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SEXUAL HEALTH

Chlamydia and gonorrhoea testing and positivity among women prescribed opioid agonist therapy in Australia

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ABSTRACT

Background. Women who inject drugs have complex sexual risk profiles, but STI epidemiology in this population is not well understood. We sought to describe chlamydia and gonorrhoea testing and positivity among women with a history of opioid agonist therapy prescriptions, as a proxy for a history of injecting drug use. **Methods.** We extracted de-identified linked data from individuals with sex recorded as female aged 15–55 years attending clinics within the Australian Collaboration for Coordinated Enhanced Sentinel Surveillance of Sexually Transmissible Infections and Blood-borne Viruses national sentinel surveillance network between 1 January 2012 and 31 December 2025. We describe overall test uptake and annual test positivity for chlamydia and gonorrhoea using a linear test of trend, reported as a *P*-value. We report by a binary age grouping of <30 and ≥30 years of age. **Results.** Of 6850 women prescribed opioid agonist therapy, 2303 (34%) had a test for chlamydia or gonorrhoea. Chlamydia overall test positivity was 4%; 7% in women aged <30 years and 3% in women aged ≥30 years. In women aged <30 years, annual chlamydia test positivity increased from 6% in 2012 to 12% in 2023 ($P = 0.158$). For gonorrhoea, overall test positivity was 3%; 4% in women aged <30 years and 2% in women aged ≥30 years. In women aged <30 years, gonorrhoea test positivity increased from 0% in 2012 to 14% in 2020 ($P < 0.001$). **Conclusions.** We found high test positivity for chlamydia and gonorrhoea among women with a history of opioid agonist therapy, indicating the sexual health needs of this population are not being met. Increasing chlamydia and gonorrhoea positivity, particularly among young women, highlights the need for more research into the epidemiology of STIs among women who inject drugs.

Keywords: chlamydia, gonorrhoea, opioid agonist therapy, people who use drugs, pharmacotherapy, sexual health, sexually transmitted infections, women.

Introduction

People who inject drugs may have higher sexually transmitted infection (STI) prevalence than the general population.[1] The World Health Organization recommends STI screening for people who inject drugs;[2] however, current Australian STI management guidelines do not explicitly address this population's sexual health needs.[3]

Women who inject drugs may have complex sexual risk profiles,[4–7] compounded by structural barriers that can prevent access to sexual health care.[8,9] In Australia, these intersecting risks have coincided with increasing syphilis notifications among women who inject drugs;[10,11] however, whether this pattern is reflected in other STIs, such as chlamydia or gonorrhoea, remains unknown. Greater investigation of the epidemiology of STIs among women who inject drugs is needed.[12]

Surveillance data do not typically report on drug use history; however, the Australian Collaboration for Coordinated Enhanced Sentinel Surveillance of Sexually Transmissible Infections and Blood-borne Viruses (ACCESS) database collates data across a range of primary care services, including data on prescriptions for opioid agonist therapy (OAT), which can act as a proxy for a history of injecting drug use, to help to examine this population. Furthermore, there is evidence that women on OAT may have a higher incidence of chlamydia and gonorrhoea.[12] We aimed to use ACCESS data to describe chlamydia and gonorrhoea testing and positivity among women of reproductive age (15–55 years) with evidence of ever being prescribed OAT in Australia.

Methods

Study design and setting

Data for this descriptive study were from the ACCESS database; a national, sentinel surveillance network for monitoring testing, treatment, and management of STIs and blood-borne viruses.[13,14] Clinics participating in ACCESS include general practices, sexual health clinics, drug and alcohol services, and community health centres.

Data collection/source

ACCESS extracts de-identified electronic medical records using specialised software (GRHANITE™). A unique patient key allows the linkage of patient records within and between participating clinics.[14] ACCESS collates data only within the scope of STI and blood-borne viruses surveillance; data for this analysis included individuals' sex and age at the time of clinical consultation, OAT prescription history, and chlamydia and gonorrhoea information, including date of test and test result.

Study population

Included individuals (henceforth, 'women') were recorded as female sex in the clinic's patient management system at the most recent clinic visit, aged 15–55 years at the time of test, with at least one electronic prescription for OAT, including methadone and buprenorphine, at any point (i.e. before or after observed test) between 1 January 2012 and 31 December 2025.

Data management and analysis

We described trends in annual chlamydia and gonorrhoea testing at any anatomical site, and test positivity by calculating the total number of women tested per calendar year, with each woman contributing a maximum of one test annually, prioritising positive tests. Test positivity was calculated as the number of women who tested positive divided by the number of women tested. Australian STI guidelines identify those who are aged <30 years as higher risk for STIs.[3] To align with this grouping and to determine if test positivity varied by age, we stratified women using a binary age grouping of <30 years of age and ≥30 years of age. To estimate the association between test positivity and time (year) within groups, we fit a generalised linear model (log binomial distribution) with robust standard errors (reported as a *P*-value).

Re-testing is recommended in Australia at 2 weeks post-treatment for gonorrhoea to test for cure and at 3 months post-treatment for chlamydia to test for re-infection.[3] For this analysis, re-testing was defined as the next chlamydia or gonorrhoea test that occurred subsequent to their first baseline positive test, within the observation period (2012–2025). We also calculated re-testing positivity as a measure for recurring risk, defined as the number of women with an observed positive test after their first observed positive test for the same infection within the study period. For re-testing, women could contribute multiple tests per year, to capture any potential re-testing within the same calendar year. All outcomes were calculated for chlamydia and gonorrhoea separately.

Statistical analyses were conducted using Stata version 18 (StataCorp) and RStudio.

Ethics

ACCESS was approved by the Human Research Ethics Committees at Alfred Hospital (248/17), Central Australia (CA-19-3355), Northern Territory Department of Health and Menzies School of Health (08/47), University of Tasmania (H0016971), Aboriginal Health and Medical Research Council (1099/15), ACON (2015/14), Victorian AIDS Council/Thorne Harbour Health (VAC REP 15/003, and St. Vincent's Hospital (08/051). As our study analysed de-identified data collected under the auspices of public health surveillance, individual patient consent was not required. Individuals were able to opt-out of the surveillance system if they wished.

Results

Data were extracted from 69 services across all Australian states and territories. A total of 6850 women aged 15–55 years had at least one prescription for OAT at an ACCESS clinic between 1 January 2012 and 31 December 2025. Of these, 2303 (34%) had a recorded test for chlamydia or gonorrhoea during the study period; the mean age at first chlamydia or gonorrhoea test was 35.6 years (standard deviation 8.7 years).

Overall test positivity for chlamydia was 4% (183/4510) and gonorrhoea was 3% (113/4213). For chlamydia, overall test positivity in women aged <30 years was 7% and annual test positivity increased from 6% in 2012 to a maximum of 14% in 2023 ($P = 0.158$). Among women aged ≥30 years,

overall test positivity was 3% and annual test positivity increased from 1% in 2012 to a maximum of 6% in 2022 (P = 0.074; Fig. 1). For gonorrhoea, overall test positivity in women aged <30 years was 4%; annual test positivity increased from 0% in 2012 to a maximum of 14% in 2020 (P < 0.001). Among women aged ≥30 years, gonorrhoea overall test positivity was 2%; annual test positivity increased from 1% in 2012 to a maximum of 5% in 2022 (P = 0.136; Table 1).

Among 167 women with a positive chlamydia test during the study period, 125 (75%) were re-tested for chlamydia at an ACCESS clinic after their first positive test. Twenty-six (21%) had at least one additional positive chlamydia test. Among 104 women with a positive gonorrhoea test during the study period, 67 (64%) were re-tested for gonorrhoea and 12 (18%) had at least one additional positive gonorrhoea test after their initial diagnosis.

Discussion

In our analysis of 6850 women aged 15–55 years with evidence of OAT prescription across Australia, we found high test positivity for chlamydia and gonorrhoea. For gonorrhoea, we found an overall test positivity of 3%; 4% for younger women and 2% for older women, higher than Australian general population estimates that vary between 1% and 2%.[15,16] We also found a dramatic increase in gonorrhoea positivity among women aged <30 years (0–14%), mirroring national trends where rates of gonorrhoea have increased 200% in the 10 years before 2025.[17] Chlamydia positivity in the general population varies between 1 and 6%;[18–20] we found an overall chlamydia test positivity of 4%; 8% for younger women and 3% for older women. Higher chlamydia and gonorrhoea test positivity in younger women may reflect changes in drug use or OAT behaviours, or sexual risk activity; these findings indicate that more research is needed into STIs among women with a history of injecting drug use and women on opioid agonist therapy.

The high test positivity we observed may reflect gender-specific sexual health risks and barriers accessing sexual health services. Women who inject drugs may have increased sexual health risk,[4,21] due to a complex intersection between drug use, gender and other social factors, including violent and coercive relationships,[7,22–24] involvement in transactional sex,[21,23] trauma,[22,25] and housing instability.[22,26] Compounding this increased risk are a multitude of structural and social barriers (e.g. stigma and discrimination, competing priorities, transport limitations, cost, childcare, service opening hours) that can

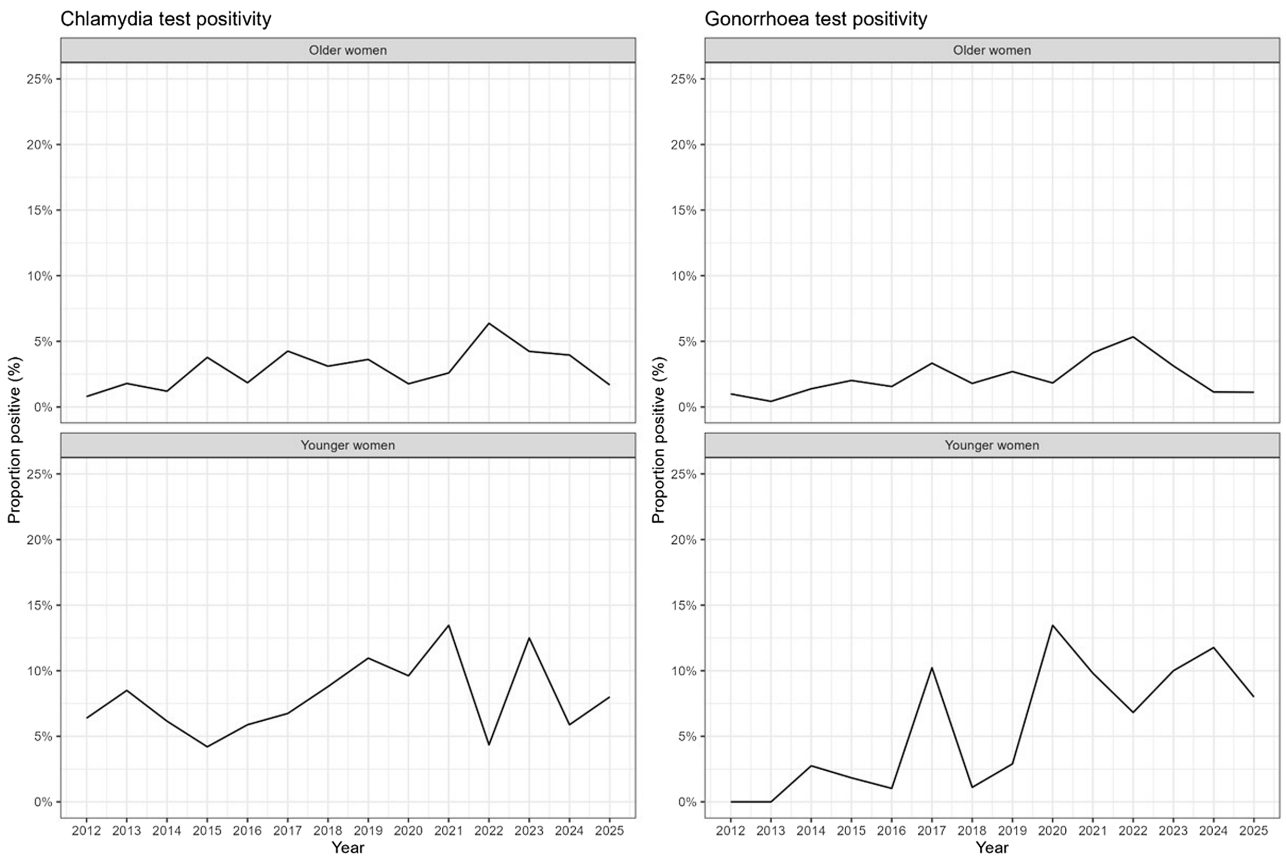


Fig. 1. Chlamydia and gonorrhoea test positivity by year and age group among women with evidence of prescription for opioid agonist therapy, ACCESS, Australia.

Table 1. Total chlamydia and gonorrhoea tests by year and age group among women with evidence of prescription for opioid agonist therapy, ACCESS, Australia, $n = 2303$.

Year	Chlamydia				Gonorrhoea			
	Women aged <30 years		Women aged ≥30 years		Women aged <30 years		Women aged ≥30 years	
	Tested	Positive (%)	Tested	Positive (%)	Tested	Positive (%)	Tested	Positive (%)
2012	141	9 (6.4)	252	2 (0.8)	109	0 (0)	202	2 (1.0)
2013	153	13 (8.5)	280	5 (1.8)	124	0 (0)	236	1 (0.4)
2014	130	8 (6.2)	250	3 (1.2)	109	3 (2.7)	217	3 (1.4)
2015	119	5 (4.2)	265	10 (3.8)	109	2 (1.8)	248	5 (2.2)
2016	102	6 (5.9)	271	5 (1.9)	97	1 (1.0)	257	4 (1.6)
2017	89	6 (6.7)	282	12 (4.3)	88	9 (10.2)	270	9 (3.3)
2018	91	8 (8.8)	290	9 (3.1)	90	1 (1.1)	279	5 (1.8)
2019	73	8 (11.0)	304	11 (3.6)	69	2 (2.9)	297	8 (2.7)
2020	52	5 (9.6)	227	4 (1.8)	52	7 (13.5)	219	4 (1.8)
2021	52	7 (13.5)	193	5 (2.6)	51	5 (9.8)	194	8 (4.1)
2022	46	2 (4.3)	204	13 (6.4)	44	3 (6.8)	206	11 (5.4)
2023	40	5 (12.5)	189	8 (4.2)	40	4 (10.0)	192	6 (3.1)
2024	34	2 (5.9)	177	7 (4.0)	34	4 (11.7)	176	2 (1.1)
2025	25	2 (8.0)	179	3 (1.7)	25	2 (8.0)	179	2 (1.1)
Total	1147	86	3363	97	1041	43	3172	70

prevent women who inject drugs from seeking sexual health care.[5,9,22,25,27] These barriers may be exacerbated in rural and regional areas. Current primary and sexual health services may lack the resources required to meet the sexual health needs of women who inject drugs.

Ensuring sexual health care is accessible and non-stigmatising for women who inject drugs is crucial. Potential approaches to improving care include integrating STI care into existing alcohol and other drugs services, blood-borne virus testing programs or settings frequently accessed by people who inject drugs, such as needle and syringe programs or safe injecting rooms.[5,28–30] Integrating sexual health services into existing harm reduction and alcohol and other drug services can reduce structural barriers, and increase service availability,[26,28] and increase trust.[31] Although sexual health services have been implemented in harm reduction settings with varying uptake and success,[32,33] future models should draw on successful hepatitis C services, including community consultation and co-design,[34] peer-involved delivery of services,[35,36] and streamlined, low-threshold care.[37–39] Furthermore, there is a complex intersection between drug use, sexual health and gender that should be considered when implementing services for women who inject drugs. Gender-specific strategies that integrate harm reduction and sexual health care, and minimise barriers to accessing care may be best placed to meet the needs of women who inject drugs.[25,40,41]

Limitations

Care that occurs outside the ACCESS network was not captured, which may change the proportion of women with a history of OAT tested for chlamydia or gonorrhoea. Length of OAT prescription is not recorded in ACCESS, limiting our ability to define whether women were prescribed OAT at the time of observed testing. As a result, women were categorised into the proxy injecting drug use group if they have ever been prescribed OAT; it is likely that some women would not have injected any drugs during this study period and that some women ceased OAT during this time. Although we analysed re-testing after positivity, we did not analyse the reason for testing; these tests may represent test for cure or test for reinfection. The women included in this analysis were prescribed OAT and STI tested; they may not be representative of women who use drugs who are not engaged in care for either OAT or STI screening. We observed declines in chlamydia and gonorrhoea testing in the later years of observation, which may have affected test positivity estimates. Because ACCESS is a privacy-preserving system, free-text clinical notes that may capture reasons for testing, such as symptoms, risk behaviour or contact tracing, are not extracted. Therefore, it is difficult to determine if the declines in testing would over- or underestimate positivity. Finally, clinical practices and testing have changed over time, including symptomatic/asymptomatic testing[42,43] and methods of testing;[44] both of these may impact test positivity.

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Ethics. ACCESS was approved by the Human Research Ethics Committees at Alfred Hospital (248/17), Central Australia (CA-19-3355), Northern Territory Department of Health and Menzies School of Health (08/47), University of Tasmania (H0016971), Aboriginal Health and Medical Research Council (1099/15), ACON (2015/14), Victorian AIDS Council/Thorne Harbour Health (VAC REP 15/003, and St. Vincent's Hospital (08/051). As our study analysed de-identified data collected under the auspices of public health surveillance, individual patient consent was not required. Individuals were able to opt-out of the surveillance system if they wished.

Data availability. Data not publicly available due to ethical or privacy reasons and may be shared upon reasonable request to the corresponding author if appropriate.

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