Why monthy regulated STI testing of sex workers should be reduced to three monthly *(cont)*

The health benefit to the women is negligible
Some of the most detailed data in the world exists for the rates of sexually transmitted infections in sex workers in Melbourne (1). These data show that despite nearly 2000 months of follow up there were no cases of gonorrhoea or syphilis. The rate of chlamydia was less than 0.1 per year. Among the one third of sex workers who had no private non paying partners the rate was 10 fold lower. Trichomonas was even less common.
It is generally accepted that testing for chlamydia on a regular basis is indicated if chlamydia is present in 3% or more of tested women. Why then is testing being recommended for sex workers at 10 times the frequency in non sex workers when their rates of disease are 10 times lower?

The cost to the community from excessively frequent tests is substantial
The cost of testing sex workers on a monthly basis is substantial. If one includes the cost of the consultation, the investigations and follow-up, the cost is more than $100 per visit and in excess of $1,200 per year.

One must also include the effect of providing these services on reducing access to health services for others. For example the necessity for monthly testing uses substantial resources at Melbourne Sexual Health Centre and therefore restricts access to our services for other individuals. This is particularly troubling when there is no benefit obtained by frequent testing of sex workers.

Monthly testing provides no health benefit to the Victorian public
The very low prevalence of sexually transmitted infections among sex workers and the 100% use of condoms with clients preclude any health benefit to the Victorian public from frequent testing. There were no cases of gonorrhoea or syphilis among the nearly 2,000 months of follow up and the rates of chlamydia and trichomonas were very low (1).

On the basis of the data provided by Lee et al above, monthly testing (compared to three monthly testing) costs about $2,000 to reduce the duration of chlamydia or trichomonas infectivity by one week. Given that condom use with clients is 100%, there is no health benefit obtained for this expenditure.

Monthly screening of legal sex workers puts a substantial burden on the services of Melbourne Sexual Health Centre. This limits access for other Victorian women at substantial risk of sexually transmitted infections who the centre is unable to see. Sex workers currently take up about 30% of female consultations, so without any increase in staff time, resources or budget, we could increase access for Victorian women to our sexual health services by about 20% simply by changing the legislation from monthly to three monthly tests. This change is likely to improve the sexual health of Victorian women by increasing the access to our services.

The cost and time commitment to the women for testing seen as punitive

A substantial reduction in the cost of testing and the time taken for individual women to access the health services by increasing testing time frames to three monthly, would encourage more women who currently work in the unregulated industry where there is a high incidence of sexually transmitted infections to be attracted to working in the regulated industry. The overall impact of this is likely to reduce the rate of sexually transmitted infections for the whole Victorian community.
The data from Melbourne indicates the tremendous success of the work undertaken in occupational health and safety in the sex industry by the government, network of sex worker programs and organizations in reducing the rate of sexually transmitted infections through prevention education and very high levels of sustained condom use over time. Indeed one could say with a high level of confidence that sex workers do not contribute to the spread of sexually transmitted infections within Melbourne.

Professor Kit Fairley and Glenda Fehler
Melbourne Sexual Health Centre, May 2008

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2. Declining prevalence of STI in the London sex industry, 1985 – 2002. H Ward, S Day, A Green, K Cooper, J Weber. Sexually Transmitted Infections, 2004; 80: 374-378

3. Victorian HIV/AIDS Strategy 2002-2004 and
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