Increasing Access by Priority Populations to Australian Sexual Health Clinics

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Abstract: Data from a network of 35 Australian sexual health clinics, in geographically diverse locations, showed that the number and proportion of patients from priority populations (ie, young people, men who have sex with men, indigenous people, and female sex workers) increased significantly between 2004 and 2011.

Although general practitioners are at the forefront of providing sexual health care in Australia, many people do not feel comfortable in talking to their usual doctors about sexual issues and are concerned about confidentiality.[1,2] In response, Australian State and Territory governments have funded sexual health clinics for many years. These clinics can be found in a range of settings, linked to either hospitals or other primary care services or as stand-alone clinics. The appearance of HIV contributed to a steady geographic expansion of such clinics in New South Wales and Queensland, whereas other jurisdictions provide a more centralized clinical model.

Australia launched a National Sexually Transmissible Infections (STI) Strategy in 2005 to guide its response to STIs, that is, to reduce transmission of STIs and the morbidity and mortality they cause. Because the clinical capacity of public sexual health clinics is finite, the Strategy encouraged clinics to focus on priority populations that include young people aged 15 to 29 years, Aboriginal and Torres Strait Islander people (indigenous Australians), men who have sex with men (MSM), and sex workers.[3] These populations are at a higher risk for acquiring STIs than the general population, owing to more risky behavior and high STI prevalence (eg, the proportion of priority populations tested positive for chlamydia at sexual health clinics in 2011 were as follows: 15.9% for young people, 17.4% for Indigenous people, 7.9% for MSM, and 6.2% for female sex workers[4]; 81% of national chlamydia notifications were in young people[5]). The Strategy encourages clinics to see more asymptomatic people from priority populations, as well as provide care for people with STI-related symptoms. In this article, we assessed the trends in the numbers and proportions of priority populations seen by the Australian sexual health clinics over an 8-year period.

We analyzed data from a network of sexual health clinics that participated in the Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS) project. The ACCESS project methods have been described in detail elsewhere.[6] Briefly, the project comprises 6 sentinel networks (5 clinical and 1 laboratory) for surveillance of chlamydia testing and positivity. The ACCESS sexual health clinics network involves 44 (53%) of the 83 clinics[7] in Australia. The 44 clinics are located across all states and territories, except South Australia, and include the larger Australian clinics, thus accounting for more than 80% of all public clinic consultations. All sexual health clinics used computerized medical records systems to collect information as part of routine care. The clinics provided the ACCESS project with deidentified data in a line-listed format. Ethical approval for ACCESS was granted by the human research ethics committees of St Vincent's Hospital and the University of New South Wales. Further approval was granted by the ethics committees that oversee each of the participating clinics.

We report on data from 35 clinics (of 44) that were able to provide data for all years between 2004 and 2011. We conducted χ^2 test for trend and Poisson regression to determine if there was a significant trend in the proportion and number of new patients from priority populations attending the clinics over time. New patients were defined as any person attending the clinic for the first time; young people were defined as patients between the age of 15 and 29 years; and the term MSM was used for men who reported having sex either only with men or with both men and women in the past 12 months. The significance level was set at 0.05, and all analyses were conducted using STATA 12 (StataCorp, College Station, TX).

A total of 251,226 new patients attended the 35 sexual health clinics between 2004 and 2011. The median age was 25 years (interquartile range, 21–32 years) for female patients and 29 years (interquartile range, 23–38 years) for male patients; 54.1% of patients were between the ages of 15 and 29 years, 4.0% were indigenous, 22.8% of male patients were MSM, and 11.1% of female patients were sex workers.

The total number of new patients attending the clinics increased significantly over time by 19.0%, from 28,988 in 2004 to 34,497 in 2011 ($P < 0.01$), whereas the total population of Australia increased by only 9.5% from 20,252,000 in 2004 to 22,183,000 in 2011.[8] Hence, the proportion of total population

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TABLE 1. Numbers and Proportion of Priority Populations Attending 35 Australian Sexual Health Clinics, 2004–2011

		2004	2005	2006	2007	2008	2009	2010	2011	% Increase	*P* Trend
Total patients seen	**N**	28988	30289	28945	29881	30540	33930	34156	34497	19.0	<0.001
Young people	N	14406	15492	15427	16099	16776	18574	19381	19907	38.2	<0.001
(15–29 y)	%	49.7	51.1	53.3	53.9	54.9	54.7	56.7	57.7	16.1	<0.001
Indigenous	n	1062	1131	1124	1121	1224	1301	1366	1416	33.3	<0.001
	%	3.7	3.7	3.9	3.8	4.0	3.8	4.0	4.1	10.8	<0.01
MSM	n	3338	3488	3491	3595	3822	4433	4709	4609	38.1	<0.001
	%	11.5	11.5	12.1	12.0	12.5	13.1	13.8	13.4	16.5	<0.001
Female sex workers	n	1368	1379	1186	1459	1612	1981	1878	1635	19.5	<0.001
	%	4.7	4.6	4.1	4.9	5.3	5.8	5.5	4.7	0	<0.001

seen at the clinics increased by 10.7%, from 0.14% in 2004 to 0.155% in 2011. There was a 38.2% increase in the number of 15- to 29-year-olds, a 33.3% increase in the number of indigenous people, a 38.1% increase in the number of MSM, and a 19.5% increase in the number of female sex workers attending the clinics from 2004 to 2011 (*P* trend <0.001 for all; Table 1). There was a significantly increasing trend seen in the proportion of all these priority populations attending the clinics (*P* trend <0.01 for all; Table 1).

This study showed that the numbers and proportion of patients from priority populations attending sexual health clinics increased significantly between 2004 and 2011. The main limitation of this study is that the ACCESS data may not be representative of all sexual health clinics in the country because of purposive sampling of the clinics; that is, smaller clinics were more likely to be excluded. However, ACCESS clinics include 53% of all sexual health clinics in the country; in addition, the national scale of the project reduces concerns about using data from a single clinic or region and is a major strength of the study.

The increase in the proportion of priority populations seen is reflective of the goals of the National STI strategy. Although only ecologically linked, it is possible that this focused increase is a result of strategies implemented in response to the National STI Strategy, particularly clinics referring asymptomatic patients that are not from priority populations to general practitioners for STI screening.[9]

In addition to an increase in the proportion of priority populations seen, there has been a significant increase in the total number of patients attending sexual health clinics. The large increase in total new patients over the 8 years may reflect improvements in clinical service efficiencies. Some clinics have adopted information technology strategies to improve service quality while reducing clinic costs[10] including the following: (*a*) standardized computer-assisted sexual interviewing, which has been demonstrated through a randomized trial to produce equivalent and, for some variables, even more accurate sexual behavior information than face-to-face interviewing[11] with high patient acceptability[12]; (*b*) implementation of express clinics combined with computer-assisted sexual interviewing, which has been shown to increase the number of patients attending overall[13]; (*c*) Web-based interventions such as use of innovative SMS messaging for partner notification and also as reminders, which have shown to increase retesting rates[14]; and (*d*) phoning for HIV results rather than return visits, which showed no adverse events with patients expressing satisfaction and a preference for telephone delivery of results.[15]

In conclusion, owing to the national scale and the routine nature of data collection, the ACCESS sexual health clinics network can be used to conduct cost-efficient research into STIs in priority populations. Although larger services are using strategies to increase their clinical efficiencies and better target priority populations, opportunities remain for wider roll-out of these strategies to all sexual health clinics in Australia. In addition, many of these strategies (SMS reminders, HIV telephone results, express clinics for STI testing) may be worth trialing in the general practice setting.

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APPENDIX A
Access Coordinating Committee

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