service integration to ensure specialist responses for women and children who have experienced sexual violence⁴⁰.

Queensland is committed to ensuring a coordinated response to all victims of sexual assault. This is evidenced by the development of *Response to sexual assault: Queensland Government Interagency Guidelines for Responding to People who have Experienced Sexual Assault* in which a number of government agencies have outlined their role in response to the often violent and complex nature of sexual assault.

Victims of sexual assault, including male victims, require access to services that are sensitive to, and can respond appropriately to their needs. In responding to a disclosure of sexual assault the following should be addressed: prioritising the safety, medical and health needs of the individual, options for pursuing justice, and the ongoing emotional needs for long term wellbeing⁴¹.

It is imperative that healthcare professionals respond to the immediate health and sexual health needs of the individual as a first priority to assess, treat and document injuries. Health services may provide access to a forensic pathway of care which requires a specialist forensic medical assessment.

The victim of sexual assault has the right to information about forensic medical examination and the right to accept or decline a forensic examination and to change that decision. The forensic medical examination is performed by a trained forensic medical officer (FMO) or forensic nurse examiner (FNE).

Health services play a role in immediate response to children and young people who have experienced child sexual abuse. Following initial emergency medical treatment to assess and treat injury, for those victims under 14 years old, a paediatrician may perform a forensic medical examination.

Appropriate and responsive services should be available to support adults who have experienced sexual assault and children and young people who have experienced child sexual abuse. These needs are immediate and may continue to impact on the child or young person as they develop and may continue into adulthood. Department of Communities, Child Safety and Disability Services (DCCSDS) allocate funding to non-government organisations to assist victims of sexual assault. These sexual assault services offer flexible, holistic support including advocacy and sexual assault counselling including crisis counselling.

Cross sector wrap around support for victims of sexual assault will assist victims in their recovery. There are a number of government agencies who collaborate with Queensland Health to provide an integrated service response to support victims of sexual assault. These include, Queensland Police Service, DCCSDS and Department of Justice and Attorney-General.

Victim Assist Queensland (VAQ) provides access to specialised support services and financial assistance for victims of personal acts of violence including sexual assault and provides information, referrals and support to victims, including assistance in making a victim impact statement⁴².



2. Improving education and support for children and young people

Starting early with protective behaviours education and continued developmentally appropriate messages about positive healthy relationships, growth and development, identity and diversity through formal school curriculum, supported by partner organisations, ensures Queensland children and young people are equipped with reliable information that builds knowledge, skills and resilience.

School based education programs for children and young people is a critical starting point for promoting positive sexual health outcomes, minimising harm and reducing stigma and discrimination.

The Australian Curriculum: Health and Physical Education (HPE) is available for delivery by all Queensland schools. The curriculum incorporates a strength based approach with a focus on supporting students to develop the knowledge, understanding and skills required to make healthy, safe and active choices. The HPE curriculum includes a component specific to relationships and sexuality education.

Initiatives such as the Daniel Morcombe Foundation's Keeping Kids Safe curriculum are available to all Queensland schools and aim to educate children regarding their personal safety, ensuring effective protective behaviours are learned and adopted by all Queensland children.

Furthermore, a range of programs are available to Queensland schools that aim to strengthen the sexual and reproductive health knowledge of children and adolescents, incorporating key messages such as promoting positive, healthy relationships, STI prevention, pregnancy, and general anatomical functions.

The school based youth health nurse (SBYHN) service provides a range of prevention and early intervention activities to support the health and wellbeing of young people in Queensland state secondary schools. They support access to information for young people about sexual and reproductive health and positive and respectful relationships.

Sexually active adolescents aged 15–19 years and young adults aged 20–29 years are at higher risk of acquiring STIs for a combination of behavioural, biological, and cultural reasons⁴³. The higher prevalence of STIs among adolescents may also reflect multiple barriers to accessing services, including social stigma and discrimination, and concerns about confidentiality.

In South East Queensland, the Deadly Choices program is delivered to young Aboriginal and Torres Strait Islander people to provide a platform for decision making. The program includes mentoring and leadership encouraging access to local primary healthcare providers, and completing health checks⁴⁴.

Queensland is committed to supporting healthy and safe sexual experiences, and has standardised the age of consent for all lawful sexual activity, which has been identified as a barrier to young people accessing safe sex information.

Adolescence is a developmental stage characterised by rapid social, emotional and physical change. Young people will often experiment and take risks with alcohol and illicit drugs that may impact on their immediate or long term health and wellbeing⁴⁸.

Evidence has consistently demonstrated that adolescents are more likely to engage in unsafe sexual practices when they have been drinking alcohol or taking illicit drugs, exposing themselves to risks including engaging in sex without a condom, exposure to STIs and possible pregnancy⁴⁹.

Interventions for at-risk adolescents which address underlying aspects of the social and cultural conditions that affect sexual risk-taking behaviours are needed, as are strategies designed to improve the underlying social conditions themselves^{50, 51}.

It is important parents and carers openly talk to their children about safe sex practices and the impact of potentially harmful substances such as drugs and alcohol, and provide avenues to educate children and young people in sexual health and sexual safety.

The national report *Writing Themselves in 3*, indicated young people who identify as same sex attracted and gender questioning (SSAGQ) may be especially vulnerable to community and school based bullying and harassment. Physical and verbal abuse experienced by young people is associated with drug use, mental health issues and suicide attempts. Disclosures to family may lead to family conflict, parental disapproval, and loss of emotional support; and lead to social disadvantage and homelessness⁵².

It is important young people are educated in an environment free of bullying and harassment. Young people who feel the school environment is threatening may disengage from school leading to lower levels of education and resultant socioeconomic disadvantage. Young people reported that having school policies which protected them from abuse resulted in lower levels of self-harm and suicide⁵³.

Free resources and support are available to equip staff and students with skills, practical ideas and greater confidence to lead positive change, be safe and inclusive. These are available to be implemented within the wider Queensland secondary school environment to deliver positive benefits to at-risk students.

Programs such as the Safe Schools Coalition Australia (SSCA), is a national coalition of organisations and schools working together and offering resources and support to students, staff and families to create safe and inclusive school environments for same sex attracted, intersex and gender diverse students.

KEY FACTS

Improving education and support for children and young people

- Maternal syphilis infection can be passed from mother to baby during pregnancy and if not treated can result in stillbirth or infant death, prematurity and congenital disease of the newborn²⁶.
- Untreated chlamydia, gonorrhoea, bacterial vaginosis and trichomoniasis can cause preterm labour and premature rupture of membranes during pregnancy, and eye and lung infections in the newborn²⁷.
- Herpes simplex virus 1 and 2 can have serious effects on the newborn if the first episode occurs late in pregnancy²⁸.

Child sexual abuse

‘Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.

This may include but is not limited to:

- the inducement or coercion of a child to engage in any unlawful sexual activity
- the exploitative use of a child in prostitution or other unlawful sexual practices
- the exploitative use of children in pornographic performance and materials⁵⁵.

The *National Framework for Protecting Australia’s Children 2009–2020* outlines six outcomes to ensure the safety and wellbeing of Australia’s children. The sixth outcome states ‘child sexual abuse and exploitation is prevented and survivors receive adequate support’⁵⁶.

In 2009–10, 40 per cent of all sexual assault victims were aged between 0–14 years. Child sexual abuse is associated with a number of negative long term outcomes including poor mental health, substance abuse, homelessness and behavioural issues⁵⁷.

The Royal Commission into Institutional Responses to Child Sexual Abuse (RCIRCSA) has identified where systems have not protected children in the past, and provides evidence on how child sexual abuse may be prevented in the future. The RCIRCSA has published research to support the benefits of protective behaviours programs for pre-schoolers⁵⁸.

There is evidence to suggest that school based sexual assault prevention programs for children and young people teaching safety rules, protective behaviours and body ownership are effective in increasing the skills and knowledge of participants contributing to prevention of child sexual abuse and sexual assault⁵⁹.

In Queensland, *Taking Responsibility: a roadmap for Queensland child protection* report outlines a ten-year plan to ensure the safety of Queensland children into the future. The overarching tenet of the report is that parents and carers take primary responsibility for the protection of their children and that, where appropriate, parents should receive support and guidance to keep their children safe⁶⁰.

The broader community has a role to play in the protection of children and young people by seeking advice if they are worried about harm to a child. There are a range of family support services within the community.

In situations where it is not possible for a parent or carer to adequately protect their child, the statutory child protection system may intervene. Mandatory reporting of physical and sexual abuse by doctors, registered nurses, police officers and teachers provides a consistent response to suspected child harm⁶¹.

Distinguishing inappropriate from normal sexual behaviour may be difficult so the use of an evidence based tool for example *Traffic lights: guide to sexual behaviours in children and young people* assists parents and carers, teachers and health professionals in recognising and responding to sexual behaviour in young children⁶².

Sexual behaviour in children may be problematic when it occurs at an earlier age than developmentally appropriate, interferes with the child’s development, is accompanied by use of coercion, is associated with emotional distress and reoccurs in secrecy after intervention⁶³.

Gender dysphoria

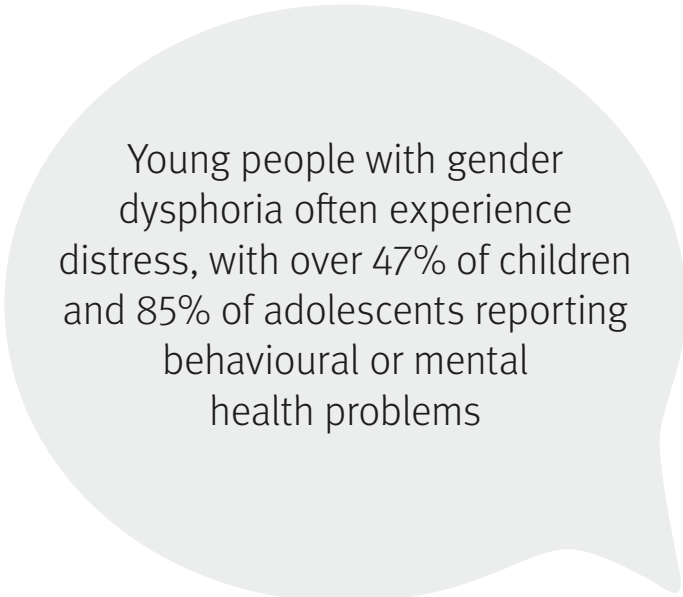
Gender dysphoria is a condition where a person experiences discomfort or distress because there is a mismatch between their biological sex and their gender identity.

There is increasing number of children and young people in Queensland seeking access to clinical services that specialise in gender dysphoria. Children and young people with gender dysphoria often experience distress, with over 47 per cent of children and 85 per cent of adolescents reporting behavioural or mental health problems⁵⁴.

Transgender children and their families may encounter a number of healthcare professionals in seeking diagnosis and ongoing management. Healthcare professionals require specific knowledge, skills and understanding to sensitively provide healthcare to transgender children and their families.

There are a very small number of experienced clinicians in Queensland who are dedicated to the diagnosis and medical management of young people with gender dysphoria; however, there is an increasing number of children requiring timely specialised and coordinated care.

Increased community awareness will assist to support transgender children and their families including siblings, to fully participate in school and community activities without fear of misunderstanding and discrimination.



Young people with gender dysphoria often experience distress, with over 47% of children and 85% of adolescents reporting behavioural or mental health problems

Female genital mutilation/cutting (FGM/C)

FGM/C refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons⁶⁴. This cultural practice is illegal in Queensland and prevention work with communities whose children are subject to this practice should continue in order to protect children and young people.



3. Responding to the needs of specific population groups

Influences on sexual and reproductive health include social and cultural factors such as gender, religion, personal beliefs, attitudes, understanding, peer influences and social norms. These and other factors need to be considered in the design and delivery of targeted approaches to achieve improved sexual health outcomes.

The following population groups are identified as requiring a targeted sexual and reproductive healthcare response:

- Aboriginal and Torres Strait Islander people
- Culturally and linguistically diverse people
- People with disability
- Lesbian, Gay, Bisexual, Transgender and Intersex people
- Risk occupation and location groups.

Aboriginal and Torres Strait Islander people

Queensland is strongly committed to closing the gap in health outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous people. *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033*, published in 2010, sets out the overarching policy and accountability framework for improving Aboriginal and Torres Strait Islander health.

The *Making Tracks Investment Strategy 2015–2018* sets out evidence-based initiatives over this three-year period, and includes two specific priorities that contribute to improving sexual and reproductive health:

- **A healthy start to life:** improving the health literacy and reproductive health of young women through culturally effective women's health services, antenatal and infant care, parenting support and child health services.
- **A healthy transition to adulthood:** to establish positive patterns of behaviour that will impact heavily on adult physical and mental health outcomes. Areas of focus include youth mental health, and sexual and reproductive health.

An anticipated outcome under the healthy transition to adulthood priority is reduced rates of STIs, while a key action under this priority is the targeting of funding towards sexual and reproductive health education and interventions to reduce current high rates of such infections.

The Aboriginal and Torres Strait Islander adolescent sexual health guideline provides health professionals with relevant insight into Aboriginal and Torres Strait Islander culture and historical influences, and provides guidance for their practice to deliver culturally competent sexual healthcare for Aboriginal and Torres Strait Islander adolescents.

Improving sexual and reproductive health in Aboriginal and Torres Strait Islander communities requires individual and community capacity building to promote culturally safe healthcare with a focus on education and health promotion⁶⁰.

Nationally, the *Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017* recognises the need for health promotion as a priority action to address the persistently high rates of STIs, the disproportionate burden of viral hepatitis, and vulnerability to an HIV epidemic in the Aboriginal and Torres Strait Islander population.

Health promotion messages for Aboriginal and Torres Strait Islander people include promotion of safer sexual practices including use of condoms, prevention of STIs and unplanned pregnancy, and safer injecting practices⁶².

In recent years there has been an increasing number of notifications of infectious syphilis, and incidences of congenital syphilis, across the northern parts of Queensland. The majority of notifications in these areas are for Aboriginal and Torres Strait Islander people, noting these notifications are not isolated to discrete Indigenous communities. In response, \$15.8 million has been allocated to implement the first three years' of the *North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016–2021*. This action plan will, in consultation and partnership with communities, provide targeted screening, appropriate treatment, improved contact tracing, and community based and led, culturally appropriate health promotion and education around safe sexual practices.

Queensland's proximity to Papua New Guinea (PNG) presents a number of health challenges for Aboriginal and Torres Strait Islander communities, including those related to sexual health.

- While there have been improvements to health services and a focus on prevention and management since the declaration of the HIV/AIDS epidemic in 2003, the HIV prevalence rate for PNG remains the highest in the Pacific region^{64, 65, 66}.
- An additional challenge is co-infection with tuberculosis (TB)⁶⁷.
- Approximately nine per cent of PNG nationals with TB are also HIV-positive⁶⁸.

Queensland Health facilities in the Torres Strait often provide services to PNG nationals that visit under the provisions of the *Torres Strait Treaty*. The Queensland and Commonwealth Governments are continuing to work together to improve cross-border health arrangements.

KEY FACTS

Sexually transmissible infections (STIs)

- Culture and cultural competency must be central to initiatives targeting Aboriginal and Torres Strait Islander people.
- Blood-borne viruses (BBV) and STI activities and messages should be embedded into broader Aboriginal and Torres Strait Islander health promotion programs.
- Local community input into the delivery of services and preventative activities supports improved outcomes.

Culturally and linguistically diverse people

Queensland is a state of cultural diversity with populations including migrant, refugee, international students and travellers. Individuals from CALD backgrounds and communities face a number of challenges to engage with healthcare providers on a range of sexual health issues including sexual assault, contraception and testing and treatment of infectious disease including STIs.

Challenges may include:

- Stigma, fear, language and cultural background when seeking to access information and services.
- Difficulty accessing treatment while on a temporary visa⁷².
- Experience of traumatic events such as physical and psychological trauma or torture, deprivation and prolonged poverty, and poor access to healthcare prior to arrival in Australia.
- Additional support requirements to navigate the healthcare system.

Health promotion programs for CALD communities should be community led, community based, and designed to overcome the identified barriers to effective sexual health promotion which may include, lack of involvement of the target community, lack of cultural sensitivity, failure to acknowledge differences in literacy, knowledge and language skills, stigma and shame associated with sexual health⁷³.

International students and travellers arrive in Queensland from a variety of countries. Their knowledge of safe sexual practices, HIV and STI transmission may vary. Health promotion messages may not be effective due to variable English language skills. In addition, international students and travellers are not eligible for Medicare and may be highly mobile; therefore accessing healthcare can be difficult.

HIV is an emerging issue for some cultural groups in Australia. These communities can experience higher rates of HIV than the Australian population as a whole⁷⁴. Individuals may be adversely affected by the community stigmatisation that comes with an HIV diagnosis. Language barriers may lead to confusion about uptake and adherence to treatment and ongoing management of chronic conditions such as HIV and hepatitis B.

People with disability

All Queenslanders, including those with disability, have the right to explore and express their sexuality in appropriate ways. Some people with disability will need ongoing, age-appropriate, accessible relationships and sexuality education across their lifespan to support them to develop positive attitudes about their sexuality, sexual orientation, sexual identity and gender.

Comprehensive and suitably targeted relationships and sexuality education, particularly from a young age, can assist people with disabilities to stay safe, reduce their risk of contracting STIs and help prevent unplanned pregnancy⁷⁵. When required, people with disability should also be supported in decisions about contraceptive use. To make these choices, people need adequate, accurate and accessible information about the reproductive system, the purpose of contraception and their contraceptive options.

Studies consistently demonstrate that people with disability are more vulnerable to being sexually abused than those who do not have a disability⁷⁶. Evidence suggests there is no correlation between the type of disability a person has and the risk of abuse⁷⁷. However, communication disorders, and behavioural disorders appear to contribute to very high levels of risk, and having multiple disabilities result in even higher risk levels.

Every person with disability should be provided with personal safety education about understanding healthy sexual relationships, what sexual abuse/assault is, including signs of sexual abuse/assault, and the support services available to them in the instance they suffer harm⁷⁸. The person's carers and families should also be educated on these topics.

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people

LGBTI people have specific health needs and health promotion and information should be targeted to specific subgroups within the LGBTI communities to address sexual health needs, particularly prevention of infectious disease.

LGBTI individuals may experience stigma, discrimination, social exclusion and isolation. These barriers to community participation and engagement may prevent LGBTI individuals from accessing healthcare when required, leading to poorer health outcomes⁷⁹.

The *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* has committed to implementing actions to prevent and reduce the adverse impacts of alcohol and drugs on the health and wellbeing of Queenslanders including responding to the needs of the LGBTI population.

- The LGBTI population when compared with the general population is more likely to use alcohol and other drugs, have higher rates of substance abuse and is more likely to continue heavy drinking into later life⁸⁰.
- The report, *A Closer Look at Private Lives 2*, explores the mental health and wellbeing of LGBT individuals and highlights poorer mental health for LGBT than the general population, with transgender experiencing the lowest levels of mental health of the LGBT population⁸¹.
- In the 2011 Census, 5987 same sex couple families were identified as residing in Queensland. Nationally the number of same sex couples residing as families was 32 per cent higher than in 2006.

Lesbian and bisexual women

Lesbian and bisexual women may experience discrimination when seeking healthcare, and barriers to GPs meeting their needs may include lack of experience in facilitating disclosure of sexual orientation. Specific sexual health needs include prevention of STIs, contraceptive advice and emotional support related to disclosure or abuse⁸².

Gay men and men who have sex with men

Gay men and men who have sex with men require an open and respectful response to sexual history taking with advice tailored to sexual behaviours.

- This population group is more likely to engage in sex without a condom with partners whose HIV status is unknown⁸³.
- For this specific population group, HIV, hepatitis C, gonorrhoea and infectious syphilis rates have risen in Queensland since 2010⁸⁴.
- Queensland is expected to have one of the largest increases in HIV positive populations in Australia in the coming years with many people living with HIV residing in major capital cities on the southern Queensland coast and far north Queensland⁸⁵.

Positive steps towards implementation of targeted preventative approaches to reduce transmission of HIV, STIs and viral hepatitis may arise through a holistic approach to healthcare promotion, such as access to non-discriminatory services and advice, access to peer education, community based health services, outreach services, and tailored media based messaging with a focus on reducing stigma and discrimination.

Other preventative strategies include use of condoms and water based lubricants which are an essential component of behavioural strategies to reduce transmission of HIV and other STIs. Increased and regular testing for STI, HIV and viral hepatitis will assist in the promotion of treatment as prevention.

The *Australian Sexually Transmitted Infection and HIV Testing Guidelines 2014* recommends all men who have had any type of sex with another man in the previous year should be tested at least once a year. Sexually adventurous men should be tested up to four times a year⁸⁶.

There remains a considerable need for health promotion messages that address the interaction between alcohol and other drug use and risky behaviours relating to the transmission of HIV and other STIs. Evidence based tools exist for screening, brief intervention, and referral to treatment, and could prove very useful particularly if combined with peer expertise and offered in a nonjudgmental service setting.

Transgender persons

Transgender persons have a number of specific health needs including appropriate assessment, diagnosis and support, and not uncommonly seek medical services to make their bodies more congruent with their gender identities. Involvement of a multidisciplinary healthcare team is often necessary in arranging such services.

Care coordination by a multidisciplinary team including primary healthcare providers and clear pathways to psychology, endocrinology and surgical services is vital for ensuring an equitable and accessible service to maximise transgender persons overall health, psychological well-being and self-fulfilment.

Moreover, many transgender people experience stigmatisation and discrimination. They may not only experience an inner sense of not belonging but also harassment, sometimes violence and denial of basic human rights⁸⁷.

It is also critical for healthcare professionals to acknowledge that transgender persons may have a sexual orientation that predisposes them to increased risk of sexual health and related mental health issues.

Many transgender people experience stigmatisation and discrimination. They may not only experience an inner sense of not belonging but also harassment, sometimes violence and denial of basic human rights.

Intersex persons

Intersex describes a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't fit the typical definitions of female or male⁸⁸.

Parents and carers of children born with an intersex condition which may require surgical intervention must be fully informed about the intersex condition specific to their child and have all available treatment options explained to them. Informed consent from legal guardians is also essential if treatment is to be undertaken on children and young people later in life for normalisation and gender affirmation. Medical management of children with intersex variation may be complex and ongoing interventions may include surgery and lifelong hormone therapy.

Delayed or absent signs of puberty may be the first indication that an intersex condition exists. Discovery of an intersex condition in adolescence can be extremely distressing for the adolescent and his or her parents, and can result in feelings of shame, anger, or depression. Experienced mental health professionals can be very helpful in addressing these challenging issues and feelings.

Medical treatment is sometimes necessary to help development proceed as normally as possible and for some conditions, surgical treatment may be recommended. Many intersex conditions discovered late in life are associated with infertility or with reduced fertility, sexual sensitivity and function.

Engagement with healthcare providers may be complicated due to past experiences of shame and stigma. Peer support is useful in assisting to navigate the health system at all ages and particularly during transition from paediatric to adult health services.

Older LGBTI people

The growing numbers of LGBTI people accessing aged care services represents an emerging and potentially challenging area for aged care service providers due to the specific health care needs of this population.

Many older people with HIV are members of minority groups (e.g. gay men, transgender, people who inject drugs). They may experience additional stigma, isolation and discrimination impacting on their mental health.

A recent report shows that older people living with HIV are five times more likely to suffer with depression than people of the same age without HIV. Depression can have a negative impact on quality of life, self-care, social life, medication adherence and physical health⁸⁹.

The risk of suicide increases with age and living long term with HIV. It is important to be aware of people in aged care expressing comments relating to hopelessness, despair or suggestive of self-harm. Older people with HIV are more likely to experience stigma, rejection, and abandonment. This contributes to anxiety, isolation and drug and alcohol dependence.

The *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy* informs the way the Australian Government supports the aged care sector to implement the delivery of care that is sensitive to and inclusive of the needs of LGBTI people, their families and carers⁹⁰.

Risk occupation or location groups

Specific occupations and people in particular locations have an increased risk of exposure to infectious disease. Due to their occupation and location these groups often require specific approaches to ensure that they and the rest of the community are protected.

People who engage in sex work

People who engage in sex work are at occupational risk for HIV, STIs and viral hepatitis due to high numbers of sexual encounters. There are a number of subgroups of people who engage in sex work that are at increased vulnerability and will require specific targeted interventions for health promotion and prevention. These include transgender, CALD, Aboriginal and Torres Strait Islander, male sex workers, people who engage in opportunistic sex work or provide sex for favours, sex workers who inject drugs and those working outside of legal frameworks⁹¹.

Despite the high number of sexual encounters, the rate of HIV and STIs amongst sex workers in Australia is low due to prevention initiatives driven by peer education, support networks and outreach. These prevention initiatives include provision of information regarding safe practices, free condoms and lubricant. The reported rate of condom usage is approximately 95 per cent however maintaining high rates of condom use and low rates of HIV, STI and viral hepatitis is contingent upon continued sex worker-specific health promotion initiatives⁹².

Sex workers who operate from licenced premises must maintain a current Certificate of Attendance to indicate that they have undergone a sexual health check. The Certificate of Attendance must be renewed every three months.

Barriers to accessing health services for sexual health testing and treatment may include affordability, social stigma and discrimination associated with sex work, fear of authority particularly for CALD sex workers and those operating outside of the legal framework.

Socio-economic disadvantage and crisis situations may encourage participation in sex work or sex for favours. Sex workers may be at risk of mental health issues, homelessness, intravenous drug use or incarceration compounding this disadvantage.

People in correctional centres

In Queensland, there are currently 11 high security correctional centres, two of which are privately operated, six low security correctional centres and 13 work camps. The adult prison population has increased over the last ten years and experienced a 16 per cent rise in the 12 months from June 2013 to June 2014.

The AIHW Health of Australian prisoners 2015 reports high rates of access to prison health services with 66 per cent of prison entrants consulting with a medical professional while in prison. Prison populations experience higher rates of mental health concerns and are reported to engage in risky health behaviours including alcohol and illicit drug use.

In Queensland, prison entrants are offered testing for HIV, hepatitis B, hepatitis C, syphilis, gonorrhoea and chlamydia.

The health of prison populations is important, and health promotion activities should include education and information about STIs, HIV and viral hepatitis transmission risk and prevention strategies.

Harm reduction methods include access to condoms and dental dams. Condoms are an important public health measure to protect against infectious disease and should be made freely available to prison populations as they are to other specific populations in the community. They are currently not available in Queensland correctional centres.

Access to hepatitis B vaccination, management of chronic hepatitis B, testing for hepatitis C and commencement of hepatitis C treatment while in prison provides an opportunity to improve the health outcomes of Queensland prison populations, preventing or reducing transmission of viral hepatitis.

Custodial settings provide an opportunity to access programs that raise awareness and reinforce prevention messages across a range of issues linked to sexual and reproductive health including drug treatment programs, sexual assault information and support including access to counselling, domestic and family violence prevention programs and positive parenting programs.

To optimise the health of women prison populations', access to reproductive healthcare is essential.

Reproductive healthcare includes breast and cervical screening, contraception including access to LARCs, pregnancy and postnatal care, breastfeeding support and menopausal care.

Initial consultation suggests a barrier to better health for prison populations in Australia is their exclusion from Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS). This exclusion acts as a disincentive for community health service providers to outreach to prisons and as such prison populations are not able to access healthcare services as they would in the community⁹⁷.

KEY FACTS

People in correctional centres

- In a 2013 survey of prison entrants there were no reported instances of HIV and rates of STIs were similar to that of the general population. There was however a high prevalence of hepatitis B and C when compared with the non-incarcerated community, 16 per cent and 52 per cent respectively⁹³.
- In the month prior to incarceration, 72 per cent of prison entrants had injected drugs. Of these entrants, 92 per cent had used sterile injecting equipment for all or most of the time⁹⁴.
- Despite being prohibited, needle sharing in prison may occur for injecting drug use (IDU), tattooing and body piercing; these practices pose a high risk for transmission of blood borne viruses⁹⁵.
- Aboriginal and Torres Strait Islander people in the Queensland prison population are over-represented at approximately 37 per cent⁹⁶.



4. The service system

The service system must support the strategic outcomes aimed at increasing community education and awareness, increasing testing and treatment of infectious diseases and provision of appropriate responses to individuals that have experienced sexual abuse, assault and trauma.

Strengthening the service system to deliver flexible, responsive, appropriate best practice sexual and reproductive healthcare is underpinned by the principles of access, equity, person centred care, partnership and collaboration and acceptance of diversity.

This Strategy aims to ensure sexual and reproductive health services are available and accessible for all Queenslanders and that specific population groups are given additional assistance to access services specific to their needs.

Accessibility

Engagement with specific populations and communities is essential to positively influence health promotion and prevention activities and encourage access to health services that are sensitive, informed and responsive to community need⁹⁸.

Community based and outreach services offering flexible operating hours, including outside of work hours, will assist in improving access to services that offer sexual and reproductive healthcare and counselling support. Peer support is known to improve access to information and services in turn empowering people to seek access to care through increased knowledge and understanding of their healthcare needs.

The barriers to accessing sexual and reproductive healthcare for specific population groups are many and may include experiences of stigma and discrimination, socioeconomic disadvantage, cultural and language barriers and difficulty navigating the health system.

Regional, rural and remote populations of Queensland face additional barriers due to distance, transportation and costs associated with travelling to secondary and tertiary services to receive healthcare⁹⁹.

At the same time individuals may be dealing with additional stressors including social exclusion, incarceration, mental health issues, drug and alcohol,

chronic or complex conditions which add further challenges to accessing healthcare services and initiating and maintaining testing and treatment regimes.

Stigma and discrimination can be reduced through delivery of sensitive, discreet and confidential healthcare provided in settings that are familiar and friendly towards specific population groups¹⁰⁰.

Private healthcare providers including, psychology and specialist services, have an important role to play in delivery of assessment, treatment and support for specific population groups. Anecdotally, barriers to accessing these services include affordability and availability.

Promoting service integration and innovative models of care will assist to provide the best person centred healthcare experience possible. Service integration is best described as:

‘The management and delivery of health services so that the clients receive a continuum of preventative and curative services, according to their needs over time and across different levels of the health system’¹⁰¹.

Service hubs or sexual health services that are co-located with other services, for example drug and alcohol services, mental health services, endocrine services, refugee health or vaccination services may assist in making sexual health services more accessible.

Outreach models of care using hub and spoke care delivery through satellite clinics, pop-up clinics and use of technology assists to increase accessibility to sexual and reproductive health services in rural and remote locations¹⁰².

Partnerships and collaboration

Partnership and collaboration between primary healthcare providers, community based organisations and specialised sexual health services is vital in providing a range of service responses and interventions, particularly outside of urban areas.

The statewide sexual health mapping survey indicates sexual health service providers in Queensland have a proven willingness to partner with other organisations with 90 per cent of respondents indicating they already have sustainable partnerships¹⁰³.

These collaborations ensure testing, treatment and ongoing management and support is available and referral to appropriate services is maintained. Partnerships may be strengthened through formalisation of referral pathways, development of local level protocols and special interest networks.

Partnerships, collaboration and communication across sectors is to be encouraged to ensure members of specific population groups are being supported to access sexual and reproductive healthcare and receive optimal treatment choices.

Service profile

It is important to understand the full range of services required to support client focused, holistic sexual and reproductive healthcare. These include primary, secondary and tertiary health services supported by public health, health promotion, Aboriginal and Torres Strait Islander health workers and allied health teams.

Primary healthcare

Primary healthcare services are often the first point of contact for individuals seeking sexual and reproductive healthcare, counselling or advice and play a pivotal role in health promotion, prevention, testing, treatment, contact tracing, referral and ongoing management of sexual and reproductive health concerns.

Primary healthcare may be delivered by providers such as GPs, nurses, health workers, pharmacists and non-government organisations based in the community.

In Queensland, primary healthcare providers are supported by PHNs who partner with Hospital and Health Services (HHSs) to identify local community need and work towards addressing service gaps.

Development of referral pathways and coordinated responses between primary healthcare and specialised sexual health services, non-government organisations and social service sectors will assist to provide wrap around support for individuals with complex health and social needs.

Coordinating care can have significant social and financial impacts on individuals so service responses and interventions that are coordinated will better meet the needs of individuals with complex sexual health needs.

Managing the complex sexual health needs of clients including treatment and management of HIV, hepatitis B and hepatitis C and transgender care has placed an increasing workload on GPs.

There is potential to further support GPs, nurses, health workers and community based organisations in the delivery of sexual healthcare through provision of education, resources and innovative models of care¹⁰⁴.

Secondary care

In Queensland, sexual health services are located at Brisbane City (Biala), Redcliffe, Caboolture, Princess Alexandra Hospital, Gold Coast, Logan City, Ipswich, Toowoomba, Sunshine Coast, Bundaberg, Rockhampton, Mackay, Townsville, Palm Island, Cairns, Mount Isa, Cape York, Bamaga and Thursday Island. These services offer specialised sexual and reproductive healthcare to all Queenslanders including specific population groups and may be hospital or community based.

Sexual health services play a role in the delivery of specialised sexual healthcare to those who need it. Often sexual health services tailor services to meet the needs of specific populations by offering comprehensive, flexible, culturally safe and accessible service that can quickly respond to the emergent needs of the community.

Sexual health services offering a multidisciplinary team approach support the delivery of holistic care to clients with complex needs. Collaborative approaches and partnerships across disciplines and with other health services is essential to providing a seamless client focused care pathway to access a range of services.

Many sexual health services are colocated with other community based health services including mental health services, alcohol and other drugs services and needle and syringe programs. Currently sexual health services offer a variable range of reproductive health services and some services partner with or refer clients to other government, non-government or private services.

Community based non-government organisations may assist to provide a variety of services including targeted

health promotion and resource development, advocacy and support, peer education and clinical services for specific population groups.

Public health units support the work of clinical service providers through collection of data, enhanced surveillance, education and advice. These activities inform responses to emerging trends in infectious disease and outbreaks of STI. Through epidemiological and population based research and evaluation public health experts can guide the delivery of sexual healthcare.

Health promotion activities in sexual health include service provider and community education, quality assurance programs, liaison and coordination of preventative activities. Health promotion teams partner with public health and sexual health services to support clinical services through education programs, outreach and community development.

Tertiary care

Specialist services are delivered in a hospital setting under specialist medical care providing specialised assessment, advanced intervention, support and follow up for highly complex or significant physical and psychological needs. In some instances, tertiary services may be required for diagnosis, treatment and ongoing management of specific or advanced infectious disease including HIV and viral hepatitis.

Medical specialties and psychological services are required in the diagnosis and management of transgender and intersex people. It is important to recognise the complexity of social and economic factors that may complicate access to specialist services in specific populations.

Victims of sexual abuse and assault who require a forensic medical examination will often receive these services in a tertiary setting by trained specialist paediatric or forensic clinicians.

The interface between primary, secondary and tertiary care; these services act as part of a continuum of care and to ensure individuals receive timely referral to appropriate services at any level of care. Recognised referral pathways, and adequate information exchange will facilitate a smooth transition of care.

Workforce profile

This Strategy acknowledges the sexual and reproductive health workforce in Queensland is varied and includes healthcare professionals as well as a community-based workforce comprising community workers, peer educators and support workers.

It is vital to recognise the role peer educators, migrant and refugee health workers and Aboriginal and Torres Strait Islander health workers play in engaging specific population groups. Evidence suggests that peers are a trusted source of information and can assist with delivery of education and support to navigate the health system¹⁰⁵.

The sexual and reproductive health services within Queensland have inherently experienced difficulties in recruiting and retaining adequately skilled staff across all disciplines. Quality, safe, efficient and non-discriminatory care relies on the right mix of staff with expert knowledge and skills and evidence-based standards of practice to ensure consistency of care delivery.

Creating an appropriately skilled workforce is contingent upon the availability of undergraduate and postgraduate education, training and continued professional development programs specific to sexual and reproductive health.

Formalised referral pathways between primary healthcare providers, secondary and tertiary services assist timely appropriate care for individuals requiring more specialised care.

Furthermore, access to best practice sexual healthcare for specific populations with complex or chronic conditions, or with complex social needs may be enhanced through implementation of collaborative models of care that support primary healthcare providers.

Medical workforce

GPs are often the first point of contact for people with sexual health concerns. Ongoing professional support and training for GPs is essential to enable initial conversations and provision of testing, treatment, contact tracing and counselling about sexual and reproductive health to be addressed in a sensitive way¹⁰⁶.

The majority of Queenslanders will access sexual and reproductive healthcare through the primary health sector. Primary healthcare providers will require support through ongoing professional development to build confidence and capability in delivering a broad range of sexual and reproductive healthcare.

If a GP wishes to expand or formalise specialist skills in sexual health, they can undertake further training. The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHAM) and True Relationships and Reproductive Health offer GP courses. PHNs also provide or coordinate GP training events in some areas. Specialist training leading to Fellowship of the Australasian Chapter of Sexual Health Medicine is overseen by the Royal Australasian College of Physicians.

Competing clinical demands, time constraints, complexity of care and lack of support and incentives have been cited as barriers to the uptake of specialist sexual health training by GPs¹⁰⁷. The number of positions accredited as specialist training posts is also very few.

GPs can become HIV treatment prescribers (s100 prescribers) to provide treatment and ongoing clinical management of people living with HIV in a community setting. In Queensland, the numbers of s100 prescribers are low, course uptake is marginal and the current prescribers are moving towards the later stages of their careers. Support and incentives may encourage training uptake and increase the number of authorised s100 prescribers to improve HIV treatment in the community.

Currently treatment for HIV and viral hepatitis is subsidised under the PBS. Arrangements vary and some treatments require them to be prescribed by a GP in consultation with a specialist. This can involve GP shared care models with specialists which require access to specialist time.

Specialist physicians offer support, education, training and research capacity as well as providing a consultancy service for all clinicians in sexual and reproductive healthcare.

Increased access to specialist training as well as mentoring through the uptake of support network initiatives may serve to support primary healthcare providers as well as making the treatment and management of HIV and hepatitis C in local community based settings sustainable.

Nursing and midwifery workforce

Nurses and midwives play an important role in the delivery of sexual and reproductive healthcare across a broad range of services. Sexual and reproductive health promotion and brief interventions can be integrated into healthcare delivered by all nurses including midwives, child and family health nurses, SBYHNs, rural and remote nurses, general practice nurses, mental health and drug and alcohol nurses.

It is essential for nurses and midwives working across all settings to have the knowledge, skills and cultural competence to support individuals seeking access to sexual and reproductive healthcare. Guidance and advice provided in a non-discriminatory, confidential and sensitive way will facilitate access to appropriate healthcare.

The nursing profession is flexible, responsive and affordable—therefore health services can be strengthened through the optimisation of nursing positions to support delivery of care in a variety of settings.

Coordinated education, training, and continued professional development programs and opportunity to maintain skills are essential to support advanced practice nurses in sexual and reproductive healthcare.

Advanced skills and knowledge can be obtained through the completion of relevant postgraduate qualifications and skill sets including cervical screening qualifications and vaccination endorsement.

Advanced practice nurses with approved education and clinical experience are guided by a HHS endorsed health management protocol (HMP) and can supply medication under an approved formulary or drug therapy protocol (DTP). Specialist sexual health contact tracing nurses are available in some centres to support and advise clinicians in performing contact tracing. Expanded scope of practice is highly desirable in a sexual health service, rural and remote locations and prison health services.

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively within a multidisciplinary team in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include, but is not limited to, referral to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.

Queensland Health is currently introducing a nurse navigator model of care that will see an additional 400 nursing roles progressively rolled out in HHSs over the next four years. Nurse navigators play a key role in supporting and coordinating a patient's entire health care journey, rather than focusing on just a specific disease or condition.

The nurse navigator roles are clinical roles held by experienced nurses with expert clinical knowledge and in-depth understanding of the health system, whose focus is to support patients with complex healthcare needs, including sexual and reproductive health needs.

Aboriginal and Torres Strait Islander health workers

There are a number of facets to sexual and reproductive healthcare and related socio-economic, cultural and health issues may add to the complexity of care. Understanding how culture, traditions, customs and history can influence health is integral to providing effective and culturally competent sexual and reproductive healthcare for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander health workers can assist to strengthen and promote tailored sexual and reproductive healthcare for Aboriginal and Torres Strait Islander people.

Barriers to education and training in skills specific to sexual and reproductive health include cultural and practical issues with training often not available in regional or rural areas.

The Aboriginal and Torres Strait Islander health worker workforce is predominately female, and the underrepresentation of males may impact the delivery of culturally appropriate sexual and reproductive health care.

Resources and initiatives dedicated to recruiting, retaining, and training a higher number of male Aboriginal and Torres Strait Islander health workers would help to meet this need.

Allied health professionals

Allied health professionals, including social workers, psychologists and pharmacists, make an important contribution to the health and wellbeing of the Queensland community and comprise a core component of integrated sexual and reproductive healthcare across the care continuum.

Allied health professionals generally work with individual patients, assessing, diagnosing and treating a wide range of conditions, such as, mental health and complex psychological conditions. In addition, health promotion forms a vital component of their role, often educating their patients to promote self-care.

eHealth, metrics and evidence

Health technology (eHealth)

eHealth has become a field in which health professionals and health consumers create and seek information. eHealth refers to internet-based healthcare and information delivery and seeks to improve health service locally. It presents new opportunities to provide online sexual health services irrespective of gender, age, sexual orientation and location.

The provision of sexual health services can continue to be enhanced through the utilisation of eHealth technology such a telehealth. The use of eHealth can empower all Queenslanders to engage with information technology to enhance their sexual health knowledge and quality of life, and address some of the stigma associated with diversity in sexualities and sexual health experiences.

In addition, e-sexual health may better support and enhance the relationship between consumers and their healthcare providers should they operate across different locations.

However, a systematic and focused approach to research and the application of findings in policy and practice is required to ensure that eHealth benefits all population groups and the information is current, culturally appropriate and clinically valid and effective, including preventative approaches for various specific population groups with diverse needs.


Surveillance and monitoring

Surveillance and monitoring currently captures a variety of data used to build a picture of emerging trends in notifiable conditions and other conditions. Incomplete data collection reduces the ability to analyse trends and inform interventions at a local level. Improving the completeness of surveillance data collection will assist in responding to identified need.

Surveillance programs need to adapt and evolve to accommodate innovation and advances in the scientific and health technology areas, such as advances in treatment and testing.

An important gap is the ability to monitor the health impact of stigma, discrimination, and legal and human rights on specific populations. Options should be explored to develop an indicator related to removing barriers to equal care that informs activities and strategies in a meaningful way.

Furthermore, comprehensive behavioural surveillance encompassing risk behaviours, prevention practices, testing routines, treatment uptake, and health needs and service use with specific populations should be maintained to better inform policy and programs addressing emerging prevention, testing, treatment, care and support needs.



An important gap is the ability to monitor the health impact of stigma, discrimination, and legal and human rights on specific populations.

Research and evaluation

A culture of continuous improvement needs to underpin program and service development, including strong formative and evaluation research.

It is important that research is undertaken in partnership with community-based organisations and a partnership approach is taken to identify research priorities. The translational mechanisms by which research can inform policy and practice, and vice versa, are strengthened through continued collaboration across disciplines. Social, behavioural and biomedical research should be well connected, including in relation to emerging issues in the changing landscape of prevention and treatment.

In partnership with the community sector, research will continue into the social, behavioural, clinical and structural drivers for and barriers to achieving optimal sexual health for all Queenslanders. This includes research on patterns of sex work, mobility and migration, and barriers to accessing services, with a focus on identifying particularly vulnerable or marginalised groups.

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The background of the page is a dark blue gradient. It features several large, stylized female symbols (a circle with a cross) and silhouettes of women's heads in profile, some facing left and some facing right. These elements are arranged in a way that they appear to be floating or layered behind the text.

Acknowledgement

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We are appreciative of the time that practitioners, consumers and organisations have given to participate in the survey and consultations sessions.

