Editorial

Time to modernise response to sexually transmitted infections

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New Zealand’s Parliament is considering changes to the Health (Protection) Amendment Bill that would make HIV, gonorrhoea and syphilis notifiable infectious diseases. Historically, New Zealand has followed the UK model of surveillance for sexually transmitted infections (STIs), with voluntary surveillance from sentinel clinics, more recently expanded to diagnostic laboratories. There are acknowledged limitations to this approach however, namely infections diagnosed in general practice and unreported.

The proposed changes are therefore welcomed by many in the sexual health sector as a step towards updating New Zealand’s responsiveness to modern STI epidemics, in a world of high international sexual mobility, Internet-facilitated partner acquisition and changing sexual norms.

Whether to include chlamydia (Chlamydia trachomatis) and its variant lymphogranuloma venereum (LGV) as notifiable conditions in the Bill remains under discussion. Although chlamydia is New Zealand’s most commonly diagnosed bacterial STI with 28,316 laboratory confirmed cases reported to ESR in 2013, LGV appears to be rare in this country with only two published cases in recent years. These infections occurred in 2008, in men who have sex with men (MSM), and were most likely acquired overseas. Under-reporting of LGV is likely as the diagnosis may not be considered, or appropriate diagnostic testing omitted.

In this issue of the NZMJ, Basu et al provide compelling first evidence of localised transmission of LGV between MSM and document the potentially serious health consequences of this infection. Their report is not entirely surprising, given more than a decade of public health intelligence identifying LGV outbreaks among sexual networks of HIV positive MSM in Europe, North America and Australia. What is important is to appreciate the significance of this report for New Zealand and seize the opportunity presented by the Bill to strengthen our STI surveillance. Notification of LGV is a necessary first step in this regard.

Notification alone however will be an insufficient response to LGV and other STIs. Transmission networks reflect sexual partnering networks; counting more cases will help, but will fail to activate effective responses if the groups most affected such as MSM remain invisible in the statistics. Unlike sex, age and ethnicity, MSM status (which could be identified simply by “sex of partners: male, female or both”) is not yet recorded in routine STI surveillance in New Zealand.

“Enhanced” syphilis surveillance, recently established among those attending sentinel sexual health clinics, demonstrates the value in doing this: of the 73 male cases in 2013, 86% were among MSM. Enhanced syphilis surveillance was instigated by sexual health clinicians in response to a rise in the number of infectious syphilis cases and published reports highlighting a preponderance of infections among MSM. An initial pilot project was led by the AIDS Epidemiology Group from 2011 and ongoing reporting taken over by ESR from 2013. Early confirmation of syphilis clusters among MSM has subsequently led to effective novel targeted interventions in Christchurch working alongside the New Zealand AIDS Foundation that continue elsewhere in Auckland and Waikato.

Reporting MSM status in STI surveillance is increasingly common around the world. In many countries national sexual health strategies provide the impetus for this. In tandem, data and strategies monitor progress on sexual health targets, prompt action, and focus prevention to those most at-risk for maximum public health impact.
In contrast, New Zealand not only lacks notification and enhanced surveillance of most STIs, but also lacks a national sexual health strategy, action plan, national and DHB targets or priorities to guide responses. The proposed Health (Protection) Amendment Bill is an excellent opportunity but is therefore only one piece of the puzzle.

Three of the five cases reported by Basu et al were co-infected with HIV, consistent with the profile of LGV among MSM in the international literature. To explain this concentrated incidence, researchers overseas have highlighted practices such as “sero-sorting” by HIV positive MSM, that is, selective sexual sorting with other HIV positive partners. Although HIV sero-sorting can limit onward HIV transmission, it offers no protection against other STIs, especially if condoms are not used.

Globally there is also a shift towards the role of chemo-prophylaxis in HIV management - “treatment as prevention”—using HIV antiretroviral therapies to reduce HIV transmissibility and HIV acquisition probabilities. While having great promise for HIV prevention, these secondary prevention approaches risk igniting serious STI epidemics if primary prevention approaches such as condom promotion and condom use wane.

Interventions designed to control STI and HIV epidemics among MSM must therefore be additive and not a “zero-sum” game. For example, LGV infection appears to facilitate sexually-acquired hepatitis C virus and HIV transmission by breaching the integrity of the anal skin and mucous membranes. This is of particular concern for HIV positive MSM and their partners. It will be a pyrrhic victory for MSM if improvements in HIV management come at the expense of worsening sexual health overall.

The reported cases highlight other challenges for STI control among MSM. Four of the five individuals with LGV were aged over 40 years. MSM of all ages are at elevated risk of incident STIs, not only the young as is generally found in heterosexual populations, reflecting a unique conflagration of vulnerabilities. These include: a high degree of sexual mixing within a very small pool of partners; a high underlying prevalence of infection in this population; anal intercourse as a highly efficient mode of STI as well as HIV transmission; and rectal STIs often being asymptomatic and unnoticed.

Such factors underlie profound and rising inequalities in the sexual health of MSM. The European CDC has reported that 33% of 39,179 reported gonorrhoea cases in 2011 occurred among MSM. In London, MSM accounted for 24% of all STIs diagnosed in sexual health clinics in 2013 while comprising just 2% of the adult population. In the absence of notification and enhanced surveillance, the extent to which MSM in New Zealand experience a similarly high burden of STIs in addition to HIV and syphilis is as yet unknown.

Community surveys have found approximately 48% of MSM seek sexual health screening at a GP, but little is known about disclosure of sexual orientation to GPs, the comprehensiveness of screening offered, or the extent of contact tracing. To promote better care, it is important that all health providers: offer safe, supportive and non-stigmatising environments for gay and bisexual males; are familiar with the health issues disproportionately faced by MSM; and implement national guidelines on recommended STI testing, screening and vaccination for this population.

Targeted health education and social marketing interventions for MSM must also be scaled up at the community level. These need to emphasise condom use and behavioural risk reduction to curtail HIV and STI spread, and promote regular HIV and STI testing for early detection and treatment of asymptomatic infections.

LGV has been a relatively rare infection in New Zealand. We have an opportunity to minimise the likelihood of this infection becoming endemic amongst local MSM, as it has in parts of Europe. The proposed Health (Protection) Amendment Bill offers the chance to improve our ability to investigate and respond to emergent STIs such as LGV in a timely way but more action is needed. These include enhanced surveillance of notified STIs by MSM status to forewarn of epidemic changes, adequate resourcing of primary prevention to address the determinants of transmission, and safe, accessible and relevant health services for MSM.
Even then, achieving progress on sexual health and wellbeing for all New Zealanders will be unrealistic without national direction and indicators in a health system driven by targets. Without such direction responses to emergent threats will continue to be ad-hoc and reactive rather than co-ordinated. It is time to prioritise the sexual health and wellbeing of New Zealanders and in particular our most vulnerable communities including MSM.

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**References**


