5th NATIONAL SEXUALLY TRANSMITTED INFECTIONS STRATEGY

2024-2030

CONTENTS

Acknowledgement of Country

The Department of Health and Aged Care acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples.

Acknowledgements

The development of this strategy has been led by ASHM Health. A small informal working group has guided the process. Members include Alexis Apostolellis, Jessica Michaels, Lucy Stackpool-Moore, Darryl O'Donnell, Deborah Bateson, and Vincent Cornelisse. We would also like to acknowledge the many organisations and representatives that participated in consultations during the formative stages of the strategy's development, workshops to inform indicators, targets, and priorities, and those that provided feedback through the public consultation process. Gratitude is expressed to all those who participated in the stakeholder consultations and contributed to the strategy's development process.

Acknowledgement of lived experience

The Department of Health and Aged Care acknowledges the individual and collective expertise of people with sexually transmissible infections and affected communities. We recognise their vital contribution at all levels for the purpose of learning and growing together to achieve better outcomes for all.

GLOSSARY

Term	Definition
Antimicrobial resistance	Antimicrobial Resistance (AMR) occurs when bacteria, viruses, fungi, and parasites change over time and no longer respond to medicines making infections harder to treat and increasing the risk of disease spread, severe illness and death.[1]
Antimicrobial stewardship	Antimicrobial stewardship (AMS) is the careful and responsible management of medications used to treat or prevent infections. It involves activities that promote and support best practice antimicrobial prescribing and use.[2]
ASHM	Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine
BBV	Blood borne viruses.
Brotherboys/Sistergirls	Aboriginal communities use these terms to describe transgender people and their relationships as a way of validating and strengthening their gender identities and relationships. Non-trans but non-conforming Aboriginal people may also use these terms.[3]
Cisgender	Refers to people who identify their gender in the same way as was legally assigned to them at birth.[4]
Co-design	Co-design is a way of bringing consumers, carers, families, and health workers together to improve services. It creates an equal and reciprocal relationship between all stakeholders, enabling them to design and deliver services in partnership with each other. Planning, designing, and producing services with people that have experience of the problem or service means the final solution is more likely to meet their needs.[5]
Community leadership	Community leadership is leadership in, for and by the community. It is often based in place and is therefore local. It can also represent a community of common interest, purpose, or practice.[6]
COVID-19	Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).[7]
Discrimination	Discrimination happens when a person, or a group of people, are treated less favourably than another person or group because of their background or certain personal characteristics.[8]
Diversity	Diversity is the range of human differences, including but not limited to race, ethnicity, gender, gender identity, sexual orientation, age, social class, physical or mental ability or attributes, religious or ethical values system, national origin, and political beliefs.[9]
Education	Education is the transmission of knowledge, skills, and character traits.

Equity	Equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically, or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, sexual orientation and more).[10]
GPs	General Practitioners.
Health workforce	The health workforce in Australia is large and diverse, covering many occupations. These include health practitioners registered with the Australian Health Practitioner Regulation Agency as well as other health professionals and health support workers.[11]
HIV	Human immunodeficiency virus.
Human rights	Human rights are based on principles of dignity, equality, and mutual respect, which are shared across cultures, religions, and philosophies.[12]
Inclusion	Inclusion is involvement and empowerment, where the inherent worth and dignity of all people are recognised.[13]
Intersectionality	Intersectionality refers to the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation.[14]
Person-centred	Being person-centred is about focusing care on the needs of the individual. Ensuring that people's preferences, needs, and values guide clinical decisions, and providing care that is respectful of and responsive to them.[15]
Prevention	Disease prevention, understood as specific population-based and individual-based interventions for primary and secondary (early detection) prevention, aiming to minimise the burden of diseases and associated risk factors.[16]
Primary Health Networks (PHNs)	Primary Health Networks (PHNs) are independent organisations that the Australian Department of Health and Aged Care fund to coordinate primary health care in their region. PHNs assess the needs of their community and commission health services so that people in their region can get coordinated health care where and when they need it.[17]
Primary healthcare system	Primary healthcare is the 'frontline' of the health care system in Australia. It is generally the first 'layer' of health care services that individuals, families and the community encounter that usually provide comprehensive and continuous care. The services provided as part of primary health care are broad, and include health promotion and education, prevention and screening, early intervention, treatment, and management.[18]
Priority populations	Different groups within society who experience a disproportionate burden of disease, leading to differences in health outcomes and life expectancy.[19]

Sex work (in person)	The provision by a person of services that involve the person participating in sexual activity with another person in return for payment or reward.
Sexual and reproductive health and rights	Sexual and reproductive health and rights (SRHR) are fundamental to health and well-being, gender equality, democracy, peace and security, and sustainable development. SRHR is grounded in the right and the ability of all individuals to decide over their own bodies, and to live healthy and productive lives.[20]
Social determinants of health	The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.[21]
STI	Sexually transmissible infections.
Stigma	Stigma refers to any negative attitude, prejudice, or false belief associated with specific traits, circumstances, or health symptoms.[22]
Transgender	People whose gender identity is different to that which was legally assigned to them at birth.
WHO	World Health Organization.

List of Case Studies

Decentralising testing and treatment: Implementing a hub-and-spoke model

Victoria

Melbourne Sexual Health Centre

Dispensing with access barriers: Piloting STI Vending Machines to deliver free self-tests

Victoria

Centre for Excellence in Rural Sexual Health

Meeting communities' needs: Tailoring culturally appropriate services to control syphilis

Western Australia

Kimberley Aboriginal Medical Service and National Aboriginal Community Controlled Health Organisation

Enabling the next generation to own their sexual health

Western Australia

Departments of Education and Health

Putting people first: Ensuring client-focused service delivery

New South Wales

Sydney Sexual Health Centre

Promoting STI awareness in communities: Using humour and gamification to improve sexual health

New South Wales

New South Wales Sexually Transmissible Infections Programs Unit

Benefiting from new technologies: Employing molecular point-of-care tests to reach Australia's most remote communities

Western Australia, Queensland and South Australia

Collaboration between academic research institutions, Aboriginal and government health organisations, pathology providers, health services, communities, and industry

Providing a safe space: Leading a trans-affirming sexual health service

New South Wales

T150, Albion Centre, Sydney

VISION STATEMENT

Knowledge and awareness of Sexually Transmissible Infections (STI) improved for all people, who will have been empowered as active decision makers in their sexual health and well-being, supported by healthcare that is inclusive, free from stigma and discrimination, and enabled by person-centered and human rights-affirming healthcare systems.

People will have timely access to safe and affordable prevention (including vaccines), testing, treatment, and care for STI, when and where they need it. Legislative and policy barriers to sexual health-seeking behaviors will have been addressed. Sexual health and the importance of attending to STI will have been normalised. Congenital syphilis will have been eliminated.

By 2030, Australia will achieve this vision for STI by having a world-leading public sexual health system and primary healthcare system that enables sexual health and well-being for all. The system will have been strengthened by quality and timely data, support for community-led interventions, and a well-resourced workforce, and will be prepared to respond to emerging concerns and new infections.

1. Introduction

STI are part of sexual and reproductive health, and sexual health is an important part of general health and well-being.[23] In this strategy, the focus on STI is about the prevention of disease, enabled by a holistic approach to prevention, testing, treatment and care for STI. This is part of sexual health and well-being for all that is made possible by stronger public sexual health and primary healthcare systems. Since the first national STI strategy in 2005, Australia's response has been underpinned by a partnership approach between the Commonwealth, state and territory governments, priority populations, community organisations, researchers and clinicians.

STI remain a public health challenge in Australia, and efforts to address STI have only partially succeeded. At the time of development of this Strategy, STI case numbers, including for congenital syphilis, are rising, even though in most cases STI are treatable. The epidemiology of STI in Australia is rapidly evolving, and there is a need for targeted health promotion, quality surveillance, timely data systems, enhanced testing, and partner notification in priority populations. Approaches must counter STI-related stigma as a known barrier to people accessing prevention, testing, treatment, and support.

This Strategy sits alongside a suite of strategies that address human immunodeficiency virus (HIV), hepatitis B, hepatitis C, blood-borne viruses (BBV) and STI in Aboriginal and Torres Strait Islander people. While there are important synergies with these strategies this Strategy focuses on the particular characteristics of STI. Many STI have antimicrobial medicines (such as antibiotics) available, however infections can often be asymptomatic or have very mild symptoms. Reducing time-to-treatment is important to prevent further transmission and supports a focus on ensuring testing is available to people affected by STI. Additionally, the health workforce need to understand that when testing is required, it needs to be readily available. Reinfection is also a focus, with contact tracing and testing of partners being a critical part of prevention. For the first time, people who have had a STI within the previous 12 months are included in the strategy as a priority population.

This Strategy presents a shift in focus from previous STI strategies which focussed on overall STI incidence. This Strategy instead brings more focus on STI-related morbidity. Although the Strategy recognises the value of screening for particular STI in specific population groups, it aims to balance the approach and concentrate STI control through efforts such as reducing morbidities specifically related to priority populations and/or specific STI where they are most likely to achieve improved health outcomes.

2. Guiding principles

Guiding principles support a high-quality, evidence-based, and equitable response to STI. These are included in each of the BBV and STI strategies and are drawn from Australia's efforts over time to respond to the challenges, threats and impacts of HIV, hepatitis B, hepatitis C, and STI. The guiding principles are based on human rights and health equity, and promote person-centred approaches.

Person-centred response

People affected by STI must be central to Australia's response. Affected individuals, their families, and communities are at the centre of policies, research, and programs across all domains (e.g., prevention, harm reduction, testing, management, treatment, care and support, and evaluation, research, surveillance, and monitoring).

In 2023, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine and National Association of People with HIV Australia released a statement on person-centred care,[24] and reflected that 'Ultimately, a person is an expert on their own needs....Respecting people's autonomy empowers them to take control of their health, promotes good quality of life, and instils hope.'

Partnership

Partnership is at the heart of Australia's response to STI. Meaningful partnerships with priority populations in all aspects of the BBV and STI response is essential to the co-design, development, implementation, monitoring and evaluation of effective programs and policies. The diversity and specific needs of priority populations must be recognised and responded to effectively, considering the settings and the needs of communities. This approach increases the effectiveness and appropriateness of the BBV and STI response.

Communities and civil society also make pivotal contributions to advocacy, service delivery, policy making, surveillance and monitoring, evaluation, and initiatives to address social and structural barriers. This enables the de-centralisation of Australia's response and allows decision-making, service delivery and initiatives which relate to this Strategy to be shifted into community settings and feature community leadership.

Human rights

Australia recognises that valuing and upholding human rights for all is essential to preventing the transmission of STI and mitigating the health, social and other impacts of diseases. People affected by STI have the right to enjoy the highest attainable standard of living, without stigma or discrimination regardless of their culture, ethnicity, language, age, sex, sexual orientation, gender identity, disability status, legal status, religion, sex work or drug use.

Australia's response to STI must work to tackle racism. This work must be done in the context of upholding the rights of Aboriginal and Torres Strait Islander people as enshrined in the United Nations Declaration on the Rights of Indigenous Peoples.

Health equity

4

The goals of the Strategy will not be achieved without addressing the inequities that drive STI and prevent people from accessing health services and being active in improving their own health. Additional efforts are needed to improve equity for people from culturally, ethnically, and linguistically diverse communities and Aboriginal and Torres Strait Islander people who face multiple layers of stigma and discrimination, and for whom there is inequitable health outcomes and access to services.

Importantly, this Strategy promotes equity by measuring progress against the targets for all priority populations and geographic areas. This is essential to ensuring that no one is left behind.

Health promotion and prevention

5

Consistent with the National Preventive Health Strategy 2021–2030,[25] prevention involves identifying and mitigating risks to the health of populations. It also involves identifying and implementing protective measures through a combination of evidence-based biomedical, behavioural, and social approaches within a supportive enabling environment.

In line with the Ottawa Charter for Health Promotion, priority populations, as well as communities and individuals, have an important role in influencing the determinants of their health, and the formulation and application of laws and public policies to support and encourage healthy behaviours and respect for human rights. Priority populations should be enabled in leading health promotion actions.

Access and quality health services

6

STI care in Australia should be accessible, high quality and affordable to all, based on need. Consideration and effort must be applied to address the social and structural determinants of health and reduce the inequalities that lead to a lack of accessible and equitable health care, particularly for priority populations.

Quality accessible health services are reliant on a multidisciplinary STI workforce, including peers, that deliver person-centered, non-stigmatising, whole of life, effective, safe, and appropriate care.

Harm reduction

7

Harm reduction approaches underpin effective measures to prevent BBV and STI transmission and should consider diversity and person-centredness.

Grounded in justice and human rights, harm reduction aims to minimise adverse health, social, and legal impacts through policies, programs, practices, and involvement of key affected populations. It focuses on working with people without judgement, coercion, discrimination, or requiring a change in behaviour as a precondition of support.

Shared responsibility

Governments and community organisations have a shared responsibility to provide the necessary information, resources, healthy public policies, and health-promoting environments within which individuals are better able to participate in choices conducive to good health. Stakeholders and priority populations also share responsibility to prevent transmission and inform efforts that address education and support needs.

Commitment to evidence-informed, enabling policies and programs

The national response to BBV and STI is built on evidence-based and high-quality research, surveillance, monitoring, and evaluation. A strong and constantly refined evidence base is essential to meet new challenges, evaluate current and new interventions and develop effective social policy. It is essential to use evidence-informed guidelines and service delivery innovations and advocate for evidence-based policy and legislation regulating sexual and reproductive healthcare. This work must prioritise health promotion and respond to the needs and lived experiences of priority populations.

Multi-sectoral partnership and collaboration
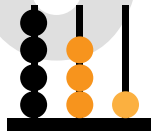
Successful implementation of all the national BBV and STI strategies requires a coordinated multi-sectoral partnership and collaboration approach. This necessitates leadership from the Commonwealth, state, and territory governments. Effective partnerships must also be maintained between priority populations, national peak organisations representing the interests of communities, the clinical workforce, and researchers. These relationships are characterised by consultation and co-design, cooperative effort, clear roles and responsibilities, meaningful contributions, empowerment, accountability, respectful dialogue, transparency, and appropriate resourcing to achieve the goals of the strategies.

3. Snapshot of STI in Australia

What are STI?

STI encompass different bacterial, viral, and parasitic infections that are transmitted through sexual contact. There are four nationally notifiable STI: syphilis, gonorrhoea, chlamydia, and donovanosis. Some examples of non-notifiable STI include *trichomonas vaginalis*, human papillomavirus (HPV), herpes simplex virus (HSV), human T-lymphotropic virus-1 (HTLV-1), and *Mycoplasma genitalium* (Mgen). There are also communicable diseases, such as viral hepatitis, mpox, and shigellosis, which are not typically classified as STI but can be transmitted via sexual activity. Human immunodeficiency virus (HIV) can be transmitted sexually and can also be considered a STI. In Australia, viral hepatitis and HIV are covered in their own respective strategies.

See online resources from ASHM with the latest information about STI in Australia: https://sti.guidelines.org.au/.

How are STI managed?

Management varies across STI, and most STI are treatable. Early detection and treatment are important in the management of all STI.

For example, bacterial and parasitic STI, such as chlamydia, gonorrhoea, and *trichomonas vaginalis*, are treated with antibiotics. HSV is treated with antivirals. While HPV cannot be cured, it is vaccine-preventable, and the cervical cancer and genital warts that it can cause are treatable.
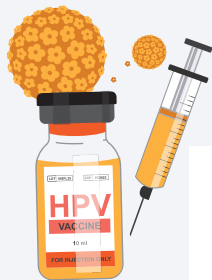
There is currently no effective cure for HTLV-1. Rather, treatment is based on the development of HTLV-1-associated disease. Medical understanding of Mgen is rapidly evolving and treatment with antibiotics is currently recommended.

What health issues do STI cause?

STI are often asymptomatic. Chlamydia is asymptomatic in 80% of people.[26] Many males and most females with gonorrhoea are asymptomatic or have very mild symptoms.

The physical consequences of STI can have a significant impact on quality of life, and untreated STI can lead to serious complications though the health impact varies across infections in type and severity. For example, infectious syphilis is highly variable in its presentation, and it is possible to have acquired it years before symptoms present, leading to higher chances of onward transmission.

Direct and indirect acute health consequences can include:

- pain and discomfort
- ectopic pregnancy
- miscarriage
- foetal and neonatal death
- throat, anal and cervical cancers.

Direct and indirect chronic health consequences can include:

- pelvic inflammatory disease (PID) and its complications, such as chronic pelvic pain, infertility, and pelvic abscess
- infertility
- urethral strictures
- facilitation of HIV transmission
- changes to cells which can lead to cancer
- congenital defects and severe long-term disability
- neurological disease, including deafness and blindness.

Stigma relating to STI can build barriers to people accessing early testing and treatment and create delays in partner notification and management. Stigma can originate from external sources, such as interpersonal relationships or messaging in society and culture and can also be internalised. Talking about STI with current and future sexual partners can be challenging, and communication skills for discussing sexual health should form part of the advice given throughout screening, diagnosis, and treatment of STI.

Prevention

The broad range of preventative strategies for STI includes:

- STI and sexual health education, including peer education
- practising safer sex (such as using condoms and other barrier methods and suitable lubricants)
- vaccination (such as for HPV and mpox)
- early detection and treatment, including as part of antenatal care.

Routes of transmission

The primary route of transmission is through sexual contact, such as vaginal, anal, or oral sex. Some STI can also be transmitted vertically from birthing parent to child, through blood contact and other fluid exchange, or from skin-to-skin contact. Some STI can also be transmitted through kissing.

Emerging concerns and preparedness

New STI threats and other public health conditions continue to challenge Australia's response to STI. At the time of writing, the ongoing spread of syphilis is considered a priority concern across Australia.

An example of a new threat is mpox. In 2022 and again in 2024, mpox was identified as an emerging global public health threat. However, a rapid response to mpox in Australia[27] and globally has meant that incidence has decreased worldwide for reasons including: immunity in the most affected population groups due to natural immunity and vaccination, behavioural change, risk communication, and community engagement.[28]

Other public health conditions, such as COVID-19, have also impacted the delivery of sexual health services. The experience of COVID-19 has shown sexual health services can adapt effectively in response to emerging public health concerns. Treatment innovations, such as in telehealth, were tested during COVID-19 and may help to continue expanding access to sexual health services.

4. About this strategy

The Fifth National STI Strategy sets the direction for Australia's continuing response to STI for 2024 to 2030. It builds on achievements and lessons learned from previous strategies and takes an approach that focuses on strengthening systems that enable the normalisation of STI (through taking responsibility for one's own sexual health, testing, and partner notification) and ensuring access to quality comprehensive STI healthcare for all.

It is one of five national strategies that, together with the research and innovation guidance of the First National Blood Borne Viruses and Sexually Transmissible Infections Research Strategy 2021–2025, outline a framework for a high-quality and coordinated national response to BBV and STI in Australia.

The other four strategies are:

- Fourth National Hepatitis B Strategy 2024–2030
- Sixth National Hepatitis C Strategy 2024–2030
- Ninth National HIV Strategy 2024–2030
- Sixth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2024–2030.

The National Elimination of Cervical Cancer Strategy under development and Australia's Primary Health Care 10 Year Plan 2022–2032 are also useful documents and processes to guide and align priorities in this STI strategy.

This Strategy (alongside the other national BBV and STI strategies) is endorsed by Australia's Health Ministers and governed through relevant committees of the Health Chief Executives Forum (HCEF) and the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS). BBVSS coordinates implementation and evaluation efforts across jurisdictions and reports to the Australian Health Protection Committee (AHPC) on progress in the implementation of the national strategies. BBVSS and the Communicable Diseases Network Australia (CDNA) will jointly monitor progress towards the targets of each Strategy, undertake evaluation and identify emerging issues and opportunities for action.

The Fifth National STI Strategy 2024–2030 aims to provide a framework for the efforts of all partners in the response to STI, guiding resourcing decisions and monitoring progress. It is informed by:

- progress made under the Fourth National STI Strategy 2018–2022[29]
- the effectiveness of current and past responses to STI in Australia and internationally
- the identification of gaps, opportunities and emerging issues or diseases
- consultation with governments, community organisations, researchers, health professionals, and other stakeholders across the country
- a range of surveillance data and research on STI in Australia, including the impact of STI on priority populations.

This Strategy complements other jurisdictional, national, and international policy documents that contribute to the national STI response and support the achievement of existing commitments. These include:

- State and territory STI strategies and action plans
- National Drug Strategy 2017–2026[30]
- World Health Organization (WHO) Global Health Sector Strategies, respectively, on HIV, Viral Hepatitis and Sexually Transmitted Infections 2022–2030[31]
- WHO Global Progress Report on HIV, Viral Hepatitis and Sexually Transmitted Infections, 2021[32]
- National Preventive Health Strategy 2021–2030[33]

- National Ice Action Strategy 2015[34]
- Australia's Primary Health Care 10 Year Plan 2022–2032.[35]
- Australia's National Antimicrobial Resistance Strategy – 2020 and beyond[36]

This Strategy acknowledges that some states and territories have or may set different targets to drive progress and that the goals and targets of this strategy are intended to facilitate jurisdictional efforts. Wherever possible, other jurisdictions are encouraged to match or exceed the targets of this Strategy.

This Strategy also supports progress towards Sustainable Development Goal 3 ('Ensure healthy lives and promote well-being for all at all ages') of the United Nations 2030 Agenda for Sustainable Development.[37] Sexual health and rights are essential for sustainable development because of the links in reducing morbidity and mortality, addressing inequities and shaping future economic development and environmental sustainability.[38] Meeting and exceeding international obligations and targets for STI are a critical part of Australia's response, and Australia supports the WHO's Global Health Sector Strategy on Sexually Transmitted Infections.[39]

The Strategy's purpose is to lay out priority actions over the next 6 years to achieve the vision of optimising sexual health care for all. Some actions to protect Australia's health and wellbeing from the impacts of STI are already underway, however, other actions will require further cross-sectoral consideration, exploration of implementation options and assessment of where further funding is required.

5. Key achievements

Australia has made some progress towards meeting STI goals under the Fourth National STI Strategy. Health promotion to increase STI testing has been highly successful in some priority populations, particularly gay, bisexual and other men who have sex with men, and sex workers.

5.1 Key achievements under the Fourth National STI Strategy 2018–2022

- **Digital innovation in sexual healthcare**
  Advances in technology have promoted timely access to testing, treatment, care, and support for people, including people with multiple and complex barriers to accessing other services. Reforms allowed telehealth to occur for sexual health-related consults (without restrictions of having seen the GP within the past 12 months at that practice), expanding access to virtual STI testing.

- **Dismantling structural barriers to sexual health**
  Sex workers have made some great strides in addressing stigma and creating an enabling environment. Policy changes have included the decriminalisation of sex work in Victoria and the Northern Territory, the repeal of mandatory testing laws for sex workers in Victoria, and the introduction of anti-discrimination protections for sex workers in the Northern Territory.

- **STI screening was at a record high**
  Rates of STI screening hit a record high in 2019. Disruptions from the COVID-19 pandemic saw some declines in both STI testing and notification rates in 2020 and 2021. The declines in Medicare-rebated STI testing, however, were no greater than the overall decline in face-to-face Medicare-rebated GP services during this period, which declined by 21% between 2019 and 2021.[40] The number of Medicare-rebated chlamydia tests in Australia increased by 31% between 2012 and 2019.[41] The proportion of people aged 15 to 29 years who attended general practice and had a Medicare-rebated chlamydia test was 17% in 2021, the highest proportion tested since before 2012. In the same year, the number of chlamydia notifications per 100 Medicare-rebated chlamydia tests was 6.1, the lowest since before 2012.

- **Significant decrease in genital warts in young people**
  High HPV vaccination coverage has been maintained for young people, leading to sustained reductions in HPV-related diseases (genital warts and cervical cancer). Between 2006 and 2021, the proportion of non-Indigenous females aged under 21 years attending sexual health clinics for the first time who were diagnosed with genital warts fell from 13% to 0.7%.

- **STI testing has significantly increased in gay bisexual and other men who have sex with men**
  Among gay, bisexual, and other men who have sex with men, STI testing has significantly increased, and prevention programs for priority populations have been maintained.[42] Results from the Gay Community Periodic Surveys show that comprehensive STI testing among gay, bisexual, and other men who have sex with men (at least four samples from separate body sites in the past 12 months) increased from 37% in 2012 to 47% in 2021.

- **Increased access to point of care testing**
  Highly accurate molecular point-of-care (POC) tests for STI (GeneXpert, Cepheid) are now enabling the provision of same-day testing and more timely treatment by clinical staff through primary care services in a growing number of communities. Preliminary results from a 2023 evaluation suggest that POC testing for STI is scalable and cost-effective and provides sustained clinical benefit, including modelled reductions in PID and preterm births.

5.2 Areas where further efforts are required

Despite these successes, the targets from the Fourth National STI Strategy 2018–2022 are not met based on 2020 data. As of the end of 2020, of the targets set, none were fully achieved, three were partially achieved, and two were not yet achieved.

Table 1: Progress against the Fourth National STI Strategy

Progress against Fourth National STI Strategy's targets, as at the end of 2020[43]
Key: 🔴 Not yet achieved   🟠 Partly achieved
🟠   **Achieve and maintain HPV adolescent vaccination coverage of 80%**
In 2020, 80.5% of girls and 77.6% of boys (75.0% and 68.0% for Indigenous adolescents) had completed the human papillomavirus (HPV) vaccination schedule by 15 years of age, up from 79.7% of girls and 73.8% of boys in 2016.[44]
🟠   **Increase STI testing coverage in priority populations**
The rate of comprehensive STI testing in the past 12 months among gay and bisexual men increased from 43.8% in 2016 to 57.1% in 2020. Of 54 sexual health clinics in the ACCESS network, 68% of gay and bisexual men had a repeat comprehensive STI screen (includes chlamydia and gonorrhoea test on any anatomical site, syphilis, and HIV test among HIV-negative men) within 13 months in 2020, up from 61% in 2016. Between 2016 and 2019, the number of Medicare-rebated chlamydia tests in Australia increased by 5.4%.[45]
🔴   **Reduce the prevalence of gonorrhoea, chlamydia, and infectious syphilis**
Chlamydia notifications increased by 11.8% between 2016 and 2019 and then declined by 15.6% in 2020 during the first year of the COVID-19 pandemic. In 2020, there were 29,497 gonorrhoea (*Neisseria gonorrhoeae*) notifications in Australia, an increase of 19% from 23,856 notifications in 2016. Infectious syphilis notifications increased by 35.7% between 2016 and 2020.[46]
🔴   **Eliminate congenital syphilis**
Between 2011 and 2020 there were 58 cases of congenital syphilis notified in Australia and 17 of those were notified in 2020.[47]
🟠   **Minimise the reported experience and expression of stigma in relation to STI**
In a survey of the Australian public, the proportion of participants who indicated they would behave negatively towards other people who had STI decreased from 58% in 2017–18 to 42% in 2020.[48]

The limited progress against some targets of the previous strategy highlights areas where more action must be taken to end STI transmission as a public health concern in Australia. The COVID-19 pandemic was a barrier to achieving aspects of the national BBV and STI strategies, particularly around testing.[49] Efforts are needed in antimicrobial stewardship and to offer integrated services so that opportunities are not missed to offer sexual health services to all who need them.

6. Measuring progress

This strategy covers the period, 2024–2030. This strategy includes specific areas of focus across different STI, populations and the health system. By 2030, across all priority areas, the following goals and targets must be the focus to drive efforts and results.

6.1 Goals and Targets

This strategy is ambitious and takes a systems approach to improving Australia's response to STI and enhancing sexual health for all. Five goals underpin this strategy, and they are supported by the key areas for action outlined in Section 8.

The goals of the National STI Strategy 2024-2030 are to:

	Reduce morbidity and complications from STI in Australia
	Integrate person-centred systems for better sexual and reproductive health for all
	Increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia
	Eliminate the negative impact of stigma and discrimination, and legal and human rights issues on people's health
	Enhance research for STI

Implementing the key areas for action outlined in Section 8 will be measured through the following targets:

Key indicator	🎯 2030 Targets
Integrated Primary Care	• Increase in the number of people, including priority populations, tested for STI via no cost and lower cost GP appointments and in accordance with guidelines. • Increase number of sexual health services providing care under expanded scope of practice arrangements by 2030.
Workforce	• Increase in non-clinical staff being able to offer STI POCT in remote Aboriginal communities • Increase the STI knowledge and capacity to offer services by primary health and community-based healthcare providers, nurses, midwives, and pharmacists through in-service training. • Sexual health, STI information and awareness of stigma is better embedded within pre-service training and medical school curricula and other health-related fields (such as pharmacy, nursing, and midwifery).
Education and awareness	• Increase the number of primary, secondary and tertiary level schools delivering sexual health education with high quality and comprehensive STI content. • Increase STI knowledge, awareness and attitudes, among general and priority populations.
Prevention Testing and Treatment	• Increase the number of people diagnosed with a STI who commence treatment within 7 days and receive treatment regimens recommended in the guidelines. • Increase in the proportion of priority and general populations using any STI prevention strategy (e.g. condoms, doxy PEP), within the past 12 months. • Increase coverage of HPV vaccination to 90% by the age of 15. • Increase number of health services offering diverse testing strategies and STI point-of-care tests where there are significant distances to laboratories and/or risk of loss to follow of for patients for treatment/care.
Equity and Access	• Reduce experiences of stigma for priority populations accessing health services, including through reducing stigmatising attitudes of healthcare workers • Reduce differences in STI rates between geographic locations and between priority populations and all Australians.

Key indicator	🎯 2030 Targets
Data, Surveillance, Research and Evaluation	• Achieve and sustain zero congenital syphilis cases and confirmed elimination (no new cases reported in a two-year period). • Decrease notification rates and morbidity of infectious syphilis. • Decrease notification rates and morbidity of all other nationally notifiable STI such as chlamydia and gonorrhoea.

7. Priority populations and settings

People who have one or more STI are a changing group for whom clear referral pathways, access to sexual health services and follow-up is important. This is an opportunity not only for treatment, care, and support, but also for awareness raising about prevention and well-being. The unique challenges and experiences within all priority populations must be considered in the responses' approaches and strategies. This includes all gender expressions and experiences, physical and mental abilities, cultural and ethnic identities, geographic settings, sexual orientations, and religious affiliations. Differences in age and the needs of young people across all these areas should be considered. Heterogeneity exists within the general population, as well as within the priority populations, with health literacy, language spoken, and socioeconomic factors potentially influencing when or if someone accesses sexual health services.

There are some data gaps, which means that the full picture of STI in some communities and within priority populations is unknown.
- Improved data and research are needed to better understand the incidence and impact of STI for trans and gender-diverse communities.[50]
- The collection and classification of ethnicity data are not currently standardised across jurisdictions in Australia, making it hard to understand the realities facing people born overseas, people from non-English-speaking backgrounds and/or people from culturally and linguistically diverse backgrounds.
- Age disaggregated data and research with and for young people under the age of 18, could be strengthened to better understand STI and sexual health considerations for diverse young people in different settings.
- Efforts to better disaggregate and analyse available STI data according to intersectional identities would be useful to inform policies and practice.

7.1 Priority populations

This section outlines the priority populations who are most vulnerable to STI due to current known high rates of STI notifications and/or are under served by the existing healthcare system and/or provision of sexual health services in Australia. A common theme in these communities is structural barriers to accessing sexual and other health services and/or consequential morbidities related to STI. The nine priority populations are:

- Young people, aged 15-24
- Aboriginal and Torres Strait Islander peoples
- Gay, bisexual and other men who have sex with men
- People from culturally and linguistically diverse backgrounds, including people born overseas and international students, particularly those from non-English-speaking backgrounds
- Sex workers
- Travellers and migrant workers
- People who are trans and gender diverse
- People experiencing housing insecurity
- People who have had a STI within the previous 12 months.

It should be noted that an individual could be associated with one or more priority population groups according to age, sexual orientation, gender identity, sexual behaviour, work practices, and cultural background. These characteristics can change over time. Recognising the complex and layered nature of people's identities and lived experiences and engaging diversely within community groups is essential. STI affect people differently. Within each priority population, attention should be paid to diversity in sexual orientation and gender identity.

Some groups or communities experience significant inequities in accessing health services and in their experience of healthcare and health outcomes. This is reflected in the epidemiology and also relates to enduring or systemic structural barriers to accessing health services. Disaggregating, understanding, and responding to the epidemiology while addressing the structural determinants of health will enhance the likelihood of success in achieving the goals of this strategy.

Considering priority populations

Targeted approaches are needed to address STI testing and treatment uptake in specific priority populations and geographic locations. STI prevention education initiatives must build the skills and confidence of priority populations in accessing and navigating the healthcare system to support increased STI testing and treatment – including increased promotion of referral pathways to appropriate health services. Targeted approaches should also address social and system-related aspects including physical access to testing, delivery of test results, costs and concerns about privacy and confidentiality, particularly in smaller and rural and remote communities.

Stigma complicates providing health services for people with STI. Behaviours that may be sensitive to disclose or discuss, and the fact that STI are found beyond groups typically characterised by demographics and sexual behaviours alone make it difficult to identify people and communities most likely to have STI.[51] Previous experiences of discrimination or fear of mistreatment may result in a reluctance to continue to access services. Recent studies have shown that communities favour specialised services and services that employ peers because the fragmented structure of health services is a barrier to accessing these services.[52] Localised surveillance and research are important for ensuring appropriate responses within local contexts.[53, 54]

Co-designing and co-delivering integrated services is an effective and ethical approach to meeting diverse community needs in an accessible and non-stigmatising way.[55] The inclusion and active engagement of young people, including those aged 15-17 years, as partners and co-designers in strategy development and implementation is important for all priority populations. There must be mechanisms and resources to ensure co-design occurs with young people who are selected based on age and also those who belong to other priority populations.

Practically, consideration of priority populations means:

- Being aware of who is and is not engaging with sexual health services within priority populations
- Ensuring that health promotion and information resources, materials and training are offered using culturally appropriate terminology and translated into relevant languages other than English
- Engaging with and responding to community leadership to co-design sexual health promotion and STI service delivery approaches
- Ensuring that multiple communication approaches are utilised to reach as many people as possible through media that they consume as part of their routine.

Table 2: Priority populations

Priority population: Young people (aged 15-24)	
Structural barriers to accessing healthcare	Social judgments about age and sexual behaviours
	Parental consent required for some sexual health services until age 18
	Inaccessible medical records
	Unable to access Medicare and/or private health insurance
	Limited knowledge and awareness of health, education, and other support systems
	Attitudinal and autonomy-related barriers to accessing education and healthcare services[56]

Key STI epidemiology	Significantly impacted by STI[57]
	STI among young people often remain undiagnosed and untreated[58]
	Diverse and large group, with differences noted between age cohorts[59]
	Focus on people who can get pregnant
	Importance of enhanced chlamydia case management to reduce the risk of repeat infection and minimise pelvic inflammatory disease[60]
Other considerations	Comprehensive STI testing[61] could be part of routine healthcare for all sexually active young people[62]
	People who often have more than one sexual partner, either concurrent or sequential
	Gap between availability and use of condoms is widening[63]
	Young people with intersecting and marginalised identities or experiences more likely to be disproportionately impacted by STI[64]
	Youth-oriented programs need to be co-developed with an intersectional lens
	Older cohorts of young people are often less connected to a regular GP than their younger peers, particularly those from a marginalised group[65]
	Young people have a right to access information and develop health-seeking skills
	The presentation of symptoms, signs, evidence or identification of STI in children and young people (< 18 years) may be a potential indicator of child sexual abuse[66]. Health professionals should ensure they know where to refer a child if they suspect child sexual abuse[1].

Priority population: Aboriginal and Torres Strait Islander people

Structural barriers to accessing healthcare	Past institutional harm, systemic bias and racism, a lack of cultural safety, gender and generational trauma[67]
	May fear and/or experience stigma and discrimination when accessing healthcare
	Culturally appropriate services are not always accessible
	61% of Aboriginal and Torres Strait Islander people live in inner and outer regional, remote and very remote areas[68], therefore face long geographical distance to sexual health services
	Impact of other health considerations[69]
	Lack of early access/engagement with antenatal services reduces opportunities for recommended antenatal STI screening/testing, treatment, and increases risk for congenital syphilis[70]
Key STI epidemiology	Disproportionately burdened by STI compared with non-Indigenous Australians
	Increase in STI notifications noted in recent years
	Congenital syphilis is a continuing concern – over 80% of all people giving birth to an infant with congenital syphilis were diagnosed late in pregnancy;[71] Aboriginal and Torres Strait Islander infants are disproportionately affected by congenital syphilis[72]
Other considerations	Closing the gap in STI requires:
	• Culturally appropriate education, prevention, testing, treatment, and care
	• Adequately resourced Aboriginal Community Controlled Health Services and Aboriginal Medical Services
	• Acknowledging and strengthening the role of Aboriginal and Torres Strait Islander health workers in sexual health

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[1] The make a report page on the National Office for Child Safety website provides information about how to report child safety concerns, including child sexual abuse see https://www.childsafety.gov.au/make-report.

Priority population: Gay, bisexual and other men who have sex with men	
Structural barriers to accessing healthcare	May fear and/or experience stigma and discrimination when accessing healthcare
	Challenges accessing services in regional, rural and remote areas
	Heterogeneity within group, taking intersectional identities into consideration with other priority populations, such as brotherboys, men selling sex, and men from non-English-speaking backgrounds
Key STI epidemiology	Disproportionately affected by STI compared with the general population[73]
	Gonorrhoea and infectious syphilis diagnosed more frequently (2016-2021)
	Infectious syphilis incidence and chlamydia notifications increased (2012-2021)
	Different rates of STI cases noted between men who have sex with men who are HIV-positive and HIV-negative
Other considerations	Recent trend towards more frequent comprehensive STI screening, particularly in urban areas, as reported by the Gay Community Periodic Survey[74]
	Greater availability and awareness of highly effective HIV prevention strategies[75]
	Evidence emerging on the benefits and costs of vaccinating men who have sex with men for HPV to prevent anal cancer
Priority population: People from culturally and linguistically diverse backgrounds, including people born overseas and international students, particularly those from non-English-speaking backgrounds	
Structural barriers to accessing healthcare	Risk of power imbalances in sexual relationships[76]
	Limited access to Medicare and/or private health insurance
	Limited knowledge and awareness of health and other support systems
	Encompass over 200 different language groups – accessing services in English can be challenging due to language barriers
	Fear and/or experience of racism in healthcare settings or other community groups
	Some people, such as refugees, may have experienced multiple traumas as a result of war and dislocation, in addition to the impact of prejudice or persecution based on their sexual or gender identity
	STI, sex, and sexual health can be a very sensitive topic in many cultures due to associated stigma and shame[77]
Key STI epidemiology	Australian HIV notification rates are higher for people born in some areas in Northeast Asia, Southeast Asia, and sub-Saharan Africa compared with Australian-born people[78]
	International students are part of the general population of young people who are known to be more vulnerable to contracting STI
	International students may use their migration experience as an opportunity to explore sexual freedoms previously unavailable to them[79]
	Focus on people who can get pregnant

Other considerations	Culturally appropriate approaches needed
	Healthcare access for international students often mediated through privately purchased health insurance, rather than Medicare[80]
	Heterogenous group, and considerations needed for culturally and linguistically diverse gay, bisexual and other men who have sex with men, people who use drugs, young people, people who are ineligible for subsidised healthcare, refugees, humanitarian entrants, sex workers, and women
	Improving STI and sexual health literacy, empowering people to make health-enabling decisions and boosting ability to navigate available sexual health services is particularly important[81,82]
	More need for robust and timely data that addresses gaps and disaggregation by language and ethnicity

Priority population: Sex workers

Structural barriers to accessing healthcare	Fear and/or experience of stigma and discrimination. Sex workers experience barriers to accessing health services including high levels of stigma and discrimination[83]
	Sex work regulatory frameworks which promote stigma and discrimination[84]
	Lack of anti-discrimination protections for sex workers impacts confidence navigating healthcare
	Cultural considerations, including perceived impacts on migration status, sex workers from non-English-speaking backgrounds and sex workers who are Indigenous
	Over-burdened free and anonymous testing services[85]
Key STI epidemiology	Rates of STI among sex workers in Australia are among the lowest in the world
	Sex workers have high levels of voluntary testing
	Increase in the incidence of chlamydia and gonorrhoea among sex workers in recent years
	Sex workers are experts in looking after their sexual health and are less vulnerable to undiagnosed STI than the general population[86]
	Sex workers, irrespective of gender, perceived impacts on migration status and modality of sex work, reported consistent condom use in a recent study in Victoria[87]
	Focus on people who can get pregnant
Other considerations	Limited data for some sex workers. Tailored approaches needed to recognise different working and cultural factors that may affect a sex worker's access to STI, and sexual health services
	Sex workers can be from any gender and may have additional considerations in accessing STI, and sexual health services
	Strength and effectiveness of peer-based support is a reason for the low rates of STI among sex workers
	Voluntary testing is a key enabler for sex workers, laws that mandate testing still exist in several jurisdictions. Some sex workers require the ability to test using a pseudonym

Priority population: Travellers and migrant workers

Structural barriers to accessing healthcare	People often behave differently when they travel, including engaging in different sexual practices
	Long geographical distance to sexual services in regional, rural and remote areas
	Timing of services may not accommodate shift-work patterns
	Access to services limited by mobility and without proof of residence
	May be additional barriers for women workers and their sexual health in relation to gender norms in their industry and accessing sexual health services[88,89]

Key STI epidemiology	Limited data on associations between STI, migration and work status
	Focus on people who can get pregnant
Other considerations	Fly-in, fly-out and seasonal workers and the communities they have contact with are important sub-populations for consideration in the response to STI[90,91]
	Movement of people to and from countries with high prevalence of STI, among them extensive drug-resistant infections that are difficult to treat
	Tailored approaches and services for travellers and mobile workers needed, including the delivery of targeted STI, sexual health promotion and education about STI both prior to travel and upon return
	Limited disaggregated data about associations between STI, migration and work status

Priority population: People who are trans and/or gender diverse

Structural barriers to accessing healthcare	Trans-affirming care is not the norm[92] – particularly regarding STI, sexual and reproductive health, where screening of intimate parts of the body can be complex for trans people
	Gender diversity and inclusive pedagogies not adequately included in relationship and sexuality education in schools[93]
Key STI epidemiology	The epidemiology of STI among transgender people attending Australian sexual health clinics differs from that of cisgender people[94]
	Data measures are not inclusive; therefore, the sexual health needs of trans and gender-diverse people are not clear
Other considerations	Lack of understanding about what surgical interventions might mean for STI
	Gender details need to be captured by health data systems – spaces and measures needed to recognise that not everyone with a particular body part is either male or female[95]
	Systems of healthcare and research must be adapted to include nonbinary people[96]

Priority population: People experiencing housing insecurity

Structural barriers to accessing healthcare	Access to services limited by mobility and without proof of residence
	Challenge of accessing antenatal services for pregnant people who are experiencing housing insecurity[97]
	Lesbian, gay, and bisexual people are more likely than heterosexual people to experience housing insecurity and may face additional stigma or discrimination in accessing STI, sexual health and other health services[98]
Key STI epidemiology	Limited information about STI for people experiencing housing insecurity
	Chlamydia and Mgen prevalent in a recent study of young people aged 12-24 who are experiencing housing insecurity[99]
	Focus on people who can get pregnant
Other considerations	Limited disaggregated information about STI and people experiencing housing insecurity

Priority population: People who have had a STI in the previous 12 months

Structural barriers to accessing healthcare	Opportunity – already engaged with sexual healthcare and clearly relevant group for focused attention
	May fear and/or experience stigma and discrimination when accessing healthcare
	May avoid healthcare if they perceive they are no longer at risk of STI after recently engaging healthcare

Key STI epidemiology	People who have one or more STI need clear referral pathways, access to STI, sexual health services and follow-up
	Focus on people who can get pregnant
Other considerations	The timely diagnosis, treatment, care, and support for people with an STI is an opportunity for awareness raising about future STI prevention, sexual health, and well-being[100]

7.2 Priority settings

STI responses can be better positioned and delivered within the social and cultural contexts of affected communities and priority populations by taking settings-based approaches. People within one or more priority populations live, work, socialise, and access healthcare in a variety of ways. This includes in-person and online settings. Geography is also an important consideration, particularly in regional, rural, and remote Australia, as distance can pose a significant barrier to accessing timely sexual and other health services.

Across all STI and sexual health promotion materials used in all settings, community leadership should be respected, and attention should be paid to language (including translation and interpretation, as well as cultural resonance), diversity and the inclusion of a range of perspectives across and within communities.

The following priority settings have been identified to help focus efforts on specific settings frequented by priority populations to enhance access to and engagement with sexual health services.[101] An important consideration is to take services to meet people where they are (literally and metaphorically), rather than expecting that people will come to existing services.

Community-based settings

Engaging people with STI in the places where they live, work, and socialise is critical, particularly for priority populations who may experience barriers to accessing mainstream primary and tertiary services. These settings play a number of different roles, including testing, treatment, and ongoing care, support for chronic disease management, health system navigation, linkages to appropriate healthcare and other social and health support services, and access to appropriate and safe health promotion and education. Some community-based settings with a particularly active or focussed role in addressing STI include:

Multicultural BBV and STI services

Multicultural BBV and STI services work with culturally, ethnically, and linguistically diverse communities to ensure equitable access to specific BBV and STI related healthcare, health promotion, education, and community development. They also forge important relationships with the broader BBV and STI and healthcare sector to advocate for better health and wellbeing outcomes for culturally, ethnically, and linguistically diverse communities.

Aboriginal Community Controlled Health Organisations/Aboriginal Medical Services

Aboriginal and Torres Strait Islander peoples experience a disproportionately high prevalence of BBV and STI compared to non-Indigenous Australians. Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services are uniquely positioned to deliver high quality services to meet the needs of Aboriginal and Torres Strait Islanders across the country. These services provide culturally sensitive integrated person-centred care and are form critical enablers to achieve the four Priority Reforms of the National Agreement on Closing the Gap – the objective of which is to overcome inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians.[102]

Community/Peer led organisations of/by Sex Workers

Peer education through peer-based sex worker organisations is essential for promoting prevention, testing and treatment for sex workers. Within this population, tailored approaches for sex worker sub-populations, including migrant and Aboriginal and Torres Strait Islander sex workers, that address stigma and discrimination and the regulatory and legal barriers experienced by sex workers is required.

Sex worker peer organisations are a priority setting through which sex workers can be reached in the national response. Sex worker peer organisations provide essential prevention education conducted by peers as well as critical linkages to testing treatment and ongoing management and care.

Harm Reduction Programs

Harm reduction programs, such as needle and syringe programs (NSPs) and opioid substitution programs (OSPs), are critical for prevention in reducing injecting risk behaviours, and improving the lives of people who inject drugs. Harm reduction programs help to ensure that people who inject drugs have access to a range of supports including, sterile injecting equipment, medically prescribed, orally administered opiates as a replacement for illicit drugs, peer support, harm reduction education, and health promotion.

Community/Peer-led organisations led by people who use drugs

These organisations provide access to de-stigmatised peer-based support, information, education, advocacy, harm reduction services, and services which aim to reduce the transmission of hepatitis B and hepatitis C with drug use.

Other community-based health and social support settings

Alcohol and Other Drug (AOD) services, mental health services, youth services, outreach services for people experiencing housing insecurity and community pharmacies, are all settings where there are opportunities for STI prevention and awareness.

Schools and educational settings (including out-of-school settings)

Services covering primary, secondary and higher education play an important role in delivering inclusive and comprehensive STI prevention education programs to encourage safer sex practices, provide linkages to STI education and support services, and reduce the burden of STI in school-aged people. All schools and educational settings should provide STI education that is comprehensive and accurate, and that does not further entrench STI stigma.

Primary and tertiary healthcare
Primary and tertiary care settings in which people affected by STI may access healthcare, are critical entryways for priority populations to receive adequate care, and can include:

- Sexual health, reproductive health and family planning services, (such as antenatal and post-natal obstetric services fertility services, including contraception, abortion, and assisted reproduction services)
- Maternal and child health
- Primary health and AOD
- Bilingual and bicultural healthcare providers
- Aboriginal community-controlled health organisations
- Emergency departments
- HIV services
- Cancer services
- Palliative care
- Genitourinary services

- Neurologic and disability services (for deafness, blindness, congenital defects and severe long-term disability)
- Pharmacies.

Multicultural and migrant health services are particularly critical in providing STI services to culturally, linguistically, and ethnically diverse communities. These settings can help promote equitable access to services by reducing language barriers and working alongside primary healthcare services and professionals to ensure that services are delivered in a culturally appropriate and accessible way.

Home-based and online settings
Home-based settings include access to telehealth and self-testing. Online settings include health promotion through dating sites, online social networking, and applications. Dating platforms have changed how people engage in sexual conduct, broadening a network of potential or actual sexual partners. Research has shown that dating sites, social media and applications provide an effective way of communicating preventative and educational messages.[103]

Geographic settings
Efforts should focus on locations with high prevalence and/or incidence of STI and difficulties accessing services. In regional, rural, and remote Australia, these settings can have additional challenges, as distance can pose a significant barrier to timely access of sexual and other health services.

Custodial settings, Corrections settings and other places of held detention
People in custodial settings are often from marginalised and disproportionally criminalised groups, including Aboriginal and Torres Strait Islander people, people who use drugs, sex workers, trans and gender diverse people, and people from culturally and linguistically diverse (CALD) backgrounds. Unwanted sex can occur in custodial settings, and people may engage in different sexual practises (prison sex, including sex between men) from when they are in the general community. Incarceration is a risk factor for STI (as well as BBV infection and transmission) due to the lack of appropriate and accessible harm reduction measures.[104]

A study by CSIRO identified that Aboriginal peoples are also substantially over-represented in the Australian juvenile detention population, with findings demonstrating the need for sexual health services to work collaboratively across government sectors and with the Aboriginal community-controlled sector to provide appropriate education, testing and support.[105]

8. Priority areas for action

The Fifth National STI Strategy includes set areas for action designed to enable the achievement of the goals and targets. Some areas for action support more than one goal and, importantly, should be viewed as mutually reinforcing. Together, they will enhance the likelihood of success in achieving the vision of this Strategy. At the same time, this Strategy must also be responsive to new STI prevention developments and support their implementation.

8.1 Integrated primary care

To achieve the goal of integrated person-centred systems for better sexual health for all, public sexual health systems and the management of sexual health in primary care must be strengthened. Further integration and innovations, such as from new technologies and approaches, can ensure that no opportunities are missed for promoting sexual health and enabling timely access to testing for, and management of, STI associated with significant morbidity.

Primary healthcare, including sexual health services, makes a significant contribution to diagnosis, treatment, care, support, and management of STI. It is essential to engage and support primary care and sexual healthcare providers, with a focus on GPs, to integrate STI testing, treatment, management, and partner notification as part of routine care. Timely and appropriate treatment and care of priority populations and their sexual partners must be improved and supported by localised health pathways and referrals. Opportunities for integration with existing services include offering STI testing alongside appropriate routine activities (for example, during visits for contraception, general health checks, antenatal visits, and appropriate vaccinations).

The early detection and treatment of STI are essential to reduce further transmission and minimise the development of complications. Improvements in contact-tracing activities should be built on, with a particular focus on contact tracing (where appropriate) and partner notifications, and on treatment systems for populations in rural and remote areas, especially areas with mobile populations.

Reducing STI transmission is dependent on increasing the likelihood of diagnosis and treatment of the sexual contacts of people diagnosed with a STI. Effective partner notification could reduce reinfection rates and allow diagnosis and treatment in people who may not realise they have been exposed to a STI, given that many STI can be asymptomatic. Contact tracing is critical to the control of STI and must be sensitive to the cultural and physical safety and privacy concerns of priority populations.

The use of technologies to better support person-centred care, including telehealth, should be promoted where relevant. It should be used as a foundation to build upon and help tailor the use of technology for preventing, identifying, and treating STI. Strengthening links between HIV and STI testing is important as new testing technologies for HIV are progressing more quickly than new technologies for other BBV and STI. This is particularly important in some priority populations, such as gay, bisexual, and other men who have sex with men.[106] As new technologies come to the fore, it will be important to develop safeguards to ensure the regulation of data, privacy and confidentiality.

Practical examples

Two case studies of initiatives implemented by the Melbourne Sexual Health Centre (MSHC) showcase opportunities for integrated primary care. A study that evaluated a decentralised hub and spoke model that was implemented in 2020 to deliver HIV and STI services found this model led to a sustained increase in HIV and STI testing in the year to July 2021. GPs were found to be well placed to deliver sexual healthcare, including primary care HIV testing and treatment as the 'spokes' in the model, with specialist services providing the training through the hub and spoke model.

A pilot study of a joint initiative between MSCH and the Centre for Excellence in Rural Sexual Health on STI vending machines that dispense free self-testing kits for chlamydia and gonorrhoea will determine success through participant satisfaction and any demonstrable uptake of testing from people who routinely do not test or who have never tested. The vending machines will be located in rural areas that lack health services or where there may be barriers to access. Buy in from health professionals in the community is considered crucial, as although the vending machines can help address access barriers, they cannot offer local health promotion and treatment advice. The pilot started in March 2023 and will run for a period of one year. See Appendix A for further detail on these case studies.

Table 3: Key areas for action – Integrated primary care

KEY AREAS FOR ACTION – Integrated primary care	
1	Improve coverage of sexual health services, particularly in rural, regional, and remote areas with a high proportion of young people (ages 15-24) by enhancing health infrastructure and building a multidisciplinary workforce capable of effectively responding to outbreaks, epidemics and prolonged transmission.
2	Engage young people in timely STI screening, prevention and treatment and co-design systems to maintain the connection with GPs as they get older.
3	Reduce risk of syphilis during pregnancy to minimise harm to unborn babies and eliminate congenital syphilis through providing support to the health workforce, increasing partner testing, and improving accessibility of antenatal services .
4	Integrate services into priority settings and connecting primary healthcare practitioners with clinical decision support tools, including strengthening access to services for people ineligible for subsidised care and availability of point-of-care testing.

Outcomes expected from this priority area include strengthened STI management in primary healthcare along with integration and innovation to ensure no missed opportunities for promoting sexual health, thereby enabling the achievement of Goal 2 (integrate person-centred systems for better sexual and reproductive health for all) of this Strategy.

8.2 Workforce development

A strong multidisciplinary workforce is vital for delivering best practice, age-appropriate and culturally appropriate STI and sexual health education and services across Australia.[107] This workforce includes health and education professionals and community health and peer-based workers from, and who work with, priority populations. There is variability in the level of STI-related knowledge and skills among the primary healthcare workforce and educators. Improved access to training opportunities would support a more consistent and effective response to STI across the country. Ensuring that health professionals have access to the necessary tools and resources to support high-quality sexual healthcare is imperative, as is timely referral and advice between specialist and primary healthcare services.

Specific education, professional development and specialisation opportunities should be made available to support the development of essential knowledge and skills across the workforce. Resources and programs should highlight the specific sexual health needs of priority population groups.[108] Hybrid approaches of online learning, web-based resources, and mobile applications, as well as face-to-face learning opportunities, should be tailored to specific workforce needs and locations (including urban, regional, rural, and remote). Professional and community-based organisations, working with specialist education providers, are well placed to tailor training in response to local needs and workforce capacity.

Evidence-based, responsive, and accessible clinical guidelines and tools play an essential role in supporting the provision of effective STI prevention and care in Australia. These guidelines must be coupled with education for health professionals to support guideline use and training to build workforce capacity and capability. Strengthened digital health systems and consolidated electronic health records can enable holistic and person-centred care, and these would need to be accompanied by significant cultural, legal, and social reforms to build trust in digital health systems from priority populations.[109]

Issues about recruitment and retention of healthcare providers, peer workers and other staff must be addressed, particularly in rural, regional, and remote areas, to ensure that the required expertise, capability and capacity exist in all areas. Innovative models adapted to local contexts can assist in addressing such challenges by utilising the skills of other appropriately trained health professionals, including nurses and Aboriginal and Torres Strait Islander health workers.

Most priority populations in Australia regularly interact with primary care services, including sexual health services. Support and education must be provided to healthcare professionals at the frontline of STI diagnosis and treatment, particularly general practitioners, to ensure that they are well informed, are aware of and have access to appropriate guidelines on testing and treatment and can provide optimal information and support to their clients. Maintaining a strong workforce to provide support and referral pathways for care at the community level is a priority.

The level of stigma experienced by people seeking to access STI testing and treatment is impacted by the attitudes of health professionals and clinic staff, and also by physical location and environment.[110] Education and awareness raising to reduce stigma in healthcare settings is considered integral to training programs for staff of all specialists, primary healthcare, and community-based service providers. Healthcare professionals working with young people need to be regularly educated and updated about these important structural issues with regard to health insurance schemes and young people's rights.

For example, it is important to ensure health professionals and relevant non-clinical staff are provided education and training about young people's right to confidential healthcare, their right to consent to their own medical treatment, and implications of STI identification in children and young people. For example, health professionals should be aware:

a) young people can access confidential care using a family Medicare number, which, if they are over 14 years, cannot be seen by a parent or guardian,

b) information pertaining to services charged to a private insurance fund for international students in Australia is not visible to parents or guardians.

Building on the trend for nurse- and peer-led testing and treatment models for other diseases will be essential over the life of this strategy, particularly to support equitable access across locations and settings. Opportunities to facilitate the provision of more nurse-led services, including required education, professional development, and specialisation opportunities, should be a particular focus.

Practical examples

A case study of a program in Kimberly, Western Australia, on tailoring culturally appropriate services to control syphilis to reach communities in need demonstrates opportunities in workforce development. The Enhanced Syphilis Response (ESR), run since 2018 by the Kimberley Aboriginal and Medical Service (KAMS) in partnership with its ACCHO members, has, as of 2023, trained over 100 ACCHO staff in point-of-care testing. KAMS has focussed on reaching people between the ages of 15 and 29 who attend clinics infrequently. Under the ESR program, rates of testing and treatment of syphilis and other STI and BBVs have increased. Increased funding to build up the sexual health workforce, using culturally appropriate health communication and outreach strategies, enabling clinics to tailor programs to their community and collaboration with people networks and partnership across organisations are key factors that have been attributed to the success of the response in the Kimberley region. See [Appendix A](#) for more detail on the case study.

Table 4: Key areas for action – Workforce development

KEY AREAS FOR ACTION – Workforce development	
5	Promote and resource sustainable models and continuity of care for STI and sexual health within the health workforce, including general practitioners, workers in ACCHOs, general practice nurses and midwives. Involve community pharmacies and peer workers to increase STI screening, vaccination, and access to treatment.
6	Embed sexual health, STI information and awareness of stigma within pre-service and prescribing training and medical school curricula and other health-related fields (such as pharmacy, nursing, and midwifery) to enable high-quality, non-stigmatising and culturally appropriate STI prevention, testing and treatment services for all.
7	Build the capacity and role of community organisations to provide education, prevention, support, and advocacy services to priority populations.
8	Enhance sexual health services by optimising and broadening nurses' and other sexual healthcare providers' scope of practice.
9	Strengthen the availability of sexual health service providers trained in STI management in rural, regional, and remote areas, and reform funding mechanisms that can support this.

Outcomes expected from this priority area include building capacity of the health workforce in STI, thereby enabling the achievement of Goal 2 (integrate person-centred systems for better sexual and reproductive health for all), Goal 3 (increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia) and Goal 4 (eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health) of this Strategy.

8.3 Education and Awareness

Normalising awareness of STI and enhancing values and attitudes around risks, rights and responsibilities for sexual health will achieve a higher awareness and understanding of sexual health for all in Australia. Tailored prevention and education by and for priority populations will strengthen these efforts.

Recognising, and seeking testing and treatment for STI, should be routine for any sexually active person. This is particularly pertinent for those who are young, with more than one sexual partner, or for anyone at the time of partner change. Australia needs a national STI campaign, as well as tailored prevention and education initiatives that are age-appropriate, culturally acceptable, translated into relevant languages other than English, and nuanced for the diverse needs of different communities, and where appropriate, trauma informed.

There is a need to increase awareness about STI, including the importance of consistent and effective safer sex practises, such as safe and correct use of condoms and other barrier method use, and greater knowledge of where to access free and affordable barrier methods. There is also a need to increase awareness about the often-asymptomatic nature of STI, transmission pathways, common symptoms when they do occur, the long-term consequences of untreated STI, when and how to access appropriate services, and the importance of vaccination where available. Effective strategies should also assist in normalising and promoting early and regular testing and treatment to reduce STI-related stigma and discrimination.

The timing of information about sexual health and prevention education is critical to ensure that it precedes the initiation of sexual activity (and is reinforced in an ongoing manner after sexual activity) and is delivered incrementally in an age and stage appropriate way as young people transition through adolescence and into young adulthood.

Raising awareness and knowledge of STI and their consequences among priority populations remains essential. This should include addressing skills to increase safer sexual behaviours and to access and navigate the health system. These activities must be relevant and accessible to the priority populations while acknowledging different cultural, social and language needs. Education and prevention initiatives should be tailored, co-designed, and resonant with priority populations.

Relationships and sexuality education (RSE) with comprehensive sexual and reproductive health (SRH) content that is both age and stage appropriate, culturally responsive, and disability inclusive, should be provided to both Australian school students and young people who are no longer in school. There is also room for primary care, sexual health, and other healthcare services to be more effective and proactive in engaging with young people on STI issues, including prevention education, promotion of immunisation and STI testing and treatment, and connecting young people to other STI education and support services.

There is emerging evidence that interventions utilising digital media (including social media and other platforms) can improve STI and sexual health knowledge.[111,112] Mass media (such as radio and television) as part of a comprehensive response, may also be effective in assisting to promote conversation and awareness and improve safer sex attitudes and behaviours. Where education and prevention initiatives are delivered is also critical and must be in the context of priority settings specific to each priority population, including where they live, work, and socialise. This includes static

efforts (such as billboards and printed materials) and interactive efforts (such as outreach and peer engagement).

Implementing STI prevention and education initiatives for priority populations to improve knowledge of risk management and prevention methods assists in reducing STI-related stigma and supports pathways to early testing and treatment. This includes a focus on infectious syphilis, particularly in Aboriginal and Torres Strait Islander communities, people who can get pregnant and their partners, and metropolitan gay, bisexual and other men who have sex with men. Ideally, initiatives should be co-designed for effective engagement and to ensure that appropriate languages and terminology are adapted to meet the diverse needs of populations. These initiatives should be tailored, age-appropriate and culturally appropriate and use a variety of relevant channels, including digital media (for example, social media platforms), mass media (such as radio and television) and in-person and online sites frequented by communities.

Peer education and support have played important roles in reducing STI transmission and connecting with some marginalised and vulnerable populations. Peers are credible, trusted sources of information and can assist in overcoming physical and socio-cultural barriers. Sex workers, for example, have played a longstanding and pivotal role in health promotion by establishing partnerships in community health initiatives and being pioneers in peer education programs. For some priority populations, effective STI education includes the use of digital platforms and social networking sites that are frequently used to meet sexual partners. Street outreach, self-collection and peer-based and online testing have demonstrated effectiveness in reaching priority populations.[37] These efforts should also be supported by a systematic increase in opportunities for priority groups to have STI tests, including by appropriate use of new testing technologies.

Practical examples

Two case studies demonstrate initiatives and innovations in education and awareness raising for different priority populations.

The Western Australia Department of Health provides several free resources to young people, parents, schools, and the community, in recognition of the vital role that comprehensive relationships and sexuality education (RSE) plays in preventing STI and BBV and reducing public health impacts. These resources include Growing and Developing Healthy Relationships resource and teacher training program available free to all WA schools; Talk soon, Talk often to support parents in having regular open conversations with their children about age- and stage-appropriate RSE topics; Yarning Quiet Ways for Aboriginal parents and their children; and Get the Facts website that provides sexual health information and free online STI testing. In 2021-2022, the Growing and Developing Healthy Relationships website received more than 230,000 unique visits, while the Get the Fact website attracted more than 752,000 visitors.

In New South Wales, the Sydney Sexual Health Centre, has been at the forefront of many service delivery innovations, including a[TEST] and MyCheck. A[TEST] is a free and confidential rapid HIV and STI testing service for gay, bisexual, and other men who have sex with men. Recently, an a[TEST] Chinese Clinic has been established to provide Mandarin-speaking gay men and men who have sex with men with easier access to sexual health screenings and information. MyCheck was launched with the NSW Sexual Health Infolink as a pilot scheme in 2021, to enable access to free testing at a location convenient for them and is now being scaled up across publicly funded sexual health clinics in NSW. See Appendix A for more detail on these case studies.

Table 5: Key areas for action: Education and Awareness

KEY AREAS FOR ACTION – Education and Awareness	
10	Commission targeted STI health promotion initiatives, codesigned and tailored to priority populations and regions that use strength-based language which is inclusive and affirms sexuality. Initiatives should cover access to STI care, including testing, consistent and effective use of all types of barrier methods, sexual health literacy, and have linkages with jurisdictions.
11	Build the capacity of the education workforce to facilitate knowledge and awareness of STI by embedding education that is inclusive and stigma-free within pre-service training for educators and teacher development processes at the primary, secondary and tertiary levels (such as university, TAFE and international colleges).
12	Coordinate and provide governance of cross-sectoral prevention and education policy and programs (for example, family and domestic violence, respectful relationships, child sex abuse, consent education and gender violence) to ensure a unified, comprehensive and best practice approach.
13	Promote advocacy and empower priority populations to access STI prevention, treatment, care, and support across community, education, workplace, and legal settings.
14	Establish a National Advisory Group for curriculum-based relationship and sexuality education (RSE) that can provide governance of best practice principles and support materials for schools and alternative education settings to deliver comprehensive RSE in line with state and national curricula.

Outcomes expected from this priority area include normalisation of awareness of STI, enhancing values and attitudes around risks, rights and responsibilities, and tailored prevention and education led by and designed for priority populations. This enables the achievement of Goal 3 (increased awareness and understanding of STI as part of sexual and reproductive health for all in Australia) of this Strategy.

8.4 Prevention, testing and treatment

To decrease morbidity and complications from STI in Australia, it is imperative that everyone has access to timely, stigma-free, and high-quality STI and sexual health services. Guidelines should be revised to recommend appropriate testing frequencies for specific populations. Local epidemiological data and expertise should inform testing frequency decisions to reduce morbidity in these populations. Bolstered primary, secondary, and tertiary prevention efforts are also essential to achieving this objective.

Ensuring access to timely, inclusive, and stigma-free and quality sexual health services for all is also imperative for strengthening secondary and tertiary prevention. Culturally safe healthcare services free from stigma and racism must be accessible to all. Online services can help expand timely access to STI testing and other healthcare services.

When managed appropriately for a person's unique situation, safe sex (including the use of condoms and other barrier methods) offers one of the most effective methods of protection against STI. Trends in condom use and condomless sex are of concern. Consistent condom use with casual partners has been declining over the past five years among gay, bisexual and other men who have sex with men.[113] While research on condom use among sex workers in Australia has shown sustained high

rates of consistent condom use,[36] there are some issues concerning condomless oral sex, which emphasise the need for targeted peer-led health promotion and harm reduction initiatives in this area.

HPV vaccination is delivered to adolescents as part of the high school-based immunisation program conducted by states and territories. A recent study showed that the program is generating herd immunity for certain types of HPV in Australia.[114] Vaccines available on the National Immunisation Program protect against nine types of HPV, including seven types associated with causing over 90% of cervical cancers in Australia. Sustained efforts are needed to continue to improve adolescent vaccination, particularly in males, to meet the target of 90% coverage by 2030.[115] The HPV vaccination is also recommended for men who have sex with men and a catch-up program is providing access to individuals up to the age of 26, as well as humanitarian entrants. Heightening awareness and education on the HPV vaccination and catch-up program is critical for preventing transmission in populations most vulnerable to STI.

Study results from the GoGoVax research program to trial a gonococcal vaccine will be available in 2025 and, if efficacious, could make a significant contribution to addressing the high and increasing rates of gonococcal infection in gay, bisexual, and other men who have sex with men and other groups.[116]

This Strategy must be responsive to emerging and new STI prevention strategies, for example, use of the antibiotic, doxycycline, as post-exposure prophylaxis (Doxy-PEP) after sex to prevent STI and targeted rollout of the meningococcal B vaccine.

Testing for STI should become part of routine self-care and clinical practice to monitor sexual and reproductive health and well-being, particularly for people changing partners or with more than one sexual partner. Taking a life-course approach, a sustained effort is needed to engage with each generation using approaches that promote awareness, bolster prevention, inform health-enabling actions and reduce barriers to accessing services.

Practical examples

Two case studies, one from New South Wales, the other from Western Australia, illustrate initiatives and programs aimed at promoting prevention, testing, treatment/management of STI and HIV.

The New South Wales Sexually Transmitted Infections Programs Unit (NSW STIPU) promotes community awareness through state-wide STI social marketing and communication campaigns, using humour and gamification to empower sexual health education. STIPU works with priority populations and the public and private health systems to build capacity for prevention, treatment, and management of STI and HIV. STIPU has three ongoing campaigns – Play Safe, a website about sexual health for young people aged 15-29 that utilises interactive tools and resources, attracting over 5 million visits; Take Blaktion, a campaign for young Aboriginal and Torres Strait Islander people in NSW that uses comedy to break down shame and stigma and promote STI testing and condom use; and the International Health Hub, co-designed with international students it provides a one stop shop to improve access to trusted sexual health information and services for international students.

In Western Australia, highly accurate molecular point-of-care tests are being employed to reach Australia's most remote communities, enabling the provision of same-day testing and more timely treatment by clinical staff through primary care services in these communities. Based on the results of the TTANGO (Test Treat ANd Go) research trial, TTANGO2 was funded, providing POC testing initially for chlamydia and gonorrhoea, with trichomoniasis added in 2018. STI testing using this approach was implemented in more than 30 primary health services in four jurisdictions. Preliminary results from a 2023 evaluation suggest that POC testing for STI is scalable, cost effective, provides sustained clinical benefits, and has strong acceptability among healthcare workers. For more detail on these case studies, see [Appendix A](#).

Table 6: Key areas for action - Prevention, testing and treatment

KEY AREAS FOR ACTION – Prevention, testing and treatment
15 Support the scale-up of evidence-based interventions aimed at reducing morbidity associated with STI, with a focus on infectious and congenital syphilis, repeat chlamydia infections and infections that cause pelvic inflammatory disease (chlamydia, gonorrhoea or Mgen) and other complications from STI for young people.
16 To respond to emerging and new STI public health threats: a) National guidelines are developed for clinicians to refer to and be educated on. b) Community education and awareness activities to be co-designed with relevant community organisations and resources translated where necessary. c) Clinical and implementation research be conducted to support the response. d) Responses to be informed by emerging evidence and changing practice.
17 Co-design and offer a range of testing methods and opportunities across settings for priority populations, including point-of-care testing and the integration of testing into existing services, with a focus on rural, regional, and remote areas, and supported by nurse-led and peer-led models of care and including multidisciplinary teams.
18 Implement comprehensive STI strategies by enhancing early and appropriate treatment and wraparound care, and establishing sustainable funding models that incentivise increased testing efforts for priority populations relating to STI risk factors.
19 Ensure that testing frequency is informed by local epidemiology and expertise to reduce morbidity, and guidelines reflect the appropriate testing frequency for specific populations.

Outcomes sought from this priority area include the enhancement of vaccination and primary prevention efforts and access to quality STI and sexual health services for all when needed, thereby enabling the achievement of Goal 1 (reduce morbidity and complications from STI in Australia by scaling up evidence-based interventions) of this Strategy.

8.5 Equity and Access

Ensuring inclusion and addressing stigma within healthcare settings promotes access to timely and appropriate services and supports a health-enabling environment. This environment must be supported by enabling legal and policy frameworks that support individuals to seek out healthcare, take preventative measures, and seek support when they experience stigma and discrimination. Healthcare settings are comprised of, and maintained by, people with diverse identities, values, cultures, beliefs, and prejudices. These settings are a microcosm of broader community and social values. Ideally, ensuring inclusion and addressing stigma within healthcare settings will be mirrored and reinforced by reduced stigma and a generally more inclusive society.

Stigma has long accompanied STI, primarily due to the association with sexuality and negatively perceived behaviours. The expression, experiences and anticipation of stigma and discrimination impact prevention and control efforts, as well as the health and quality of life of individuals.[117] Stigma creates barriers to openly discussing sexual behaviours and possible exposure to STI, requesting, or being offered a test, taking medication, notifying sexual partners, and seeking support from family, friends, and healthcare providers. Stigma can increase the harm caused by STI for the individuals affected and increase missed opportunities to prevent or reduce transmission of STI.[118]

Experiences of stigma relating to STI are influenced by intersecting characteristics of identity, community, and culture. This includes sexual orientation, gender and gender identity, cultural background, migrant or refugee status, HIV status, disability, history of substance use or misuse, and being a sex worker or person in a custodial setting. Strategies to address stigma and discrimination must acknowledge and account for this complexity as these experiences may compound STI stigma, resulting in poorer health outcomes for these individuals and communities.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction.[119] The type of service accessed or whether it is accessed at all depends on several factors, including proximity, availability of the service, cost, legal environment, affordability, and an individual's comfort in accessing the service.

Practical examples

A case study on a service for people who are trans and gender diverse in Sydney, New South Wales, illustrates successful initiatives to improve equity and access. t150, part of the Albion Centre in Surrey Hills, Sydney is Australia's first publicly funded trans-specific sexual health and HIV service, providing free gender-affirming care alongside specialist sexual health and HIV care, testing and prevention. Established in 2018, staffed by clinicians and a community peer, t150 works to improve the community's access to services and healthcare engagement through providing a safe, dedicated clinical space. More than 50% of clients come from culturally and linguistically diverse populations, and 10% represent Aboriginal and Torres Strait Islander people. Word of mouth referrals from the community are higher than predicted, with the waiting list the service's current biggest challenge. For more detail on this case study, including advice for people wishing to establish a trans-affirming sexual health service, see Appendix A.

Table 7: Key areas for action - Equity and Access

KEY AREAS FOR ACTION – Equity and Access
20 Ensure that STI education, prevention, testing, and treatment initiatives support efforts to counteract STI-related stigma. This includes establishing policies and practices for diversity and inclusion in clinical services that support the provision of stigma-free STI and sexual and reproductive health services.
21 Establish a dialogue between health and other sectors aimed at reducing stigma and discrimination against people with STI and affected individuals and communities.
22 Monitor and address legal, regulatory and policy contexts, which result in stigma and discrimination and impact health-seeking behaviour among priority populations and their access to STI testing and services, including those that address criminalisation of STI transmission, and consider how these can be addressed.
23 Set national standards for a minimum package of STI services that can be adapted for settings based on epidemiology and population ratios.

Outcomes expected from this priority area include inclusion for all within health care settings, the elimination of STI related stigma, and legal and policy frameworks that enable priority populations to seek out healthcare and take preventative measures to look after their sexual health and wellbeing. This enables the achievement of Goal 4 (eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health) of this Strategy.

8.6 Data, Surveillance, Research and Evaluation

The epidemiology of STI in Australia is changing rapidly. Continuous improvement of data collection and systems is important for supporting a comprehensive understanding of current and emerging STI in Australia. However, this must be appropriately targeted to avoid unnecessary burdens on health services and frontline staff and ensure privacy and confidentiality for all.

Data surveillance and its timely feedback must be sustained and made accessible to inform clinical practice. Rapid epidemiological and laboratory surveillance data are available and reported to the Australian Government Department of Health and Aged Care every quarter. This data should be made accessible to improve tailored public health and community-led responses. Potential areas for greater involvement of community and peer-based organisations in surveillance should also be identified, given their strong knowledge of priority populations.

Opportunities to improve the granularity of data to better identify trends and issues of concern for specific priority populations and other demographics should be explored. These opportunities include improved reporting of Aboriginal and Torres Strait Islander status in clinical and pathology settings and improved data on stigma and discrimination, gender and sexuality, and quality of life for people with STI.

Surveillance data is only collected for the four notifiable STI at the national level, limiting understanding of the full impact of STI in Australia. Some populations and locations are known to experience high rates of non-nationally notifiable STI, such as the high rates of *Trichomonas vaginalis* and endemic rates of HTLV-1[2] among many remote Aboriginal and Torres Strait Islander communities. A further limitation is that surveillance is focussed on case notifications, with limited reporting on other aspects in of disease acquisition such as accessible provision of services, testing and positivity rates, success of contract tracing, or disease consequences such as the morbidities and disability resulting from a STI.

As well as having access to high-quality, timely surveillance data, it is critical that there are opportunities to improve the capacity to respond to current and emerging STI. Improved STI management and notification systems and clear roles and responsibilities are necessary to support effective responses to increased STI incidence, including during outbreaks. Essential elements of an effective response include comprehensive follow-up treatment and effective contact tracing, measures to prevent further transmission, and review of STI treatment guidelines.

In partnership with the community sector, research on the social, behavioural, clinical, and structural drivers for, and barriers to, achieving optimal sexual health for all Australians must continue. Understanding the drivers of these changes is key to developing the most appropriate public health response.

Research is important to identify and examine:
- The key changes in the epidemiology, knowledge, and attitudes about STI and sexual health behaviours among priority populations (for example, patterns of sex work, mobility, and migration)
- Drivers of behaviours (such as having condomless sex with multiple partners and not seeking regular STI testing)
- Emerging issues and concerns on new approaches and/or in response to community perspectives
- Barriers and enablers to accessing evidence-based prevention, testing and treatment across jurisdictions

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[2] HTLV-1 is a notifiable disease in the Northern Territory. https://health.nt.gov.au/public-health-notifiable-diseases

- Lived experience of STI for priority population groups, especially when taking an intersectional approach that recognises diversities within groups and between different realities.

This research is critical to inform targeted responses in priority populations and settings, including identifying particularly vulnerable and/or marginalised people. Analysis of the rates of STI in young people from one or multiple priority population groups in Australia compared with their older counterparts is currently limited. Disaggregation of data in a comparable, appropriate, and confidential way is paramount.

There is scope for raising awareness of the purpose, scope and value of research, data collection and evaluation among communities, particularly priority populations, to understand the role of research and inform consent processes. Results from research and community-based data collection should be made available to priority populations to enhance the validity of that research, as well as enable communities to gain the benefits of the knowledge generated through the research process.

Strains of multi-drug resistant gonorrhoea and shigella have been detected in Australia. Multi-drug resistant strains are a serious public health problem because infections can be difficult to treat. Surveillance of these infections is critical to prevent further spread.

Table 8: Key areas for action – Data, Surveillance, Research and Evaluation

KEY AREAS FOR ACTION – Data, Surveillance, Research and Evaluation
24 Monitor trends in STI knowledge and attitudes, invest strategically in social research and science to address gaps in prevention efforts within priority populations, and support interdisciplinary studies to inform priority actions and enhance STI normalisation efforts.
25 Regularly update, maintain, and promote the use of evidence-based national clinical guidelines and resources for STI testing and treatment to increase early detection, including the identification of gaps in clinical management and the translation of those gaps into guidelines.
26 Identify gaps and develop systems to support a more coordinated, prompt response between jurisdictions, private pathology labs, sexual and reproductive health services, and general practices to address STI issues, including real-time accessibility of surveillance data, improved communication channels with primary care, improved person-centred care and case management and notification systems, and specialised local and regional support staff.
27 Identify and address gaps in data and evidence base to public health responses including the targets in this strategy, in particular those addressing availability, equity and provision of accessible sexual health care.

Outcomes sought from this priority area include improvement of data, surveillance, evaluation and addressing gaps in research. This supports the achievement of Goal 5 (enhance research for STI) of this Strategy.

9. Implementing this strategy

9.1 Leadership, partnership, and connections to community

Australia's response to STI is built on a model of partnership between affected communities, governments, peak organisations, health and community organisations, researchers, and the multidisciplinary workforce.

The Australian Government is committed to providing strong national leadership by working across portfolios and jurisdictions to achieve the goals of this Strategy. The Australian Government Department of Health and Aged Care leads the coordination of the national response to STI under the National STI Strategy 2024-2030. The success of this Strategy is contingent on productive partnerships between Commonwealth, state and territory governments and partners, including community peak organisations, priority populations and affected communities, health workers, researchers, and others. In the case of research on STI, it is imperative that this is conducted in partnership with communities and is aligned with the priorities of the five national strategies.

The Fifth National STI Strategy 2024-2030 is a shared responsibility between governments, community, and the health sector to provide evidence-informed interventions built on high quality research, surveillance, monitoring, evaluation, and the expertise of priority populations, affected communities and community peak organisations. As such, continuous monitoring and evaluation of current and emerging interventions will be essential in enabling cost-effective decision making and guiding existing partnerships to implement agreed directions.

Achieving implementation of the actions in this strategy and achievement of targets requires investment and mobilisation of resources to be across all levels of government, from national direction to local jurisdictions. This strategy is a coordinating mechanism that ensures that resources are utilised to achieve maximum impact and desired outcomes.

9.2   Surveillance and monitoring plan

This Strategy spans 2024-2030 and represents a departure from the shorter lifespan of previous strategies. The targets will provide data from which a comprehensive review of progress can be undertaken. This process and timing are consistent with the WHO global strategy.

The identification of areas in need of improvement and action is an essential part of remaining accountable to the 2030 elimination goals, as well as ensuring the ongoing relevance of key aspects of the Strategy. The Strategy will be implemented in a dynamic manner, recognising there are unforeseeable point-in-time contextual pressures that may require its priorities to be readjusted.

This strategy brings a focus to the provision of accessible, equitable sexual health services, with integration into primary care, supported through the health workforce. Surveillance and monitoring will need to align with this, and may require support for new data measures, and new data collection measures to reflect the new focus.

Appendix A: CASE STUDIES

Integrated primary care

Case study: Decentralising testing and treatment: Implementing a hub-and-spoke model	
Location	Victoria
Organisation	Melbourne Sexual Health Centre (MSHC)
Strategy outcomes	▪ Goal 1: Reduce morbidity and complications from STI in Australia by scaling up evidence-based interventions to enhance access to quality STI and sexual health services for all when needed. ▪ Goal 2: Integrate person-centred systems for better sexual and reproductive health for all. ▪ Goal 4: Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health.

'It is great that more GPs can be upskilled to provide quality sexual health in this hub-and-spoke model, but this does not replace having multiple sexual health clinics (NSW model), which is the ideal. Over the next five years, I'd like to see better access to specialist sexual health services in Victoria and across Australia – that would be fantastic!'

– Associate Professor Jason Ong, Head, HIV/STI Economics and Health Preference Research, Melbourne Sexual Health Centre (MSHC)

In 2020, MSHC, part of Alfred Health, implemented a decentralised hub-and-spoke model to deliver HIV and STI services. The model is a network with a central facility (the 'hub') that provides a full array of sexual health primary and specialist services and supports geographically dispersed secondary services (the 'spokes'). In Victoria, MSHC serves as the specialist hub for HIV and STI testing and treatment, supporting GP spokes that provide primary care HIV and STI testing and treatment.

A study found that from July 2020 to July 2021, this model led to a sustained increase in HIV and STI testing (see Table 1). It concluded that GPs are well placed to deliver sexual healthcare, with specialist services providing support and training through a hub-and-spoke model.

Table 1: Sustained increase in HIV and STI testing (monthly average) as a result of the hub-and-spoke model

	HIV	Chlamydia	Gonorrhoea	Syphilis
Before implementation	68.8	61.6	52.2	53.2
After implementation	99.3	155.1	114.5	93.5

Associate Professor Ong's top tip for those wishing to implement their own hub-and-spoke model is to ensure that acceptability and feasibility are discussed with GPs and other primary care clinicians, clients, and funders prior to implementation and scale-up. 'In particular, tailoring the training provided to GP spokes to meet the needs of each clinic is critical,' he said. 'Plus, we've heard from GPs that providing these services as a bulk-billed appointment is not sustainable, so we are investigating alternate models of reimbursement.'

More information	www.mshc.org.au

Case study: Dispensing with access barriers: Piloting STI vending machines to deliver free self-tests	
Location	Victoria (rural)
Organisation	Centre for Excellence in Rural Sexual Health (CERSH)
Strategy outcomes	▪ Goal 1: Reduce morbidity and complications from STI in Australia by scaling up evidence-based interventions to enhance access to quality STI and sexual health services for all when needed. ▪ Goal 3: Increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia.

'We are always looking for innovative ways to help the regional and rural communities in which we live and work. If these machines enable people to complete an STI test and find out their status, it's a win for us.'

– Dr David Evans, Senior Health Promotion Manager, Centre for Excellence in Rural Sexual Health

In March 2023, CERSH, with the Melbourne Sexual Health Centre (MSHC), announced a new joint initiative – STI test vending machines. The machines dispense free self-testing kits for chlamydia and gonorrhoea and require only electricity and a mobile phone service to function. This makes it easy to place them in rural communities that lack health services or where there may be other barriers to access. After completing their test, the self-tester places it in a pre-paid postage box and posts it to MSHC. If treatment is required, a specialist will follow up by phone to discuss options.

For the pilot period of one year, success will be determined through participant satisfaction and any demonstrable uptake of testing from people who routinely do not test or have never tested. Buy-in from health professionals in the community is crucial, according to Dr Evans. 'These machines excel at providing access to testing in marginalised communities where barriers, such as poor transportation and privacy concerns, exist,' he said. 'But they cannot offer local health promotion and treatment support.'

More information	medicine.unimelb.edu.au/cersh

Workforce development

Case study: **Meeting communities' needs:** Tailoring culturally appropriate services to control syphilis	
Location	Kimberley, Western Australia
Organisation	Kimberley Aboriginal Medical Service and National Aboriginal Community Controlled Health Organisation
Strategy outcomes	- Goal 1: Reduce morbidity and complications from STI in Australia by scaling up evidence-based interventions - Goal 2: Integrate person-centred systems for better sexual and reproductive health for all - Goal 3: Increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia - Goal 4: Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health.
Priority population	Aboriginal and Torres Strait Islander people

'The Enhanced Syphilis Response hit the ground very quickly. People got training, supplies, and started testing within a few months of funding being released in the Kimberley. Services would have been struggling without it.'

– Katy Crawford, former Sexual Health Regional Facilitator, Kimberley Aboriginal Medical Services (KAMS)

For more than 50 years, Aboriginal Community Controlled Health Organisations (ACCHOs) have worked on the frontline to improve access to primary healthcare and address health inequities faced by many Aboriginal and Torres Strait Islander people across Australia.

Since 2018, KAMS has partnered with its ACCHO members to deliver the Enhanced Syphilis Response (ESR) across the Kimberley region of Western Australia. **As of 2024**, over 100 ACCHO staff have been trained in point-of-care testing, and rates of testing and treatment for syphilis and other STI and BBVs have increased. KAMS has focused on reaching people between the ages of 15 and 29 who attend clinics infrequently.

'Syphilis point-of-care testing has been very useful to health workers as on-the-spot testing can reduce time to treatment and difficulties with follow-up in highly transient populations. It also provides a visual aid to help people understand that they are infected even if they have no symptoms.' – Molly McCulloch, KAMS remote sexual health nurse

Key factors attributed to the success of the response in the Kimberley region have been:

- Increased funding to build up the sexual health workforce, including tailored training and mentorship for Aboriginal health practitioners, sexual health nurses and GPs
- Using culturally appropriate health communication and outreach strategies, including localised strength-based communication and outreach testing
- Enabling each clinic to tailor the program to best serve its community
- Collaboration and building a strong network of people and partnerships across organisations

These factors align with the national findings and recommendations outlined in the 2021 ESR evaluation.

More information	naccho.org.au

Education and awareness

Case study: Enabling the next generation to own their sexual health	
Location	Western Australia
Organisation	Departments of Education and Health
Strategy outcomes	• Goal 3: Increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia • Goal 4: Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health.

'Best practice STI and BBV prevention approaches need to start by educating young people before they begin sexual relationships so that they are empowered to make informed decisions. STI education cannot happen in isolation, it must be taught in the context of broader sexuality education.'

– Lisa Bastian, Manager of Sexual Health and Blood-borne Virus Program (SHBBVP), Communicable Disease Control Directorate, Western Australian Department of Health (WA DoH)

The WA DoH recognises the vital role that comprehensive relationships and sexuality education (RSE) plays in preventing STI and BBV and reducing public health impacts.

For more than two decades, the WA DoH's Growing and Developing Healthy Relationships resource and teacher training program has been available for free to all WA schools. Its website provides best practice curriculum support materials to help deliver comprehensive RSE in WA schools, receiving more than 210,355 unique visits (**2021-2022**).

In a media-saturated world, reliable and accurate sexual health information has never been more vital. Based on the guiding principle that RSE is the shared responsibility of parents, schools, and the community, the WA DoH also offers free resources for parents and young people. Talk soon. Talk often (TSTO) is a hardcopy guide and interactive website developed to support parents in having regular open conversations with their children about age- and stage-appropriate RSE topics. Yarning Quiet Ways, an adapted version of TSTO, is a culturally appropriate resource for Aboriginal parents and their children. For young people, WA DoH offers guides on topics such as puberty, relationships, sexting, consent, and condoms. It hosts Get the Facts, a website that provides sexual health information and free online STI testing. It attracted more than 752,000 visitors in **2021-2022**.

'In recent years, there has been significant public interest and a call to action to address concerns relating to many elements of RSE: consent education, intimate partner violence, respectful relationships, sexual violence and access to abortion,' Lisa Bastian said. 'Moving forward, a united national approach is required to best utilise resources and ensure comprehensive, high-quality equitable access to prevention and education programs across Australia.'

Case study: Putting people first: Ensuring client-focused service delivery	
Location	Sydney, New South Wales
Organisation	Sydney Sexual Health Centre (SSHC)
Strategy outcomes	- Goal 1: Reduce morbidity and complications from STI in Australia by scaling up evidence-based interventions. - Goal 3: Increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia. - Goal 4: Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health.
Priority populations	Gay, bisexual and other men who have sex with men People from culturally and linguistically diverse backgrounds

'Consumer involvement at all stages has been hugely valuable. Both a[TEST] and MyCheck highlight the continual need to tailor our services to the local population – there is no such thing as a "one size fits all" approach.'

– Dr Rick Varma, Senior Staff Specialist at Sydney Sexual Health Centre (SSHC)

SSHC offers testing, treatment, and management for STI and HIV. In partnership with community organisations, SSHC has been at the forefront of many service delivery innovations, including a[TEST] and MyCheck, over its 90-year history.

Launched a decade ago with ACON, a[TEST] is a free and confidential rapid HIV and STI testing service for gay, bisexual, and other men who have sex with men. An a[TEST] Chinese Clinic was established recently to provide Mandarin-speaking gay men and men who have sex with men with easier access to sexual health screenings and information. As with all a[TEST] clinics, no Medicare card is required.

Launched as a pilot scheme with the NSW Sexual Health Infolink in November 2021, MyCheck enables SSHC clients to access free STI testing at a location convenient to them. For now, the service is available only to pre-existing clients who have no symptoms. It involves a quick assessment over the phone and then attending a commercial or public pathology collection centre. There is no need to attend the sexual health clinic. Negative results are delivered to clients via SMS. Clients with positive results receive a phone call from a clinic nurse to set up an appointment or coordinate the provision of treatment.

MyCheck is now being scaled up across publicly funded sexual health clinics in NSW. Scale-up includes the addition of a fully online self-assessment, which clients can complete as an alternative to the phone assessment with a nurse.

For anyone looking to implement or scale up a similar service in their state, Dr Anna McNulty, Director of SSHC, shared: 'Undoubtedly, it is initially resource intensive to establish such a seamless service as it does require a substantial technology investment. In addition, staff buy-in is critical to ensure that they support and proactively offer the service to clients.'

More information	https://www.sshc.org.au

Prevention, testing, and treatment

Case study: Promoting STI awareness in communities: Using humour and gamification to empower sexual health action	
Location	New South Wales
Organisation	New South Wales Sexually Transmissible Infections Programs Unit
Strategy outcomes	▪ Goal 1: Reduce morbidity and complications from STI in Australia by scaling up evidence-based interventions. ▪ Goal 3: Increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia. ▪ Goal 4: Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health.
Priority populations	Young people Aboriginal and Torres Strait Islander people People from culturally and linguistically diverse backgrounds

'The Play Safe website is great! Really relevant content for young people and heaps of information about stuff we're too "scared" to ask others.' – Anonymous, 19 (Sydney, Australia)

The New South Wales Sexually Transmissible Infections Programs Unit (NSW STIPU) aims to reduce acquisition of HIV and STI and associated morbidity and mortality in NSW. This is achieved by working with priority populations and the public and private health systems to build capacity for prevention, treatment, and management of HIV and STI. A key STIPU objective is to promote community awareness through state-wide STI social marketing and communications campaigns.

Three of its ongoing campaigns are Play Safe, Take Blaktion and The International Student Health Hub:

- Launched in 2014, the Play Safe website was designed by young people for young people and aims to educate this cohort, aged 15-29, about sexual health. Focused on promoting regular STI testing and condom use, the website utilises interactive tools and resources, including a sexual health nurse Q&A service, a testing location finder and sexual health knowledge quizzes. More than 5 million people have visited the website.

- Launched in 2015, Take Blaktion is an integrated communication and sexual health education campaign aimed at young Aboriginal and Torres Strait Islander people in NSW. Through comedy skit videos and event activations, the campaign uses humour to break down shame and stigma and increase awareness of STI testing and condom use. Take Blaktion relies on Aboriginal engagement at every level.

- Launched in 2021, The International Student Health Hub is a one-stop shop to improve access to trusted sexual health information and services for international students. Over 70 organisations collaborate on the website, which is co-designed with international students. The Hub has recorded more than 10,500 unique visits and 27,000 page views.

'It's critical that credible health information has a place online given how much inaccurate information is available,' STIPU's Social Marketing and Health Promotion Program Manager, Jordan Murray, said. 'To anyone considering developing a content-based website like we have, I'd suggest involving the target group and co-designing it with them as much as possible. Plus, invest in the right digital agency, develop a great approval process with your communications team and don't be afraid to push the boundaries when it comes to content.'

More information	stipu.nsw.gov.au playsafe.health.nsw.gov.au takeblaktion.playsafe.health.nsw.gov.au internationalstudents.health.nsw.gov.au

Case study: Benefiting from new technologies: Employing molecular point-of-care tests to reach Australia's most remote communities	
Location	Western Australia, Far North Queensland, and South Australia
Organisation	Collaboration between academic research institutions, Aboriginal and government health organisations, pathology providers, health services, communities, and industry
Strategy outcomes	- Goal 1: Reduce morbidity and complications from STI in Australia by scaling up evidence-based interventions. - Goal 3: Increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia. - Goal 4: Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health.
Priority populations	Aboriginal and Torres Strait Islander people

Many regional and remote Aboriginal and/or Torres Strait Islander communities in Australia experience unacceptably high rates of STI. Reasons are complex, but the development of highly accurate molecular point-of-care (POC) tests for STI (GeneXpert, Cepheid) is enabling the provision of same-day testing and more timely treatment by clinical staff through primary care services in these communities.

Following a field evaluation to identify the most suitable POC technology, the TTANGO (Test Treat And GO) research trial was conducted from 2013 to 2015 to determine the acceptability, performance, and clinical impact of this technology for the detection of chlamydia and gonorrhoea in these communities. It was the first randomised controlled trial of molecular POC tests for chlamydia and gonorrhoea performed in regional and remote primary health services internationally. It found that POC testing could be accurately performed by trained clinical staff in regional and remote Aboriginal and/or Torres Strait Islander communities and led to significantly improved treatment uptake and timeliness.

Based on the results of the TTANGO research trial, TTANGO2 was funded. POC testing for chlamydia and gonorrhoea continued, with trichomoniasis added in 2018. Between 2016 and 2019, STI testing using this approach was implemented in more than 30 primary health services across four jurisdictions.

Preliminary results from a 2023 evaluation suggest that POC testing for STI is scalable and cost-effective and provides sustained clinical benefit, including modelled reductions in pelvic inflammatory disease and preterm births. It found strong acceptability of this approach among healthcare workers but emphasised that scale-up efforts should communicate the clinical benefits of POC testing for STI and ensure adequate training. Further, strategies to increase community awareness of POC testing for STI and reduce stigma or embarrassment associated with sexual health more generally should underpin scale-up efforts.

More information	ttango.com.au

Equity and access

Case study: Providing a safe space: Leading a trans-affirming sexual health service	
Location	Sydney, New South Wales
Organisation	t150, Albion Centre
Strategy outcomes	▪ Goal 1: Reduce morbidity and complications from STI in Australia by scaling up evidence-based interventions. ▪ Goal 3: Increase awareness and understanding of STI as part of sexual and reproductive health for all in Australia. ▪ Goal 4: Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health.
Priority populations	People who are trans and gender diverse

'The ability to feel safe and understood by staff, provided hormones and be able to get my tests and PrEP all in the one place is great.'

– t150 client

Established in 2018, t150, part of the Albion Centre in Surry Hills, Sydney, is Australia's first publicly funded trans-specific sexual health and HIV service. Staffed by clinicians and a community peer, it provides free gender-affirming care alongside specialist sexual health and HIV care, testing and prevention. By providing a safe, dedicated clinical space, t150 works to improve the community's access to services and healthcare engagement.

More than 50% of clients come from culturally and linguistically diverse populations, mainly in the Philippines and Thailand. In total, 33% are Medicare ineligible, presumably international students, overseas visitors or temporary visa holders, while 10% represent Aboriginal and Torres Strait Islander people.

Of the sexually active clients seen in the first two years, 25% had never undergone sexual health or HIV testing, and 10% were diagnosed with at least one STI in their first 12 months. A total of 38% of trans women commenced PrEP use within six months of regular clinic attendance.

There are challenges, Maggie Smith, Clinical Nurse Consultant at t150, said: 'There isn't enough mental health support and case management with our complex cohort. Plus, word of mouth within the community has increased referrals to t150 more than we ever could have predicted – our waiting list is our current biggest challenge.

'Ideally, we would like to increase the number of clinics to meet demand and expand the service to include case management and mental health support.'

For people who want to establish a trans-affirming sexual health service, Dr Melissa Kelly, Medical Lead at t150, advised: 'Start by collaborating with community, identify the gaps, develop, or strengthen ties with primary health, and collaborate with any local trans services. A service does not necessarily need to be a trans-only space. Ask communities what they want, co-design and collaborate. And ensure all staff have trans health education and training – the reception team will make or break your service.'

More information	http://thealbioncentre.org.au/clinical-services/t150/

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