National Healthcare Agreement: PI 02-Incidence of sexually transmitted infections and blood-borne viruses, 2011 QS

Identifying and definitional attributes

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- Health, Superseded 04/12/2012

Relational attributes

Indicators linked to this Quality statement: National Healthcare Agreement: PI 02-Incidence of sexually transmissible infections and blood-borne viruses, 2011
Health, Superseded 30/10/2011

Data quality

Quality statement summary:
- The data used to calculate this indicator are from an administrative data collection designed for real-time surveillance of communicable diseases. Data are reportable under jurisdictional public health legislation.
- A major limitation of the notifications data is that, for most diseases, they represent only a proportion of the total cases occurring in the community, that is, only those cases for which health care was sought and a diagnosis made, followed by a notification to health authorities. The degree of under-representation of all cases is unknown and is likely to vary by disease.
- All notified cases are included in the numerator, even though some diseases included in this indicator, are not necessarily sexually acquired.
- For some diseases, in some jurisdictions, the high level of non-reporting of Indigenous status made disaggregation by Indigenous status too unreliable for publication.

Institutional environment: Cases are reported to state governments from clinicians and laboratories under relevant public health legislation. The Department of Health and Ageing receives data for all notified diseases except for HIV on to the NNDSS and acts as the custodian of that data. The National Centre in HIV Epidemiology and Clinical Research, a research institute based at the University of NSW, is responsible for maintaining national HIV data reported by the jurisdictions.

The tables for this indicator were prepared by the Department of Health and Ageing and quality-assessed by the AIHW. The Department of Health and Ageing drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) and then further comments were added by the AIHW, in consultation with the Department. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator. For further information see the AIHW website.

Timeliness: Data relates to 2009.

Accessibility: The NNDSS website enables the public to access the following levels of data for all of these infections, except HIV:

- Age group
- Sex
- Disease
- State

This is provided in both case count and rates outputs. See:

Interpretability: The current NNDSS case definitions, including any historical edits, can be found at www.health.gov.au/casedefinitions.

Relevance:

Syphilis

All cases reported in the 0–4 years age group were notified as being congenitally acquired cases. Congenital syphilis is transmitted transplacentally from an infected pregnant woman to her foetus, and is not considered to be sexually transmitted.

STIs are not necessarily sexually acquired

Not all notifications of chlamydial infection, gonococcal infection, and syphilis are sexually acquired. The national case definitions for these infections do not specifically distinguish between sites of infection or modes of transmission. In children aged under 4 years an STI, even of the genital area, may have been acquired from the mother at the time of delivery or via inadvertent non-sexual spread. For example, rectal and genital infection with Chlamydia trachomatis in young children may be due to persistent perinatally acquired infections, which may persist for up to three years; and gonococcal conjunctivitis can be acquired at the time of delivery or transmitted from child to child. Also, congenital syphilis is transmitted transplacentally from an infected pregnant woman to her foetus, and is not sexually transmitted.

Indigenous status

Information about Indigenous status is only presented for jurisdictions with response rates of 50 per cent or more to the Indigenous status data item. The Australian rate provided is a summary of those jurisdictions where completeness of the Indigenous status data item was greater than 50 per cent for 2009. Due to the variable jurisdictional completeness, comparisons of 'national' Indigenous status rates over time may be inaccurate. See Table 10.

Table 10: Completeness of response rates to the Indigenous status data item by jurisdiction and infection/virus, 2009 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Syphilis	92.3	97.7	97.2	100	100	100	100	100
HIV	94.0	98.0	97.0	99.0	96.0	100	100	100
Hepatitis B	15.4	37.0	34.1	95.6	93.4	72.9	79.2	89.1
Hepatitis C	12.7	29.2	38.8	92.5	90.9	66.1	5.5	89.1
Chlamydia	6.1	54.8	51.8	79.6	91.5	74.4	1.4	91.0
Gonococcal infection	8.8	64.4	55.9	99.9	94.5	95.2	47.3	98.1

Remoteness and socioeconomic status

The analyses by state/territory, remoteness and socioeconomic status are based on residential postcode of the case at the time of diagnosis and as recorded in the NNDSS. Where a postcode for a case was not available or was not assigned a category by the ABS, they were not included in the remoteness and SEIFA disaggregations. These postcodes consisted of post office box numbers, special NNDSS postcode formats which indicate the state of residence but not the specific postcode location, invalid postcodes, missing postcodes and new postcodes that have not yet been assigned a category by the ABS. Over 95 per cent of records had a postcode assigned that was able to be included in disaggregations by remoteness and socioeconomic status.

Where a postcode was allocated to more than one SEIFA or remoteness category, cases were allocated based on the proportion of the population allocated to the respective SEIFA or remoteness category within a postcode.

Postcode information usually reflects the residential location of a case,

however in some jurisdictions it may be based on the postcode at the time of testing.

Accuracy:

All jurisdictions have approved the provided data.

A major limitation of the notification data is that, for most diseases, they represent only a proportion of the total cases occurring in the community, that is, only those cases for which health care was sought and a diagnosis made, followed by a notification to health authorities. This proportion may vary between diseases and over time, with infections diagnosed by a laboratory test more likely to be notified. States and territories may have varying reporting requirements by medical practitioners, laboratories and hospitals, and differing levels of case follow-up.

Notifications were extracted using 'diagnosis date' for 2009. Please note the date of diagnosis is the onset date or where the date of onset was not supplied, the earliest of the specimen collection date, the notification date, or the notification receive date. As considerable time may have elapsed between the onset and diagnosis dates for hepatitis B and C unspecified cases, the earliest of specimen date, health professional notification date or public health unit notification receive date was used for these conditions.

The Department of Health and Ageing used tables and concordance files to construct population estimates. These tables and concordance files were provided by the AIHW, based on ABS statistical products.

Indigenous status

The level of completeness of the Indigenous status data item is highly variable by disease and jurisdiction.

For table NHA.2.3, incomplete notifications where Indigenous status was ‘not stated’ or blank or unknown were counted as 'not Indigenous' and included as ‘Other Australians’. In each jurisdiction where more than 50 per cent of notifications had a ‘not stated’, blank or ‘unknown’ response to Indigenous status data item, the disaggregation between Indigenous and Other Australians has not been provided as the data are not considered of sufficient quality to report this disaggregation.

These data need to be interpreted cautiously. Due to the high proportion of asymptomatic presentations of STI infections, diagnoses are heavily influenced by testing patterns. High rates of STI diagnoses in Indigenous populations may be due to higher levels of screening and not necessarily associated with increased levels of transmission among Indigenous persons.

Hepatitis B and C

All notifications of hepatitis B and C have been included regardless of whether they were notified as ‘newly acquired’ or as ‘greater than 2 years or unspecified period of infection’. The two categories have been combined to represent all new diagnoses of hepatitis B and C in 2009 and not just newly acquired infections. This is due to inconsistent follow-up of cases between jurisdictions, which is required to determine the date of acquisition and hence period of infection.

Sex of cases

Where the sex of the case was either unknown or not reported, these cases were included in the 'total' data for each state and Australia.
Cells have been suppressed to protect confidentiality (where the presentation could identify a person or a single service provider), where rates are highly volatile (for example, the denominator is very small), or data quality is known to be of insufficient quality (for example, where Indigenous identification rates are low).

Coherence:

Changes in surveillance and testing practices or promotion over time and by jurisdiction may make comparisons both over time and across jurisdictions difficult.

Changes in the national case definitions for the requirements of what constitutes a case will also affect the coherence of the data over time. The current NNDSS case definitions, including any historical edits, can be found at www.health.gov.au/casedefinitions.

Relational attributes

Related metadata references:

Supersedes National Healthcare Agreement: P02-Incidence of sexually transmitted infections and blood-borne viruses, 2010 QS

- Health, Superseded 08/06/2011

Has been superseded by National Healthcare Agreement: PI 02-Incidence of sexually transmitted infections and blood-borne viruses, 2012 QS

- Health, Retired 14/01/2015