



AUSTRALASIAN SEXUAL HEALTH & HIV NURSES ASSOCIATION INC.

**Focus**

**Indigenous sexual health**

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## Aboriginal Health in Australia

Aboriginal and Torres Strait Islander people are the traditional inhabitants of Australia and diverse in language and cultures which are dynamic and still evolving.<sup>1,2,3</sup> Health for Aboriginal people comprises not only physical health, but also spiritual wellbeing, linked to family, the community and the land.<sup>3</sup>

There are clear disparities between the health of Indigenous and non-Indigenous Australians, with many factors interacting to contribute to the disproportionate ill-health experienced by Indigenous people.<sup>1</sup> Estimated life expectancy for Aboriginal and Torres Strait Islander people is much lower than that of other Australians,<sup>1</sup> and Indigenous people have death rates greater than non-Indigenous people in every age group and for almost all causes of death.<sup>4</sup> Kidney disease and diabetes are among the significant health problems experienced by Aboriginal people.<sup>4</sup> Sixty-five percent of Indigenous people report at least one long term health condition, including many who also report life stressors including death of a family member or close friend, alcohol and drug problems, divorce or separation, and discrimination/racism.<sup>5</sup> Although there is no national data on mental health disorders, there are higher hospitalization rates for Indigenous people, related to substance abuse and higher rates of suicide.<sup>4</sup> Babies born to Indigenous mothers are twice as likely to be born prematurely, have low birth weight, or die at birth, or during the early postnatal period.<sup>4,6</sup>

With the potential to impact on these already excessive levels of morbidity and mortality, higher rates of diagnosis of blood borne viruses (BBVs) and sexually transmitted infections (STIs) occur among Aboriginal people than among non-Indigenous people.<sup>7</sup>

## Contributing Social, Economic and Behavioral Factors

The broader social context and social determinants of health play a key part in the issue of Indigenous health and wellbeing in Australia, with Indigenous people remaining disadvantaged across a range of areas compared to the social and economic circumstances of non-Indigenous Australians.<sup>1</sup> These areas include low income, poor education, unemployment or working in a menial or unrewarding job, limited access to health service and poor housing.

Indigenous households have higher rates of public housing, below average rates of home ownership and are more likely to be homeless than other Australians. Another factor contributing to homelessness in Indigenous Australians is their higher levels of mobility due to the need for many to leave their home to access services or to observe cultural obligations.<sup>1</sup>



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Poor housing, including overcrowding and poor sanitary conditions are associated with higher rates of infectious and parasitic diseases, including meningococcal disease, tuberculosis and respiratory infections.<sup>1,4,8</sup> Socioeconomic disadvantage has also been shown to be associated with higher rates of renal disease which is the most common diagnosis for hospitalisation among Indigenous Australians.<sup>1</sup>

Particularly vulnerable are Indigenous people who live in rural and remote areas.<sup>3</sup> Barriers to accessing services for Aboriginal and Torres Strait Island people include distance from services, lack of transport (particularly in remote areas), financial difficulties and proximity of culturally appropriate services.<sup>1</sup> As well, there may be shortage of clinicians and relatively few Indigenous health professionals.<sup>8</sup> Although remoteness is a disadvantage in many ways, not all the problems of Aboriginal health can be explained by remoteness, and low incomes, poor education and some medical conditions are similar or worse in some non-remote areas.<sup>1</sup>

Also of concern are health risk behaviours in Indigenous people with higher rates of obesity and smoking combined with poor nutrition putting them at higher risk for kidney disease, Type 2 diabetes, cardiovascular disease and other chronic conditions. While research shows that Indigenous people are less likely to drink alcohol, those who do drink more frequently consume it at hazardous levels, causing alcoholic liver disease, high blood pressure, stroke and some cancers. High consumption of alcohol is also linked to injuries, accidents, assault and self-harm, domestic violence and financial, social and legal problems. Use of illicit substances such as marijuana, heroin, amphetamines and inhalants contributes to these problems, with petrol sniffing being a major problem in some Aboriginal communities.<sup>4</sup>

***Other factors that may contribute to higher rates of BBVs and STIs among Aboriginal people include STI transmission dynamics and potential for differences in transmission risk due to networks of sexual contact within cultural groups; high rates of screening in some communities leading to early detection and treatment of bacterial STIs; being a much younger and more mobile population;***

Historical factors and the substantial amount of shame associated with having and or being diagnosed with an STI; and mainstream STI and BBV social marketing messages not always reaching and having impact with Aboriginal and Torres Strait Islander communities across Australia.<sup>7</sup>

## **The Role of Historical Factors**

Many factors, including past Government policies and practices have contributed in shaping Aboriginal peoples health and lifestyle. Colonisation by European settlers resulted in a drastic decline of the Aboriginal population, as a result of random killings, punitive expeditions, organised massacres and introduced diseases, such as smallpox, influenza and measles.<sup>10</sup> It is estimated that of over 500 Indigenous languages which were in existence before colonisation, only approximately 50 remain today.<sup>11</sup> Many indigenous survivors were moved onto reserves or missions and from the end of the nineteenth century, laws were implemented to segregate and control a large part of the Indigenous population. Protection and assimilation policies included separate education for Indigenous children, curfews, alcohol bans, lower wages, no social security and State guardianship for Aboriginal children. Indigenous children could be lawfully taken without their parents' consent, and placed in non-Indigenous institutions, orphanages or foster homes. Many were trained to be domestic servants or labourers, received little or no education, were forbidden to speak their Aboriginal language and told that their parents did not want them. Many also experienced neglect as well as physical, emotional and sexual abuse.<sup>10</sup> Many members of these Stolen Generations have still not been reunited with their families. Other practices such as forcible removal of Aboriginal women from their homes, for sexual health examinations, treatments and surveillance and compulsory contraceptive injections, which occurred in South Australia during 1910-1960s, have a continuing impact, shaping how young women engage with sexual health services today.<sup>12,13</sup>

The effects of the treatment of Indigenous people in Australia continue today, as they continue to feel betrayed and exploited by the system which forcibly removed them from their traditional land and forcibly removed their children.<sup>9,11</sup> The legacy has been a huge impact on the self-esteem of Aboriginal people, their spiritual and cultural identity, social and parenting skills, survival skills, and ability to develop relationships.<sup>10</sup> This loss of well-being and poor mental health contributes substantially to the poor physical health of Aboriginal people.<sup>14</sup>

## What role can nurses play in addressing Aboriginal health inequalities?

Sexual health nurses may be well placed to provide health promotion, health education, client and community support and advocacy and consultation with local Aboriginal communities.

- Ensure you are equipped with appropriate cultural knowledge and clinical expertise to respond to the needs of the Indigenous community.<sup>2</sup> Attend Cultural Awareness education that may be available in your area, or organise a session for all your staff members. All nurses should be as skilled in cultural care as they are in their clinical capacity.<sup>13</sup>
- Adjust your policies and practices to be culturally respectful. Prepare written protocols specific to Indigenous communities if required. This includes such principles as having a holistic approach to health care, including attention to the physical, spiritual, cultural, emotional and social well-being of clients.<sup>2</sup> The Aboriginal client needs to be acknowledged in terms of the family and the whole community.<sup>15</sup>
- Involve local Aboriginal communities in decision-making to define and identify their needs and priorities, and increase their involvement and control within services.<sup>2,16</sup> Young Aboriginal women have identified feeling more comfortable accessing sexual health services when the non-Indigenous nurses have worked closely with Aboriginal health workers or Elders, prior to commencing their clinical work with them.<sup>13</sup>
- Demonstrate respect for the cultural beliefs and practices of the local Indigenous community by taking the time to develop trusting relationships with Aboriginal people, learning their views and values and gaining input into preferred design and delivery of health programs, such as the provision of gender-specific clinics.<sup>11,12,13,17</sup>
- Lobby your health care service to implement training and accreditation processes for professional Aboriginal and Torres Strait Islander interpreters if working in an area where this is required.
- Familiarise yourself with appropriate, non-offensive terminology when working with Aboriginal people and communities, and when developing policies. A useful document to consult is *Communicating positively: a guide to appropriate Aboriginal terminology*.<sup>18</sup>

*For the purpose of brevity, the terms Aboriginal people or Indigenous people used in this paper are also inclusive of Torres Strait Islander people, although it is acknowledged that these groups are ethnically and culturally very different (NSW Health, 2004).*

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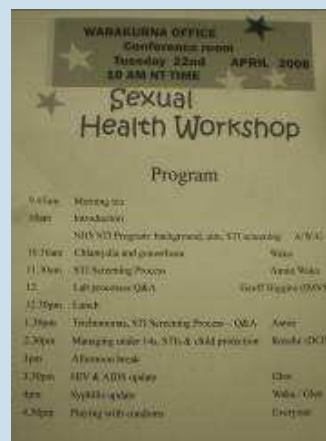
# Annual community STI screening in the western desert

Glen Curran CNC, PhD

In 2008, I worked for Ngaanyatjarra Health Service helping them with their annual community STI screen for 14-40year old community members. My role was to provide screening for Wati (men). The STI screen is held within the context of a comprehensive sexual health programme which is based on the 'Ngaanampa Eight Ways to beat HIV Model', which demonstrates a consistent reduction in STIs in aboriginal lands (Huang, et, al. 2008). The annual community STI screen is designed as one clinical strategy and does not replace a more systematic sexual health consultation.

Ngaanyatjarra land in remote Western Australia sustains a low population density of approximately 2000 people over 200,000 sq km — about the size of Tasmania. Distances between Ngaanyatjarra communities are huge (east–west Cosmo–Wingellina 737km; north–south Kiwirrkurra–Cosmo approx 1150km; Sydney–Brisbane is 957km), as it takes about 12 hours drive to go from Alice Springs to Warburton.

Today, Ngaanyatjarra people live in 12 communities between 50 and 600 people (Warburton, Blackstone, Warakurna, Kiwirrkurra, Wanarn, Jameson, Patjarr, Tjekarli, Kanpa, Cosmo Newberry, Wingellina and Tjukurla). In past-times up to 1960, they lived in small hunter gatherer bands of 12-20 people in family hearth groups roaming defined lands. In 1963 and 1984, a small Pintibi mob came in from the Great Sandy Blight and Gibson Desert (near Kiwirrkurra), and had never seen white-fellas. In less than 50 years this extraordinary culture have maintained intrinsic elements of a traditional lifestyle while accommodating modern western lifestyles while. Although the Ngaanyatjarra lands are "dry" (alcohol free) communities, some social disruption is experienced due to violence, alcohol, pot and sniffing.



Planning STI Workshop: Annie Tangey (Coordinator), Paul 'Waka' Williams & Glen Curran

Annie Tangey coordinates the Sexual and Reproductive Health Program and has worked in Alice Springs for 21 years. Annie said the challenges of running the annual STI screen in remote communities include: aboriginal health care has many different aspects to western based health care; sexual health is often seen as a lesser priority in busy acute clinics; staff are not always familiar with sexual health when they first work remote; strong traditional gender roles exist between aboriginal men and women, and services are costly as it takes five times longer to do anything because of the distances, and a lot of negotiation and coordination is needed.

The annual STI screen is a quick intervention, questions are minimised, signs and symptoms checked, urine analysis, swabs and urine are self collected and blood is taken for syphilis (HIV testing is offered after a positive STI result, to allow time for pre-test information). Syndromic management means treat on suspicion (symptoms, urinary threads and/or leucocytes) according to CARPA (Central Australian Rural Practitioners Association Guidelines (2003) with a ZAP Pack (1G Azithromycin, 1G Probenecid, 3G Amoxil).

Chlamydia, trichomonas and gonorrhoea tests use NAAT/PCR technology, and gonorrhoea urine and swabs are cultured where possible to determine penicillin resistance, but getting a good specimen to pathology without degradation is the problem. Fortunately, HIV infection appears to have avoided outlying aboriginal lands, which is surprising given the high rates of other STIs. Communities are working with Comprehensive STI programmes to reduce the risks of this happening, with reductions in STI rates being a major aim. Ngaanyatjarra Health Service has just started an education project for young people as a major prevention strategy

Coming from an urban sexual health clinic I found this work very different. In this cultural context a non-confrontational approach allows access to STI testing. I found the males did not provide much information about their sexual history or symptoms, so non-verbal cues are really important. The best approach was not to talk too much because this is incredibly rude, talk in the third person, ask questions in a not-to-direct manner, and limit direct eye contact. In this type of quick screen one adapts to obtaining and interpreting a minimal sexual history with limited consultation time despite language barriers.



### STI screening poster and supplies for each remote clinic

Working in a culturally appropriate manner is crucial and one attempts to have an aboriginal health worker to act as a cultural broker. Aboriginal people cannot be removed from their cultural context so it is important to find out what is happening, as they will assume you know about family business, recent births and deaths and to pay respects. The challenges are enormous, priorities for aboriginal people are different which can give the perception that they appear to move at a slower pace to whitefellas', who are always busy getting work done — always running around. And, you learn to work slowly with clients within a quick consult which is a time warp encounter and flat out afterwards managing specimens, paperwork and computer records.

In aboriginal culture it takes a long time to build relationships as relationships mean everything — relationships with land, clans and family seem more important than individuals. They were more interested in wanting to know who my family were and what land, or country I was from, whereas in western egocentric culture, I tend to introduce myself by 'who I am', as defined by work or status. I found it helpful to have an A4 sheet with several photos of my family and home, and this proved a useful friendly introduction.

I found the annual STI screen well supported by local aboriginal communities, but the last bastion of resistance is young men. The contact tracing list showed I needed to speak with some men, so it was agreed to have a BBQ and talk about Men's 'sexual' Business, so long as I bought frozen marlu (kangaroo) tails, sausages, bananas, bread and cordial, and cooked it for them — very smart men.

I used the STI video made by local aboriginal leaders, and went over the STI/HIV men's flip chart, while several translated this into their language. I learnt by experience not to feed the men before the session as they leave after eating, not to be seen again. It was amusing to see the men pick up my vegetarian sausages, give a quizzical look and quickly put them down. While the marlu tails were cooking I was able to test the few young blokes who had been avoiding the clinic.



At another community, a cultural broker helped me find a suitable place to work as the health clinic was busy. We settled on a room in the local Community Development Adviser's building, a perfect location with private room, toilet, phone and computer access. However, an older more senior aboriginal man decided this was not the right place and told us to go over to the community hall, a large bleak dusty building with no table, chairs, working toilets, or running water, and with an old Troopie parked in the middle of the hall. I set up on the stage and the men arrived all at once, which is a nightmare as you need time to talk, test and treat. Just imagine testing gear, sharps container, gloves, blood taking equipment spread out over several blueeys on a hastily cleaned stage, impatient men milling around, dogs barking and muggins undertaking a quick STI screen. I had the cultural broker running for water from the nearby laundry so the men could have their ZAP packs.

On reflection, this male STI screen in the hall was highly unusual compared with the other screening locations and facilities. It only happened this way because the senior man directed it, and while it sounds inappropriate the imperative was somehow normalised by the men themselves. Confidentiality was maintained to a relative degree, there was existing community knowledge between the men about their sexual partners and practices, no-one heard the client conversation and records were kept private. Anywhere else this approach is problematic but out in the desert I had to be flexible, adaptable and provide the best possible professional service.

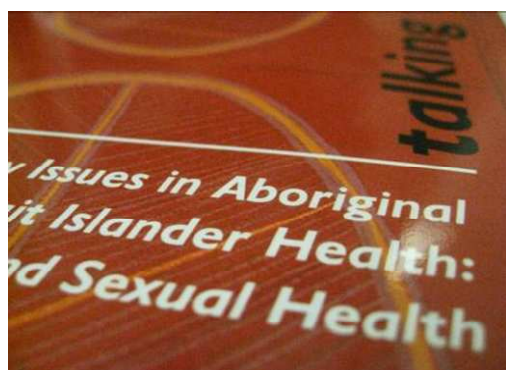
Promoting the annual STI screen is challenging because each community is so remote. Despite the big distances Ngaanyatjarra Health Service organise a yearly STI workshop to focus attention on the annual screen, which is attended by cultural workers, Remote Area Nurses, Doctors and Pharmacist. The STI screen is promoted via radio, posters, music festivals and youth expos, and condoms are generally well accepted. Classically, clients always think their sexual partners are the only ones.

STI rates fell 50% in the first three years of the programme and a gradual decrease has been sustained over the past eight years due to a comprehensive strategic approach which includes more testing and treatment. Each health clinic is well equipped with a pharmacy (managed by a mobile pharmacist and his dog) and satellite linked computer based record system, which helps locate highly mobile clients who need follow up. Electronic pathology results are posted directly into client records and sexual health specialists are on hand for consultation.

I found Ngaanyatjarra people magnificent and was grateful to experience a little of their culture. These guardians helped me embrace the desert and now their dust is in my blood. It was pleasing to see how well Ngaanyatjarra Health Service was organised from orientation to service delivery, and how the staff do their absolute best in the most difficult of situations. Despite the many problems of remote area work I had a fantastic time and cannot wait to return.

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## Report on the NSW Aboriginal Sexual Health Advisory Committee (ASHAC)

*Karen Biggs, with acknowledgement to Mr Victor Tawil for his input*

The principle function of ASHAC is to provide advice to the NSW Department of Health AIDS/Infectious Diseases Branch (AIDB) and the Aboriginal Health and Medical Research Council of NSW (AH&MRC). ASHAC works to ensure that HIV/AIDS, STI and Hepatitis C issues are placed within the context of broader Aboriginal health issues. The Committee also aims to increase the profile of HIV/AIDS, STIs and Hep C as a priority across Aboriginal Health. At the upcoming Mid Term Review Forum for the NSW HIV/AIDS, STI and Hepatitis C Strategies, and their Implementation Plan for Aboriginal People, ASHAC will be a key player, and oversee the main issues that need to be progressed over the next two years of the statewide strategies.

ASHAC meets four times a year and has representation from key stakeholders in Aboriginal sexual health across NSW, with ASHHNA being the only nursing body represented on the committee. The current Chair is Mr James Ward, on behalf of the AH&MRC.

### ASHAC's significant achievements over the last two years include:

- Discussion aimed at ensuring improvement of Aboriginal people's access to Hepatitis C testing at specialist and community services
- Discussion and provision of feedback on the mid-term stocktake of the implementation of the National Strategies
- Discussion of lessons learned and futures to be avoided from the Canadian experience, in relation to blood borne viruses among Aboriginal people who inject
- Discussion of key issues and programs for Aboriginal people in custody
- Formation of a working group to oversee the Aboriginal Epidemiology Project and the Syphilis Project
- Undertaking an annual review of education resources available and provision of feedback for future development of resources
- Provision of opportunities for showcasing local issues and projects by different invited guests
- Showcasing of working partnerships, facilitation of discussion on gaps and provision of advice on partnership development
- Annual updates from Aboriginal Sexual Health Worker reports
- Forum for progress reports on one-off statewide projects

ASHAC provides a forum for the interests of target populations and key stakeholders to be tabled, and there is a standing item on the agenda for stakeholders to raise relevant issues. As your representative, I am interested to hear input from ASHHNA members on nursing issues pertaining to Aboriginal sexual health. If you would like to showcase a working partnership, local issue or project, even if this has been achieved in another state or territory, please contact me and I will put you in touch with the Committee.

Matiu Bush

Sexual Health Nurse Practitioner Candidate

## Case Presentation

# The rash of secondary syphilis in MSM

The manifestations of syphilis are becoming a regular clinical presentation in sexual health centres in Melbourne.

A 40-year-old homosexual male recently arrived from overseas attends for review of a rash primarily located on his arms and hands. The client noticed the rash on his hands (palms) a week ago, there was some itchiness associated with the appearance of the red spots. The rash then progressed to his torso over the last week prior to his attendance. The client has a past history of psoriasis on his genitals and torso. His last sexual contact was oral sex, two weeks ago with a casual male contact. The last episode of unprotected anal intercourse (receptive) was 9 weeks ago, again with a casual male contact in Australia. The client had not commenced any new medications recently or changed hygiene products such as body wash or laundry detergents. This was his first sexual health check up and his first HIV test despite beginning sexual active and involved in the gay community for many years.

## Examination

The oral and genital exams were normal, there was no lymph involvement, no visible chancres present. The rash was obvious on his hands and arms, no rash on the soles of his feet. Observing the rash on the torso was difficult due to the extent of skin affected by psoriasis. The client had no recent history of headaches, vision disturbances or other sensory changes.



## The clients syphilis serology results where;

<b>Serum RPR</b>	<b>R512</b>
<b>TPPA</b>	<b>Reactive</b>
<b>IgM-EIA</b>	<b>Reactive</b>
<b>EIA Total antibody</b>	<b>Reactive</b>

## Investigations

Opportunistic screening for asymptomatic infections included anal swabs for Chlamydia and gonorrhea, a throat swab for gonorrhea and first pass urine for Chlamydia. Serological investigations included HIV antibody test, syphilis serology, and hepatitis A and B antibody serology. Dark ground microscopy was not attempted due to the dry and flat nature of the rash. The client was willing to have a polymerase chain reaction (PCR) swab for syphilis of the macular papular rash after breaking the surface of the skin.

## Diagnosis and Treatment

The client was diagnosed with Secondary Syphilis and treated with Benzathine Penicillin 1.8g. Possible Jarisch Herxheimer reaction was discussed and he was advised to take panadol as required if he experienced any symptoms for the preceding 24 hours after treatment.

Client agreed to contact previous sexual contacts using an anonymous internet based SMS service ([www.dramadownunder.com](http://www.dramadownunder.com)). He was encouraged to have no sexual contact until the rash resolved. Repeat syphilis serology in 3 months was indicated to assess an adequate response to treatment (a four fold drop in RPR from 512).

The PCR of the broken skin of the rash was positive, the clients HIV test was negative and all other tests results were negative.



### Summary of important points

- Suspect syphilis in MSM who present with a rash
- The rash of secondary syphilis can appear six weeks to six months after the primary lesion
- In secondary syphilis the maculopapular rash may be transient or last for many weeks
- The rash is infectious
- Repeating the syphilis serology 3 months after treatment aids in assessing adequate response to treatment

Clinical photos courtesy of Melbourne Sexual Health Centre

## The 7C's of Chlamydia: an online learning module about the testing and treatment of Chlamydia

**A new online resource for training nurses and health professionals has been launched on the NSW STI Programs Unit website.**

The online learning module, The 7 C's of Chlamydia, provides information about the steps involved in testing and management of Chlamydia infection in a fun, interactive online board game.

The game plays on the theme of the seven seas creating an engaging visual learning environment. Incorporated in the module are pre and post knowledge quizzes to reinforce the information gained.

The module has been focus tested with targeted nursing groups of practice nurses, women's health nurses, youth health nurses and midwives; and was developed with funding from the NSW Health Nursing and Midwifery Office Innovation Scholarship.

Use the module for training new staff, as in inservice presentation, in a sexual health workshop or when working with young people. Email the link to colleagues and friends

Play the game at [www.stipu.nsw.gov.au/resources.html](http://www.stipu.nsw.gov.au/resources.html)

**Donna Tilley**  
**Clinical Nurse Consultant**  
**Sydney Sexual Health Centre**  
**ASHHNA President**

**Sail the 7C's**  
 and learn about the  
 testing and treatment  
 of Chlamydia

The 7 C's of Chlamydia is an online learning module developed for nurses about a common sexually transmitted infection - Chlamydia.

You can play the game at  
[www.stipu.nsw.gov.au/resources.html](http://www.stipu.nsw.gov.au/resources.html)

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## Care Search - an Australian online palliative care resource

Nurses have different needs for palliative care information, which is dependent upon their experience, previous education, level of interest and their area of work. Palliative care is applicable not only for those with cancer, but also for patients with chronic debilitating or life limiting illnesses such as HIV and AIDS, who face many of the same issues and challenges. The need for palliative care in HIV management is underlined by the high prevalence of pain and symptoms, side effects, co-morbidities, high incidence of malignancies and the comparatively higher death rates among the infected individuals (Harding et al, 2005)

For health professionals involved in providing palliative care, the care needs of patients reflect complex physical, social, emotional and spiritual issues. While palliative care is often not the main role that nurses fulfil, it is something that most will encounter at some point in their practice. For these times, finding good quality palliative care information in an Australian context can be challenging. A simple search for “palliative care” using Google will return around 3.8 million items with little guidance as to the quality of the resources.

CareSearch is a quality online palliative care resource that enables access to a comprehensive suite of resources including clinical information, brokered access to palliative care literature and resources for patients and families. It also has features to support research and to contribute to continuing professional development.

The CareSearch website supports the use of evidence within current practice to improve outcomes for patients and families. CareSearch has pages written especially for patients, carers, families and friends, providing timely and practical information on a range of issues from understanding palliative care, living with illness, being prepared for end-of-life decisions to feelings and emotions and practical caring tasks. Patients, carers, families and friends can be directed to the website or alternatively pages are freely available to be downloaded and given to patients.

Health professionals can use CareSearch for their own continuing education, with information on short courses and web based learning modules. Many aspects of CareSearch are also applicable to other members of the healthcare team such as community nurses and colleagues working in Allied Health who can also be directed to the site. Updates can be found in the ‘What’s new in palliative care’ and ‘What’s new in the literature’ pages, helping practitioners to stay up to date. Published literature can also be searched using expertly written topic searches using an experimentally tested palliative care search filter.

Project staff have worked interactively with many health professionals including nurses from different care settings in developing these resources. Feedback from nurses at various conferences and presentations has led to a monthly online newsletter for nurses recently being introduced. It provides information about evidence based palliative care and introduces the many resources within CareSearch highlighting their usefulness to nurses.

The website is freely available at [www.caresearch.com.au](http://www.caresearch.com.au) Nurses can register for the nurses newsletter (CNIN: CareSearch Nurses Information Newsletter) online or can email the project team at [caresearch@flinders.com.au](mailto:caresearch@flinders.com.au)

***CareSearch is funded by the Australian Government Department of Health and Ageing as part of the National Palliative Care Program.***

### References

Harding R, Karus D, Easterbrook P, Raveis V, Higginson I and Marconi K (2005) Does palliative care improve outcomes for patients with HIV/ AIDS? A systematic review of the evidence. *Sex Transm Infect.* Feb; 81 (1); 5-14

## BOOK REVIEW **RAPE** A history from 1860 to the present, By Joanna Bourke

I hoped this book would inform my future practice, consolidate my learning experiences, build on and conceptualise the theory of sexual assault and provide me with some insight to the historical precept on what remains a contemporary issue. I was not disappointed, while this book is not light reading and initially appeared daunting, it was well worth the effort.

The authors' motivation for writing on the subject was the anger she experienced when she learnt that the United Kingdom had a 5 % conviction rate for rape, however this anger hasn't dominated this book. Ms Bourke provides a scholarly historical examination of sexual assault which includes victims their perpetrators.

The book begins where it must, exploring the common beliefs and assumptions about rape. Many of the modern rape misconceptions have their origin in both medical and psychiatric texts of the 1900's. Take for example *The Medical Jurisprudence, Forensic Medicine and Toxicology* text book published in 1890 which observed that "a fully mature woman, in full possession of her faculties cannot be raped contrary to her desire".

Ms Bourke's definition of rape is interesting, sex she says, "is what ever some one calls sex and rape is any act any body involved or a witness calls abuse ". This gives the book a wider range of sexual violence exploration. The examination of consent in view of the broad definition of sexual assault is illuminating. This book covers the history of treatment therapies for perpetrators including castration, aversion therapy through to psychology-based programs. Current treatments options are discussed, success is reported as limited. The book acknowledges that the current therapies offered are poorly researched, funded and inconsistent in their delivery.

Bourke provides case studies on a range of sexual offenders from exhibitionists to sexual psychopaths. She examines the shift from legal intervention to a psychiatric focus which she believes blurs boundaries and argues that this shift threatens the rule of law.

The first case study is of the domestic servant Harriet Stump, 14 years old who was raped by her employer in 1880. It appears that Harriet was just as distrusted by the legal system as rape victims are today. The examples given of behaviour that impugns women's reputations during this time for example, caught singing in public then as is now highlight how victims are "caught with in a sexual script biased towards the perpetrator".

The book explores sexual assault in marriage, prisons, the military, and examines the women who are perpetrators of sexual assault. Rape in the context of war and torture are also discussed using the recent Abu Ghraid revelations and private Lynndie England's role in that that event, this is difficult content. This book may be uncomfortable and challenging for some to read as it explores areas that are conspicuous in their absence in popular discourse on sexual assault today.

Bourke has researched the book well, it challenged me to think about sexual assault beyond popularist and conventional frameworks. I was struck her analysis of the use of the terms victim or survivor of sexual assault.

The last chapters are reserved for the exploration of the legal reforms and punishment of sexual assault. Bourke states that rape is a 'crisis of manliness' and until all men have more to lose from committing rape the situation will remain the same. These arguments are unconvincing given that patriarchy is the dominant culture in most countries.

Ms Bourke categorical states she has no sympathy for any definition of rape that ignores the experience of the victim and her book supports that statement. Much of the content is flavoured by the western developed world and culturally and linguistically diverse communities and religious dimensions are absent in this discourse. The author ignores gay, lesbian transgender and intersex victims of sexual assault

The sense of entitlement that a rapist feels that they have over their victims sexual being I believe goes beyond arguments of control, power, patriarchy or mental defect and for me at least her questions after reading this book remains unanswered.

**By Sheranne Dobinson Sexual health Nurse**

## ASHHNA Educational Scholarship – Applications now open

The \$3000 scholarship is open to all ASHHNA members, with thanks to CSL Biotherapies for their generous support.

Previous recipients have used the scholarship to attend conferences, attend an interstate workshop and undertake research.

The scholarship funds may be allocated to more than one applicant, so it is worth applying. To download the application form go to [www.ashhna.org.au/scholarships](http://www.ashhna.org.au/scholarships). You can also contact Belinda Davis with any questions. [Belinda.davis@nt.gov.au](mailto:Belinda.davis@nt.gov.au).

**Applications close 31<sup>st</sup> July 2009!**

### Development of a nurse led clinic for women presenting with sexual difficulty



Cath Hakanson

In 2008 I was awarded an ASHHNA scholarship to assist in developing a nurse led clinic for women presenting with sexual difficulty. This clinic first opened in mid 2007, ethics approval was granted in July 2008, and data collection started in October 2008. If we reach our target recruitment, enrolment should cease in October 2009, with final questionnaires to be completed in April 2010. With fingers crossed, the final report should be completed by May 2010.

To date, recruitment has been slow to start. There are positives and negatives to this. Positives include that it has given me time to 'fine tune' research procedures eg development of a system that eases questionnaire chasing, record keeping, etc. Negatives include that it means that we may have to extend recruitment, and that I will have to start putting more pressure on women to 'sign up'. Currently, 1 out of approximately every 2-3 women sign up for the trial. I find this quite perplexing, as I have had better success with this sort of thing in the past.

I only like to send one reminder, as I don't want to harass women but I also think that if they can't be bothered to do the first form, that they will then have the same problem with the rest .

I have just completed the first draft of the clinical guidelines. I somehow managed to gain assistance from the WA Office of Chief Nursing. I remembered that a listserver email had been circulated re NSW providing support for nurses wishing to publish. So I thought I would try to find something similar in WA. It was new idea to them but they provided me with a mentor – Jeannette Robertson from the DOHWA and Curtin University. Jeannette has a strong research and publishing/editing background and is also involved with the Joanna Briggs Institute meaning that she is a guru on clinical guidelines. She has been a wonderful resource for me.

The writing of the guidelines has been hard work. Having a template document to follow was a good place to start (<http://www.ocno.health.wa.gov.au/practitioner/protocols.cfm>). I have spent a lot of my time trying to find existing clinical guidelines. I have searched nationally, internationally and cross discipline. I have had no success so basically I have had to 'invent the wheel'. I have been lucky in that I have found some valuable resources in regards to key texts on the management of sexual dysfunction.

#### ***This research project consists of 2 parts:***

*the development of the nursing scope of practice in managing clients presenting with sexual difficulty, and the evaluation of the impact of nurse led care on women presenting with sexual difficulty.*

The development of the nursing scope of practice has been both challenging but rewarding. I have spent a lot of time trying to find nurses who are working within this field within a similar scope of practice. Not easy to find as many seem to work more as a counsellor instead of a nurse. Of those that I have found, the general consensus was to base the role within the first 3 levels of the PLISSIT model (permission, limited information and specific suggestions). The fourth level of 'intensive therapy' is more for those who wish to practice at a higher level. I am looking a developing a model that many women's and sexual health nurses can easily step into. I see sexual difficulty as a natural progression within the field of women's and sexual health.

This project has always been my project but it would never have been possible without the support of many others. I have coerced our Public Health Physician, Dr Charles Douglas, into analysing my data. I have convinced my nurse managers into supporting this project (Kalgoorlie Community Health). I have convinced my workplace, Goldfields Women's Health Care Centre, into offering this clinic as a new service and for funding it for one day a week ([www.gwhcc.org.au](http://www.gwhcc.org.au)). I have received a Research Fellowship Award from the Nurse and Midwives Board of WA that allows me to shunt my toddler to day care for a whole day a week to enable me a day of uninterrupted toil on this project. The Office of Chief Nurse (WA) have provided me with a mentor to ensure that I do publish my findings. I have also accessed the knowledge and support from many related associations/ organisations ie ASHHNA, AWHNA (Australian Women's Health Nurses Association), WASS (WA Sexology Society), the School of Sexology – Curtin University WA.

So that is where I am at! I learnt a long time ago to ask for help, and it is amazing what you get if you do ask. So I am now just plodding along, trying to not get stressed by slow recruitment. Child number 2 is due in August so that has given me a deadline for the completion of the clinical guidelines. Luckily I have found a good day care centre, so this baby will be heading off to there for half days once it and I have adapted to life together. I have put too much work into the development and promotion of this new clinic to close it for 6-12 months. So it will be off to evening clinics pretty much within a few weeks of birthing. But hey, it isn't what I would call hard work talking to people about their sex lives!

**Editor – Thanks Cath you are amazing!**

## INTERNATIONAL NURSES DAY

Jo Perks

*The 12<sup>th</sup> May was designated International Nurses Day which is Florence Nightingales birthday. Jo Perks was privileged to represent ASHHNA inc at Admiralty House.*

The theme of this years International Nurses Day was “**Delivering Quality, Serving Communities: Nurses Leading Care Innovations**” which is timely given the current nursing and political climate.

I had my picture taken with the Governor General and also pictured is Linda Oliver who is the current president of the Australian Women's Health Nurses Assn.



## Journal Watch

Matiu Bush

### Delayed diagnosis of HIV infection in Victoria 1994 to 2006

*C Lemoh, R Guy, K Yohannes, J Lewis, A Street, B Biggs, M Hellard*

Delay in the diagnosis of HIV infection is common in Victoria, but potentially avoidable in the majority of cases. Most people with delayed diagnosis had a history of male homosexual contact, injecting drug use, birth in a high-prevalence country or sexual contact with such individuals. An accurate sexual history, together with knowledge of their country of birth, should identify most individuals who should be offered an HIV test

### The C-project: use of self-collection kits to screen for *Chlamydia trachomatis* in young people in a community-based health promotion project

*L Martin, E Freedman, L Burton, S Rutter, V Knight, A D'Amato, C Murray, J Drysdale, S Harvey*

This study identified that free testing kits and online communication worked well as a means of engaging young people and raising awareness of sexual health. However, the requirement to drop-off urine samples at selected locations was not well accepted.

### Discrepancies between young people's self-reported sexual experience and their perceptions of 'normality'

*M. Lim, C Aitken, J Hocking, M Hellard*

Young people's sexual behaviour is influenced by their perceptions of peer norms. In this survey of 445 people aged 16 to 29 years, 69% of participants believed they had fewer lifetime sexual partners than average. Comparison to a national survey also showed that peers' average sexual experience was overestimated. Adolescents are highly susceptible to the influence of peer norms, hence it is concerning that their perceptions of these norms are so distorted.

### Risk reduction as an accepted framework for safer-sex promotion among women who have sex with women.

*P Cox, R McNair*

Safer-sex information for women who have sex with women (WSW) is often very difficult to locate. Girl2girl.info is one of the only websites focussed on safer sex for WSW. The present article describes the predevelopment consultation and evaluation of girl2girl.info. A risk-reduction framework was used to develop the website. The article concludes that the promotion of a risk-reduction approach – including non-latex-based safer-sex practices – for WSW is both a theoretically appropriate and engaging form of health promotion for WSW.

### An increase in overseas acquired HIV infections among heterosexual people in

**Western Australia.** *B Combs, C Giele*

There has been a recent increase in the number of heterosexually acquired HIV infections among non-Aboriginal people in Western Australia (WA), which has not been reported in other Australian jurisdictions. This report describes the epidemiological features of this increase. There has been a recent increase in heterosexually acquired HIV infections among male and female WA residents, many of whom reported acquiring HIV overseas. Safe sex campaigns in WA should continue to reinforce safe sex messages among people travelling overseas

### Access to sexual health advice using an automated, internet-based risk assessment service

*D Lee, C Fairley, J Sze, T Kuo, R Cummings, J Bilardi, M Chen*

The present study aimed to determine the sexual risk profile of people using an automated, internet-based service that allows internet users to receive recommendations on sexually transmissible infection screening ('Check your risk' (CYR)). Individuals who accessed an automated, internet-based sexual risk assessment service were at substantial risk for sexually transmitted infections, similar to those attending a sexual health service

# President Report

Donna Tilley

Welcome to the mid year edition of the ASHHNA newsletter, we hope you like the fresh new format. Over the past year ASHHNA has continued to grow and the name change to specifically include HIV nurses reflects the true nature of nursing membership.

The executive has a busy few months ahead. Activities include finalising the arrangements for the ASHHNA/ QLD Sexual Health Society nurses meeting on the Wednesday of the Australasian Sexual Health and HIV/AIDS conferences in September; and commencing the review of the ASHHNA competencies.

Last year was the inaugural Kendra Sundquist Nurses Prize at the Sexual Health conference. This year we will be continuing to offer a prize to nurses who present an oral or poster presentation at the conferences, as an acknowledgement of the contribution nurses make to the specialty and to raise the profile of nursing research. If you are attending either of the conferences this year let your local exec member know, as we will be needing ASHHNA members for prize judging.



Executive ASHHNA Inc. Committee

More good news that is the 2009 ASHHNA educational scholarship is now open.

The scholarship is generously provided by CSL Biotherapies to the value of \$3000.

I encourage all members to apply if there is a course, training or research you are interested in (eg. Immunisation course, developing a nursing resource or undertaking research). T

he application form and reports of past recipients are on the website. [www.ashhna.org.au/scholarships](http://www.ashhna.org.au/scholarships)

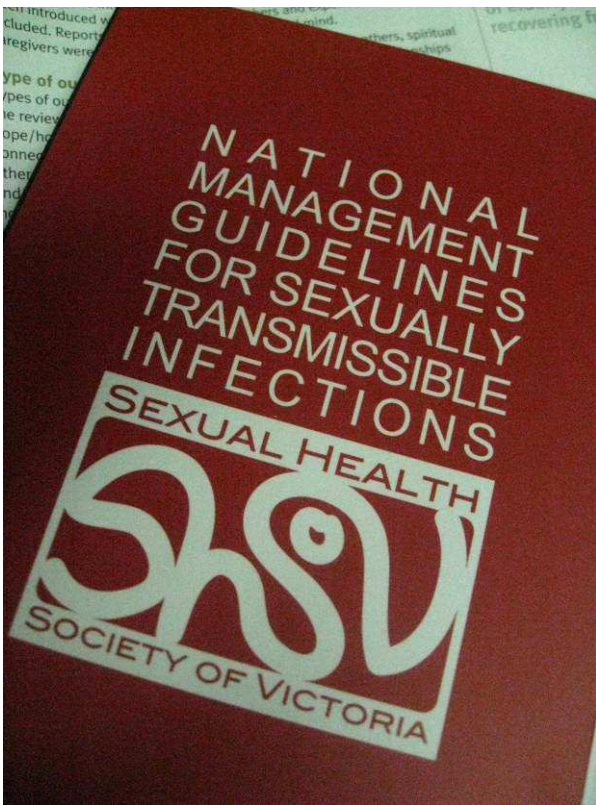
Back row: Donna Keeley, Jo Perks, Matiu Bush, John McAllister, Brad Whitton

Front row: Glen Curran, Jenny Walsh, Donna Tilley, Belinda Davis, Sue Porter, Shane Jasiak

To the website, last year saw a revamp of the look of the site and some new areas including a section where all members can share and access educational resources.

To be able to continue offering these member benefits we have made a small increase on the membership fee to \$ 60.00 per year. For this annual (and tax deductible) fee I encourage you to take advantage of all the member benefits – Newsletter, Nurses Prize, Scholarship and Knowledge Network: email list and website.

If you are unsure of your current member status contact Matiu Bush [mbush@mshc.org.au](mailto:mbush@mshc.org.au). We now offer year round membership applications and renewals. Take advantage and encourage your colleagues to join.



## New Guidelines Launched

The 7th edition of the *National management guidelines for sexually transmitted infections*, produced by the Sexual Health Society of Victoria are now available from

### AChSHM

[www.racp.edu.au](http://www.racp.edu.au)

### Melbourne Sexual Health Centre

[www.mshc.org.au](http://www.mshc.org.au)

### Department of Health and Ageing

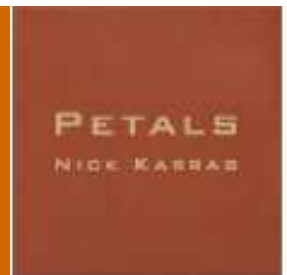
[www.health.gov.au/sexualhealth/](http://www.health.gov.au/sexualhealth/)

The guidelines have been endorsed by ASHNA and a range of organisations involved in the sexual health care of Australians

## CLINICAL RESOURCES

## CATH HAKANSON

Cath Hack bought *Petals* by Nick Karras years ago and uses it frequently in clinical practice. The book is used with clients dealing with sexual difficulty, women's health issues and STIs. The book is composed of a compilation of black and white photos of vulvas from women aged from 18 to 80.



The photos of the vulvas have been directed by the women being photographed. The black and white images makes compelling viewing. There is another similar book that is in colour (*Femalia* by Joani Blank). I chose the black and white photos over colour as I felt they were tasteful, approachable, and useful for women of all ages. Clinically, I use it with every woman who discloses that she thinks her genitals are ugly. I also use it with young females when chatting about the variations in genitals or when they drop an urban myth on me (eg 'my 14 year old friend has had her labia trimmed'). I use it with older women when talking about age related changes. I also use it with sexual difficulty in addressing misconceptions and also for an educational purpose.

### GENITAL MODELS



I have other genital resources I can use eg vulva cushion and diagrams, but I find that often they aren't the right resource when seeing women with sexual pain. Women often don't have the terminology or connection to their genitals to be able to adequately describe the location of their pain. This resource has solved that problem! The vulva is fantastic for sexual pain especially in defining the location of pain. Other clinical situations I have so far used them in include locating sore spots in the vulva that are now absent, and assessing chronic thrush. I also use it for those women who need some anatomical lessons. It never ceases to amaze me how many women don't own their own genitals! The penis I mainly use with young teenagers who are 'coming to grips' with being sexual. Myths and misconceptions are rife, and I find a lifelike model is perfect for education. In summary, I have added these to my toolkit of essential items!

## Subscribe today

As an ASHNA member you have access to:

- a biannual newsletter
- annual scholarship
- annual nurses prize
- a national knowledge network of online resources
- representation at national nursing and health forums
- the ASHNA website
- local area sub branches and supported education meetings



Richard Norris  
and John McAllister

Download a  
membership form  
from  
[www.ashna.org.au](http://www.ashna.org.au)

## Introducing New Executive Member Sonia Harris Nurse and Midwife Education Coordinator at Shine SA

Sonia has recently joined the executive and is keen to lift the profile of sexual health nurses in South Australia. Sonia's role includes coordination of Certificate in Sexual Health for nurses, Pap Smear Provider Training, Pregnancy Choices Training, responding to staff development needs of SHine SA Nurses and Midwives, and coordination of South Australian Nurses and Midwives Network.

SHine SA is the leading sexual health agency in South Australia. SHine SA works in partnership with government, health, education and community agencies to improve the sexual health and wellbeing of South Australians.

## Sub-Branch Information

Sub-branches offer an opportunity for ASHNA members to establish a formal local mechanism in which to meet and promotes and enhances networking and communication between sexual and reproductive health nurses within a designed geographical area and / or state.

Sub-branches aim to:

- Provide a direct line of communication between members and the executive
- Ensure local issues are dealt with appropriately Provide a forum for networking in common geographical areas
- Provide a local forum for the exchange of information
- Provide local educational activities for members.

# SUB BRANCH REPORTS

SUE PORTER SUB BRANCH LIASON OFFICER



## WA

WA has recently established an ASHNA sub-branch. The first meeting has been held and an invitation has been issued to all WA ASHNA members inviting their involvement in future meetings. Meetings will be held as either telephone or video conferences, allowing all members to be involved.

The aims of the sub branch include:

- to provide a direct line of communication between members and the executive
- to ensure local issues are dealt with appropriately
- to provide a forum for networking in common geographical areas
- to provide a local forum for the exchange of information
- to provide local educational activities for members

The next meeting is scheduled as a teleconference on Tuesday 19 May 2009 at 1.30pm. If you did not receive your invitation or are a new member, please email Cath Hakanson on [Cathhak@gmail.com](mailto:Cathhak@gmail.com) for further information.

Cath Hakanson

## ACT

The ACT sub branch held our first meeting for 2009 on March 23rd, and 12 members attended. We had a guest speaker from the Junction Youth Health Service updating us on sexual health services including outreach to youth centres and colleges conducted by their nurses. We then shared information on each of our agencies current programmes and events. Supper was a great networking affair, and we will meet again in June. Denise Fairall RN Canberra Sexual Health Centre

Denise Fairall

## SA

ASHNA SA plans to meet every 3 months. Our focus is mostly looking at research. Articles, literature searching, critically analysing journal articles etc. The main reason we have this focus is that SA also has a Sexual Health Nurses and Midwives Network (SHNMN) that is run by Shine SA (Family Planning in SA). SHNMN also has 4 meetings a year and mostly focus on education updating sessions.

Generally we only aim to have about 6-8 people (and that's a good turn out!!). We meet from 5.30 - 7.30pm with light refreshments being provided By ASHNA.

Our next session we will be focusing on writing for publication and abstracts from conferences.

There are 2 more sessions planned for later in the year.

Heather Woods

## VIC

The Victorian Sub branch will be holding its annual Sex Talk in October this year. Last year over 40 nurses from a variety of back grounds attended the day long conference that incorporated workshops on sexual history and genital wart treatments. Brad Whitton, one of the organisers for this year hopes the topics will be of great interest for the participants "Its all part of providing relevant sexual health education to nurses who may not be working in the area on a daily basis as well as delivering up to date evidence based information for the more experienced clinicians."

For more information on the Victorian sub branch and Sex Talk 2009 please email [mbush@mshc.org.au](mailto:mbush@mshc.org.au)

Matiu Bush & Brad Whitten

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