Communicable Disease Control Branch

South Australian Sexual Health Services Review: Department for Health and Wellbeing Response

Response to the recommendations from the South Australian Sexual Health Services Review final report submitted by RPR Consulting

February 2024

Government of South Australia
SA Health

Contents

Acronyms

ACCHS	Aboriginal Community Controlled Health Services
ACRRM	Australian College of Rural and Remote Medicine
AHCSA	Aboriginal Health Council of SA
AMR	antimicrobial resistance
AOD	alcohol and other drug
ASHC	Adelaide Sexual Health Centre
BBV	blood borne virus/es
BBVSS	Blood Borne Viruses and Sexually Transmissible Infections Standing Committee
CALD	culturally and linguistically diverse
CALHN	Central Adelaide Local Health Network
CDCB	Communicable Disease Control Branch, SA Health
CPD	continuing professional development
CRSE	comprehensive relationships and sexuality education
DHW	Department for Health and Wellbeing
Doxy-PEP	doxycycline prophylaxis
GBMSM	gay and bisexual and other men who have sex with men
GP/s	general practice/practitioner/s
HCEC	Health Chief Executive Council
HIV	human immunodeficiency virus
HIV s100 prescribers	clinicians who are accredited to prescriber section 100 drugs under the Pharmaceutical Benefits Scheme's Highly Specialised Drugs Program
LGBTIQA+	lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual
LHD	local health district
LHN/s	Local Health Network/s
MBS	Medicare Benefits Schedule
MSM	men who have sex with men
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO/s	non-government organisation/s
NSW	New South Wales
PASH	Peers Advocating for Sexual Health
PEP	post-exposure prophylaxis
PHN/s	Primary Health Network/s
PIP QI	Practice Incentives Program Quality Improvement
PN	partner notification
PrEP	pre-exposure prophylaxis
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RSS	Rural Support Service (SA Health)
RTO	Registered Training Organisation
SA	South Australia
SAMESH	South Australia Mobilisation + Empowerment for Sexual Health (a partnership between SHINE SA and Thorne Harbour Health)
SASBAC	South Australian STI and BBV Advisory Committee

SHS	sexual health services
SIN	SA Sex Industry Network
SRH	sexual and reproductive health
STI	sexually transmissible infection/s
TasP	treatment as prevention
UNSW	University of New South Wales
WA	Western Australia
WCHN	Women's and Children's Health Network
WHO	World Health Organization

Background

Successive South Australian governments have committed to the 'National Sexually Transmissible Infections Strategy'[*] and associated state implementation plans, which set the following overarching goals:

- Reduce the transmission of and morbidity and mortality associated with sexually transmissible infections (STI) in Australia;
- Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health; and
- Mimise the personal and social impact of STI.

The South Australian Sexual Health Services Review (the Review) was commissioned by SA Health at the request of the South Australian STI and Blood Borne Virus (BBV) Advisory Committee (SASBAC) in the context of:

- Rates of notifiable STI and associated disease burden increasing significantly both in South Australia (SA) and nationally over the past decade, with these impacts disproportionately borne by some priority populations[†].
- Evidence that improving access to sexual health care and reducing time from STI acquisition to effective treatment is the most impactful and viable prevention strategy to address these trends.
- Increasing challenges to accessing sexual health care across specialist and primary care settings.
- Existing barriers to accessing sexual health care were compounded during the COVID-19 pandemic. Reductions in testing during the period 2020-2022 have prompted concerns regarding levels of undiagnosed, untreated STI circulating in the community in SA and nationally, and potential for further increases in transmission and complications associated with delayed diagnosis and treatment.

This is the first time that SA's sexual health system has been externally evaluated. RPR Consulting undertook the review in 2022 in close consultation with a Project Advisory Group (see Appendix 2 for membership).

The final report was submitted to the Communicable Diseases Control Branch (CDCB) in December 2022. Department Executive was briefed in July 2023, the Health Chief Executive Council (HCEC) was briefed in August 2023, the Minister for Health and Wellbeing was briefed in September 2023, and SASBAC was briefed in November 2023.

Aims and methods

The Review aimed to inform work towards an optimal statewide model of sexual health services based on contemporary evidence, expert advice, and clinical, consumer and community needs, including future commissioning and coordination of publicly funded sexual health services in SA.

Over 160 people participated in the Review from more than 30 organisations, including clinicians, community stakeholders (from community-based organisations, and people from priority populations) and government agencies.

A mixed methods approach was applied and included key informant interviews and focus group discussions, as well as secondary data analysis drawing on epidemiological, health service activity and funding data, and service mapping.

The final phase of the Review involved co-design, review and testing the model with the Project Advisory Group and key informants.

[*] Australian Government Department for Health and Aged Care, 2019, *Fourth National Sexually Transmissible Infections Strategy 2018-2022,* Canberra.

[†] Including young people, First Nations people, men who have sex with men, sex workers, people from culturally & linguistically diverse communities, travellers and migrant workers, people who are trans and gender diverse, people who use drugs, and people experiencing housing insecurity.

Key findings

The first key finding was that **"SA's sexual health system needs strengthening to contain epidemics and reduce the disease burden associated with STI"**.

SA did not achieve the goals and targets of the 'South Australian STI Implementation Plan 2019-2023', nor its commitments to successive National STI Strategies, with the sustained rising prevalence and disease burden of STI, and the inequitable impacts of STI on some populations.

The Review highlights evidence that while escalation of STI epidemics is multi-factorial, improving access to sexual health care and reducing time from acquisition of an STI to treatment (and therefore infection duration) can have a powerful effect on health outcomes including risk of disease progression and onward transmission, and that efforts to strengthen the system should be aligned with these fundamentals.

Sexual health services must be accessible to all sexually active people – geographically, socially and culturally, logistically and financially, and linked to people's regular points of care, when this is what clients prefer.

Further, a system that delivers safe and high-quality sexual health care will:

- ensure strong mechanisms for leadership and coordination across services
- facilitate timely access to training and clinical guidance
- use data and research to inform practice at a service and system level.

The Review found that the foundations of SA's sexual health system are strong and importantly that there are examples of best practice across the system.

However, the system is currently not operating at the scale required to adequately respond to current STI epidemics. This also poses significant challenges to the state's capacity to respond to future and emerging threats (e.g. mpox and other novel sexually transmissible pathogens).

As a result, South Australians experience barriers to accessing sexual health care across specialist and primary care settings, with particular disparities for some populations.

The second key finding was that **"modernisation of SA's sexual health system is possible".**

The Review recognises that despite the significant risks reported currently, many of the essential components of an effective sexual health system already exist in South Australia. There are existing high quality services in SA that have the expertise to shape an effective and sustainable health system response to contain STI epidemics. These services, and other success stories from across the state, are highlighted throughout this report and in the Review.

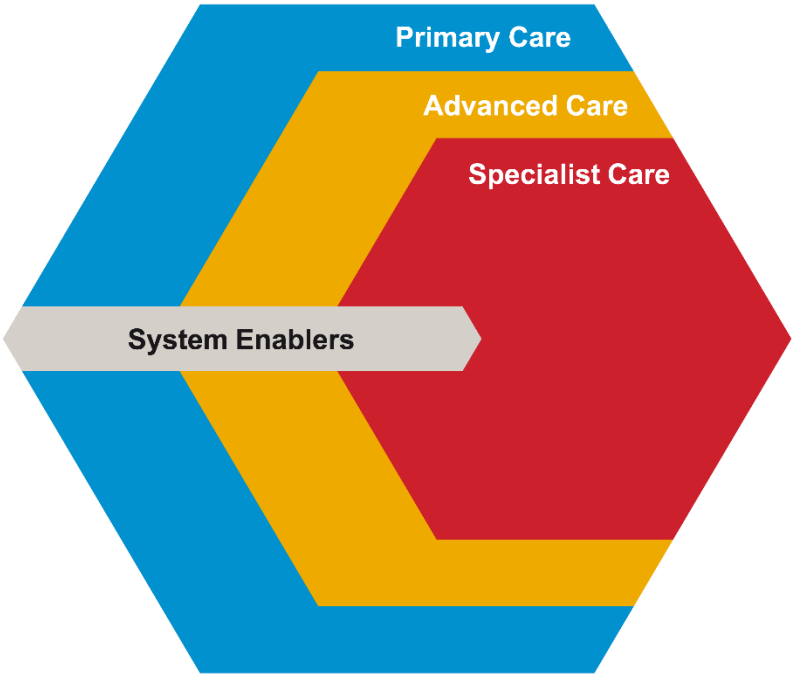
Further, as a smaller state with a well-coordinated sexual health services sector based on strong and long-standing partnerships between community, clinical and government services, South Australia is well positioned to build from this strong foundation, trial new or scale up existing effective models, and strengthen weaker elements of the system within a short period of time (Figure 1).

The Review provides a suite of practical recommendations and a roadmap for the South Australian health system to deliver on this, minimise the downstream health, social and economic impacts of these infections, and to improve sexual health outcomes for South Australians[‡]. These recommendations are evidence-based and expert informed, and in many cases, reflect existing practice in other jurisdictions or for other health issues within SA.

With timely, strategic attention given to these areas, the Review finds that such a transformation is both realistic and achievable.

[‡] For further information about the burden associated with STI in SA please refer to the Review final report.

Figure 1: Recommended South Australian Statewide Sexual Health Model of Care



	Services	Who for	Who provides
Primary care	• Low complexity SRH care inc. STI testing and clinical management • Referral to specialist if required.	• Entire community.	• Mainstream GPs
Advanced care	• Medium complexity SRH care inc. STI testing and clinical management • Referral to specialist if required.	• Priority populations and medium complexity care.	• HIV S100 prescribers and other specialist GPs (inc. O'Brien Street GP). • Key clinical services accessed by priority populations (e.g. ACCHS).
Specialist care	• High complexity SRH care inc. STI testing and clinical managment • Research and innovation.	• Priority populations and high complexity care.	• Adelaide Sexual Health Centre • SHINE SA
System enablers	• System leadership • Strategy and governance • Education for communities • Coordination and capacity building for health services • Surveillance, complex case management, partner notification.		• CDCB • Aboriginal Health Council of SA • Adelaide Sexual Health Centre • SHINE SA • Other STI/BBV NGOs.

Acronyms

ACCHS	Aboriginal Community Controlled Health Services
BBV	blood borne virus/es
CDCB	Communicable Disease Control Branch
GP	general practice/practitioner/s

inc.	including
NGO	non-government organisation/s
STI	sexually transmissible infection/s
SRH	sexual and reproductive health

Recommendations

The Review provides recommendations under eight 'shifts' to strengthen the South Australian statewide sexual health model of care (Figure 2), and build a system that is efficient, effective and fit for the current and future needs of the South Australian population.

As noted in the Review, these shifts are highly interdependent, and mutually reinforcing.

Figure 2: Eight 'Shifts' Recommended by the Review

Shift 1 | Strategy: Set an overarching vision for an integrated SRH system.

Shift 2 | STI Control: Strengthen surveillance, complex case management, and partner notification functions.

Shift 3 | Specialist Services: Empower specialist services to lead the system.

Shift 4 | Innovation: Innovate and diversify models of sexual health service delivery.

Shift 5 | Inequity: Address geographical and other forms of inequity of access to sexual health care.

Shift 6 | Primary Care: Invest in the enablers for primary care to play an enhanced role in sexual health care.

Shift 7 | Governance: Strengthen statewide governance of the system.

Shift 8 | Prevention and Health Promotion: Strengthen prevention and health promotion.

The Review envisaged that all recommendations would be implemented over a three-to-five-year period, providing South Australians with:

- A best-practice, integrated SRH policy framework.
- A public health unit and specialist sexual health services which are adequately equipped to lead a statewide sexual health system and address South Australian SRH needs, with a focus on addressing inequity.
- Dedicated capacity to address sexual health service needs in each Local Health Network (LHN), with a focus on expanding access arrangements in outer metropolitan, rural and regional areas.
- Enhanced supports in place for delivery of sexual health care in primary care settings.
- Expanded capacity for community-based testing and treatment through support for new and innovative models of sexual health service delivery, co-designed and delivered with clinicians and community-based organisations.
- Increased awareness and understanding of STI as part of sexual and reproductive health, and access to evidence-based primary prevention strategies.

The Department for Health and Wellbeing (DHW) agrees in principle with all recommendations.

However, it is noted that:

- The Review did not specify the quantum nor source of funding required to implement recommendations as this was not in scope. Further work will need to be undertaken to identify the optimal and most cost-effective solution(s), provide greater clarity on service configurations, and sources of funding for each recommendation.
- The varied scale and complexity of recommendations has been carefully considered by DHW, and the timeframes proposed by the Review were deemed to be unfeasible. The revised list provided below indicates the order in which implementation is realistically likely to be achieved. It does not indicate when work towards specific recommendations will commence, this will be determined by SASBAC. Implementing the Review recommendations will involve multi-agency collaborative work. Several recommendations involve establishing new partnerships in SA with agencies for whom sexual health has not been a key focus, and with stakeholders from the Commonwealth and potentially other jurisdictions.

DHW proposes the following consolidated list of recommendations and SA Health lead agencies for progressing this work (Figure 3).

Other key stakeholders/partners for each shift are identified within the relevant sections of the DHW Extended Response Report.

Figure 3: SA Sexual Health Services Review consolidated recommendations in proposed order of implementation, and SA Health lead agency

Recommendation	SA Health Lead Agency
Shift 2 | Strengthen STI surveillance, complex case management, partner notification and system leadership functions.	• Public Health Division and Adelaide Sexual Health Centre
Shift 8 | Undertake a strategic review of the South Australian government's approach to primary prevention and health promotion in sexual health and commence work to address any gaps identified.	• Public Health Division
Shift 7 | Develop appropriate statewide policy and governance arrangements, outlining minimum requirements for access to sexual health care across all Local Health Networks (LHN), and a coordination mechanism for clinical services which comprise the SA sexual health system model of care.	• Public Health Division and Local Health Networks
Shift 3 | Scope and commission expansion of specialist services to lead the SA sexual health system and enhance coordination across specialist services.	• Public Health Division and Local Health Networks
Shift 4 | Scope and commission an online STI and BBV testing service.	• Public Health Division and Local Health Networks
Shift 5 | Scope and commission expanded access arrangements and pathways to address sexual health service needs in each LHN, tailored to the local population and health service landscape, and integrated into the statewide sexual health services system.	• Public Health Division and Local Health Networks
Shift 6 | Strengthen support for delivery of sexual health care in primary care, ensuring a coordinated national approach to this issue.	• Public Health Division

Shift 1 | Transition from the current disease-centric STI Strategy towards a Sexual and Reproductive Health (SRH) Strategy to guide a sustainable, long-term, integrated policy and programmatic response to population SRH needs.

SA Health Lead Agency

- Public Health Division and Local Health Networks

Governance

The South Australian STI and BBV Advisory Committee (SASBAC) is the peak advisory structure for the state's response to HIV, STI and viral hepatitis through partnership between government, non-government organisations, researchers, clinicians and affected communities.

DHW proposed prioritisation and governance arrangements to progress Review recommendations (Figure 3) have been endorsed by SASBAC.

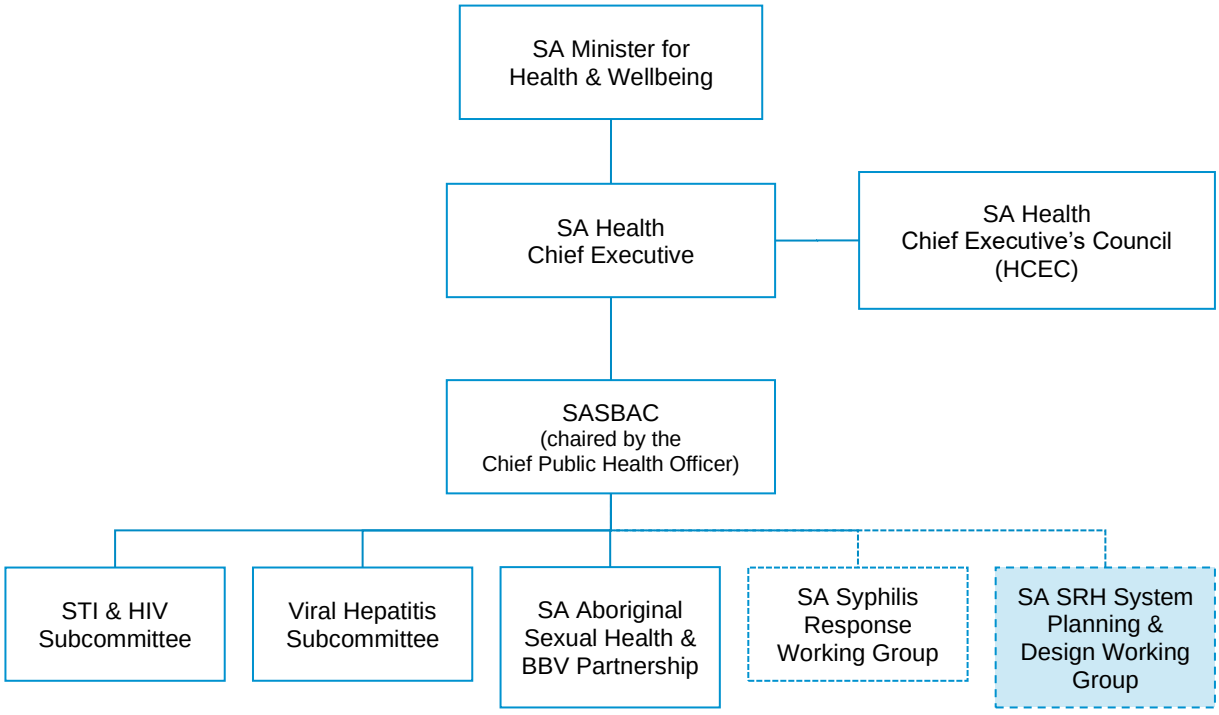
A SA Sexual and Reproductive Health (SRH) System Planning and Design Working Group (Working Group) of SASBAC will be established to coordinate further work to progress the recommendations of the Review (Figure 4).

Aim: The Working Group will develop a series of more detailed and costed business cases to strengthen the South Australian sexual health services system, for consideration by SASBAC and through SA Health commissioning processes. These proposals will be aligned with the Review recommendations and progressed in order of priority. This work will inform future commissioning and coordination of sexual health services in SA.

Chair: The Working Group will be chaired and coordinated by the Communicable Disease Control Branch (CDCB), SA Health.

Membership: The Working Group membership will be appointed by SASBAC and will comprise agencies and individuals from SASBAC and its subcommittees, as well as external agencies and individuals with expertise required to progress this work, as required.

Figure 4: Governance of the South Australian public health response to HIV, STI and viral hepatitis



Communicable Disease Control Branch

DHW Extended Response Report

South Australian Sexual Health Services Review:
Department for Health and Wellbeing Response

February 2024

Government of South Australia
SA Health

Contents

DHW Response to Shift 1 | Strategy

Shift 1: Set an overarching vision for an integrated sexual and reproductive health system
1. Establish a statewide integrated strategic framework for sexual and reproductive health. *For more detail, refer to Appendix 1, Recommendations 1.1.1 to 1.1.2.*
DHW Response
Agree in principle. Timeframe needs to be revised and further consultation with key stakeholders across relevant policy areas is required to determine optimal arrangements.

Rationale

- The development of a comprehensive, integrated statewide sexual and reproductive health (SRH) strategy for South Australia would represent a significant shift from current fragmented policy arrangements for STI control and SRH at both a state and national level, and an important step towards improved SRH outcomes for South Australians.
- A mature statewide sexual health strategy must be comprehensive and holistic in its ambit, focused on SRH and wellbeing and addressing stigma in relation to SRH care, including but not limited to STI control.
- A revitalised strategy should leverage key health system components to align disease specific and SRH care efforts at the policy, programmatic and service delivery levels. It must influence meaningful structural reform across the health system and avoid becoming a superficial marketing or rebranding exercise.

Relevant models and approaches locally and in other jurisdictions

Integrated SRH policy and service delivery is recognised internationally as best practice:

- The World Health Organization's (WHO) 'Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030' identifies several strategic and operational shifts to end STI and BBV as public health concerns by 2030, including to 'increase integration of STI services with primary health care, sexual and reproductive health, family planning, adolescent health, and HIV services'.[1]
- In its policy position on sexual health, the United Kingdom's (UK) Association of Directors of Public Health recommends a whole systems approach, bringing together the reproductive health, sexual health and HIV sectors, to achieve joined up strategic and program planning, commissioning, health promotion and, ultimately, integrated services. It emphasises that attempts to tackle SRH issues in isolation will lead to siloed working and will not optimally support people's experiences of SRH.[2]

The UK have adopted integrated SRH policy frameworks, including the 'Framework for Sexual Health Improvement in England' released in 2013, which committed to tackling stigma, reducing unwanted pregnancies, reducing the rate of HIV and STI, and promoting integration and value for money.[3]

Within Australia, the Victorian Government conducted a review of the state's sexual health and service needs in 2019, the findings of which emphasised that service and system integration is crucial to offering patient-centred, holistic SRH care, irrespective of geographical location or priority population. Last year it introduced the 'Victorian sexual and reproductive health and viral hepatitis strategy 2022-30', with seven accompanying plans (systems enablers, Aboriginal SRH, hepatitis B, hepatitis C, HIV, STI and women's SRH).

In SA, SHINE SA is already delivering an integrated model for sexual and reproductive health services (including clinical services, education and capacity building programs targeting clinicians and members of the community) that is aligned with this best practice framework.

Prioritisation

Prioritisation to be confirmed following consultation with SASBAC and other key stakeholders.

While this recommendation is a high priority, the timeframe proposed by the Review to implement this recommendation, 12 months, is unfeasible given the extent of planning and consultation that will be required to develop a holistic statewide SRH strategic framework that can meaningfully influence system strengthening and reform, rather than a superficial re-branding exercise.

It is proposed that this work should instead occur over a longer time period, coinciding with timeframes for renewal of state and national STI strategies.

It is proposed that once the 'Fifth National STI Strategy 2024-2030' is finalised, SASBAC will explore opportunities for a more holistic statewide SRH Strategy. This work will guide a sustainable, longer-term policy and programmatic response to population SRH needs. To be determined by SASBAC, the foundations for this may be laid within the next state implementation plan for the 'Fifth National STI Strategy 2024-2030'.

Actions to date

N/A

Key stakeholders

SA Health:	CDCB, LHNs (including the Women's and Children's Health Network (WCHN)), Preventative Health SA.
Committees:	SASBAC.
Others:	Government agencies working in reproductive health, family planning services, primary care providers, consumers from priority populations (see Shift 7 | Governance for suggested approaches for engaging).

References

[1] *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030*. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO. https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/strategies/global-health-sector-strategies.

[2] The Association of Directors of Public Health (2019). *Policy Position: Sexual Health*. United Kingdom. https://www.adph.org.uk/resources/policy-position-sexual-health/.

[3] Department of Health (2013). A Framework for Sexual Health Improvement in England. London, United Kingdom. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf.

DHW Response to Shift 2 | STI Control

Shift 2: Strengthen surveillance, complex case management, and partner notification functions

2. Expand STI and BBV surveillance and intelligence functions.
3. Expand and reinvigorate the approach to STI partner notification and complex STI case management.

For more detail, refer to Appendix 1, Recommendations 2.1 to 3.3.

Also see:

- Shift 3 | Empower specialist services to lead the system
- Shift 4 | Innovate in sexual health service delivery
- Shift 5 | Address the significant inequity of access to sexual health care
- Shift 6 | Invest in the enablers for primary care to play an enhanced role in sexual health care.

DHW Response

Agree in principle.

Further work will need to be undertaken to identify the optimal and most cost-effective solution(s) and source of funding.

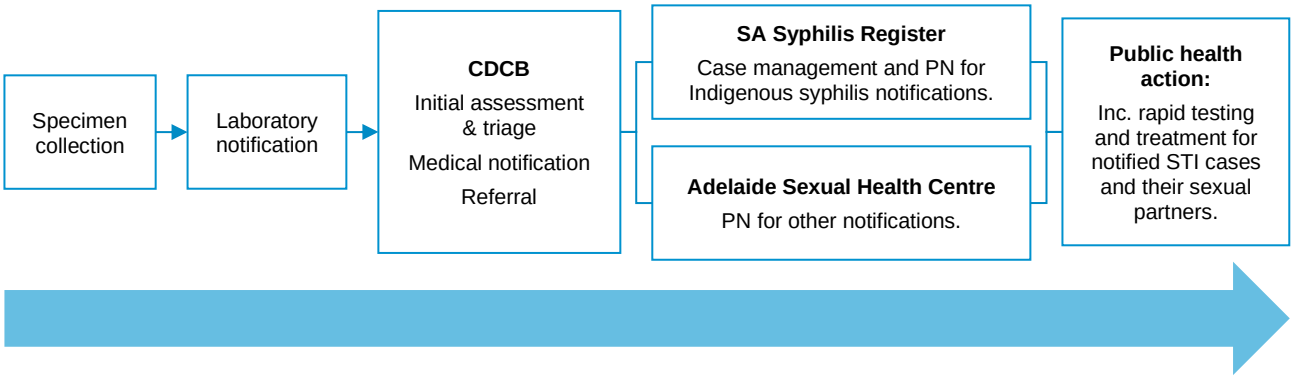
Rationale

The Review highlights strong evidence for the important role of STI surveillance, complex case management and contact tracing/partner notification (PN) in protecting South Australians from escalating risk of STI related morbidity and mortality.

These functions (Figure 5), which are currently delivered by the Communicable Disease Control Branch (CDCB) and Adelaide Sexual Health Centre (ASHC), influence outcomes at an individual and population level through:

- analysis of epidemiological trends to inform strategy and service planning;
- ensuring timely linkage to care following notification of HIV and STI cases to the CDCB; and
- follow up testing for sexual partners of known HIV and STI cases.

Figure 5: South Australian HIV and STI case and contact management pathway, 2023



The Review recommends strengthening these functions (including systems and human resources), and that this should be addressed as a priority. The Review finds that despite increasing volume and complexity of STI diagnoses notified to CDCB, STI surveillance and epidemiology functions have remained static, and there has been a decline in the state's STI PN capacity (a fundamental function of STI control[1]).

Proactive PN approaches to facilitate testing and treatment of sexual partners are strongly supported by evidence.[2] As PN caseload increases there is increasing risk of delays to follow up and poor outcomes including disease progression and onward transmission.

In May 2023, ASHC's STI PN service reported >100 active cases under investigation. ASHC has a dedicated staff member (1.0FTE) responsible for PN. ASHC's STI PN service advises that a workload of 30-50 active cases per PN officer is considered safe to manage, and under current funding arrangements is unable to invest more in this area.

Capacity constraints have also limited the ability of ASHC and CDCB to trial new and innovative PN approaches, including use of dating apps and social media, or build systems to better support diagnosing clinicians to conduct their own PN.

Relevant models and approaches locally and in other jurisdictions

- Sexual Health Infolink (SHIL) is a statewide, nurse-led, NSW Health service. The service has been delivered by sexual health nurses since 1989 and handles on average 10,000 calls per year. SHIL supports health professionals and members of the public with complex partner notification. It also supports health care workers in NSW by providing clinical advice on STI and BBV testing and clinical management guidelines, clinical support for post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) prescribing, specialist HIV and syphilis support, and referral to sexual health and infectious diseases specialists. The service also provides the NSW public with information about STI and BBV, including STI testing, HIV PEP and PrEP, sexual health risk assessments, and referral to and/or booking sexual health services.[3]
- The Victorian health department's VICS team (Victorian Investigation of Complex STI team) employs a team of partner notification officers who are registered nurses with significant expertise and experience in sexual health, HIV, mental health and drug and alcohol issues. They are also authorised officers under *Victoria's Public Health and Wellbeing Act 2008*. VICS partner notification officers two main roles are HIV and STI partner notification and complex case management for people living with HIV (PLHIV) and people who have been diagnosed with syphilis. During 2021, the VICS team followed up 335 women with infectious and late syphilis, of whom 21 were pregnant and more than half would likely not have been treated adequately for syphilis in pregnancy.[4]
- In Western Australia (WA), population/public health units (based in metropolitan Perth, as well as seven units across regional WA) undertake partner notification and link index cases and sexual contacts of a person diagnosed with an STI (particularly HIV, syphilis and antimicrobial resistant gonorrhoea) into treatment when individuals are reluctant to or do not comply with advice from their primary health care provider.[5]

Prioritisation

Prioritisation to be confirmed following consultation with SASBAC and other key stakeholders.

Actions to date

Recommendations 2 and 3: Since the Review was received, the Public Health Division has worked on defining the value proposition and requirements for STI surveillance, case management and partner notification capacity to ensure these are aligned with contemporary population health needs. To this end:

- CDCB staff have worked extensively within existing resources to optimise STI surveillance, case management and partner notification systems to meet the growing volume and complexity of workload, and ensure SA continues to meet or exceed national benchmarks. This work has been ongoing, occuring prior to and in parallel with the Review.
- In addition, during 2023 two time-limited positions were appointed within the CDCB to undertake a 'Surveillance and Systems Planning' project. Through this project, opportunities to enhance CDCB surveillance systems were identified in the context of all notifiable conditions including, but not limited to, STI and BBV. It is noted that implementation of improvements identified through this project may have resource implications. Work is currently underway to address this.

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Recommendations 2 and 3: In addition to strengthening capacity, there is also a need to define the scope and responsibilities of agencies working in surveillance, case management and partner notification functions to ensure that:

- processes and outputs meet nationally and locally agreed minimum standards
- this work is prioritised appropriately based on level of risk
- work across agencies is complementary and optimises population health outcomes.

To address this need, CDCB and ASHC have collaborated to develop a statewide PN agreement. PN priorities are subject to shift dependant on notification trends and the future resourcing of PN in SA.

Key stakeholders

SA Health:	CDCB, ASHC.
Committees:	SASBAC.
Others:	SHINE SA, other services providing STI testing (including General Practice, Aboriginal Community Controlled Health Services, hospital services, prison health services, alcohol and other drug services, migrant and refugee health services, travel medicine, university health services, etc).

References

[1] Golden Matthew R., Gibbs Jo, Woodward Charlotte, Estcourt Claudia S. (2022) 'Priorities in the implementation of partner services for HIV/STIs in high-income nations: a narrative review of evidence and recommendations'. *Sexual Health* 19, 309-318. https://doi.org/10.1071/SH22060.

[2] Schierhout G, Guy R, Donovan B, Kaldor J. *Evidence review for NSW Sexually Transmissible Infections (STI) Strategy: an Evidence Check rapid review*, brokered by the Sax Institute for the Centre for Population Health, NSW Ministry of Health, October 2015. Access online: https://www.saxinstitute.org.au/evidence-check/evidence-review-for-nsw-sexually-transmissible-infections-sti-strategy/#:~:text=This%20Evidence%20Check%20review%20reports,and%20prevention%20of%20re%2Dinfection.

[3] *Sexual Health Infolink*. NSW Health. New South Wales. Australia. Access online: https://www.shil.nsw.gov.au/.

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[5] 'Contact tracing'. *Silver book – STI/BBV Management Guidelines*. (2020) Sexual Health and Blood-borne Virus Program, Department of Health, Government of Western Australia. Access online: https://www.health.wa.gov.au/Silver-book/Contact-tracing-managing-sex-partners.

DHW Response to Shift 3 | Specialist Services

Shift 3: Empower specialist services to lead the system

Specialist sexual health services

4. Articulate the respective clinical and leadership roles of Adelaide Sexual Health Centre (ASHC) and SHINE SA in statewide sexual health care delivery.
5. Increase the quantum of funds, and update the funding model, to enable ASHC and SHINE SA to deliver on agreed outcomes.
6. Further strengthen collaboration between ASHC and SHINE SA.
7. Continue to develop ASHC and SHINE SA as multi-disciplinary centres of excellence with staff working at the top of their scope of practice.

Capacity building for Aboriginal Health Services

8. Increase the capacity of the SA Aboriginal Sexual Health and Blood Borne Virus Program (delivered by AHCSA) to provide system leadership and coordination for delivery of sexual health care within their member Aboriginal Community Controlled Health Services and in other priority settings accessed by Aboriginal and Torres Strait Islander people.
9. Strengthen coordination and collaboration between AHCSA, NACCHO and their member services to ensure a robust and accessible sexual health system for Aboriginal and Torres Strait Islander people.

For more detail, refer to Appendix 1, Recommendations 4.1 to 9.1.

DHW Response

Agree in principle.

Further work will need to be undertaken to identify the optimal and most cost-effective solution(s) and source of funding.

Rationale

SA's specialist SRH services, Adelaide Sexual Health Centre (ASHC) and SHINE SA, are well positioned to lead reform of the state's sexual health system.

However, these services report increasing challenges meeting demand for sexual health care, which will need to be addressed for them to fully deliver on the system leadership and capacity building function envisaged by the Review.

- Responsibility for providing specialist care, clinical leadership and building capacity for the broader SA sexual health system should continue to be vested with ASHC and SHINE SA as the leading providers of sexual health services in SA.
- To ensure an integrated approach, there will be a need for close coordination and collaboration between these two organisations to clarify and delineate scope and roles, increase complementarity, and reduce risk of duplication.
- Since 2011, SHINE SA's core agreement with SA Health has been cumulatively reduced by more than 20%. This led to the closure of multiple SHINE SA clinics in Adelaide's outer metropolitan suburbs, and of their online STI testing service. In 2018, SHINE SA were instructed to further optimise Medicare billing for clinical services to increase revenue, and prioritise SA Health funding for delivery of sexual health education and workforce development programs. However, increasing challenges to delivery of sexual health care across all Medicare funded health services are highlighted throughout the Review. Subsequent reviews of SHINE SA's clinical services model, including an independent review, have confirmed that there are limited opportunities for SHINE SA to further optimise revenue through Medicare billing.
- The Review recommends substantial changes to ASHC's funding arrangements and service delivery models. Over the past five years, ASHC has faced increasing challenges meeting demand associated with STI control and rollout of HIV PrEP, culminating in increasing restrictions on

populations who can access the service. In addition, constraints related to ASHC's activity-based funding model have hindered its ability to fulfil its remit as a statewide service.

Optimal models of care and service configurations should be clearly defined through the development of more detailed, costed business cases for expansion of specialist sexual health service capacity in SA.

- The Review recommends that multidisciplinary, person-centred models of SRH care, in particular nurse-led models and Aboriginal Health Practitioner/Worker-led models, should be central to any efforts to expand capacity of specialist sexual health services in SA, with a view to ensuring staff within these services are supported to work to the full scope of their practice.
- As a small state, SA is well positioned to rapidly pilot and scale up efficient models of SRH care. SA is leading the nation in progress towards hepatitis C elimination. A key factor in this success has been the strategic investment in a flexible statewide nurse-led model of care, and robust coordination mechanisms to leverage maximum impact out of these investments.[1,2]

In addition to SHINE SA and ASHC, the Aboriginal Health Council of SA (AHCSA) is also identified as a specialist service within the Review, through its role providing SRH system leadership and coordination for delivery of sexual health care to Aboriginal and Torres Strait Islander people across SA Aboriginal Community Controlled Health Services (ACCHS). There is robust evidence underpinning the impact and continuing need for this program. In addition, continued investment in relationships between all key stakeholders for Aboriginal sexual health in SA will also be critical, to ensure that State and Commonwealth Government programmatic investments in this space are cohesive, strengths-based and not duplicative, aligned with locally determined needs and strategies, and underpinned by authentic engagement.

Australia's university and research sector provides important strategic leadership in HIV and sexual health, insights into population health needs and epidemiological trends, and a vehicle to trial innovative models of service delivery. There are opportunities to improve links between this sector and specialist sexual health services in SA, and to build capacity within the university and research sector in SA to play a more active role in this area of public health.

To realise this vision and ensure that SA is positioned at the cutting edge of sexual health service delivery, ASHC, SHINE SA, AHCSA and CDCB should invest in strengthening partnerships with universities and research institutes both in South Australia and nationally and engage more strongly in the design and implementation of collaborative national sexual health research projects, including clinical trials and implementation research.

Relevant models and approaches locally and in other jurisdictions

The World Health Organization's (WHO) 'Global Health Sector Strategies 2022-2030' emphasise that to end STI epidemics, there is a need to 'vastly scale up primary prevention and increase access to screening for STI' and that 'sufficient financing for STI services as part of national health financing mechanisms' must be ensured.[3]

The Review considered several models of care for STI screening and SRH service delivery which have been favourably evaluated in SA and other jurisdictions. These include nurse-led and express clinics, point of care testing, and community based, peer-led models. Under Shift 4 | Innovation, examples of digital platforms for sexual health service delivery (integrated with specialist services) that have been introduced in other jurisdictions are also provided for consideration.

Nurse-led sexual health care models are commonplace and heavily utilised in the United Kingdom (UK)[4]. Greater involvement of nurses in STI screening in primary care[5], the provision of PrEP[6], and the provision of sexual health care in correctional settings[7] is strongly supported by available evidence. The findings from a study currently underway in rural and regional Australia (the ORIENT study), which is evaluating the provision of long-acting reversible contraceptives and medical abortion via nurse-led models of care, task sharing and telehealth, will also be pertinent to informing the design of similar models of care in SA.[8]

While South Australian SRH services have collaborated with the research/tertiary education sectors on a number of HIV and STI related projects, there has been greater investment in these partnerships in other jurisdictions, with flow on benefits including growth in sector capacity.

Examples include the:

- Western Sydney Sexual Health Centre, an amalgamation of Paramatta and Mt Druitt Sexual Health Clinics and University of Sydney's STI Research Centre funded by NSW Health
- Melbourne Sexual Health Centre's strong research and education ties with Monash University and University of Melbourne
- Centre for Excellence in Rural Sexual Health at Melbourne Medical School
- Melbourne School of Population and Global Health's Sexual Health Unit
- Kirby Institute's HIV, sexual health and viral hepatitis program streams, University of New South Wales (UNSW)
- Australian Research Centre in Sex, Health and Society, La Trobe University
- Centre for Social Research in Health, UNSW
- Burnet Institute.

Prioritisation

Prioritisation to be confirmed following consultation with SASBAC and other key stakeholders.

Actions to date

Recommendation 5: ASHC is exploring opportunities to have its designation and funding arrangements reviewed – as despite functionally operating as a statewide service, it is not funded in the same way as other statewide SA Health services*. This restricts the type and scale of services it can deliver.

Recommendation 8 and 9: AHCSA's Sexual Health and BBV Team delivers specialist training in Sexual and Reproductive Health for Aboriginal health workforce, in conjunction with the AHCSA Registered Training Organisation (RTO) Team. There is a need to continue to promote and enhance this valuable capacity building work.

Additional time-limited State and Commonwealth enhancement funding has been allocated to build capacity for delivery of Aboriginal sexual health programs in SA. Work is underway to sustain these arrangements.

There has also been substantial work undertaken to strengthen Aboriginal led governance of the public health response to STI and BBV in SA, and coordination between services working in this space.

Key stakeholders

SA Health:	CDCB, ASHC, Commissioning and Performance Division, Procurement and Supply Chain Management.
Committees:	SASBAC, Australian Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS).
Others:	SHINE SA, AHCSA, National Aboriginal Community Controlled Health Organisation (NACCHO), ACCHS, university and research sector.

* SA Health's statewide services include: BreastScreen SA, Drug and Alcohol Services SA, SA Ambulance Service, SA Dental, SA Pathology, SA Pharmacy and the Statewide Eating Disorder Service.

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DHW Response to Shift 4 | Innovation

Shift 4: Innovate and diversify models of sexual health service delivery
10. Design and implement a model of care for online STI and BBV testing that is appropriate for the needs of South Australians. *For more detail, refer to Appendix 1, Recommendations 10.1 to 10.6.*
DHW Response
Agree in principle. Further work will need to be undertaken to identify the optimal and most cost-effective solution(s) and source of funding.

Rationale

Access to testing is a key pillar of HIV and STI control.

Australian research provides evidence of the importance of increasing access to testing to ensure timely diagnosis and reduce STI (particularly HIV and syphilis) prevalence and risk of disease progression, including modelling to inform targets for testing coverage in some populations.[1,2,3]

A recent review on the cost effectiveness of HIV and STI prevention in high income countries also provides evidence to support the expansion of screening services and treatment as prevention (TasP), with differing frequency of testing recommended in some populations. The authors note that this is a crucial strategy to reduce risk of HIV and STI transmission, disease progression, and downstream health, social and economic impacts.[4]

To this end, there is a need to invest in innovative and diverse models for access to SRH prevention, testing and care to modernise the sector, create greater choice for consumers, and address inequity in access to services in SA.

Online and home-based STI testing models are highlighted in the Review as a particularly salient option given the state's geography and population distribution, the concentration of specialist services in the inner Adelaide metropolitan region, suboptimal access to SRH care in outer metropolitan, rural and regional areas, and increasing out of pocket costs for SRH care in primary care settings.

Online testing models are discreet and can help overcome barriers associated with accessing screening, particularly for people from priority populations and individuals who experience discomfort or embarrassment in seeking our sexual health care[5], or who do not wish to be tested by their regular primary care provider[6].

As the Review identified, there is significant interest in online testing models nationally and internationally, and while there are a small number of private providers operating in SA, these are associated with high out of pocket costs, pointing to the need for a more accessible publicly funded service. Due to funding constraints SHINE SA decommissioned its Online Chlamydia Initiative in 2018, despite evidence of high acceptability and yield.

These recommendations are nationally salient. Therefore, opportunities for collaboration between jurisdictional and Commonwealth governments on a national digital sexual health platform integrated with local services should be considered. DHW recommends exploration of opportunities for national collaboration on translational research to identify and scale up optimal models of online based SRH, and evaluate patient outcomes and/or experiences.

Relevant models and approaches locally and in other jurisdictions

The UK's Association of Directors of Public Health recommends that sexual health commissioners and services embrace the introduction of evidence-based innovative technologies and digital services, ensuring that these initiatives are adequately and sustainability resourced.[7]

The UK's SH:24 service provides free and confidential online sexual health services.

The SH:24 model was developed between public health and National Health Service specialist services and provides testing for STI, online chlamydia treatment, clinical support, and contraception, including emergency contraception, 24 hours a day.[8]

Online testing now accounts for around half of all HIV and STI tests conducted annually in England, demonstrating the acceptability and scalability of such models (Figure 6 and Figure 7).

Figure 6: Chlamydia tests from internet and face to face testing and total diagnoses among women aged 15 to 24 years, 2018 to 2022, England[9]

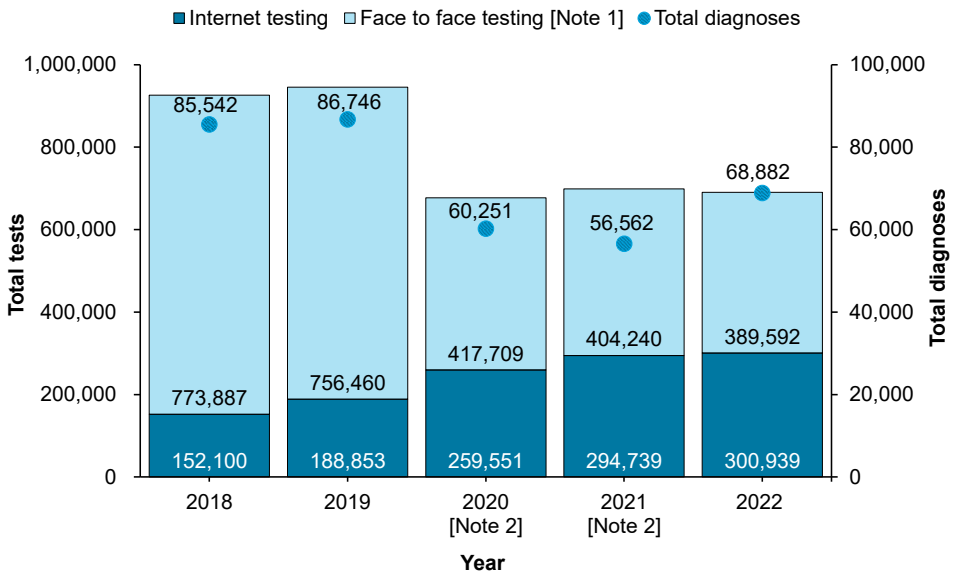
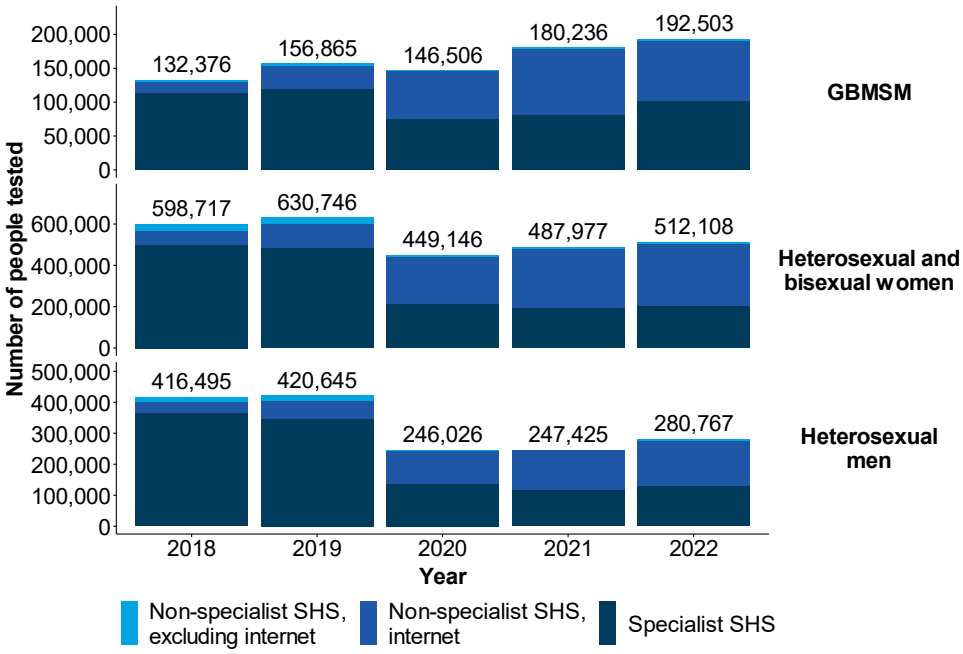


Figure 7: Number of attendees tested for HIV at all sexual health services (SHS) by service type, gender and sexual orientation, England, 2018 to 2022[10]



Note: Different scales are used on the y-axes of the graphs in Figure 7.

Mirroring the UK's model and utilising the UK's 'SH:24' digital platform, the Republic of Ireland's Health Service Executive, Sexual Health and Crisis Pregnancy Programme, launched a free national online STI testing service in 2022, which provides people aged 17 and older the option to test at home.[11]

NSW Health are currently undertaking consultation to inform the development of their proposed new statewide online STI and BBV testing service.[12]

Melbourne Sexual Health Centre's 'TESTme' service provides free and confidential urine testing and genital swabs for males to test for chlamydia and gonorrhoea (as well as treatment for positive tests) by mail. The service is for Aboriginal and Torres Strait Islander people, and young people aged 25 and under and MSM from rural Victoria.[13]

Similarly, Queensland's '13 HEALTH Webtest' provides free urine testing for genital chlamydia and gonorrhoea for people aged 16 years and older. Tests can be ordered online and without a Medicare card.[14]

Australian research is currently underway to explore the acceptability of online testing among priority populations, the findings of which can inform the development of innovative models in SA:

- The Kirby Institute's 'MOST (More Options for STI Testing) Study'– aims to provide new ways to increase the frequency of STI testing and will trial two innovative strategies with young people in remote Aboriginal communities in Central Australia, including a model that will enable people to test without visiting a clinic.[15]
- The Univeristy of Melbourne's 'Digital Sexual Health Hub Study' – will develop an online STI testing clinic that is co-designed with young people under age 30. The online clinic will provide STI testing, treatment prescribing, and partner notification, as well as links to sexual health information and resources. The project will assess STI testing and diagnosis rates, user experience, and cost-effectiveness.[16]

Access to PrEP via online models has been introduced in New Zealand, Australia and the US:

- Burnett Foundation Aotearoa partners with MedOnline (a GP telehealth service) to provide access to HIV PrEP online via their website. Users answer six screening questions and, if eligible, are directed to the MedOnline website to book a virtual appointment. The consultation includes lab test forms and forwarding the prescription to a pharmacy if the results indicate PrEP is suitable. The advantage of this approach is that it allows people to take action immediately without leaving their homes (Spina 2023).[17]
- Two private Australian providers have established similar online services – PrEP.Health and PrEP Connect.[17]

Prioritisation

Prioritisation to be confirmed following consultation with SASBAC and other key stakeholders.

To mobilise an online STI and BBV testing model in SA, systems level planning and cost-effectiveness analysis will be vital. In scoping an online model, the following will need to be considered:

- A variety of online testing models exist and should be assessed for suitability in the SA context. Contemporary research conducted in Australia and overseas, and consultation with local key stakeholders including priority populations should inform service planning and design.
- Turner *et al* (2019) highlight that taking a whole of system approach, online testing for STI has a lower unit cost than face to face testing in clinical services, and that online services may change testing behaviour in the community, generate new demand for testing, and shift activity between services.[18]
- There will be a need to ensure sustainable funding arrangements including for pathology costs, which may be generated without a clinician providing an occasion of service, or may be conducted outside laboratory settings (e.g. home-based self-testing).

- Online testing models require capacity to facilitate assessment of the client's needs (e.g. through a survey), access to clinically indicated tests, provision of results and (in case of positive result) triaging to a clinically appropriate care pathway. Investment in clinical care (through strengthening the role of primary care and increasing the capacity of specialist sexual health services) to triage and act on referrals generated through online testing, and in complementary models of e-pathology and e-pharmacy, will also be required.
- Opportunities for online access to SRH care more broadly (beyond STI and BBV testing) should be explored. This includes, but is not limited to, HIV PrEP, PEP, contraception, emergency contraception and medical abortion screening and provision of medications.

Actions to date

Recommendation 10: A pilot nurse-led online HIV PrEP program is currently in development, led by ASHC. The aim of this pilot is to simplify and improve access to HIV PrEP through a virtual pathway, reduce the need for face-to-face clinical appointments for PrEP related requirements including routine STI testing, and create additional clinical capacity at ASHC.

Key stakeholders

SA Health:	CDCB, ASHC, SA Pathology, SA Pharmacy, LHNs (including WCHN), Rural Support Service (RSS).
Committees:	SASBAC, BBVSS.
Others:	Commonwealth Department of Health and Aged Care, SHINE SA, AHCSA, other community organisations, local and national universities / research institutes, private laboratories.

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DHW Response to Shift 5 | Inequity

Shift 5: Address geographical and other forms of inequity of access to sexual health care

Priority populations

11. Strengthen the capacity of Aboriginal Community Controlled Health Services to deliver sexual health care through investment in dedicated staff, training and support for Aboriginal health practitioners and Aboriginal health workers to expand their scope of practice.
12. Embed and scale up opportunistic STI testing in key clinical settings for other priority populations (e.g. Women's Health, Youth Health, Refugee Health, Homelessness Health, Sexual Assault, Domestic and Family Violence, Alcohol and other Drug services, Mental Health, Prison Health, etc).
13. Maintain access to community-based sexual health care for PLHIV and LGBTIQA+ communities.

Geographic equity

14. Each Local Health Network (LHN) to establish access points and pathways for sexual and reproductive health care, including STI testing and treatment, in their region.
15. Build capacity of specialist services and the CDCB to provide leadership, coordination, and support for the statewide network of sexual health services and formalise governance of these arrangements.

For more detail, refer to Appendix 1, Recommendations 11.1 to 15.3.

DHW Response

Agree in principle.

Further work will need to be undertaken to identify the optimal and most cost-effective solution(s) for each LHN, and source(s) of funding. Optimal arrangements including source(s) of funding to improve equity of access to sexual health care may differ across LHNs and need to be explored further. The Review presents options for consideration.

Rationale

The Review presents data highlighting the disproportionate burden of STI for some populations and regions of SA. There is insurmountable evidence that to optimise health system performance, health inequity must be addressed.[1]

The Review highlights the limited geographical distribution of SRH services in SA, and the potential for this to exacerbate health inequalities and poor outcomes associated with STI and other SRH issues. There are currently no publicly funded sexual health services outside the Central Adelaide Local Health Network (CALHN) region (Figure 8).

The Review also highlights inequity in SRH and STI related outcomes across different population groups.

Inequity and differential outcomes in relation to SRH and STI are typically a consequence of the intersecting vulnerabilities and marginality experienced by some priority population groups. While there is limited data demonstrating the full extent of SRH health inequity in Australia[2], concepts such as 'syndemic theory'[3], 'deprivation amplification'[4], 'inverse care law'[5] and 'recursive cascades'[6], coupled with the geographic distribution of STI notifications and hospital admissions help us to understand the complex social determinants and disadvantage that contribute to the uneven burden of disease and poor outcomes associated STI in SA.

For some populations, strengthening access to SRH services is a priority not only for the response to STI, but also to meet the South Australian government's commitment to eliminate HIV transmission by 2030.

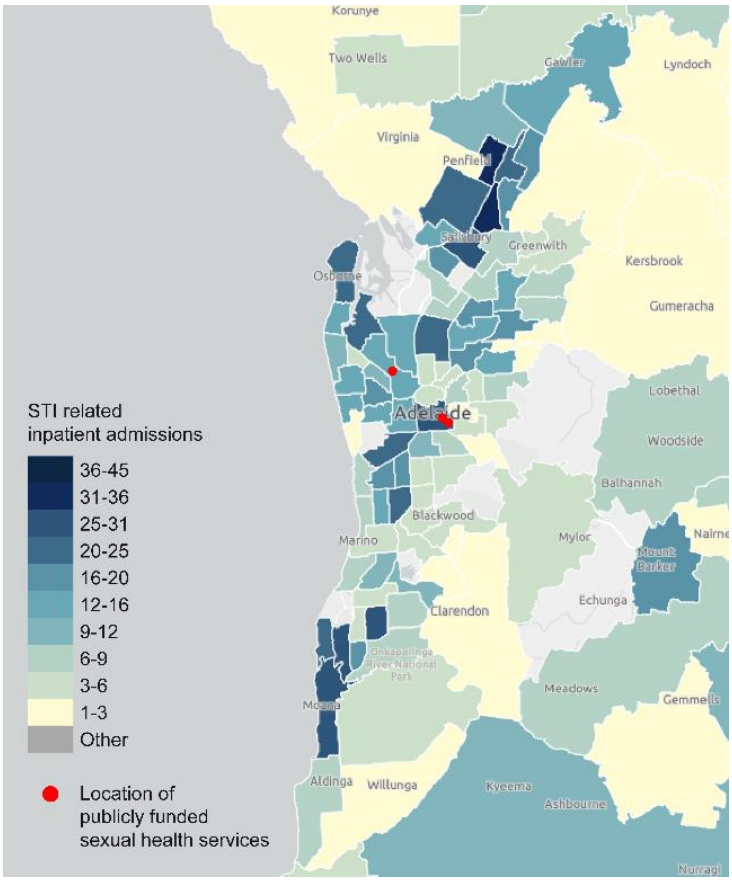
The National HIV Taskforce Report launched on 30 November 2023 highlights that "low rates of testing in many communities are contributing to rising rates of late HIV diagnosis", and that "eliminating HIV transmission will require renewed efforts to increase prevention, testing, diagnosis, care and treatment, especially among priority populations including overseas-born gay and bisexual and other men who have sex with men (GBMSM), young people and First Nations communities". This includes people who are

ineligible for Medicare and/or have unstable visa arrangements (e.g. international students, temporary residents on work visas, etc).

The Review presents options to address these and other forms of inequity.

These will need to be explored further to determine the optimal and most cost-effective solutions, with consideration given to funding arrangements and the unique population health needs and existing service landscape across each LHN. Co-design in partnership with affected communities will also be important, particularly given the differing sociodemographic characteristics within and between LHN.

Figure 8: STI related public hospital inpatient admissions by statistical area level 2 (SA2) of residence, South Australia, 2016 to 2022[7]



Suggested options for consideration by SA Health to address SRH inequity could include:

- Establishing a dedicated sexual health clinic(s)
- Integrated, nurse-led services with statewide remit including regional areas (e.g. the SA Health Viral Hepatitis Nursing Program)
- Investment in the proposed online STI and BBV testing service (as per Shift 4 above)
- Enhanced supports for general practice(s) to become a viable focal point for SRH care (e.g. HIV s100 prescribers)
- Integrated, person-centred approaches such as embedding the promotion and provision of opportunistic STI screening in existing key clinical settings which are preferred by or more accessible may help to bring SRH care to populations who face particular barriers to accessing care in mainstream primary or antenatal care settings.* The Review identifies populations and settings that need to be prioritised to achieve this, and opportunities to sustain and enhance existing SRH access arrangements.

* To prevent further cases of congenital syphilis in South Australia there is an urgent need to expand opportunistic screening and outreach options, particularly for people of reproductive age who may not be accessing SRH services (including antenatal care) or STI screening, but may have increased susceptibility due to homelessness, drug use, residency status etc.

To ensure a coordinated statewide response to addressing SRH inequity, there is a need to clarify roles and responsibilities of agencies within the broader SA sexual health system model of care, ensure support needs for these agencies are met including through strong linkages with established specialist sexual health services, and underpin these arrangements with a formalised governance framework (which may include policy or formal agreements).

Through this process, an enhanced role in system planning for Primary Health Networks (PHN) and opportunities for an integrated approach across PHNs and LHNs to address inequity of access to SRH service delivery in each region should also be explored.

Relevant models and approaches locally and in other jurisdictions

The UK's Integrated Sexual Health Service (ISHS) model aims to improve sexual health by providing specialised non-judgmental and confidential services, where the majority of sexual health and contraceptive needs can be met at once, often by one health professional, in services with extended opening hours and locations which are accessible by public transport. Services are increasingly being provided remotely and online. Service models and access arrangements are regularly informed by local review and service user feedback.[8]

Across NSW, publicly funded sexual health clinics operate across the state, with services available in each local health district (LHD) providing a range of medical, counselling and health promotion services to those most at risk of STI, including HIV. This network includes dedicated sexual health clinics, outreach models for homeless populations (e.g. Health on The Streets[†]), services in regional and rural communities, and dedicated health services including free and anonymous sexual health care for highly marginalised populations (e.g. South Eastern Sydney LHD's Kirketon Road Health Centre).[9]

In response to the syphilis outbreak in WA, Homeless Healthcare was funded by WA Health to deliver the nurse-led Sexual Health Outreach program in the Perth metropolitan area, providing street based outreach services.[10]

In Victoria, the Centre for Culture, Ethnicity and Health's Multicultural Health and Support Service works with communities and health professionals to promote the health and wellbeing of people from refugee and migrant backgrounds, asylum seekers and international students, integrating sexual health care into primary care.[11] In South Australia, Refugee Health Service is available for newly arrived refugees and asylum seekers.

In SA, efforts to integrate hepatitis C testing and treatment into priority settings where people living with hepatitis C are more likely to present (e.g. prisons, alcohol and other drug (AOD) services, mental health services, etc) have been demonstrably successful. This work has underpinned efforts to eliminate hepatitis C in SA and provides a template for how a similar strategy could be operationalised for access to sexual health care. This is particularly salient noting emerging evidence of cross-over in priority populations for syphilis and hepatitis C.

Prioritisation

Prioritisation to be confirmed following consultation with SASBAC and other key stakeholders.

To create additional access points and pathways for sexual health care in SA, systems level planning and cost-effectiveness analysis will be vital. In scoping new arrangements, the following will need to be considered:

- Population health needs and existing service landscapes, and therefore the optimal solution(s) to this recommendation, may vary across LHN.
- The source and quantum of funding for implementation of recommendations was out of scope for the Review and requires further exploration. This applies to all recommendations.

[†] Health on the Streets is an initiative of Coast & Country Primary Care, NSW. https://healthonthestreets.org.au/.

- The SA Health Commissioning Framework outlines the approach by which the Department for Health and Wellbeing (DHW) identifies the health and wellbeing outcomes that need to be achieved – and then designs, implements and manages the South Australian health system to enable these outcomes to be delivered within available resources.[12]

In progressing this recommendation, consideration will need to be given to the Commissioning Framework and to timeframes for DHW and LHN needs assessments and priority setting processes for commissioning.

Actions to date

Recommendation 11: The *Health Insurance Amendment (Professional Services Review Scheme) Bill 2023* reform to expand the range of health professionals who can independently order STI and BBV pathology is progressing, and further consultation is underway. SA Health is supporting and maintaining contact with the Commonwealth in relation to the proposed reform.

As per 'Shift 3 | Specialist Services', additional time-limited State and Commonwealth enhancement funding has been allocated to build capacity for delivery of Aboriginal sexual health programs. Work is underway to sustain these arrangements.

There has also been substantial work undertaken to strengthen Aboriginal led governance of the public health response to STI and BBV in SA, and coordination between services working in this space.

Recommendation 12: In collaboration with the SA Syphilis Response Working Group, the CDCB has identified and worked in partnership with a range of key clinical settings for priority populations at higher risk of syphilis to increase health promotion, workforce development, and access to SRH care including STI testing. During 2023, the CDCB has prioritised engagement with antenatal care services, correctional settings, the alcohol and other drug (AOD) sector, and mental health services.

Recommendation 13: SA Health continues to invest in the O'Brien Street General Practice (which is relocating), and SHINE SA's Hyde Street and Woodville practices, maintaining these key access points to meet the primary care (including sexual health care) needs of PLHIV, LGBTIQA+ and other communities. Furthermore, LGBTIQA+ mental health and AOD treatment services have recently been established in the Adelaide CBD (funded by Adelaide PHN, delivered by Thorne Harbour Health).

Key stakeholders

SA Health:	CDCB, LHNs (including WCHN), Commissioning and Performance Division, Procurement and Supply Chain Management.
Others:	Commonwealth Department of Health and Aged Care, NACCHO, AHCSA, SHINE SA, university/research sector within SA and nationally, non-sexual health services providing services to priority populations (drug and alcohol, homelessness, prison health, mental health, family and domestic violence, women's and youth health services, travel and migrant health, etc).

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DHW Response to Shift 6 | Primary Care

Shift 6: Invest in the enablers for primary care to play an enhanced role in sexual health care

16. Develop a coordinated and systematic approach to GP engagement and education built on data-driven approaches to prioritisation and strengthened engagement via GP professional bodies and Primary Health Networks.
17. Identify, support, and promote GPs with a special interest in sexual health.
18. Explore innovative funding models to sustain high-caseload GPs.
19. Collaborate with the Commonwealth and other jurisdictions to strengthen Medicare arrangements for delivery of sexual healthcare and engagement with Primary Health Networks.
20. Strengthen the whole-of-practice response to STI and sexual health, with a focus on data and systems-based quality improvement projects, and training for non-medical GP workforce.
21. Provide GPs and Primary Care Nurses with more frequent, tailored training opportunities.
22. Provide GPs and Primary Care Nurses with easy access to information and support on delivery of guideline-based care, including more regular communication, integrating guidelines into clinical systems, and building capacity for specialist services to provide real-time support.

For more detail, refer to Appendix 1, Recommendations 16.1 to 22.4

DHW Response

Agree in principle.

Responsibility for strengthening delivery of sexual health care in primary care sits across both State and Commonwealth Governments, and a nationally coordinated approach to this issue is required.

Rationale

Promoting STI and BBV prevention, testing and management in primary care is vital to supporting early detection of infections and timely treatment to prevent disease progression and onward transmission.

The Review finds that there are a number of opportunities to better support primary care settings to embed, normalise and strengthen delivery of SRH care.

However, the Review also found significant structural issues affecting the accessibility of primary care more broadly in Australia (particularly for more marginalised and disadvantaged populations, and people in rural areas), which in turn impact quality and access to sexual healthcare in this setting.

These two issues are distinct but interlinked and compounding, and need to be considered fully in any attempts to implement Review recommendations under Shift 6. Further, responsibility for addressing these issues sits across both State and Commonwealth Governments, pointing to the need for a nationally coordinated approach to this issue.

Goller *et al.* (2023) report that GPs are facing unprecedented hardships, including significant workload burden, burnout among a significant portion of the workforce, substantial administrative burdens and inadequate remuneration for services provided.[1] The COVID-19 pandemic has compounded these issues. Additionally, a shortage of GPs is expected in the next decade.

SA Sexual Health Services Review participants noted that:

- “These trends are most acutely felt by GPs managing patients with more complex healthcare needs who require longer consultations, and patients who are least able to afford co-payments. There is a convergence of these factors in blood borne virus (BBV) and sexual health medicine”.
- “Static Medicare revenue coinciding with rising overhead costs is pushing some practices to reduce or eliminate bulk billing even for long-term patients with concession cards, and to refer primary management of STI to specialist sexual health services and HIV back to infectious diseases hospital outpatient clinics”.

Despite barriers to accessing SRH in primary care, trends in diagnosing service for infectious syphilis notifications highlight the ubiquitous role of GPs in the provision of STI screening. In 2022 and 2023 (year to date), specialist sexual health services have accounted for less than half of all infectious syphilis notifications in SA.

However, due to the complexities associated with the clinical management of infectious syphilis and the varied levels of experience among non-specialist clinicians such as GPs in diagnosing and managing this infection, intensive support from the CDCB and ASHC is often required to ensure consistent linkage to care and partner notification.

Scalability of this type of support for GPs as the syphilis epidemic continues to escalate presents challenges, pointing to the need for exploration of alternative models to support provision of sexual health care in primary care settings.

This anecdotal evidence from SA is reinforced by findings from a NSW Ministry of Health commissioned review that sought to identify effective initiatives that engage and support general practice to increase STI and BBV screening. This review found that barriers to screening in general practice are well established and include time and workload constraints, varied levels of knowledge and capacity, misconceptions that patients are not receptive to discussing STI testing in an unrelated consultation, and patient knowledge. These barriers are compounded for priority populations, including Aboriginal people, people from culturally and linguistically diverse (CALD) backgrounds, and people from the LGBTIQA+ community who report stigma and poor patient–provider relationships.[1]

Despite these challenges, building SRH capacity in primary care remains a national priority. There are a range of opportunities to achieving this which should be explored through a nationally coordinated approach.

- Solutions to some structural issues will need to be explored through the Strengthening Medicare Taskforce and implementation of Australia's Primary Health Care 10 Year Plan 2022–2032 (the 10 Year Plan), including the Scope of Practice Review.
- There is a need for innovative policy responses that promote greater participation of GPs in the SRH system. Funding arrangements should be reviewed, with a focus on improving overall health system efficiency and population level health outcomes while avoiding siloed strategy and diversion of demand and healthcare costs towards the acute care sector.
- While the Commonwealth Government funds capacity building of the primary care workforce through the PHN program and organisations such as ASHM, SA Health also has responsibility for capacity building in specific specialist areas. SRH education opportunities and support tools are promoted to primary care providers by SHINE SA, AHCSA and ASHM on behalf of SA Health. The Review highlights the importance of strengthened partnerships with PHNs and primary care professional bodies, and a coordinated and data driven approach to scale up of the suite of SRH capacity building programs for primary care providers, prioritising populations and regions of greatest need.

Expanding on Review recommendations, it is noted that other speciality fields, including travel medicine[2], addiction medicine[3], university health services and migrant health also play critical roles in promoting SRH and STI control, and opportunities to better engage these services in capacity building activities should be explored.

Models and approaches in other jurisdictions

Following the Victorian Government's review of sexual health services, a 'hub and spoke' model partnership between Melbourne Sexual Health Centre and general practices in metropolitan Melbourne was piloted in 2020 and has since expanded to 11 practices, including several in country Victoria, increasing the geographical coverage of STI clinical services across the state.[4]

An evaluation of the pilot reported that in the short term there was a statistically significant increase in STI and HIV testing across participating GPs following the intervention, and that clinicians reported increases in knowledge level and confidence in offering STI testing and managing a greater variety of sexual health cases (Figure 9 and Figure 10).[5]

However, participating GPs also advised that providing these services as bulk-billed appointments is not sustainable in the long term, and that alternate models of reimbursement need to be explored.

Figure 9: Number of chlamydia tests ordered by participating GPs before and after the hub-and-spoke model was launched, Victoria, 2019 to 2021[5]

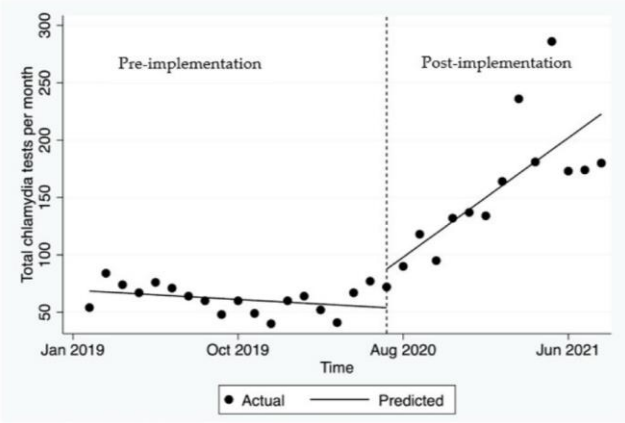
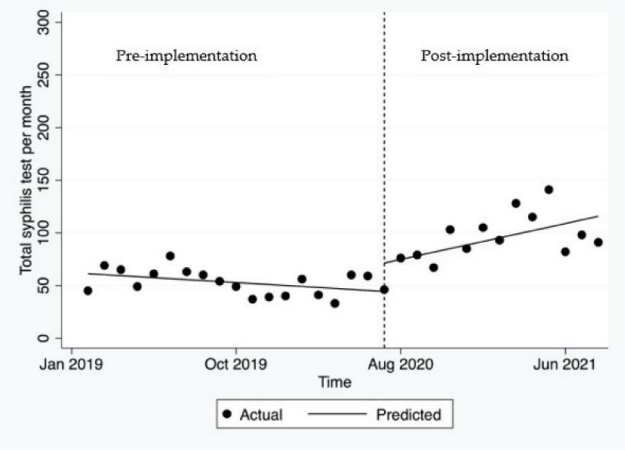


Figure 10: Number of syphilis tests ordered by participating GPs before and after the hub-and-spoke model was launched, Victoria, 2019 to 2021[5]



As SRH and HIV medicine may be less lucrative than other services offered in the general practice context, it is important to consider alternative funding models to attract and more adequately renumerate GPs with specialist expertise or interest in this area, while promoting continuous quality improvement and high quality care with a focus on population health outcomes.[6,7]

There are several models that have been implemented nationally in primary care settings that could be adapted or replicated to incentivise and support STI testing and management and broader SRH care within the general practice context, such as:

- A combination of State and Commonwealth funding arrangements are currently utilised in South Australia to support delivery of SRH and HIV medicine at SHINE SA and the O'Brien Street GP (outside tertiary hospital outpatient clinics). Other examples include Thorne Harbour Health's Centre Clinic in Victoria, and the Kirketon Road Centre in NSW.
- The Practice Incentives Program Quality Improvement (PIP QI) Incentive program, which provides financial incentives to accredited general practices that commit to improving the care they provide to their patients and reporting on specific improvement measures set by the Commonwealth Government to their local PHN.[8] The introduction of a PIP QI improvement measure focused on routine sexual health screening could help to scale up and normalise screening in non-specialist primary care settings.
- The annual health check for Aboriginal and Torres Strait Islander people (MBS Item 715), which is not age restricted and includes taking a patient's SRH history and STI screening for people aged 15 to 54 years within a more holistic primary care model. This approach could be applied to other populations.
- Enhancement of Australia's National Cervical Cancer Screening Program to include self-collection, providing an additional and more discreet option for cervical screening. In addition to urine testing, self-collected vaginal and/or anal PCR testing in asymptomatic patients could similarly be offered to screen for STI.

In a number of regions, there is evidence of strong collaboration on SRH between jurisdictional health departments and Primary Health Networks (PHNs), specific examples include:

- The Central and Eastern Sydney PHN region, which has the highest rates of STI in NSW, has a sexual health program, a viral hepatitis strategy and dedicated FTE within the PHN focused on sexual health and viral hepatitis, supporting general practice with STI and BBV screening and management.[9]
- The Victorian HIV and Hepatitis Integrated Training and Learning (VHHITAL) consortium delivers comprehensive education and training for the primary health care workforce for the diagnosis, treatment and management of STI and BBV, and includes the provision of training and certification for practitioners who prescribe s100 medications. The consortium brings the skills and resources of clinical subject-matter experts, research expertise, program development and accreditation, training and education for health professionals, and people with lived experience. The program is funded by the Victorian Department of Health and is delivered and managed through a consortium comprising of North West Melbourne PHN, ASHM Health (formerly the Australasian HIV, Hepatitis and Sexual Health Medicine Society), Alfred Health, and the Doherty Institute.[10]

The UK's National Chlamydia Screening Program aims to reduce the harms of untreated chlamydia infection by proactively offering chlamydia screening to young women in community settings, such as GPs and pharmacies.[11]

Prioritisation

Prioritisation to be confirmed following consultation with SASBAC and other key stakeholders.

To strengthen access to and quality of SRH in primary care, a nationally coordinated approach is required.

Actions to date

Recommendations 16, 17, 18 and 19: In 2023, BBVSS endorsed the formation of a working group that will explore strategies to strengthen access to and delivery of BBV and sexual health care in primary care.

Additionally, BBVSS recommended consideration of:

- Opportunities to prioritise HIV, viral hepatitis and sexual health within PHN Needs Assessments.
- Sustainable arrangements for SRH related Telehealth MBS items.

Recommendation 16: In 2023, SA Health have been meeting with Adelaide PHN to discuss opportunities for stronger collaboration on SRH priorities.

Recommendation 20: In 2023, the University of Adelaide in partnership with SA Health has offered a PhD research project on sexual health care in primary care, with a quality improvement focus.

Recommendation 21: SA Health is collaborating with ASHM Health to develop an STI Audit Tool CPD module for medical practitioners nationally.

Key Stakeholders

SA Health:	ASHC, LHNs (including WCHN), Commissioning and Performance Division, Procurement and Supply Chain Management.
Others:	SHINE SA, AHCSA Sexual Health and BBV Team, AHCSA RTO Team, Adelaide and Country SA PHNs, Royal Australian College of General Practitioners (RACGP), Australian College of Rural and Remote Medicine (ACRRM), ASHM Health, Royal Australasian College of Physicians (RACP), BBVSS, other state and territory health departments.

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DHW Response to Shift 7 | Governance

Shift 7: Strengthen statewide governance of the system
23. Create an appropriate overarching statewide policy and governance mechanism to coordinate the SA sexual and reproductive health system.
DHW Response
Agree in principle. Further work will need to be undertaken to identify the resources needed and a source of funding. Arrangements to be developed through the proposed SA SRH System Planning and Design Working Group and presented to SASBAC for consideration.

Rationale

Proposed new governance arrangements for the SA SRH System

As identified under Shift 5 | Inequity:

- "to ensure a coordinated statewide response to addressing SRH inequity, there is a need to clarify roles and responsibilities of agencies within the broader SA sexual health system model of care, ensure support needs for these agencies are met including through strong linkages with established specialist sexual health services, and underpin these arrangements with a formalised governance framework (which may include policy or formal agreements)."

To this end, a new working group of SASBAC, the SA SRH System Planning and Design Working Group (the Working Group), will be formed to provide oversight for implementation of the Review recommendations (Figure 11).

Among a suite of priorities, the Working Group will:

- Develop appropriate statewide policy and governance arrangements, outlining minimum requirements for access to sexual health care across all Local Health Networks (LHNs), and a coordination mechanism for clinical services that comprise the SA sexual health system model of care.
- Over time, it is proposed that the Working Group will transition into a statewide SA SRH Model of Care Reference Group, with similar scope and function to the SA Viral Hepatitis Model of Care Reference Group (Figure 11).

  These groups should have clearly defined linkages to key existing governance structures across SA Health (e.g. SASBAC, DHW Department Executive and the Health Chief Executive's Council (HCEC)).

Exploring opportunities to build capacity within the CDCB will be important to coordinate this body of work and ensure timely implementation of Review priorities, alongside other core responsibilities for this team.

Robust governance mechanisms to oversee the planning and implementation of activities recommended by the Review are critical to mitigate fragmentation and ensure that investment into the SRH system is aligned with population health needs, government policy and sector endorsed strategic priorities, and not diluted over time.

SA Health's highly successful and nationally acclaimed Viral Hepatitis Nursing Program is underpinned by a model of care and guideline-based governance. Stakeholders have identified that robust policy and service agreements scaffolding investments like this are also important to prevent erosion of programs over time, and diversion of human resources towards activities outside of the original program scope and intent, to address service gaps in other areas.

Review findings

Through efforts to strengthen governance, system coordination and integration, the Review recommended that current arrangements need reconsideration by SA Health to address:

- Fragmentation of key areas, including for specialist sexual health services and partner notification services. As a consequence, services are "disconnected; working the best they can within their own sphere, but without the linkages needed to operate as part of an integrated sexual health system for the people of South Australia".
- "Governance arrangements [that] do not drive or enable a coordinated and strategic response to STI or sexual health across SA, but rather perpetuate fragmentation and inequitable access".
- The Review recommends a review of governance arrangements for ASHC, to ensure that this service is empowered to provide statewide leadership, and deliver flexible and diverse models of care.
- As described above (see Shift 3 | Specialist Services) a partnership agreement between ASHC and SHINE SA is recommended to more formally and explicitly delineate their system leadership roles and responsibilities within the statewide model of care, enhance coordination and collaboration, and leverage the unique skillsets and funding arrangements of these services for maximum reach and impact.
- The Review notes that these services are "interdependent and complement one another; together they are the engine of the sexual health system in South Australia… In order to get the level of collaboration required, this feature must be highly valued and resources and energy must be devoted to building strong, collaborative working relationships; from the governance level through to staff on the ground this must be part of the ethos of each service. KPIs must be set for each service in relation to the way the services work with one another, and regularly evaluated to ensure ongoing improvement."
- While the Review did not make explicit recommendations regarding formal governance arrangements between the CDCB and ASHC/CALHN, this will also be important to empower collaboration on strategy, service planning and resource allocation. Close collaboration between the two agencies is likely to become increasingly pertinent as SRH service planning and program implementation becomes a priority in other LHNs.
- Engagement with the non-specialist primary care sector and with consumers through development of the Review was limited. These stakeholders should be embedded within the proposed governance structure (Figure 11) to support the planning and design of models of care that will best meet the needs of SA's diverse priority populations, and primary care providers to provide SRH services.

Figure 11: Proposed governance structure for the SA sexual health services system (*Tier 3 committees to be determined by the SA SRH System Planning and Design Working Group*)

Tier	Committee	Function	Suggested membership	Suggested meeting frequency	
1	**SASBAC**	• Strategy, policy and system leadership • Endorsing Review implementation priorities and working group governance.	• Existing committee. • Potential gaps to current membership to be considered by SASBAC.	2/year	
2a	**SA SRH System Planning and Design Working Group**	• A time limited working group tasked with oversight for implementation of Review recommendations. • Develops a series of detailed and costed business cases to strengthen SA's sexual health services system, for consideration by SASBAC and through SA Health commissioning processes. • Proposals to be aligned with Review recommendations and progressed in order of priority. • This work will inform future commissioning and coordination of sexual health services in SA. • Reports to SASBAC.	• To be determined by SASBAC, membership may include representatives from: ○ CDCB (lead agency) ○ SA Health Commissioning & Performance Division ○ ASHC ○ SHINE SA ○ AHCSA ○ LHNs (metro & country), including WCHN ○ RSS ○ Primary Care • The Working Group will invite additional expertise to progress specific recommendations, as required.	4/year	**SA SRH Community and Consumer Reference Group^** Collaborates with both the SA SRH System Planning and Design Working Group and the MOC Reference Group. Mechanism to ensure that communities and consumers have opportunities to participate in planning and co-design of SRH services and activities, including health promotion.
2b*	**SA SRH Model of Care (MOC) Reference Group**	• This group will eventually supersede the SA SRH System Planning and Design Working Group (following transition from planning and design phase to implementation phase). • Function will be similar to the SA Viral Hepatitis Model of Care Reference Group. • The Group will provide oversight of all phases of the statewide SA SRH MOC, including: ○ Clinical governance of and collaboration between SRH services and programs across the system. ○ Research and innovation. ○ Data strategy and governance to ensure minimum standards for SA SRH service data collection and reporting and inform service quality improvement and the broader health system response to SRH. • Reports to SASBAC.	• Membership may include representatives from: ○ ASHC (co-lead agency) ○ SHINE SA (co-lead agency) ○ CDCB ○ LHNs (including WCHN) ○ General Practice ○ STI BBV non-government sector ○ Consumer/Community representative/s	2/year	

* SA SRH MOC Reference Group membership to be determined by the SA SRH System Planning and Design Working Group.

^ Structure, membership, frequency and mode of engagement to be determined by SA SRH System Planning and Design Working Group and the MOC Reference Group (noting that this may change over time dependant on phase, i.e. planning and design / implementation). Options for consideration include a single reference group with representation from priority populations or embedding consumer representation into each priority project stemming from the Review.

Relevant models and approaches locally and in other jurisdictions

Queensland has established a Sexual Health Ministerial Advisory Committee to provide advice to the Minister for Health on SRH-related matters associated with the Queensland Sexual Health Strategy.

Historically, NSW Health have negotiated Local Health Districts (LHD) service agreements to formalise arrangements for provision of SRH services in each LHD region.

As described earlier, the SA Viral Hepatitis Model of Care Reference Group oversees the SA Health Viral Hepatitis Nursing Program.[1] It is envisaged that the SA SRH Model of Care Reference Group proposed above will operate in a similar way, albeit with a system rather than programmatic level scope.

Prioritisation

Prioritisation to be confirmed following consultation with SASBAC and other key stakeholders.

To be addressed as soon as practical, as implementation of other Review recommendations is contingent on determining and establishing a governance framework.

This report (DHW Response to the Review) will be presented to SASBAC.

Expert advice from SASBAC membership will be sought in relation to the proposed governance structure outlined above.

Actions to date

Public Health Division strategic planning work is currently underway. Through this work, opportunities to support SHSR priorities are being explored.

BBVSS (a standing committee of Australian Health Protection Principal Committee (AHPPC)) is working to address some of the Review's recommendations at a national level.

Key Stakeholders

Committees: SASBAC and proposed new groups, as detailed above (Figure 11), to be formed.

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DHW Response to Shift 8 | Prevention and Health Promotion

Shift 8: Strengthen prevention and health promotion
24. Undertake a strategic review of the South Australian government's approach to primary prevention and health promotion in sexual health and commence work to address any gaps identified.
DHW Response
Agree in principle. Consultation with other government and non-government agencies will be required to progress this.

Rationale

A statewide coordinated and targeted approach to sexual health promotion is vital to ensuring that priority populations, health professionals and the broader community have access to SRH information that is consistent, timely, accurate and useful.

The Review recommends that sexual health promotion and education activities across the state should be mapped and reviewed to identify opportunities to enhance the reach and impact of these programs, including:

- Targeted sexual health promotion programs for priority populations that are co-designed, impactful and relevant to cultural and social contexts.
- Comprehensive relationships and sexuality education (CRSE) for young people in education settings.

Targeted health promotion programs for priority populations

Partnerships between government, clinicians, researchers and affected communities have been central to the success of Australia's world leading response to HIV and viral hepatitis over many decades.

The Australian response to the 2022 global mpox outbreak has re-iterated the importance of community and peer-led programs in rapidly and effectively responding to public health issues affecting some populations, and that this is built on a foundation of longstanding trust, social capital, and expertise in how to engage with these communities that has required many years of sustained investment to establish.

The Review highlights that STI epidemics are not only escalating but evolving rapidly with different populations being affected.

Therefore, there is an ongoing need to review sexual health promotion strategies to ensure that these are aligned with current epidemiological trends and population health needs, and to address any gaps.

CRSE in education settings

Strong evidence exists to support universal CRSE in schools.

Family Planning Alliance Australia recommends whole-school CRSE approaches and that governments fund, implement and evaluate mandatory age and developmentally appropriate programs for all schools, as well as community programs for young people not engaged in schools.

The Focus Schools Program has been delivered by SHINE SA in partnership with SA Health and the Department of Education since 2003.

- Approximately 80% of public secondary schools are enrolled in the program.
- SHINE SA regularly receives requests from private schools to deliver CRSE to students.
- The program is aligned with international best-practice principles and has been designed to utilise strong relationships between teachers and their students to empower young people to make informed decisions concerning relationships, consent, SRH and wellbeing.

- The program is regularly reviewed to support quality improvement.

There are opportunities to enhance the reach and impact of the SHINE SA Focus Schools Program.

The South Australian Commissioner for Children and Young People's 'Sex Education in South Australia' report presents key findings from a survey of 1,225 children and young people across public, independent and Catholic schools in SA. Of note:

- Most survey respondents (90%) reported that CRSE is 'very important'; and the majority called for: access to CSRE to be expanded; new, co-designed modalities of CRSE delivery to be explored; and CRSE to be embedded into school curriculum as a fundamental right for children and young people.
- Key recommendations of this report include:
  - expand access to relationships and sexual health education (including year 11 and 12 students, and strategies to engage with young people outside education settings)
  - explore new, co-designed modalities of education including online models
  - embed relationships and sexual health education into school curriculum as a fundamental right for children and young people
  - build capacity for young people to safely use technology as part of their sexual agency.[1]

There is also potential to expand health promotion and primary prevention in post-secondary education settings in SA. Relationships with these settings, developed though the CONNECT free HIV self-test program pilot delivered by SAMESH and Thorne Harbour Health, provide a strong platform for this work to occur.

Relevant models and approaches locally and in other jurisdictions

CRSE and other school-based initiatives:

- In Victoria, sexuality and consent education are part of the state's curriculum, mandated for Government and Catholic schools statewide, and consent education in all government schools is mandatory from Foundation to Year 12. Schools are not required to seek parental permission for the inclusion of sexuality or consent education. However, a parent or carer may decide to not allow their child to participate in sexual education.[2]
- To support the whole of school approaches across the education sector, dedicated CSRE subjects are offered as part of pre-service training for undergraduate and postgraduate education students in Victoria at Deakin University[3] and Victoria University[4].
- In WA, through the Child and Adolescent Health Service, school-based community nurses provide primary health care for young people between the ages of 11 and 18 years, with a focus on relationships and SRH.[5]

SRH education and health promotion activities targeting priority populations:

- Nationally, organisations like Health Equity Matters (formerly AFAO), Thorne Harbour Health and ACON provide targeted and highly impactful community led health promotion for LGBTIQ+ communities and people living with or affected by HIV, including collaborative multi-jurisdictional initiatives such as Emen8.[i]
- NSW STI Programs Unit maintains a sexual health website for young people, 'Play Safe', that features a sexual health Q&A service (Nurse Nettie), an online forum, a service locator and a quiz.[6]
- The Peers Advocating for Sexual Health (PASH) is an award-winning developmental training program delivered by UNSW students to advocate and facilitate SRH literacy. PASH Peers lead

[i] Emen8 is a national digital HIV prevention and sexual health resource for gay, bisexual and other men who have sex with men (GBMSM).

conversations, run workshops, and facilitate sexual health testing, supported by the UNSW Health Promotions Team.[7]

- Sexual Health Victoria's IRL sexual health app includes information on what sex is, legal rights, consent, contraception, STI, and pregnancy that is gender and sexuality neutral, stigma-free and medically accurate.[8]
- WA Health's 'Healthysexual' multimodal sexual health awareness campaign is targeted at the statewide, general population aged 16 to 60 years, with segmented information for key priority populations. The campaign's aims are to: increase testing for syphilis and other STI; encourage safer sex; raise awareness of syphilis prevention and treatment; and to reduce stigma and discrimination associated with STI.[9]
- In SA, the sexual health promotion activities of both SHINE SA and AHCSA for First Nations people have been commended nationally. The campaign delivered in partnership between AHCSA and SHINE SA, 'Syphilis Respect U + Me', was awarded people's choice best sexual health poster at the 2022 Australasian Sexual Health Conference.

  At the 2023 Australasian Sexual and Reproductive Health conference, a doctoral research project identified SHINE SA's approach to digital health promotion targeting young people as an example of best practice nationally.

  In addition, SAMESH, SIN and PEACE Multicultural Services are also funded by SA Health and deliver targeted, highly regarded community and peer-led sexual health promotion initiatives to gay, bisexual and other men who have sex with men, sex workers, and CALD communities, respectively.

Prioritisation

Prioritisation to be confirmed following consultation with SASBAC and other key stakeholders.

The CDCB intends to collaborate closely with SA Health Communications, Adelaide Sexual Health Centre, SHINE SA, AHCSA, SAMESH, SIN, PEACE Multicultural Services, Hepatitis SA and other STI BBV sector non-government organisations (NGO) over the coming 12 to 18 months. In addition, opportunities for partnership with SA Health's newly established health promotion agency Preventative Health SA will also be explored. The aim of this collaborative work will be to strengthen the Focus Schools Program as well as undertake a mapping and gap analysis of other sexual health primary prevention and health promotion activities statewide and commence work to address these.

Actions to date

In October 2023, the Chief Public Health Officer met with SHINE SA to discuss the successes of and opportunities to further strengthen delivery of comprehensive relationships and sexuality education (CRSE) for young people in education settings.

During 2023, the CDCB has been closely collaborating with SA Health Communications, including in the development of a sexual health media and communications plan for 2024 that will build on the funded syphilis awareness raising campaign delivered in 2022 and complement more targeted sexual health promotion activities being delivered by the non-government sector.

In January 2024, the Australian Government launched 'BeforePlay', a national education campaign targeting young people raising awareness of STI prevention strategies with an emphasis on testing and safer sex.[10]

There are emerging opportunities for the primary prevention of STI that were not covered through the Review. For example, the '2023 ASHM Consensus Statement' on the use of doxycycline prophylaxis (Doxy-PEP) for the prevention of syphilis and other STI among men who have sex with men (MSM).[11]

- Among gay, bisexual, and other men who have sex with men (GBMSM), clinical trials of Doxy-PEP have shown significant reductions in syphilis (by 70–80%), chlamydia (by 70–90%), and to a lesser degree, gonorrhoea (ineffective in some trials, or 50–55% reduction in other trials).[11]

- However, uncertainty remains regarding unintended harms from Doxy-PEP. These may include disruptions to their microbiome and increased antimicrobial resistance (AMR) in STI and other organisms, and harms to the community through increased population-level AMR.[11]
- In late 2023, the CDCB met with key sector stakeholders in SA and nationally regarding options to support consistency in guidelines for prescribing of Doxy-PEP, community led health promotion messaging, and opportunities for a nationally coordinated approach to research and evaluation of the use of Doxy-PEP.

Furthermore, a recently published three-year evaluation of SA's world leading meningococcal B vaccination program provides evidence of cross-protection against gonorrhoea infection, owing to the genetic similarity between *Neisseria meningitidis* and *Neisseria gonorrhoeae*.[12]

- In November 2023, the UK Joint Committee on Vaccination and Immunisation (JCVI) published recommendations to the UK government for a routine targeted vaccination program for the prevention of gonorrhoea, alongside advice on a routine vaccination program for mpox for those at highest risk.
- Recommendations for vaccination against gonorrhoea and mpox should be reviewed through a nationally coordinated approach and via appropriate mechanisms.

Key Stakeholders

SA Health:	CDCB, DHW Corporate Communications, ASHC, other LHNs (including WCHN), Preventative Health SA.
Others:	SHINE SA, Department for Education, Association of Independent Schools of South Australia, post-secondary education sector stakeholders including universities and TAFE SA, the Australian Technical Advisory Group on Immunisation (ATAGI), ASHM Health, other STIBBV NGOs.

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Appendices

Appendix 1 – Complete list of South Australian Sexual Health Services Review Recommendations by RPR Consulting

Shift 1 | Strategy: Set an overarching vision for an integrated sexual and reproductive health system

1. Establish a statewide integrated strategic framework for sexual and reproductive health:
    - 1.1. Develop a policy framework that brings together sexual and reproductive health, including but not limited to STI
    - 1.2. Facilitate the integration of sexual and reproductive health care in both specialist and community health streams.

Shift 2 | STI Control: Strengthen surveillance, complex case management, and partner notification functions

2. Expand STI & BBV surveillance and intelligence functions:
    - 2.1. Increase investment in STI & BBV surveillance and epidemiology functions, integrated into general communicable disease control.

3. Expand and reinvigorate the approach to STI partner notification and complex case management:
    - 3.1. Increase investment in the statewide STI partner notification service, so as to increase capacity to:
        - 3.1.1. Undertake targeted partner notification at a scale commensurate with population health needs
        - 3.1.2. Develop localised referral pathways across the state
        - 3.1.3. Provide training and real-time support to GPs, community health services and other health services on integrating partner notification in routine sexual health care.
    - 3.2. Strengthen the statewide model for STI partner notification:
        - 3.2.1. Formalise the statewide model and clarify the respective responsibilities of key contributors, including CDCB, ASHC and General Practice
        - 3.2.2. Develop an agreement and formalise data-sharing arrangements between CDCB and ASHC
        - 3.2.3. Identify and implement innovative approaches to partner notification, including, where appropriate, incorporating greater use of technology
        - 3.2.4. Strengthen governance and cross-organisational collaboration.
    - 3.3. Formalise and strengthen the statewide approach to case management for people with complex public health management needs:
        - 3.3.1. Increase investment in the statewide complex case management function within CDCB, so that case management for people with complex public health management needs who are diagnosed with an STI are supported to navigate the system and access care.

(See also – Shift 3: Empower specialist services to lead the system, Shift 4: Innovate in sexual health service delivery, Shift 5: Address the significant inequity of access to sexual health care, and Shift 6: Invest in the enablers for primary care to play an enhanced role in sexual health care).

Shift 3 | Specialist Services: Empower specialist services to lead the system

<u>Specialist sexual health services</u>

4. Articulate the respective clinical and leadership roles of Adelaide Sexual Health Centre (ASHC) and SHINE SA in statewide sexual health care delivery:
    - 4.1. Recognise the role of each of these services as statewide services, particularly the roles in relation to building capacity for sexual health care delivery in every LHN and provide leadership for this statewide network.
    - 4.2. Develop a role delineation guide that confirms the roles of ASHC and SHINE SA proposed through this Review
    - 4.3. Update the funding agreement between SA Health and SHINE SA to reflect the agreed roles.

5. Increase the quantum of funds, and update the funding model, to enable each service to deliver on agreed outcomes:
    - 5.1. Identify a source of increased funding to ASHC and SHINE SA, commensurate with current and projected population health needs
    - 5.2. Explore alternative funding models for ASHC which blend both block funding and activity-based funding to improve the sustainability, impact and efficiency of the service.

6. Further strengthen collaboration between ASHC and SHINE SA:
    6.1. Develop a partnership agreement between ASHC and SHINE SA which outlines their respective roles and their collaborative approach to system leadership
    6.2. Explore co-location of ASHC and SHINE SA, as a strategy for increasing complementarity and strengthening referral pathways.
7. Continue to develop ASHC and SHINE SA as multi-disciplinary centres of excellence with staff working at the top of their scope of practice:
    7.1. Continue to strengthen nurse-led models of care in ASHC and SHINE SA
    7.2. Continue to grow and develop the complementary roles of nurses, doctors and allied health care clinicians
    7.3. Continue to work with the Commonwealth on strategies to empower sexual health nurses to work at the top of their scope of practice.

Capacity building for Aboriginal Health Services

8. Increase the capacity of the SA Aboriginal Sexual Health and Blood Borne Virus Program (delivered by AHCSA) to:
    8.1. Provide coordination, leadership, and support to Aboriginal Community Controlled Health Services
    8.2. Provide coordination, leadership, education, and support to other organisations working across a range of settings to embed sexual and reproductive health into their work with Aboriginal clients, including SA Health Aboriginal Primary Health Care Services, Adelaide Sexual Health Centre, SHINE SA and Local Health Networks.
    8.3. Provide coordination, leadership, education, and support to other practitioners to embed sexual and reproductive health into their work with Aboriginal clients, including Aboriginal Maternal Infant Care workers.
    8.4. Deliver the STI and BBV Module in the Aboriginal Health Practitioners [Certificate III and IV] and participate in other programs training Aboriginal Health Practitioners in sexual health.
9. Strengthen coordination and collaboration:
    9.1. Continue to strengthen the partnership between the National Aboriginal Community Controlled Health Organisation (NACCHO), the Aboriginal Health Council of SA, and the South Australian Aboriginal Community Controlled Health Services for a robust and accessible sexual health system for Aboriginal and Torres Strait Islander people.

Shift 4 | Innovation: innovate and diversify models of sexual health service delivery

10. Design and implement a model of care for online STI and BBV testing that is appropriate for the needs of South Australians:
    10.1. Co-design the model of care with priority populations and key stakeholders
    10.2. Adapt the model of care to meet the specific needs of priority populations
    10.3. Commission statewide implementation of the model of care for online STI and BBV testing
    10.4. Commission the delivery of the Online STI and BBV Testing Service, including investment in core elements of delivery (pathology costs; training for and coordination with pathology providers; and secure online storage of patient details) and related service capacity (clinical staff to review, triage and follow up results)
    10.5. Invest in the supporting capacity in one or both of the specialist services to enable access to education, counselling, treatment and management for those returning a positive test result.
    10.6. Undertake regular evaluation to ensure reach and accessibility and to monitor, yield and continue to adapt the service to ensure that it is making optimal contribution to public health outcomes.

Shift 5 | Inequity: Address geographical and other forms of inequity of access to sexual health care

Priority populations

11. Strengthen the capacity of Aboriginal Community Controlled Health Services through:
    11.1. Providing dedicated investment to sustain existing and create additional Aboriginal Sexual Health Worker positions
    11.2. Continuing to collaborate with the Commonwealth government on legislative and regulatory changes to enable Aboriginal Health Practitioners and Aboriginal Health Workers to independently order Medicare-rebated STI and BBV testing
    11.3. Enabling Aboriginal Health Practitioners to undertake other relevant activities within their scope of practice to support culturally safe, accessible, high-quality STI and BBV clinical service provision to Aboriginal people (see also Shift 6, Capacity building for Aboriginal Health Services).

12. Embed and scale up opportunistic STI testing in key clinical settings for other priority populations (e.g. Women's Health, Youth Health, Refugee Health, Homelessness Health, Sexual Assault, Domestic and Family Violence, Alcohol and other Drug services, Mental Health, Prison Health, etc), through:
    - 12.1. Revising clinical protocols and guidelines to include opportunistic STI testing with patient consent
    - 12.2. Revising nursing scope of practice to ensure STI testing, and care is appropriately incorporated
    - 12.3. Providing tailored training to clinical staff to address key knowledge and skills required to integrate STI testing and treatment
    - 12.4. Identifying the source of funds for pathology costs, to support delivery of guideline-based sexual health care for all clients of these services
    - 12.5. Contributing to the development of commissioning plans and ensure that services remain responsive to local needs, including the needs of local members of priority populations
    - 12.6. Developing innovative and cost-effective service models and solutions in response to commissioning decisions and local needs.
13. Maintain access to community-based care for PLHIV and LGBTIQA+ communities, through:
    - 13.1. Ongoing investment in the O'Brien St General Practice, including strengthening:
        - 13.1.1. clinical workforce and infrastructure to provide high quality, safe patient care
        - 13.1.2. linkages between O'Brien St General Practice and Adelaide Sexual Health Centre
        - 13.1.3. consultation with priority populations.
    - 13.2. Maintain SHINE SA's Hyde Street service as a key access point for LGBTIQA+ communities and PLHIV.

Geographic equity

14. Each Local Health Network to establish access points and pathways for sexual and reproductive health care, including STI testing and treatment, in their region.
    - 14.1. SA Health to identify a source of funding to support each LHN to establish an access point and pathway/s for sexual health care.
    - 14.2. SA Health to develop a funding formula to ensure efficient and equitable allocation of funds for sexual health service delivery across LHN, taking into account indicators including the distribution of priority populations, STI epidemiology, etc.
    - 14.3. SA Health to allocate funding for sexual health service delivery via the commissioning process
    - 14.4. Each LHN to identify the most appropriate service model for addressing the needs of local populations and then co-design the service with priority populations and other key stakeholders.
15. Strengthen leadership, coordination, and support for new sexual health service access points and pathways to ensure these are fully integrated into the statewide network.
    - 15.1. SA Health to commission one of the established sexual health specialist services to perform a leadership, coordination and support role for the statewide network, the functions of which would include: establishing quality standards for the services, leading the development of clinical protocols and guidelines, leading, and coordinating strategic projects, providing training and development, dissemination of research and data, and ongoing clinical and organisational support
    - 15.2. Communicable Disease Control Branch to expand the capacity of the STI and BBV Section to provide strategic leadership and coordination for the statewide response
    - 15.3. Each LHN to enter into a formalised partnership agreement with the service providing leadership, coordination, and support, clarifying respective responsibilities and contributions.

Shift 6 | Primary Care: Invest in the enablers for primary care to play an enhanced role in sexual health care

16. Develop a coordinated and systematic approach to GP engagement and education:
    - 16.1. Develop data-driven strategies to identify GPs serving communities of greatest need and prioritise allocation of resourcing for capacity building and other supports accordingly
    - 16.2. Create and resource coordination between SA Health, SHINE SA, ASHC, the Primary Health Networks, the Royal Australian College of General Practice, Australian College of Rural and Remote Medicine, the Australian Medical Association, ASHM and the Australasian Chapter of Sexual Health Medicine - RACP to enable a multi-faceted approach to training for General Practice
    - 16.3. Advocate to the Commonwealth for Sexual Health to be a priority issue for Primary Health Networks commissioning frameworks.

17. Identify and promote General Practices/GPs with a special interest in sexual health:
    - 17.1. Provide additional support to practices in areas of need
    - 17.2. Develop a list of GPs who have a special interest in sexual health and disseminate that information widely through other service providers and to the broader community, including via community-led organisations
    - 17.3. Support GPs with a special interest in sexual health to actively promote that [e.g. through marketing] as one of their offerings, and generate demand for clinics.

18. Explore innovative funding models to sustain high-caseload General Practices:
    - 18.1. Explore innovative funding models to support GPs specialising in sexual health and BBV medicine in order to sustain access to HIV PrEP, HIV treatment, and STI diagnosis and care in community settings, and reduce burden on tertiary hospital outpatient services
    - 18.2. Develop a commissioning plan and KPIs to support monitoring of access and outcomes.

19. Collaborate with the Commonwealth and other jurisdictions on Medicare arrangements:
    - 19.1. Identify and address Medicare arrangements which create barriers to quality, accessible sexual health care in General Practice
    - 19.2. Advocate to the Commonwealth to review available STI-related MBS items to ensure these support optimal public health outcomes and health system efficiency
    - 19.3. Advocate to the Commonwealth for Sexual Health to be a priority issue for Primary Health Networks needs assessments and commissioning frameworks.

20. Strengthen the whole-of-practice response to STI and sexual health:
    - 20.1. Explore opportunities for sexual health care quality improvement projects in partnership with Primary Health Networks (e.g. audits, establishing recalls/alert prompts for guideline-based STI testing, and other projects identified in consultation with primary care)
    - 20.2. Offer clinical audits as a practice development opportunity
    - 20.3. Provide training to Practice Managers and Practice Nurses on Medicare billing options for STI and sexual health, including Telehealth arrangements.

21. Provide GPs and Primary Care Nurses with tailored training:
    - 21.1. Expand existing training to incorporate new modalities, including reflective practice, and providing local data to assist GPs to identify local needs
    - 21.2. Ensure that training offered in this area is CPD accredited
    - 21.3. Identify opportunities to integrate GP and Practice Nurse training into other modules
    - 21.4. Invest in the existing networks of GPs with an interest in sexual and reproductive health, with a view to offering a Community of Practice and targeted events to those GPs
    - 21.5. Develop targeted training for Primary Care Nurses to expand their knowledge, skills, and role in STI testing and education
    - 21.6. Strengthen induction and support for International Medical Graduates.

22. Provide GPs and Primary Care Nurses with easy access to information and support:
    - 22.1. Incorporate links to the National STI Testing Guidelines on pathology results for STI tests
    - 22.2. Expand the remit and resourcing of one of the existing phone lines to provide real-time support and advice to GPs and Practice Nurses providing sexual health care
    - 22.3. Provide regular communication to GPs and Practice Nurses about STI and sexual health
    - 22.4. Continue to promote use of HealthPathways for sexual and reproductive health.

Shift 7 | Governance: Strengthen statewide governance of the system

23. Statewide governance:
    - 23.1. Create an appropriate overarching statewide policy and governance mechanism to coordinate the SA sexual and reproductive health system. This could be done through expansion of SASBAC, or establishment of an Advisory Committee with a complementary focus on broader sexual and reproductive health
    - 23.2. Create additional capacity within the CDCB to provide coordination and leadership of the statewide public health response to STI
    - 23.3. Strengthen statewide collaboration between ASHC and SHINE SA via a formal partnership agreement
    - 23.4. Formally designate ASHC as a statewide service and modify the Service Agreement with CALHN to reflect that status
    - 23.5. Further explore the optimal strategic and clinical governance arrangements for ASHC, given its enhanced role as a statewide service and the imperative for flexible, efficient community-based models of care.

Shift 8 | Strengthen prevention and health promotion

24. Strategic review of primary prevention and health promotion:

    24.1. Undertake a strategic review of the South Australian government's approach to primary prevention and health promotion, in order to ensure that the scale and distribution of health promotion is evidence-informed and sufficient to improve knowledge and access to services and peer support, and to drive down rates of STI and improve sexual health outcomes for South Australians

    24.2. Augment primary prevention and health promotion for young people by expanding the reach of SHINE SA's comprehensive relationships and sexual health education programs, including strengthening governance arrangements with the Department for Education, and addressing barriers to engagement with young people across South Australia (including comprehensive age and developmentally appropriate programs for all schools, as well as community programs for young people not engaged in schools).

Appendix 2 – South Australian Sexual Health Services Review Project Advisory Group Membership

Name	Role	Organisation/sector
Catherine Carroll	Sexual Health/BBV Program Clinical Support Officer	Aboriginal Health Council SA
Sarah Betts	Coordinator, Sexual Health Program	
Dr Rae-Lin Huang	Public Health Physician, STI Control and HIV Prevention Program	Nganampa Health Council
Litza Myers	HealthPathways Coordinator	Country SA Primary Health Network
Dr Erin Oliver-Landry	GP	McIntyre Medical Centre
Dr William Donohue	Manager	O'Brien Street General Practice
Memoona Rafique	Manager	PEACE Multicultural Services, Relationships Australia SA
Angela Rutland	Clinical Practice Consultant, HIV	RDNS SA
Skye Bartlett	Manager	SAMESH
Craig Shrubsole	Peer Navigation Officer	
Natasha Miliotis	CEO	SHINE SA
Helen Calabretto	Clinical Services Director	
Kat Morrison	General Manager	SIN
Dr Alison Ward	Head of Unit	Adelaide Sexual Health Centre, Central Adelaide Local Health Network - SA Health
Claire Burt	Nurse Unit Manager	
Sue Dunford	Associate Nurse Unit Manager	Refugee Health Services, Central Adelaide Local Health Network - SA Health
Suzanne Foot	Nursing Director, Sexual Health and ID	Royal Adelaide Hospital, Central Adelaide Local Health Network - SA Health
Prof Mark Boyd	Chair of Medicine, Research Director	Northern Adelaide Local Health Network - SA Health
Kathryn Edwards	Director, Aboriginal Health	Limestone Coast Local Health Network - SA Health
Dr Matt McConnell	Public Health Consultant	Rural Support Service, Dept. Health and Wellbeing - SA Health
Fay Jenkins	Executive Director (Executive Sponsor)	Communicable Disease Control Branch, Dept. Health and Wellbeing - SA Health
Rebecca Beazley	Disease Surveillance and Investigation	
Jana Sisnowski	Epidemiologist	
Tom Rees	Manager, STI and BBV Section	
Holley Skene	Senior Project Officer, HIV & STI	
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