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BACKGROUND

AHCSA is a membership-based peak body with a leadership, watchdog, advocacy and sector support role, and a commitment to Aboriginal self-determination. AHCSA is the health voice for Aboriginal peoples across South Australia, and all Aboriginal Community-controlled health services (ACCHSs) in SA are members of AHCSA.

AHCSA provides support to Aboriginal Community-controlled health services in SA though a number of specific programs. This includes programs for the control of Sexually Transmitted Infections (STIs) and Blood-Borne Viruses (BBVs). Support for STI issues is provided by the HERO Team (Health Education, Respecting Others; consisting of a Program Manager and a Project Officer) and for BBV issues by a BBV Program Co-ordinator.

This Handbook has been developed by AHCSA to facilitate a standardised evidence-based approach to control programs for STIs and BBVs at the primary health care level within ACCHSs in SA.

All ACCHSs in SA use Communicare as the health information system. An STI template has been developed for use within SA. Every time a person is screened for an STI, or a diagnosis is made, or treatment given, the STI template should be used. Details about how to use the STI Template are included in this handbook.

Thanks to Julia Vnuk, Nick Williams, Beth Hummerston and Nicola Chynoweth for comments on an earlier draft of the Handbook.

Thanks to IMVS for permission to reproduce the fact sheet on infectious disease tests in page 17, and Port Lincoln Aboriginal Health Service for their hepatitis flowcharts to be adapted for the use of other ACCHSs in SA (pages 33-35).

Aboriginal Health Council of South Australia Inc.
‘Our health, our choice, our way’
www.ahcsa.org.au/sexual-health

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CHLAMYDIA & GONORRHOEA

Chlamydia and gonorrhoea are bacterial STIs, and both occur at much higher rates in Aboriginal people compared to non-Aboriginal people. They are the commonest STIs we deal with in Aboriginal health services, and are the ones we should be thinking about and testing for all the time.

The key message concerning chlamydia and gonorrhoea is that they are “easy to get, easy to test, and easy to treat”.

It is important to pick up and treat Chlamydia and Gonorrhoea because if not treated they can cause PID (Pelvic Inflammatory Disease) in women which can lead to ectopic pregnancy, infertility or chronic pelvic pain.

Chlamydia and gonorrhoea infections may be symptomatic (meaning the patient can tell that something is wrong) or asymptomatic (meaning the patient does not know that anything is wrong unless they have a test).

Symptoms of chlamydia and gonorrhoea in men are pain on passing urine, and/or a penile discharge. In women, the infections can cause vaginal discharge, pain on passing urine, bleeding or spotting between periods or after sex, or lower abdominal pain. However many infections are asymptomatic, so we should use every opportunity to test for these infections so that if the person is infected, they can be treated to prevent complications and further spread of the infection.

Note that a woman with lower abdominal pain (+/- discharge) may have PID, which requires examination and specific treatment (see page 9).

Treatment for chlamydia is with azithromycin 1 g (2 x 500 mg tablets) as a single dose.

Treatment for confirmed gonorrhoea is ceftriaxone 500 mg by intramuscular injection (see page 6 for how to administer ceftriaxone). In the past it was treated with amoxycillin 3g and probenecid 1g as a single oral dose. This has now been changed to ceftriaxone due to emerging penicillin-resistant gonorrhoea. However, currently most cases of gonorrhoea in Aboriginal people in SA are still responsive to amoxicillin. Also, ceftriaxone is a painful injection. Therefore, when we are treating somebody for an STI without a laboratory result confirming gonorrhoea, it is sufficient to use amoxicillin and probenecid.

If somebody presents with symptoms of an STI, specimens should be collected (see page 16) to be sent to the laboratory to make the diagnosis, and they should be treated on the spot before waiting for laboratory confirmation.

If a woman has any other symptoms of an STI other than pain on passing urine or vaginal discharge, (eg lower abdominal pain, bleeding or spotting between periods or after sex) it is preferable if she can be offered a full women’s check-up which may include a pap smear and check for PID. If there is no-one available to do this check-up or the women doesn’t want this now, then specimens should be collected (see page 16) and the woman should be offered immediate treatment with the ZAP pack. She can be advised to have a full women’s check as soon as possible.

As it is not possible to distinguish between chlamydia and gonorrhoea on symptoms alone, we should treat for both. In this case, the patient should be given a “ZAP pack” (1 g azithromycin, 3g amoxicillin, and 1g probenecid). If the lab result showed gonorrhoea, the patient should then be offered ceftriaxone 500mg injection. Sometimes the laboratory results show a mixed infection (chlamydia plus gonorrhoea) in which case the patient should be given azithromycin 1g and ceftriaxone 500mg. More often, only a single STI is found (either chlamydia or gonorrhoea). However, because laboratory tests are not perfect, and because if a person has one STI they are at a significant
risk of having another STI, it is recommended that when one of either chlamydia or gonorrhoea is found, we should treat for both chlamydia AND gonorrhoea.

So the treatment for a confirmed case of chlamydia is with the ZAP pack. And the treatment for a confirmed case of gonorrhoea is with ceftriaxone 500 mg IMI plus azithromycin 1g. (Note that ceftriaxone and azithromycin is often recommended as the treatment for gonorrhoea alone, due to emerging ceftriaxone resistance).

If a diagnosis of gonorrhoea is made with urine PCR, before giving treatment, a specimen should be collected from the patient to be sent to the laboratory with a request for “Gonorrhoea culture and sensitivity”. The best specimen is a swab (urethral swab for men, vaginal swab for women) but if necessary a urine specimen will suffice. These specimens should be transported to the Lab to arrive within 24 hours if at all possible. This will assist in maintaining surveillance of antibiotic sensitivity patterns in the Aboriginal population in SA.

When somebody has an STI, as well as ensuring that they get the correct treatment as soon as possible, we should:

- Carefully ask for the names of sexual contacts, and take appropriate steps to ensure any named contacts get followed-up (see page 23).
- Advise testing for syphilis, HIV, hepatitis B and C.
- Give advice on safe sex
- Advise avoiding sex till one week after treatment of the person and their partner
- Arrange a recall for 3 months later for re-testing, to make sure the treatment has been successful and that the patient has not been re-infected.
- Ensure that treatment has been recorded in the patient’s notes, using the “STI Treatment” template in Communicare.
ADMINISTRATION OF CEFTRIAXONE

YOU NEED:

- 100mg or 1g vial of ceftriaxone
- 1% lignocaine (without adrenaline)

INTRAMUSCULAR INJECTION

- Check the order, right drugs, right patient

- If using 500mg vial of ceftriaxone, inject 1.8 mls of lignocaine into the ceftriaxone vial, shake thoroughly, withdraw full amount, and administer to the correct patient.

- If using 1g vial of ceftriaxone, inject 3.5 ml lignocaine into the vial, shake thoroughly, withdraw 1.8 ml of the reconstituted medication and administer to correct patient. Discard unused reconstituted medication.

- Use 21 or 23 gauge needles.

- Record the medication given in patient’s files (using STI treatment template)
TRICHOMONAS

Trichomonas is an STI which also occurs at higher rates in Aboriginal people than non-Aboriginal people. Like chlamydia and gonorrhoea, it can be symptomatic or asymptomatic, and can cause significant problems if not treated.

Whereas rates of chlamydia and gonorrhoea are roughly equally shared between men and women, trichomonas is much commoner in women than men, because the protozoal parasite *Trichomonas vaginalis* which causes trichomonas infection lasts much longer in women (at least 3-5 years if untreated) than in men (approximately 4 months).

In women, the infection can cause a smelly discharge, possibly with itch or discomfort, but is often asymptomatic. Trichomonas increases the risk of getting PID. If the woman is pregnant it increases the risk of preterm labour and low birth weight. In men, it is usually asymptomatic, but can cause symptoms similar to chlamydia or gonorrhoea.

For these reasons it is advisable to test for trichomonas when testing for chlamydia and gonorrhoea. The test can be performed on the same specimens that are collected for chlamydia and gonorrhoea, so it is just a matter of ensuring that the laboratory form includes a request for trichomonas as well as chlamydia and gonorrhoea.

When trichomonas is found, it should be treated with metronidazole 2 g as a single dose, or tinidazole 2g as a single dose with food. Advise no alcohol for 24 hours as this may make them feel very sick (like a bad hangover).

If a woman with trichomonas is pregnant discuss treatment with a doctor. Usually, treatment with metronidazole or tinidazole should be avoided in early pregnancy. A recall for treatment should be made for the time when the woman reaches 36 weeks, and treatment delayed until after this. If the woman has symptoms, the symptoms can be treated with clotrimazole vaginal cream daily as required.

When somebody has trichomonas, as with other STIs, as well as ensuring they get the correct treatment as soon as possible, we should:

- Carefully ask for the names of sexual contacts (see page 24), OR current partner should be treated if possible
- Advise testing for syphilis, HIV, hepatitis B and C.
- Give advice on safe sex
- Advise avoiding sex till one week after treatment of person and partner
- Arrange a recall for 3 months later for re-testing, to make sure the treatment has been successful and that the patient has not been re-infected

However, because men are more likely to clear the infection spontaneously, and an infected woman may have been infected for a considerable period of time, if there are concerns about the possibility of domestic conflict as a result of contact tracing, a decision may be made that it is better to avoid rigorous contact tracing in the event of a case of trichomonas infection in a woman without other STIs. This decision should be made by the health staff based on local knowledge.
PELVIC INFLAMMATORY DISEASE (PID)

(Much of this section has been extracted from the Women’s Business Manual http://www.remotephcmanuals.com.au/html/home. Refer to this for more information)

Women with chlamydia, gonorrhoea, or trichomonas (and some other bacteria which are found in the vagina but are not STIs) can develop Pelvic Inflammatory Disease (PID). PID is a cause of **lower abdominal pain in women**. It is generally diagnosed through clinical history and examination rather than the results of laboratory tests. PID can cause difficulties in becoming pregnant (infertility) or ectopic pregnancy.

**PID is an important condition, with significant complications, and is sometimes missed. Always consider PID in an Aboriginal woman with lower abdominal pain. (But also think about other causes of lower abdominal pain, especially ectopic pregnancy).**

PID should be diagnosed if there is lower abdominal pain (+/- deep or internal pain with sex) and any of the following signs on a bimanual examination: Uterine tenderness or Cervical motion tenderness (excitation) or Adnexal tenderness. **When a bimanual examination is not possible, treatment for PID should be given to women with lower abdominal pain and/or tenderness and vaginal discharge.** If there is no history of vaginal discharge, treatment for PID may be considered in women under 35 with other indicators such as deep or internal pain with sex, bleeding between periods, or an STI or PID in the past year.

If a diagnosis of PID is being considered, do a full STI check. Always offer a bimanual examination in the case of lower abdominal pain, if you are skilled. Also do a urine pregnancy test and send midstream urine for MC&S on all women even if no urinary symptoms.

In the following factors are present, the woman should be transferred to hospital:

- **Severe PID** (fever above 38°C, pulse more than 100 beats/min or systolic BP less than 100 mmHg, Severe pain with guarding or rebound tenderness; Severe pain with guarding or rebound tenderness; Severe pain with guarding or rebound tenderness; Pelvic mass or swelling — may be an abscess
- **Recent birth, miscarriage or termination of pregnancy**
- **Significant vaginal bleeding**
- **The woman has already failed community treatment and has ongoing symptoms**
- **Surgical problem, e.g. appendicitis cannot be excluded**
- **Pregnant — for extra tests to rule out ectopic pregnancy or other problems**
- **Diagnosis is uncertain**

Women with mild–moderate PID, and who are not pregnant, are treated in the community. It is very important to see the woman often during treatment for PID. Start treatment straight away – do not wait for results.

**Day 1**

- **Give ceftriaxone 500mg IM or IV stat, and doxycycline 100mg orally twice daily for 14 days,**
- **and metronidazole 400mg orally twice daily for 14 days.**
- An alternative to the doxycycline 100mg twice daily is azithromycin 1g orally on day 1 and day 8

- Give paracetamol or paracetamol-codeine 2 tablets orally every 4–6 hours for pain
  (maximum 8 tablets in 24 hours)

**Talk with the woman about**

- Contact tracing to identify the woman’s sexual partner/s from the last 3 months
- Her partner/s need to be treated straight away so she does not become reinfected
- Explain that she should not have sex until one week after both her treatment is finished and her partner/s are treated
- Talk about condoms and safe sex
- The importance of taking medicine for 2 weeks even if she feels well, to reduce the risk of tubal damage

**Day 3**

- Examine the woman, ask her if her symptoms are improving, and check if there are any problems with taking the medication
- If she is not improving, talk with a doctor and arrange evacuation to hospital

**Day 7**

- Check the test results. Even if the gonorrhoea and chlamydia tests are negative, the woman can still have PID
- Examine the woman — if she is not improving seek advice – she may need to evacuate to hospital
- Check to see if she has taken the first week of doxycycline and metronidazole and if she has the correct amount for the second week of treatment
- If using azithromycin, give second dose azithromycin 1g orally

**Day 14**

- Examine the woman and repeat a bimanual examination
- If she still has symptoms or any tenderness on abdominal or bimanual examination, get further advice
- Discuss safe sex and condom use
- Arrange recall for 3 months.
SCREENING FOR CHLAMYDIA, GONORRHOEA AND TRICHOMONAS

As many cases of chlamydia, gonorrhoea and trichomonas do not cause symptoms, and even when symptomatic may cause embarrassment which may be an obstacle to presenting to a clinic. We are unlikely to have a significant impact on decreasing the rates of chlamydia, gonorrhoea and trichomonas if we just wait for people to present for treatment. For this reason, we should consider offering screening for these infections.

Chlamydia, gonorrhoea and trichomonas are ideal conditions for screening in Aboriginal communities, for the following reasons:
- They are often asymptomatic, which means that the person does not know they have the disease unless they have a test.
- There are high rates of the diseases.
- They can have a significant health impact.
- A simple reliable screening test is available.
- An effective treatment is available.

There are two main ways we can conduct screening for chlamydia, gonorrhoea and trichomonas:
- Opportunistic screening
- Community screening.

Whenever STI screening occurs (whether opportunistically or as part of the community screen), or when somebody presents with STI symptoms, the “Check-up: sexually transmitted infections” tab on Communicare should be used (accessible via the STI tab).

Opportunistic screening (that is, offering a test to people when they present to the clinic for other reasons) is important, and should be encouraged. However, community screening (that is, attempting to test all people in the target age group over a short period of time) is likely to have a much greater impact on reducing the rates of chlamydia, gonorrhoea and trichomonas, for the following reasons:
- Some people in the target age-group may not present to the clinic for other reasons, and hence may be missed if we rely only on opportunistic screening);
- By “blitzing” the whole target group with screening and treating all positive cases at around the same time, there is a greater likelihood that transmission of the infections will be interrupted.

Also, by having a period of a few weeks every year where there is an emphasis on STI screening, this can help to remind everybody concerned about the importance of STIs as a health issue, and be an opportunity to up-skill health service staff in STI control activities.

Therefore, Aboriginal Community-Controlled Health Services in South Australia have supported a program of providing a community screening program around April-June each year (as well as opportunistic screening throughout the year).

The experience of Nganampa Health Council, as referenced below, has demonstrated the effectiveness of this approach.
References:


COMMUNITY STI SCREENING PROGRAM

1. GENERAL ISSUES

1. All ACCHSSs in South Australia are encouraged to participate in the STI community screening program, although the decision lies with each health service. Staff from AHCSA H.E.R.O. Team will be available provide support and advice. Nganampa Health Council has its own program and protocols.

2. Each year, recommended dates, consisting of a six-week period around April – June, for the STI community screening will be decided early in the year. Individual health services may adjust these dates if they wish.

3. The STIs screened will be chlamydia, gonorrhoea and trichomonas.

4. The target age-group should be those aged 16-30. If the health service decides to do so, it can increase the upper age (e.g. to 35, 40, or 45). Screening of younger children (e.g. those aged 14 or 15) in whom there is thought to be a reasonable likelihood of sexual activity should be encouraged, but informed consent including signed permission from their parents or carers should be obtained (see page 16).

5. The aim should be to test everybody from the health service client database in the target group, and to treat every person with a positive test as soon as possible after the diagnosis has been made.

6. This program may provide ideal opportunities for full health assessments, and where possible this should be done. It should also provide an opportunity to administer seasonal flu vaccination. However, the priority over this six week period is to try and get everybody in the target group screened for STIs.

7. To ensure maximum coverage, it will be necessary to go out of the health centre to various places within the community (including people’s homes) to locate people on the list and to offer testing.

8. It is important to have informed consent from people who provide specimens. They should be aware of why the specimens are being requested, that the specimens will be sent away to a laboratory to test for chlamydia, gonorrhoea and trichomonas, and what it will mean if chlamydia, gonorrhoea or trichomonas are detected. It is not necessary to get written consent, unless the person is under 16 years of age, in which case a parent/carer should sign the consent form.

2. PREPARATION FOR THE SCREENING PROGRAM.

1. Efforts should be made to ensure that community members are aware of the planned screening program prior to its commencement, through appropriate promotion activities.

2. The Board and staff of the health service should be fully aware of the activities involved in the program.

3. A person, or small team, should be appointed to coordinate the screening program in each health service. However, as many staff as possible should be encouraged to help with the screening program.

4. A list of the target population should be obtained from the health service database. Each health service should ensure a system is in place to keep track of who has been screened, whether results have been received, and whether the appropriate follow-up has occurred.
5. Supplies which will need to be obtained include urine specimen containers, swabs, Styrofoam eskies, amoxicillin, probenecid, azithromycin, ceftriaxone and metronidazole.

6. Staffing rosters should be arranged to ensure that appropriate staff have times allocated to the screening program throughout the screening period. AHCSA may be able to assist with extra staff at various times.

7. Staff involved in the screening program should know how to use the STI screening templates in Communicare.

8. The recall for “Check-up STI” should be set for all people aged 16-30 to be activated on the first day of the screening period.

9. Staff involved in the screening should know how to generate pathology request forms. Preferably this should be printed by Communicare, but in some cases pre-printed pathology request forms may be used.

3. DATA ISSUES

1. On the first day of the screening period, an immediate recall for “STI screen” should be generated for each person aged 16-30 who is a permanent patient of your health service.

2. When a patient is screened, the information should be entered on that day in the STI template. This will automatically remove that name from the recall list.

3. Each morning during the screening period, a new list can be generated of those patients in the target age-group who are still awaiting screening.

4. When the information that a person has been screened has been entered on the STI template, an IMVS pathology request form will be generated, to be sent with the specimen as soon as feasible to IMVS.

5. When the IMVS result is electronically returned to your service it should appear as usual in the “Communicare in-tray”. It is important that somebody checks the in-tray daily during the screening period. If a positive result is received, a recall should be entered for “STI Treatment” and the appropriate staff notified.

6. When a patient has a positive result, treatment should be given as soon as possible, and the date of treatment recorded in the STI template.

4. TIPS FOR SUCCESSFUL SCREENING

- Promotion of the event for several weeks leading up to the Screening Period will help to raise awareness.

- Ensure that staff are allocated specific times to work on the screening program.

- Make sure all staff are aware of the screening program, so that they can help if possible.
• All positive cases should be treated ASAP. Treatment should be attempted on the day you are notified of an infection if possible.

• It is essential to use the list of people to be screened and to go out of the clinic looking for them. If you wait for people to come to the clinic, you will miss a lot of people. Specimens can be collected at any site, not necessarily at the clinic – but they must be labelled and the information entered on Communicare when you return to the clinic.

• Organise special events e.g. men’s health evenings, and use the occasion for health promotion as well as screening.

• Consider arranging with sporting clubs, schools, etc, to visit these sites for screening purposes.

• If people on your list, or named contacts, are away from your community, find out where they are if possible and contact the appropriate health service and ask them to do the screening and to let you know when it has happened. The AHCSA H.E.R.O. Team can help if necessary.
SUGGESTED TEMPLATE FOR WRITTEN CONSENT FROM PARENT OR CARER
FOR CHILD UNDER 16 YEARS TO BE INCLUDED IN SCREENING

HEALTH SERVICE LETTERHEAD

I give permission for staff from .................................................. Aboriginal Health Service to request my son/daughter/ward to provide a specimen for testing for chlamydia, gonorrhoea and trichomonas.

Name of young person: ..............................................................................................................................................

Date of birth: .................................................................................................................................................................

I understand that if chlamydia, gonorrhoea or trichomonas is detected, the child will be provided with treatment free-of-charge, and will be asked to give the names of any sexual contacts.

I also understand that any suspicion of sexual abuse will result in reporting to Families SA.

Signed: ..............................................................................................................................................................................

Name: ...............................................................................................................................................................................

Witness signature: ..........................................................................................................................................................

Name of witness: ............................................................................................................................................................

Date: ....................................................................................................................................................................................
TESTING FOR CHLAMYDIA, GONORRHOEA & TRICHOMONAS

1. Males need to provide a urine specimen only, for urine PCR tests for chlamydia, gonorrhoea and trichomonas.

2. Females should be requested to provide self-collected swabs (white-top swabs for PCR chlamydia, gonorrhoea and trichomonas; and a blue-top or a charcoal swab for M/C/S. A charcoal swab should be used in most places outside Adelaide where there is likely to be a delay of more than 8 hours in getting the swab to the lab; in Adelaide a blue-top swab can be used). Any woman who is reluctant to provide swabs should be requested to provide a urine specimen.

3. When people are asked to provide a urine specimen, it should be remembered that there are sensitivities around urine. Any talk about urine, and the handling of the specimen, should be as discreet as possible, with gender separation maintained as much as possible.

4. Ideally, the urine collection should be made with the first urination of the day, but practical considerations must take precedence. A first-pass specimen (not a mid-stream specimen) should be obtained.

5. Urine specimens should be refrigerated as soon as possible after collection.

6. All specimens should be sent to IMVS.

7. The “Check-up: sexually transmitted infections” item on Communicare has a direct link to the request form for PCR for chlamydia, gonorrhoea and trichomonas (and M/C/S for woman who have provided swabs). Delete tests not required.

8. Rural and remote ACCHSs in SA have registered with the BAS scheme with the Commonwealth Department of Health and Ageing, which enables Communicare to be set up to allow RNs and AHWs to generate request forms, which do not require a doctor’s signature. This should be printed on “Std plain paper pathology” rather than pre-printed pathology (see bottom left hand corner of the pathology request form on Communicare). The generated form, when printed, should have “Doctor’s signature not required” already written on it.
## Infectious Disease Tests

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<tr>
<th>TEST</th>
<th>USE / ORDER</th>
<th>WHAT TO COLLECT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Micro, Culture and Sensitivity</strong></td>
<td></td>
<td>Site swab</td>
</tr>
<tr>
<td>(MC&amp;S)</td>
<td>Amies Transport Swab</td>
<td></td>
</tr>
<tr>
<td><strong>Virus Detection</strong></td>
<td></td>
<td>Site swab, fluid or crust</td>
</tr>
<tr>
<td>Culture or PCR</td>
<td>Viral Transport Swab</td>
<td>Note: For respiratory viruses preferred samples are combined throat and deep nasal swab or Nasopharyngeal aspirate (NPA). NPA: Viral Transport Medium (VTM) is available for these samples on request.</td>
</tr>
<tr>
<td><strong>Chlamydia/Neisseria gonorrhoea</strong></td>
<td></td>
<td>Urine / Swab</td>
</tr>
<tr>
<td>genital PCR tests</td>
<td></td>
<td>Urine - First void (first 20mls)</td>
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<tr>
<td></td>
<td></td>
<td>or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Swab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female - Endocervical or urethral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male - Urethral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Amies swab is unsuitable for Chlamydia/N. gonorrhoea PCR test.</td>
</tr>
<tr>
<td><strong>Gynaecological specimens</strong></td>
<td></td>
<td>Swab</td>
</tr>
<tr>
<td>for bacterial culture including</td>
<td></td>
<td>Make smear then place swab in</td>
</tr>
<tr>
<td>Neisseria gonorrhoea if delay in</td>
<td></td>
<td>Amies charcoal transport media.</td>
</tr>
<tr>
<td>transport to the lab (&gt;8hrs) is expected.</td>
<td></td>
<td>Female - smear + cervical or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>urethral swab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male - smear + urethral swab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: smear - air dry only.</td>
</tr>
<tr>
<td><strong>Mycology/skin scraping</strong></td>
<td></td>
<td>See kit instructions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Thanks to IMVS for permission to reproduce this fact-sheet)
Sexual Health Screening – A step by step guide

- Person to be screened – explain reason for screening for chlamydia/gonorrhoea
- Obtain the specimen
- Complete the recall “STI Check up” on communicate
- Generate Pathology request form on communicate from STI template
- Send specimen and pathology request form to IMVS laboratory

Females
Self applied swabs (LVS) PCR and charcoal M/C/S or,
First catch urine PCR 20mls

Males
First catch urine PCR 20mls

Check communicate “In-tray” for results daily

-VE chlamydia
-VE gonorrhoea

No Further action required

+VE chlamydia
-VE gonorrhoea

Treat with – STAT
1gm Azithromycin and 3gm Amoxycillin and 1gm Probencid
“(Check for allergies first)”

-VE chlamydia
+VE gonorrhoea

Treat with – STAT
500mg Ceftriaxone IMI and 1gm Azithromycin
“(Check for allergies first)”

+VE chlamydia
+VE gonorrhoea

Treat with – STAT
1gm Azithromycin and 500mg Ceftriaxone IMI
“(Check for allergies first)”

- In a culturally sensitive way discreetly ask for sexual contacts
- Ask permission (informed consent) and take blood to test for HIV, syphilis, Hepatitis B and C
- Encourage safer sex practices and offer condoms
- Complete recall for ‘STI Treatment’

Review in 3 months and test for re-infection
STI Screening using Communicare in South Australia

Clinical items
Participating sites in South Australia will have a set of clinical items to record the screening for and treatment of Chlamydia and gonorrhoea. These items appear on a button labelled 'STI':

Check up: Sexually transmitted infections

STI Treatment

Followup: Sexually transmitted infections
Recall rules
The following rules should be enabled at the start of the screening period:

On Registration - Check up: Sexually transmitted infections - Minimum Age 16 years - Maximum age 31 years - Age 16 years

On Completion - STI Treatment triggers Followup: Sexually transmitted infections - Offset 3 months

Process
Screening
Using the report Report | STI Screening | Recalls Due with the Recall Type option set to STI Check up recalls to contact and screen clients. This report allows you to filter by locality group, current status and gender.

Complete the recall for Check up: Sexually transmitted infections and generate a pathology request for appropriate tests.

NOTE: if you have upgraded to version 10.2 or later there will be a button on the screening with pre-selected tests, otherwise you must make a pathology request in the usual way by selecting the tests manually. The tests recommended are: 'Gonorrhoea and Chlamydia PCR', 'Micro culture and sensitivities, swab' and/or 'Micro culture and sensitivities, urine'.

If you have upgraded to version 10.2 or later then clicking the Request Investigation button preselects tests for a request:
If treatment is given as part of the screening then add one or more of the STI treatment items (see above), prescribe and treat appropriately.

Continue to use the report. Once a client has been screened then their name does not appear on the list.

**Results**

When the doctor reviews the results as they arrive he/she should add a recall for treatment if the result requires treatment. If the result does not require any further action then it is reviewed and the process for that patient ends. Use should be made of the comment field when adding the recall to add any specific details of the result or the treatment required.

The treatment recalls are itemised above. In some cases, two different recalls for treatment may need to be added.

The report Report | STI Screening | Recalls Due should be run with the Recall Type option set to STD Treatment recalls. Clients on this report should be recalled for treatment.

**Treatment**

Once a patient is recalled for treatment the treatment should be prescribed and given appropriately. The recall must then be completed. This will trigger a recall for a follow up in three months.

**Follow up**

The report Report | STI Screening | Recalls Due should be run with the Recall Type option set to STI Follow up recalls. Clients should be recalled for follow up.

If required the follow up item can be enhanced after upgrade to version 10.2 to have a test request button with specific tests pre-selected.

**Wind up**

Once the screening period is over the recall rule 'On Registration - Check up; Sexually transmitted infections' should be disabled.

The report Report | STI Screening | Recalls Due should be run with the Recall Type option set to <All STI recalls>. This will show outstanding treatment and follow up recalls and any manually altered check up recalls.
Management Reports

Report | STI Screening | Audit Report - this report totals how many recalls remain, how many have been completed and how many have been cancelled.

<table>
<thead>
<tr>
<th>STI Screening Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE GROUP</td>
</tr>
<tr>
<td>18-20</td>
</tr>
<tr>
<td>21-25</td>
</tr>
<tr>
<td>26+</td>
</tr>
</tbody>
</table>

Report | STI Screening | Patients Screened Analysis - this report shows counts of completed checks, test requests (by type), results received (by type and outcome), results recorded manually at treatment and treatments completed, broken down by age group.

<table>
<thead>
<tr>
<th>Patients Screened for STI</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUBTITLE</td>
</tr>
<tr>
<td>Check for Sexually transmitted Infections</td>
</tr>
<tr>
<td>Check for Sexually transmitted infections</td>
</tr>
<tr>
<td>b. Investigation requests</td>
</tr>
<tr>
<td>Gonorrhea &amp; Chlamydia PCR</td>
</tr>
<tr>
<td>Gonorrhea &amp; Chlamydia PCR</td>
</tr>
<tr>
<td>c. Results received</td>
</tr>
<tr>
<td>Microscopy smear / culture</td>
</tr>
<tr>
<td>Microscopy smear / culture</td>
</tr>
</tbody>
</table>

Report | STI Screening | Response Time for Treatment - this report analyses the average time between a recall for treatment and the completion of that recall and also analyses the average time between requesting and receiving a result.

<table>
<thead>
<tr>
<th>STI Treatment Response Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>TITLE</td>
</tr>
<tr>
<td>Average response time in days from last request collection date to recall</td>
</tr>
<tr>
<td>Average response time in days from treatment recall to treatment completion</td>
</tr>
</tbody>
</table>

All reports allow filtering by locality group, current status and gender.
CONTACT TRACING

(Adapted in part from notes by Dr. Will Hope, Nganampa Health Council, 1995, and ‘Recommendations for Contact Tracing in Aboriginal Communities’ by Peter Patterson and Rob Monaghan, NSW State-wide Sexual Health Coordinators)

1. Explain to the person with the STI (the index case) that contacts have a right to examination and treatment for STIs. If the contacts are not treated, the risk for re-infection of the index case is very high. It is crucial to treat contacts ASAP. Emphasize the need to avoid intercourse until the contacts have been treated.

2. If the index case is a male it may be useful to explain that most of the serious consequences of STIs occur in women, and to children born to mothers with STIs. An explanation along these lines may prompt the index case to name contacts.

3. Emphasize CONFIDENTIALITY. It should be stressed that contact tracing is a confidential process, and the name of the index case will not be passed on to the contacts or to anybody else.

4. Contacts are never told the name of the case that named them. They are just informed that an STI check-up and treatment is advisable at that time.

5. Use non-judgmental language, and language that is easy to understand.

6. Give the index case time to understand the implications of the diagnosis and the need and purpose of contact tracing. Do not apply too much pressure.

7. Record the name and address of the contact on a piece of paper. It should not be recorded in the index case’s Communicare notes. Ask for the approximate age, nicknames, aliases, and other contact details if possible.

8. If the contact is a patient of the same health service put in a recall for “STI Treatment” and add the qualifier “named as contact by patient with c, g +/or t”. Notify the appropriate person in your health service that the person named as a contact needs urgent follow-up.

9. If the contact is not in the local community, contact the appropriate person in the Aboriginal health service where the contact is located. If there are difficulties locating the contact, advise the AHCSA HERO team and/or Clinic 275.

10. If you are advised by somebody from another area that one of your patients has been named as a contact, open the contact’s Communicare notes and put in a recall for “STI Treatment”, and add the qualifier “named as contact by patient with c, g +/or t”. Notify the appropriate person in your health service that the person named as a contact needs urgent follow-up.

11. Whenever possible, ensure that the gender of the practitioner is the same as that of the client.

12. Be innovative – if conventional methods of contact tracing are proving unsuccessful, identify areas where the client frequents e.g. parks, sporting clubs, other relatives houses, hotels and taverns and attempt to make contact with the client.

13. Always be mindful of client confidentiality.
Contact Tracing –
A guide to following up Named Contacts of STI’s

- Enter the information in patient record on communicare and generate “STI Treatment” recall.
- Arrange for the contact to see appropriate health care provider as soon as possible.

- When patient available explain they have been named as a contact of a STI
- Complete recall ‘STI check up’ on communicare
- Obtain specimens, ask permission to take blood for HIV, syphilis, Hepatitis B and C
- Generate pathology request form on communicare ‘STI’ template
- Send specimen and request form to IMVS laboratory
- Give ZAP pack of primary contact had chlamydia and/or gonorrhoea, metronidazole 2g if primary contact had trichomonas (and not pregnant). Check for allergies first.

Check Communicare Daily for results

- Ve chlamydia - Ve gonorrhoea
- No Further Action required

+Ve chlamydia - Ve gonorrhoea
- No Further Treatment Required (assuming ZAP pack already given)

- Ve chlamydia + Ve gonorrhoea
- Treat with – STAT 500mg IMI Ceftriaxone and azithromycin if not already given
  *(Check for allergies first)*

+Ve chlamydia + Ve gonorrhoea
- Treat with – STAT 500mg IMI Ceftriaxone and azithromycin if not already given
  *(Check for allergies first)*

- Females
  - Self applied swabs (LVS) PCR and charcoal M/C/S or,
  - First Catch urine PCR

- Males
  - First catch urine PCR

  Give ZAP Pack STAT
  1gm Azithromycin and 3gm Amoxicillin and 1gm Probenecid

- In a culturally sensitive way ask for names of sexual contacts
- Encourage safer sex practices and have condoms readily available and easily accessible
- Complete recall for ‘STI treatment’ on communicare

Review in 3 months and test for re-infection
Condoms should be freely available for your patients. It is a good idea to have them available in places where patients can discreetly obtain them (e.g. in toilets). They also should be at hand in consulting rooms when you are providing advice on safe sex to your patients, so that they can be handed to the patient.

It is important that condoms that are held at your health service are stored correctly:

- Condoms should be stored in a cool, dry place. Preferably at or below room temperature. Condoms should NOT be stored in excess of 35 degrees or below 0 degrees Celsius.
- Care should be taken to protect latex and polyisoprene condoms against prolonged periods of exposure to extreme low or high temperatures, moisture, direct sunlight and fluorescent light.
- Improper storage can lead to premature aging and deterioration of the product.
- Storage information is marked on every case of LifeStyles® condoms.
- Hints:
  - Do not keep condoms in the trunk of a car.
  - Do cover the windows in your storage area so product is not exposed to direct rays of the sun.
  - Practice rotation of inventory: FIFO – first in, first out.
  - Expiration dates are clearly marked on cases and product. Discard expired or nearly expired stock.

Condom suppliers:

Australian Therapeutic Supplies PTY LTD
(Four Seasons Condoms)
5/25 George Street
North Strathfield NSW 2137
Tel: 02 9743 6144
Fax: 02 9743 6244
Email: ats@australiantherapeutic.com

GLYDE Health Pty Ltd
PO Box 265 Lindfield NSW 2070.
Tel: 1300 364 811
Fax: 1300 364 855
Email: sales@glydehealth.com

SA SIN (SA Sex Industry Network)
276 Henley Beach Road
Underdale, SA 5032
Tel: 08 8351 7626
www.sin.org.au
SURVEILLANCE OF STIs IN ACCHSs IN SA

For all our programs, to improve the quality of service provision, it is necessary to collect data to establish how well we are doing. AHCSA is now able to support ACCHSs with improved STI data collection methods and systems within the sector, particularly with regard to opportunistic STI screening and diagnostic testing occurring within the health services throughout the year.

Most health services currently use the IMVS laboratory for their STI testing and each service receives the results of this testing from the IMVS electronically. AHCSA has negotiated with the IMVS to obtain a monthly data extract containing all STI pathology requests and results from all participating ACCHSs in SA throughout the year.

The data extract does not contain the names of patients. A new unique patient identifier is generated by the IMVS. Protection of privacy and personal information is an important consideration and this system utilizes privacy sensitive information handling practices.

The data extracts are treated as confidential and will be transferred electronically using a secure data transfer system. Data provided is only be used for the purpose of improving the understanding of STI epidemiology and service activities within the health service areas. Data are stored securely on computers or drives at AHCSA that are password protected. Data are not further transferred or stored on additional USB drives. No individual identifiers will be reported or published.

AHCSA then transfers to staff of each health service nominated by the CEO the monthly data for that health service. The health services retain ownership of the testing population’s dataset. Health services do not have access to, or be able to review the results of health services, other than their own.

Improved systems for collecting STI data provide more accurate information on prevalence rates of these STIs in the communities concerned particularly during non-screening periods provide information on rates of testing and will ultimately lead to better surveillance of STI trends within Aboriginal communities served by the ACCHSs.

Importantly, an enhanced understanding of local STI epidemiology will better inform continuous quality improvement activities at the local health service level, leading to ongoing improvements in the quality of STI service delivery within the services.
Collecting data for CQI in Sexual Health 2014

STI pathology collected @ Aboriginal Community Controlled Health Service & sent to IMVS

IMVS sends result of pathology to ACCHS for appropriate action

Unique Patient Identifier generated to ensure confidentiality for data collection purposes

Enhanced understanding of local STI epidemiology improves quality of STI treatment & prevention programs

Monthly STI data reports to each individual ACCHS. Health services only have access to their own data & cannot view results of other services.

De identified data of each test & Results sent to AHCSA & securely stored. N.B No individual identifiers will be reported or published
**SYPHILIS:**

The prevalence of syphilis in Aboriginal communities has decreased in recent decades, and is now only rarely found in Aboriginal people in SA. However, cases still occur, and a recent outbreak of infectious syphilis in an Aboriginal community in Queensland is a reminder of the importance of testing for syphilis when appropriate.

The most important risk factor for syphilis is another STI, so anybody who has been diagnosed with an STI should be advised to have a blood test for syphilis serology (as well as HIV and hepatitis B&C serology).

Other people who should be tested for syphilis serology include:

- Antenatal patients, as part of routine antenatal screening;
- Anybody with an ulcer in the genital area (take swab for NAAT for herpes, syphilis and donovanosis as well as blood test);
- Anybody with a skin rash when the diagnosis is unclear (especially on palms of hands and soles of feet);
- Hair loss (including eyebrows and beard)
- Neurological symptoms with unclear diagnosis
- Opportunistically, when taking blood for other reasons - it is good practice to consider asking the patient if they would agree to have a check for syphilis also on these occasions.

Syphilis serology results may be difficult to interpret, so if necessary contact the duty sexual health physician at Clinic 275 (8222 5075).

The treatment for infectious syphilis is Bicillin LA 1.8g IMI weekly, 3 doses one week apart (see CARPA standard Treatment Manual).

**HIV:**

Despite fears since the 1980s that there is high risk of rapid spread of HIV in the Aboriginal community, rates of HIV infection in the Aboriginal community are not significantly different from rates in the general Australian population.

However, Aboriginal people who become infected with HIV are more likely than non-Aboriginal people to do so as a result of sharing needles, so anybody who is known or suspected to be an IV drug user should be advised to have an HIV test regularly (as well as testing for hepatitis B & C).

Also, having another STI is a risk factor for HIV, so anybody who has been diagnosed with an STI should be advised to have a blood test for HIV serology (as well as syphilis and hepatitis B&C serology).

**Donovanosis** is now a rare condition, but was not uncommon two or three decades ago especially in remote communities. It causes a pinkish-red ulcer, usually in the genital area, which might be raised and beefy, and might be smelly. Take a swab for NAAT for herpes, syphilis and donovanosis when any ulcerated lesion around the genital area is found. Treatment is with azithromycin (see CARPA Standard Treatment Manual).
Genital herpes and viral warts also occur in Aboriginal people, although not seemingly at rates higher than in the non-Aboriginal population. See CARPA Standard Treatment Manual for more details of diagnosis and treatment.
HEPATITIS B & C

Chronic hepatitis B and C both occur at higher rates among Aboriginal people compared to non-Aboriginal people, but the pattern of distribution of these chronic infections is different within the Aboriginal population.

Hepatitis B is more commonly found in remote Aboriginal communities. Hepatitis B has been endemic in these communities for many generations, probably since before the European invasion of Australia. As all children now should be immunised against hepatitis B, hopefully it should be almost eradicated within a generation. However, there are still a significant number of adults from remote Aboriginal communities who have chronic hepatitis B, probable contracted around birth (usually from a mother with chronic hepatitis B).

Hepatitis C is usually contracted through sharing needles. Since IV drug use is still rare in remote Aboriginal communities, but is not uncommon in urban areas, hepatitis C is more commonly found in Aboriginal people from more urbanised areas.

It is important to identify anybody who has chronic hepatitis B or C because they can cause serious problems, including liver cancer or liver failure, which can be prevented with treatment. The available treatments have improved over past years, but still too many Aboriginal people with hepatitis B or C are not being offered treatment. There is a need to develop shared management protocols with specialists to ensure that people who would benefit from treatment are able to get the treatment and follow-up required.

The blood tests to establish somebody’s immune status for hepatitis B (i.e. whether they are susceptible, naturally immune, immunised or infected) are:

- Hep B surface Antibody
- Hep B core Antibody
- Hep B surface Antigen

If a person is found to be susceptible to hepatitis B, they should be offered immunisation.

If a person is immune to hepatitis B (whether naturally acquired or through immunisation), immunity is life-long and no further testing is required.

If a person has chronic hepatitis B, this diagnosis should be entered on the main summary, and appropriate recalls entered to ensure proper follow-up (see accompanying flow-chart, and the CARPA standard Treatment manual).

Health services should ensure that they are aware of the hep B status of any Aboriginal person who lives on or comes from a remote community. If a person is found to be susceptible to hep B, they should be offered immunisation, and offered a blood test following immunisation. If a person is immune, either naturally acquired or from immunisation, no further testing is required.
The blood test to check whether somebody has been exposed to hepatitis C is *Hepatitis C antibody*. If this is positive, a blood test for *hep C RNA* should be requested to see whether or not the person has cleared the infection.

If a person has active hepatitis C, the diagnosis should be entered on the main summary, and appropriate recalls entered (see accompanying flow-chart, and the CARPA standard Treatment manual).
Hepatitis protocol

Initial screening
1. Offer screening to anyone but especially the following groups*:
   - During antenatal care screening
   - During STI screening
   - For those who have an STI
   - At adult health checks
   - When doing routine blood tests for chronic diseases
   - Intravenous drug users
   - Anyone who has been imprisoned
   - Men who have sex with men
   - Those undergoing dialysis
   - Those undergoing chemo- or immuno-suppressive therapy
   - Those with chronically elevated liver enzymes – ALT/AST
2. Conduct pre-test discussion
3. Order ‘Hepatitis screening’ from the Communicare Investigation button or ‘STI and BBV screening’ from within the adult and sexual health check clinical items [this will order: Hepatitis B surface antibody (HepBsAb), Hepatitis B surface antigen (HepBsAg), Hepatitis B core antibody (HepBcAb), Hepatitis A serology, Hepatitis C serology]

Results:
1. Hepatitis A serology
   - IgG positive = previous infection now cleared
     - Enter condition ‘Hepatitis A Immune’ in Communicare via Diagnosis button
   - IgG Negative
     - Not immune – offer vaccination

2. Hepatitis B serology
   - HepBsAg positive = Hepatitis B infection
     - Post test discussion/counselling, evaluate comorbidities
     - Enter condition ‘Hepatitis B’ in Communicare via Diagnosis button
     - Refer to hepatitis nurse who can facilitate further management – see over
   - HepBsAb >10 (HepBsAg neg, HepBcAb pos or neg) = immune to Hep B
     - Enter condition ‘Hepatitis B Immune’ in Communicare via Diagnosis button
   - HepBsAb <10 (HepBsAg neg, HepBcAb neg) = susceptible (unless previous blood test results show HepBsAb >10)
     - Offer vaccination (or enter Hepatitis B immune in Communicare if evidence of previous immunity)
     - HepBsAb <10 (HepBcAb pos, HepBsAg neg) = see over for interpretation

3. Hepatitis C serology
   - Hep C Antibody positive
     - Order Hepatitis C viral PCR (HCV RNA) and genotype, LFTs, AFP, FBC, INR
   - Hep C Antibody negative
     - Annual testing if risk factors present
   - HCV RNA positive = Hepatitis C infection
     - Post test discussion/counselling, evaluate comorbidities
     - Enter condition ‘Hepatitis C’ in Communicare via Diagnosis button
     - Refer to hepatitis nurse who can facilitate further management – see over
   - HCV RNA negative, LFTs normal
     - Most likely previous infection but cleared. Repeat HCV RNA, LFTs in 12 months

*Check record for existing documented immunity to Hepatitis A and B
2. Hepatitis C management protocol

Adapted from PLAHS protocol 2013

Chronic hepatitis C

Information/education

Lifestyle advice to reduce progression
- Minimal alcohol
- Healthy weight

Contact tracing of sexual contacts

Stabilise health and address possible contraindications to therapy:
- Significant alcohol consumption
- Unstable social/accommodation/work situation
- Medical conditions such as
  - Major untreated psychiatric illness
  - Autoimmune disease
  - Major concurrent medical disease
- Injecting drug use does not exclude people from treatment but unstable injecting drug use is a contraindication.
- Pregnant or unwilling to comply with adequate contraception.

Discuss current treatment options

If considering treatment now or in future then organise referral to liver clinic in Adelaide (or to visiting hepatologist if there is one)
Liver clinic staff will:
- Organise appointment in Adelaide
- Work with PLAHS staff to ensure all pre-appointment tests are performed
- Provide support at specialist appointment in Adelaide
- Provide telephone support if treatment commences
- Facilitate blood test monitoring whilst on treatment

Extra tests for specialist referral
- Iron studies (to exclude haemochromatosis)
- TFTs
- Fasting BSL and lipids
- HIV serology
- Autoimmune screening
  - ANA, SMA, LKMA
- Alpha-1 antitrypsin
- Copper, caeruloplasmin

Monitoring
Test at least annually (order blood tests by requesting following tests from Communicare):
- LFT, HCV RNA, AFP
- Ultrasound
  (Test frequency will depend on condition)

Offer other referrals as appropriate
- Social and emotional wellbeing team
- DASSA
- Counselling/psychology

Offer GP Management Plan
CONTACT LISTINGS

- Aboriginal Health Council of South Australia Inc H.E.R.O Team
  T: 08 8273 7200 or
  Sarah Betts 0447 010 751
  David Scrimgeour 0427 150 003
  E: sexual.health@ahcsa.org.au

- Aids Council of SA Inc (08) 8334 1611

- Second Story (08) 8232 0233

- Yarrow Place (08) 8226 8787

- SA SIN (SA Sex Industry Network): www.sin.org.au

- Relationships Australia (08) 8340 2022


- HEP C council (08) 8362 8443

- Shine SA: www.shinesa.org.au

- Sexual Healthline: 1300 883 793; Toll free: 1800 188 171 (country callers only)

- Youth Health line 1300 131 719

- Clinic 275 (08) 8222 5075

- Rape and Sexual Assault line 1800 817 421

- www.letthemknow.org.au

- www.bettertoknow.org.au

- www.getcheckednow.com.au
Aboriginal Community Controlled Health Services:

- Port Lincoln Aboriginal Health Service Incorporated (08) 8683 0162
- Pika Wiya Health Service (08) 8642 9999
- Umoona Tjutagku Health Service (08) 8672 5255
- Pangula Mannamurna Inc (08) 8724 7270
- Nundyara Wellbeing Centre Inc. (08) 8649 4366
- Ceduna Koonibba Health Service (08) 8626 2500
- Nunkuwarrin Yunti Inc (08) 8223 5217
- Tullawon Health Service (08) 8625 6237
- Maralinga Tjarutja Health Service (08) 8670 4207
- Nganampa Health Council
  Dr Rae-Lin Huang (STI Control and HIV Prevention Co-ordinator)
  M: 0427 358 757
  F: (08) 8953 3252