Improving Regional Access to Sexual and Reproductive Health

Project Report 2024

Funded by
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Acknowledgements

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Special thanks to Katina D'Onise AM for producing this report.

Note on language

Aboriginal and Torres Strait Islander people have been respectfully referred to in this report in the inclusive term of Aboriginal people, following the advice of South Australian Aboriginal people.

Executive Summary: Model summary and recommendations

This report describes the findings of a project by SHINE SA, funded by Country SA PHN, to understand how sexual and reproductive health services could be improved for people living in regional and remote SA.

The aims of the project were to:

- identify potential models of service delivery for sexual health and reproductive health services in regional SA, including primary, secondary and tertiary prevention.
- increase the knowledge and confidence of healthcare practitioners in rural and remote SA in sexual and reproductive health services.

This project found clear evidence that there are substantial gaps in service delivery for sexual and reproductive health across much of regional South Australia. There are pockets of very high-quality services that demonstrate that service delivery is possible with some support.

The most recent data for abortion indicates that only 10.9% of people who are resident in country SA had an abortion within country SA. The vast majority of abortions are conducted in the public system, and in 2022 there were 104 terminations of pregnancy in a country area. From the available data, there appears to be service gaps for abortion across all areas of regional SA, with significant gaps in Fleurieu-Kangaroo Island, Mid North, Eyre Peninsula (other than Port Lincoln) and Outback North and East.

There have been increasing rates of notification for chlamydia, gonorrhoea and syphilis, including across country SA. While there is incomplete information about where testing for STIs occur for people who live in a regional area, the data suggest a substantial proportion of the total amount of testing is occurring in metropolitan areas. The Eyre and Far North, and the Barossa, Hills and Fleurieu have the highest number of notifications across chlamydia and gonorrhoea, although there are high numbers of chlamydia notifications across the state.

Given the diversity of community need and differing preference for service delivery, a best practice model requires that choice be made available to clients. This includes choice in how the service will be accessed (e.g. in town, in the next town, remotely via telehealth or in metropolitan Adelaide), the service provider (medical, nursing/midwifery, Aboriginal health practitioner or anonymously online), and the choice of method (medical or surgical termination, self-collected or clinician collected STI samples).

Further, the health system presently serves a large proportion of the population well, but as is clear from the report, there are still many people who are not able to access affordable, timely, appropriate, empathic/non-stigmatising sexual and reproductive health services. The model presented in this report is informed by the need for services for this diverse group of people, the importance of service integration, a primary health care focus and the need for choice.

In summary, the model components are:

1. **Enhance the capacity of primary health care (PHC) to offer integrated sexual and reproductive health services**
    a. Training for clinical staff, nursing and medical, on STI testing, long-acting reversible contraception (LARC) insertion and removal and early medical abortion (EMA) prescribing.
    b. Training for administrative staff in addition to supports to provide a welcoming and culturally safe environment for clients.
    c. Training and provision of access to point of care ultrasound for dating and confirmation of intra-uterine pregnancy for early medical abortion.
    d. Availability of STI testing sampling options, including clinician collected samples, self-collection in the clinic, take-home self-testing or sampling from a pathology collection centre.
    e. Software that allows digital prescribing, ordering of radiology or pathology.
    f. Availability of guidelines fit for purpose in primary health care (PHC) (Health Pathways model is pending for EMA but not yet for STI testing).
    g. Specialist support through the local health network (LHN), Adelaide Sexual Health Centre, Pregnancy Advisory Centre or the proposed central online/telehealth unit.
    h. Consideration of a short, standardised screening tool or questionnaire and process for clients to complete in a waiting room (Berlan et al).
    i. Encourage participation in a supportive clinical network (AusCAPPS, recently re-funded for a further three years by the Commonwealth) to support ongoing learning and collegiate support.

2. **Develop a website with the following features:**
    a. Written and short video resources on sexual health (including general education, STI testing, safer sex practices, contraception choices), pregnancy options, abortion access, translated at a minimum into Thai and Mandarin.
    b. Listings of specific services, available geographically.
    c. Separate front end for young people, Aboriginal people and a general audience.

3. **Expand and support the role of nurses, midwives and nurse practitioners to task share or lead sexual and reproductive health services (both face to face and telehealth models) including:**
    a. Counselling on pregnancy choices, sexual health and contraception.
    b. Providing psychosocial care.
    c. Pre-testing for EMA eligibility: history, assessment of gestational age, how to take the medications.
    d. STI testing, interpretation of results, prescribing treatment, notification, follow up.
    e. Facilitated access to telehealth, establishing local referral pathways for ultrasound and medication access.
    f. Post abortion care: abortion completion evaluation, contraception discussion, further follow up and referral if needed.

    For nurse practitioners and endorsed midwives, there is also the ability to request the necessary investigations pre-EMA, prescribe the MS-2 Step and seek consent to the medical termination of pregnancy and provision of contraception.

4. **Local Health Networks to play a role in supporting the model, in particular services where they are required to back up community health, specialist services advice and support where needed and provision of timely ultrasound.**

5. **Online and telehealth model to support gaps in service delivery (sexual health and reproductive health services) at the community level and provide choice for service access.**
    a. Online sexual transmitted infection testing.
    b. Telehealth for either STI testing or EMA provision.
    c. Both to include options for the method of testing: at home or in a pathology centre.
    d. Includes models of follow-up care.
    e. Includes safety protocols (digital and for clients accessing the services).

Specific Aboriginal Community Controlled Health Service recommendations:

1. Aboriginal Health Practitioner (AHP) training is a critical need to support culturally safe sexual health services and reproductive health services in Aboriginal Community Controlled Health Organisations in SA. There should be consideration for a funded traineeship program whereby individuals are employed in STI roles and can concurrently be funded to undertake the necessary training through the Aboriginal Health Council of SA.
2. Support AHPs to provide care under their full scope of practice. AHPs across SA may not be working at their full scope of practice. It is not known why this is occurring, and how commonly. Further work is recommended to understand this as it presents a significant barrier to care for Aboriginal people.
3. Local area partnerships to design regional models of care for STI and EMA access, which could be supported by an AHP who increases awareness of the changes to laws for abortion in SA but also support regional planning and partnerships.
4. There appears to be a major gap in the ability of some Aboriginal Health Services to provide contraceptive intra-uterine device (IUD) insertion and removal. Gaps are in access to training in the procedure that can be sourced locally. A regional approach where a number of staff can be trained locally with a visiting trainer is needed, with the clinical part of the training able to be conducted (with consent) using a local patient list.
5. STI testing can be supported by an active campaign to de-stigmatise STI testing. This includes various merchandise such as t-shirts for staff, posters, videos for the televisions in the waiting room which encourage clients to talk about sexual health matters to staff. Condoms should be readily available, visible, and use encouraged.
6. Safe spaces for women to conduct women's business in a private, confidential manner. A residential Women's Space in selected regional towns would provide a safe space for women to receive abortion services. It would extend beyond abortion services to other health needs for women, ensuring that confidentiality is maintained (the service is not known only as an abortion service which would risk confidentiality).
7. The delivery of in-school, Aboriginal-specific programs for Aboriginal young people should be re-established, with a broad, comprehensive focus on healthy relationships and sexual health. The previous program, Yarning On was found to be an effective program at capacity building and was ceased due to withdrawal of funding, not because it was ineffective.

Further recommendations to support the system of sexual and reproductive health care:

1. Communications to all stakeholders about new service provision, providing updates on existing resources and models available to them.
2. Health promotion including LARC support and ready access to condoms.
3. Community education including in schools, expanded beyond current services.

Project Background

Sexual and reproductive health is critical to our wellbeing and is considered a core part of primary health care service delivery. Despite this, sexual and reproductive health care can be difficult to access.

In regional and remote SA there are known gaps in delivery for a range of primary health care services, but there are particular gaps in sexual and reproductive health services. These services can be subject to stigma as well as conscientious objection which further compounds access issues.

Country SA PHN sought the advice of SHINE SA on how to improve sexual and reproductive health service access for people who live in country SA. Of particular interest was access to sexually transmitted infection (STI) testing and early medical abortion access (EMA). A broader consideration was also given to sexual health and reproductive health more holistically, including for example, contraception access.

The aims of the project were to:

- identify potential models of service delivery for sexual health and reproductive health services in regional SA, including primary, secondary and tertiary prevention
- increase the knowledge and confidence of healthcare practitioners in rural and remote SA in sexual and reproductive health services.

The priority groups considered in SA and national strategic plans and the basis of this report were:

- young people
- Aboriginal people
- gay men and men who have sex with men
- sex workers
- Culturally and Linguistically Diverse (CALD) people
- people in custodial settings
- pregnant people.

The project was conducted in three phases:

Phase 1: Review of the peer reviewed and grey literature to describe best practice models of sexual and reproductive health, including previous models implemented but no longer in place in SA.

Phase 2: Undertake a consultation with organisational stakeholders (SA government, Non-government organisations, Aboriginal Community Controlled Health Organisations) to:

- Understand the existing service landscape, unmet need and barriers/enablers to access and service delivery in regional SA.
- Gather information on what models could improve service access in regional SA, with explicit consideration of priority groups.
- Test potential models of service delivery for feasibility, effectiveness, acceptability, and accessibility.

Phase 3: Design a best practice model based on phase 1 and 2 and in line with state and national strategic plans and clinical guidelines, and test/finalise with a smaller number of stakeholders.

Early Medical Abortion Access

Introduction

Since early medical abortion (EMA) was made available in Australia, there has been the hope that EMA provision would be provided substantially in community health care settings. In the past South Australia has faced significant barriers to EMA provision due to restrictions under the *Criminal Law Consolidation Act 1935*, which has now been replaced with the *Termination of Pregnancy Act 2021*. Despite this, the uptake in primary health care (PHC) has been slow and the number of General Practice providers is low. This is a particular barrier to access for people living in rural and remote South Australia.

Background and the strategic environment

MS-2 Step (Mifepristone and Misoprostol) is the combination of two medications which are used for medical termination of an intrauterine pregnancy up to 63 days gestation (noting in other countries, the use of these medications is for later gestations than 63 days). This combination is referred to as EMA.

The*Termination of Pregnancy Act 2021* commenced in mid-2022. This new Act changed lawful termination of pregnancy care in SA in key areas relevant to this project. These include a removal of the requirement for a termination of pregnancy to occur in a prescribed hospital facility, removal of the need for an in person consultation allowing for a telemedicine model, the allowance of health practitioners other than doctors to prescribe early medical abortion if it is within their scope of practice.

Alongside these changes, the national Therapeutic Goods Administration, which is responsible for the lawful way in which medicines can be used in Australia, changed the requirements relating to MS-2 Step in 2023. There is no longer a requirement for clinicians prescribing the medicines to be certified to make the prescription. Further, the changes enable appropriately qualified health practitioners, such as nurse practitioners or midwives to become prescribers. Pharmacists no longer need to be registered to dispense the medicines. Alongside these changes the Pharmaceutical Benefits Authority changed the Pharmaceutical Benefits Schedule to streamline the authority prescription process and included appropriately qualified midwives or Nurse Practitioners as funded under the PBS for MS-2 Step.

There are 198 Nurse Practitioners in SA as of December 2023, and 94 endorsed midwives. The top ten areas of speciality do not include sexual and reproductive health. There has been a recent budget announcement that the Medicare rebate for Nurse Practitioners will rise by 30% which will make these roles more affordable in PHC.

Challenges and barriers (from the literature and consultation)

From an SA Health policy perspective, there is a mandatory requirement for all Local Health Networks to provide access to options and information on termination of pregnancy in addition to providing access to a termination of pregnancy provider, MS-2 Step medication and an ultrasound for gestational dating (SA Health). However, in country areas, the limited availability of timely ultrasound remains a significant barrier to accessing EMA. Reports through the consultation process have identified up to three weeks' delay for an ultrasound appointment, by which time the eligibility for EMA can have passed.

In addition to the barriers in legislation for nurse led EMA, there are also barriers for medical practitioners to be prescribers. A recent Australian study surveyed 150 GPs and 150 registered nurses and found the following barriers (Haas et al):

- Lack of clinical guidelines
- The long time for consults due to the need for information provision and counselling
- Concern about people not presenting back for follow up
- Stigma of being involved in EMA care.

The researchers suggested the need for a community of practice to help with these concerns. The same researchers have established, under funding by the NHMRC, a network for providers called the Australian Contraception and Abortion Primary Care Practitioner Support (AusCAPPS) Network (SPHERE). It was recently announced that AusCAPPS will be funded for the next three years by the Commonwealth Government.

Another study of GPs found training and support to be a major barrier, as well as inadequate financial reward for the work and the practicalities of access to the required services and medications (Ogden et al). A lack of regular exposure to the need to prescribe also limits confidence in prescribing (Newton et al). A study from 2023 examined experiences of GPs prescribing EMA with culturally and linguistically diverse communities. GPs described needing specific cultural competency training to support their care, particularly how best to manage concerns around reproductive coercion (Singh et al).

Conscientious objection is always a challenge with termination of pregnancy (TOP) service delivery, although the legislation is clear about the obligations for a timely referral to a provider who does provide services. This limitation to the accessibility of services for TOP should be explicitly considered in any strategy to increase the capacity of PHC.

The need for pregnant people to travel to Adelaide for EMA access places people at further risk where there is domestic, family and sexual violence, delaying or preventing access to services (Campo).

Service needs, service availability and identified gaps

There is evidence that potential clients of EMA services are supportive of different clinical staff undertaking abortion care. Unsurprisingly, potential clients are also supportive of low-cost care options and accessible medical TOP in rural locations (Hulme-Chambers et al).

The latest available published data for abortion in South Australia are for the calendar year 2022, which have been sourced from the “South Australian Abortion Reporting Committee: Annual Report for the Year 2022” (South Australian Abortion Reporting Committee). There were 4,777 abortions in SA, with a relatively stable abortion rate since around 2014. The teenage pregnancy rate had been declining since 2008 and has plateaued since 2019. The abortion rate has also been declining (now at 8.3 per 1000). The biggest proportion by age group of people having a termination of pregnancy is the age range 20 to 34 years old (72%).

The proportion of people who live in regional areas accessing an abortion in regional areas in South Australia had been declining. In 2021 the lowest recorded proportion of people accessing a termination of pregnancy in a regional area of South Australia was 9.9%, with the other 90.1% being required to have their termination of pregnancy in the metropolitan area.

Following the commencement of the new *Termination of Pregnancy Act 2021* in mid-2022, there was a modest increase in the proportion of termination of pregnancy being conducted in regional areas, up to 10.9% for the second half of 2022. A further 0.8% of people living in the country used a telemedicine abortion service within South Australia.

The table below was reproduced from the *South Australian Abortion Report 2022*.

Table 1: Pregnancy termination by residential region and health service location, South Australia, 1 January – 6 July 2022

	Health service location				
Residential region	**Metropolitan**		**Country**		**Total**
	Number	% of residential region	Number	% of residential region	Number
Metropolitan	1924	99.6	8	0.4	1932
Country	433	90.2	47	9.8	480
Unknown	2	100.0	0	0.0	2
Total	2359	97.7	55	2.3	2414

Table 1a: Pregnancy termination by residential region and health service location, South Australia, 7 July-31 December 2022

	Health service location						
Residential region	**Metropolitan**		**Country**		**Telemedicine**		**Total**
	Number	% of residential region	Number	% of residential region	Number	% of residential region	Number
Metro-politan	1833	98.0	34	1.8	4	0.2	1871
Country	423	88.3	52	10.9	4	0.8	479
Unknown	13	100.0	0	0.0	0	0.0	13
Total	2269	96.0	86	3.6	8	0.3	2363

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General practitioners conducted 36% of all termination of pregnancy in South Australia, with the largest proportion of termination of pregnancy being conducted in a specialist family advisory clinic (45.6%).

The method most commonly used for termination of pregnancy was the combination of Mifepristone and Misoprostol (MS-2 Step) for first trimester pregnancies, the majority for early medical abortion (before 63 days gestation), at 58.3%. Details in the table below sourced directly from the *2022 Abortion Report*.

Table 2: Method of pregnancy termination by trimester, South Australia, 2022

Method of TOP	First trimester		Second trimester		Total Number
	Number	%	Number	%	
Mifepristone +/- Misoprostol	2784	64.1	74	17.2	2858
Vacuum aspiration/ dilatation and curettage	1408	32.4	7	1.6	1415
Dilatation and evacuation	153	3.5	328	76.1	481
Vaginal prostaglandin	0	0.0	13	3.0	13
Other	1	0.0	9	2.1	10
Total	4346	100.0	431	100.0	4777

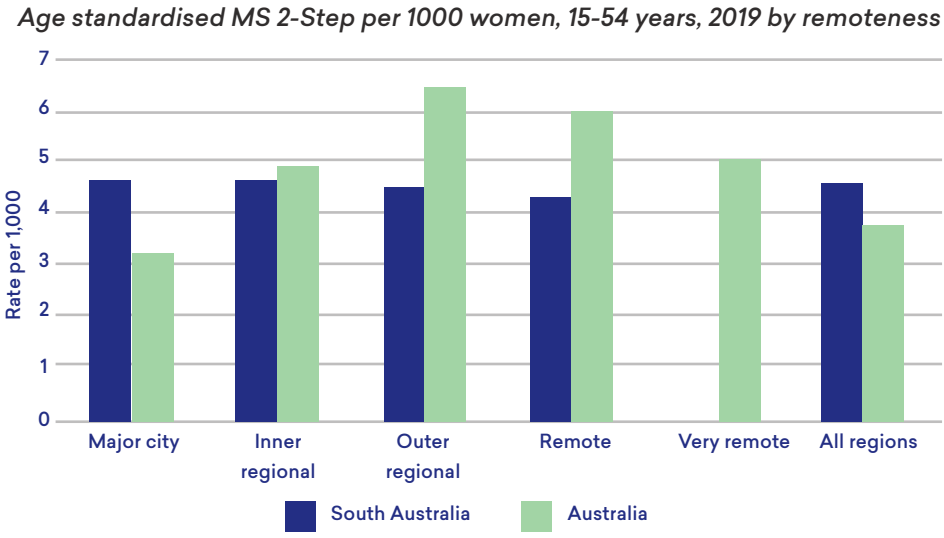
South Australian Abortion Report 2022

Availability of services across South Australia

The vast majority of abortion services have been conducted from a public hospital service in South Australia, with the most recent data reported from the 2022 year. In that year over 99% of all termination of pregnancy was conducted in a public hospital facility. The proportion conducted in the country, of all termination of pregnancy, was 2.3% or 104 terminations.

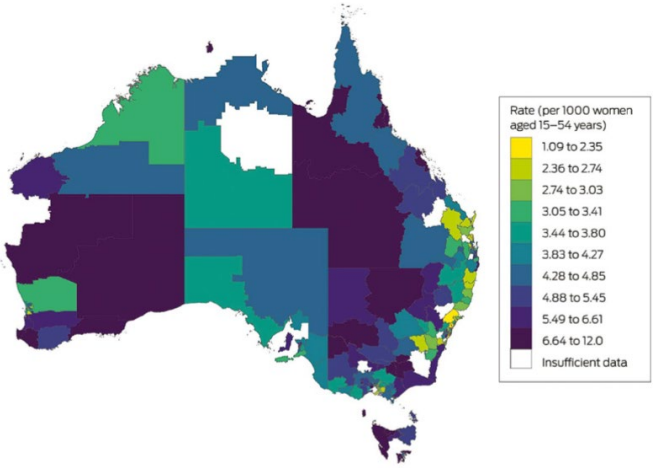
The new legislation affords an opportunity for EMA services outside of a hospital, in a general practice setting, in addition to telemedicine services for gestation up to 63 days. A recent paper published in the Medical Journal of Australia used Pharmaceutical Benefits Scheme data to map MS-2 Step across Australia (Subasinghe et al). The paper highlights the following: there is no MS-2 Step prescribing identified in very remote South Australia. In less remote and outer regional South Australia the prescribing rate is less than the average for Australia, as below:

Figure 1: Age standardised MS 2-Step per 1000 women, 15-54 years by remoteness, 2019 (Subasinghe et al)



About 30% of women aged 15-54 and 50% of women in remote Australia lived in a Statistical Area Level 3 (SA3) in which MS 2-Step had not been prescribed by a GP in 2019. In total 64% of SA3 in South Australia did not have a GP prescriber in 2019, the highest proportion in Australia.

Figure 2: MS 2-Step prescribing and dispensing by SA3, 2019 (Subasinghe et al)



This lack of access sits in stark contrast to the evidence that people living in rural areas are 1.4 times as likely to experience an unintended pregnancy (Subasinghe et al).

A search of the SA Health website and from the consultation process identified the availability of medical abortion prescribers in the following regional centres:

- Clare and Burra
- Jamestown
- Murray Bridge
- Port Lincoln
- Ceduna
- Wallaroo/Kadina
- Victor Harbour
- Barossa Valley
- Naracoorte
- Mount Barker
- Loxton/Renmark
- Mount Gambier.

More recent data requested from the South Australian Abortion Registry describes where EMA was prescribed and undertaken in regional areas, by SA3. There was no or low EMA prescribing in the regions of: Fleurieu-Kangaroo Island, Mid North and Outback North and East.

Table 3: Number of early medical abortions by health service location, South Australia, 7 July 2022-31 December 2023, South Australian Abortion Registry

SA 3 Region	Number of EMA
Barossa	20
Eyre Peninsula and South West	43
Fleurieu – Kangaroo Island	..
Limestone Coast	27
Lower North	20
Mid North	..
Outback North and East	..
Murray and Mallee	63
Yorke Peninsula	22
Metropolitan Adelaide	4024
Total	4224

.. = Data not presented due to low numbers.

Data for the 2023 calendar year (not the same time period as above) from the Pregnancy Advisory Centre demonstrates where people had come from to receive a service in metropolitan Adelaide for EMA. There were high numbers of services provided for people who lived in Murray and Mallee, Mid North, Outback North and East, Barossa and Limestone Coast.

Table 4: Number of EMA undertaken at Pregnancy Advisory Centre for people residing in a regional area in SA, 2023.

SA 3 Region	Number of EMA
Barossa	45
Eyre Peninsula and South West	27
Fleurieu - Kangaroo Island	17
Limestone Coast	33
Lower North	10
Mid North	16
Outback - North and East	31
Murray and Mallee	52
Yorke Peninsula	11

In summary, from the available data, there appears to be service gaps for abortion across all areas of regional SA, with significant gaps in Fleurieu-Kangaroo Island, Mid North, Eyre Peninsula (other than Port Lincoln) and Outback North and East.

Sexual Health Service Access

Introduction

There are key challenges in the control of sexually transmitted infections (STI) in SA. There are rising rates of *Chlamydia trachomatis* (chlamydia hereafter) and *Neisseria gonorrhoeae* (gonorrhoea hereafter), and a recent substantial rise in *Treponema pallidum* infection (hereafter syphilis) notifications has been accompanied by cases of congenital syphilis as part of a multi-jurisdictional outbreak. Infections continue to be over-represented in some communities in SA. This rising burden of disease presents significant challenges to all aspects of STI control.

Background and the strategic environment

The Fourth National Sexually Transmissible Infections Strategy (2018-2022) outlines a comprehensive approach to STI and BBV control in Australia (Department of Health). This is built on the pillars of education and health promotion; testing and treatment; equitable access for different settings including sexual health, primary health care (PHC), community health and antenatal services and through innovative models of care; increased workforce capacity and capability; addressing stigma; and data, surveillance, research and evaluation.

The WHO BBV and STI strategy for 2022-2030 additionally includes an action that sexual health service should be integrated with reproductive health services, and mental health services, in addition to specifically calling out the need for sexual health services within PHC (WHO). The use of digital health services in line with the broader architecture of the health system was also highlighted.

The recently published SA Sexual Health Services Review identified major challenges to be addressed in order to better control the current STI burden in SA (RPR Consulting):

- SHS are not operating at the scale required to contain the STI epidemics, relating to specialist care, primary health care and public health services. This impacts on insufficient health promotion, testing, treatment and contact tracing.
- There is inequitable access to SHS, which includes people living in regional areas which currently have no dedicated, specialist STI services.

Within the recommendations of the review, the following are relevant to the scope of this project:

- Capacity building for Aboriginal Health Services
- Build a model of care for online STI and BBV testing
- Scale up opportunistic testing in key clinical settings
- LHN establish access points for SHS and RHS
- Build capacity of General Practice
- Strengthen prevention and health promotion.

Challenges and barriers (from literature and consultation)

There is limited evidence for interventions that change behaviour in relation to exposure and infection with STIs, but there is good evidence for how to increase testing rates.

Stigma is a significant barrier to seeking screening, diagnosis and treatment for STIs (Hood et al). Powerful (and harmful) socio-cultural norms can increase the risk of stigma, reinforced by the media, risk-based public health messaging and sometimes, health services themselves. This can lead to the denial of STI risk and reduce testing and treatment seeking. Stigma can cause psychological and interpersonal distress and discourage partner disclosure or notification.

For migrant communities in Australia there are socio-cultural, religious, financial and stigma barriers to screening. Ways to overcome these barriers are thought to be education, increasing cultural competence of providers and actions to reduce stigma (Agu et al).

In a recent systematic review of the preferences for young people for STI testing services, there was a wide range of barriers and preferences for the different population groups in the studies. This led to the following recommendations: there should be a variety of services available, they should be accessible, address stigmatising features, offer a variety of collection methods, be low cost, provide quick results, include reminder systems and partner notification support (among other factors) (Gan et al).

Service needs, service availability and identified gaps

Data have been sourced from the report, *Surveillance of sexually transmitted infections and blood-borne viruses in South Australia, 2019*, in addition to data provided from a data request to the Communicable Disease Control Branch (Communicable Disease Control Branch, Table in Appendix 3 in addition to methodology notes).

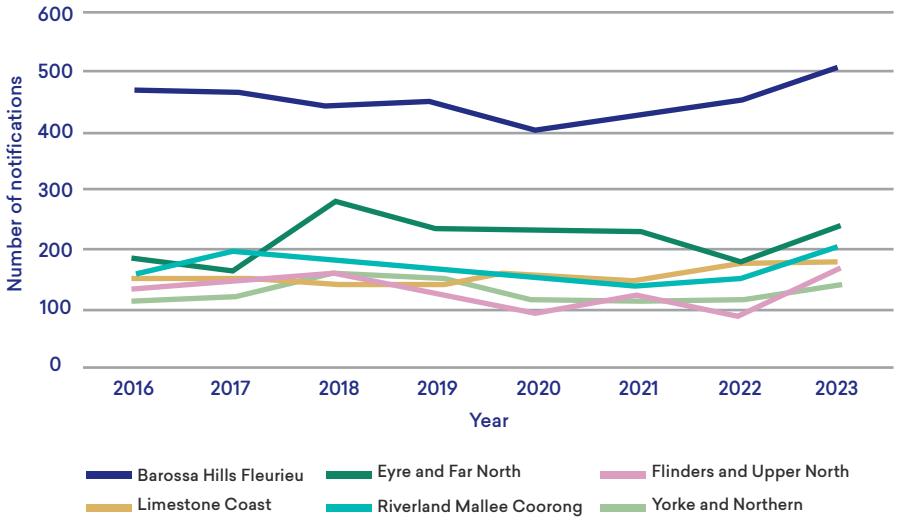
These data come from notification of infection diagnosis under the *South Australian Public Health Act 2011*. For notification to occur a test must be taken and a diagnosis made, which is a smaller number than the true infection number in the community. The difference between cases notified and the true case number is different for different diseases and depends on factors such as the proportion of people who have worrisome symptoms, and the availability and accessibility of testing services.

Chlamydia

Chlamydia is a common infection, with 6430 notifications in 2019, and an increasing number of infections each year across SA. It is likely this is a large undercount of the true number of infections in SA as this is a commonly asymptomatic infection and screening rates are relatively low. Notifications are most common in those 15-29 years (75%). The rate of infection for Aboriginal people is higher than the non-Aboriginal population, estimated to be at least two times higher.

For residents of regional SA, the highest number of notifications were seen in the regions of: Barossa, Hills and Fleurieu, followed by Eyre and Far North.

Figure 3: Chlamydia notification by Local Health Network of residence, 2016-2023



The reason for undertaking a test that had a positive result was known for 4,362 cases. Of these 44.9% were for an asymptomatic screen, 20.2% from partner notification and 34.9% due to presentation with symptoms consistent with chlamydia infection.

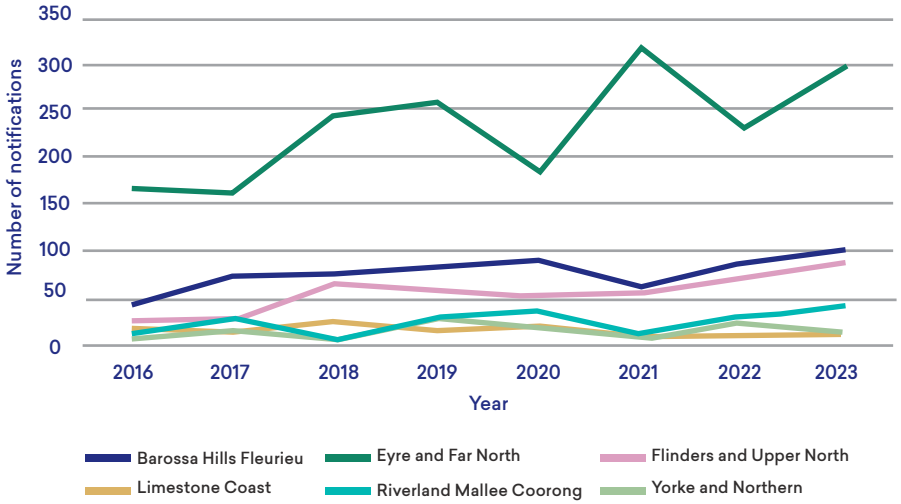
There is incomplete information about where people who live in regional SA go to get a test for chlamydia. For those that tested positive in 2019, GPs in country areas diagnosed 6%, and an additional 2.4% were diagnosed in Aboriginal Health Services, the majority of which are in regional areas. There were additional infections diagnosed from Prison Health Services regionally. Given around 22% of South Australians live in regional SA it is likely that more than half the chlamydia infections for those who reside in country areas were diagnosed in metropolitan Adelaide.

Gonorrhoea

There were 2,094 notifications of gonorrhoea in SA in 2019, which was a sharp rise in infection notifications from the previous year (1289). Notifications are most common for men and those aged 20-39 years (77%). The rate of infection in Aboriginal people is substantially higher than the non-Aboriginal population by an estimated nine-fold.

For residents of regional SA, the highest number of notifications were seen in the regions of: Eyre and Far North followed by Barossa, Hills and Fleurieu.

Figure 4: Gonorrhoea notification by Local Health Network of residence, 2016-2023



The reason for undertaking a test that had a positive result was known for 2094 cases. Of these 38.5% were for an asymptomatic screen, 15% from partner notification and 46.5% due to presentation with symptoms consistent with gonorrhoea infection.

68% of cases in Aboriginal people resided in rural and remote regions of SA, compared with 11% of non-Aboriginal cases.

There is incomplete information about where people who live in regional SA go to get a test for gonorrhoea. For those that tested positive in 2019 GPs in country areas diagnosed 4.3%, an additional 12.9% in Aboriginal Health Services the majority of which are in regional areas. There were additional infections diagnosed from Prison Health Services regionally.

Syphilis

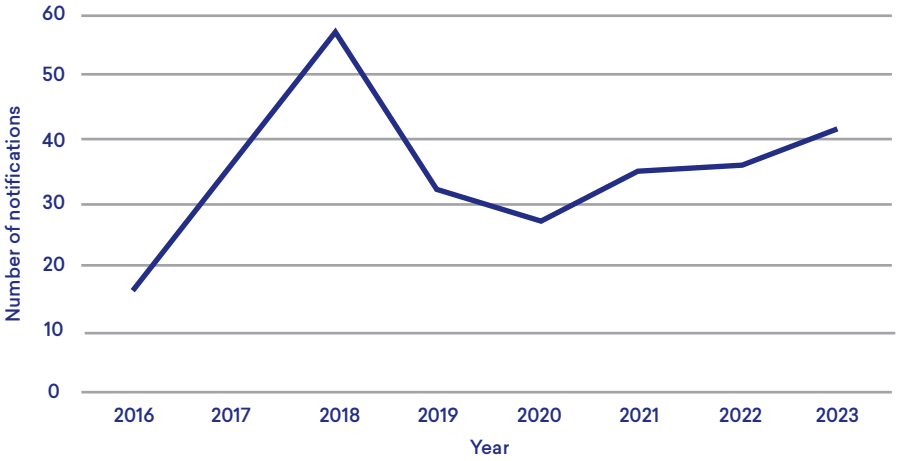
There were 161 notifications for infectious syphilis in SA in 2019 which was higher than the five-year average from 2014-2018 of 110 notifications per year. This was in addition to the 148 notified cases of non-infectious syphilis in the same year (greater than two years' duration of infection). Case numbers began to rise in 2015 after a previously relatively stable low but persistent case numbers. Notifications are most common in men (84%).

There were 34 cases who were Aboriginal, 22 who were residents of metropolitan Adelaide and 12 of rural SA, whereas non-Aboriginal cases were predominately living in the metropolitan area at diagnosis.

The most common age groups were 25-39 years old, with 54.7% of cases.

The trend of rising notification of infectious syphilis is also found in regional SA as demonstrated in the graph below.

Figure 5: Infectious syphilis notification, Country SA Local Health Networks, 2016-2023



The reason for undertaking a test that had a positive result was known for 159 of 161 confirmed and probable infectious cases. Of these 46.5% were for an asymptomatic screen, 8.8% from partner notification and 44.7% due to presentation with symptoms consistent with syphilis infection.

There is incomplete information about where people who live in regional SA go to get a test for syphilis. For those that tested positive in 2019 GPs in country areas diagnosed 6.2%, an additional 8.2% in Aboriginal Health Services the majority of which are in regional areas.

Table 5 was sourced additionally from the Communicable Disease Control Branch. It presents the LHN of patient residence and the LHN in which the diagnosis was made for infectious syphilis where it was outside the resident LHN. Central Adelaide made a large proportion of diagnoses, particularly for Barossa, Hills Fleurieu, Riverland Mallee Coorong and Yorke and Northern.

Table 5: Infectious syphilis cases with discordant LHN of patient residence and LHN of diagnosing service, Australia, 1 January 2016 to 31 December 2023

LHN of patient residence	LHN of diagnosing service					
	Barossa Hills Fleurieu	Central Adelaide	Eyre and Far North	Flinders and Upper North	Northern Adelaide	Southern Adelaide
Barossa Hills Fleurieu	N/A	37	0	0	6	4
Eyre and Far North	0	0	N/A	1	1	1
Flinders and Upper North	0	3	3	N/A	0	0
Limestone Coast	0	5	0	0	0	0
Riverland Mallee Coorong	0	10	0	1	0	0
Yorke and Northern	1	11	0	0	1	1

Note: Data were extracted from the SA Health Notifiable Infectious Disease Surveillance (NIDS) system on 15 April 2024. Data are presented by date of calculated onset, which reflects the earliest recorded date associated with a notification; for STIs this normally defaults to the specimen collection date. Data on both residential and diagnosing LHN was available for 95% (n=267/281) of infectious syphilis cases.

A multi-jurisdictional syphilis outbreak was identified in 2015 and was identified to include SA in November 2016 in Aboriginal people in the Western and Eyre and Far North regions of SA. An increase in cases of syphilis for those who are Aboriginal was then identified in metropolitan region in 2018 which was added to the outbreak. In 2019, 33 SA cases met the outbreak definition and were considered to be part of the outbreak.

HIV

There were 50 cases of HIV notified in 2019. The trend over the previous 10 years is relatively stable, with the majority of infections notified in males consistently (76%). It is unclear if there is any difference in the notification rate of HIV in Aboriginal and non-Aboriginal people in SA due to low numbers of notifications.

Of the new notifications 40% were previously diagnosed overseas. The majority of male cases identified as men who have sex with men (68%).

For those that tested positive, 8% were diagnosed by a country GP, the vast majority of cases were diagnosed in metropolitan Adelaide.

While there is incomplete information about where testing for STIs occur for people who live in a regional area, the data suggest a substantial proportion of the total amount of testing is occurring in metropolitan areas. The Eyre and Far North, and the Barossa, Hills and Fleurieu have the highest number of notifications across chlamydia and gonorrhoea, although there are high numbers of chlamydia notifications across the state.

Opportunities and recommendations - General

Evidence is clear that sexual and reproductive health services should be integrated, and this was supported by the majority of stakeholders. It is also accepted internationally that community-based services for sexual and reproductive health services, including EMA provision through primary health care is safe and effective and can be provided at a lower cost than alternate models (Smith et al, Cameron et al, Ong et al). Primary health care also is an opportunity to scale service delivery, which is an important objective for both sexual and reproductive health (Kularadhan et al).

Given the diversity of community need and differing preference for service delivery, best practice requires that choice be made available to consumers (Ludwig et al). This is choice in how the service will be accessed (e.g. in town, in the next town, remotely via telehealth or in metropolitan Adelaide), the service provider (medical, nursing/midwifery, Aboriginal Health Practitioner or anonymously online), and the choice of method (medical or surgical termination, self-collected or clinician collected STI samples).

Further, the health system presently serves a large proportion of the population well, but as is clear from the preceding sections, there are still many people who are not able to access affordable, timely, appropriate, empathic/non-stigmatising sexual and reproductive health services (Hood et al). Services for this diverse group of people, considering the importance of service integration, a primary health care focus, and the need for choice, forms the basis of the model presented.

Capacity building and support for clinicians in PHC to prescribe EMA

The preferred model for capacity building in PHC involves a number of key components which will support capacity building from a training and system strengthening perspective (WHO, Dzidowska et al, Berlan et al, Ong et al).

Given the issue of cultural safety and conscientious objection, it is clear that not every PHC service is able or could provide this type of service. As such, there should be a mapping exercise to determine which practices are likely to be interested in the service, relative to the known gaps in service provision. Ideal practices are ones where there is ready access to a bedside ultrasound and expertise/interest in sexual health and reproductive health services (SH and RH), for example, GP Obstetricians. Bespoke regional models should be considered, and individual practices supported to be the regional provider, with consideration of providing incentives. These models will include consideration of the dispensing pharmacy and where the ultrasound can be sourced in a timely and affordable way, in addition to the ability to provide care in the event of a complication. Where there are service gaps and no likelihood of local PHC service delivery there should be negotiation with the local LHN to establish and provide an EMA service.

Capacity building should consider the following:

1. Training and education for health staff across a range of topic areas:
    a. The most critical factor to support PHC provision of MS 2-Step is access to ultrasound. Some practices in rural areas have access to ultrasound machines to rapidly identify an intra-uterine pregnancy and confirm gestation. An audit will determine where these are, if they have vaginal probes (although a model using only an abdominal probe from 6 weeks gestation can be sufficient), and if refresher training is necessary to support use. Where there are gaps there should be consideration for funding point of care ultrasound for providers who are willing to prescribe MS 2-Step, alongside training in their use. The cost for high quality point of care ultrasound that plugs into a mobile phone start at around $4000.

b. SHINE SA's Certificate in Sexual Health for Registered Nurses and Midwives can support high quality nurse led models of care in PHC settings. For nurse prescribers, training in prescribing should also be offered.

c. Medical training as part of CPD training for SH and RH including EMA (formal and informal). There appears to be a gap in knowledge for some GPs regarding the change in legal requirements, issues relating to being a procedural GP for insurance purposes in addition to dealing with stigma as a provider. Competency in sexual and reproductive health should be part of basic GP Registrar training, however currently they are elective.

d. Clinic room staff set the tone for the clinical interactions, either through the phone or face to face in the clinic. These workers are critical to ensuring people feel comfortable and safe in discussing SH and RH with the clinicians. Training is required to support a non-judgemental, welcoming environment (Moulton et al). Resources including a telephone script also support high quality service delivery. Currently the Pregnancy Advisory Centre can undertake such training and resource support.

e. There is a need for expanded long-acting reversible contraception (LARC) training for GPs, nurses and midwives. SHINE SA's IUD Insertion Training currently requires supervision over three clinical sessions to meet the competency, this training is currently oversubscribed. Implanon training offered by SHINE SA includes three hours of training, available remotely on application.

2. For STI testing there should be options available for sampling, including clinician collected, self-collection in the clinic, take-home self-testing or in the pathology collection centre.
3. Software that allows digital prescribing, ordering of radiology or pathology.
4. Availability of guidelines fit for purpose in PHC (Health Pathways model is up-to-date).
5. Specialist support through the local LHN, Adelaide Sexual Health Centre, Pregnancy Advisory Centre or the proposed central online/telehealth unit.
6. Consideration of a short, standardised screening tool or questionnaire and process for patients to complete it in the waiting room (Berlan et al)
7. Encourage participation in a supportive clinical network (AusCAPPS, recently re-funded for a further three years by the Commonwealth) to support ongoing learning and collegiate support.

There is a significant gap in information for the community about where to seek services. Given the stigma associated with SH and RHS, in addition to conscientious objection, people do not know where to access safe and supportive services. A website (which could be part of the online/telehealth model below) should be established. This website should include the following features:

- Written and short video form resources on sexual health (including general education, STI testing, safer sex practices, contraception choices), pregnancy options, abortion access, translated at a minimum into Thai and Mandarin
- List of specific services available geographically
- Separate front end for young people, Aboriginal people and a general audience.

Expanding the role of nurses

Critical to building the capacity of PHC in SH and RHS is establishing a task sharing model with practice nurses and nurse led model with Nurse Practitioners and Endorsed midwives. From the literature, there is strong support from consumers for nurses to be involved in abortion care in the community (Smith et al), and there is evidence from a high-resource health system that nurse-midwife provision of abortion services is more cost effective, and as safe, as those provided by physicians (Sjostrom et al, Mainey et al). Services being provided in a PHC setting enables medical back-up if required for the Nurse Practitioner model, and shared care with the task sharing model.

There are a number of components in a task sharing model that could be undertaken by practice nurses independently, with appropriate training (Newton et al, Mainey et al, Moel-Mandel et al):

- Counselling about pregnancy choices, sexual health, contraception.
- Providing psychosocial care.
- Pre-testing for EMA eligibility: history, assessment of gestational age, how to take the medications.
- STI testing, interpretation of results, prescribing treatment, notification, follow up.
- Facilitated access to telehealth, establishing local referral pathways for ultrasound and medication access.
- Post abortion care: abortion completion evaluation, contraception discussion, need for further follow up and referral if needed.

For Nurse Practitioners and endorsed midwives, there is also the ability to request the necessary investigations pre-EMA, prescribe the MS-2 Step and seek consent to the medical termination of pregnancy and provision of contraception.

Telehealth and online services

Given the geographic makeup of SA and the relatively limited primary health care services in country regions compared with metropolitan, online and telehealth models of care are an important part of the health system. A public EMA service could be integrated with a sexual health service, providing a one-stop-shop service for people in sexual and reproductive healthcare, in line with best practice models and evidence internationally. With regards to EMA, telehealth services remove the geographic barrier, while being safe, effective and acceptable to consumers (Mazza et al, Reynolds-Wright et al). There is good evidence that telehealth abortion is safe and effective, with telephone follow up after EMA using low sensitivity urine pregnancy test and telephone evaluation for signs and symptoms using a questionnaire (Melville, et al). For some people in the community, confidentiality is a paramount concern and seeking care outside of their regional area is preferable. For these communities an online telehealth model is an opportunity for care that is currently not available.

STI testing considerations

An online service, attached to the telehealth model can be developed to allow for self-testing at scale and at a lower cost. Remote self-sampling (referral from a clinician to undertake testing at home or in a pathology service) and self-testing (testing without clinical involvement via online or direct purchase of test kits) exists as a service in SA but is currently fee-for-service from private providers. It is unclear the proportion of rural and remote living people who access these services within South Australia.

There is a role for funded remote self-sampling for people at increased risk/priority population groups as is in place in other jurisdictions. This is particularly the case in regional SA as there is a known significant shortage of PHC services, in addition to a lack of adequate SHS. There is evidence from other countries that online users are more likely to test negative and come from higher socio-economic areas (Barnard et al, Sumray et al). Online access increases the rate of testing in people who had previously never tested (Wilson et al). In this model, the main access point to the service is via a website. An important part of the model is that the provider is trusted, given the need to collect information as part of the clinical process. It is also important that the provider can offer clinical services should this be necessary (Jayes et al).

Digital services need to be developed in line with guidelines, which is not always the case with existing models in Australia and internationally (Clarke et al).

The website contains information to support safer sex and testing practices, in addition to how to access services. A questionnaire is the main means to determine if the individual is eligible for remote testing, given there are some scenarios where urgent medical care or face to face care is more appropriate. Through the questionnaire individuals can opt for a telehealth consult or order a test kit without any consultation process. The questionnaire further determines which test is the most appropriate for the individual.

The test itself can be sampled at home from a self-testing kit tailored to the individual's testing needs or could be a pathology form to take to a local pathology collection centre to collect there.

Test results are provided back to the individual via SMS. In this model, clinicians review the results and can directly reach the individual if there is a positive test finding. Otherwise, the individual receives the result via text and without any further follow up. The SMS can also be used thereafter for reminders about re-test or to return the kit (Vialard et al, Burns et al). A model that also informs partners anonymously is also possible to add on. Consideration should be had for the opportunity to allow anonymity or aliases for people accessing STI testing as there are many people who need confidentiality assured before they will consider using the service.

EMA considerations

Safety protocols should be part of the model, looking for evidence of reproductive coercion. These can include elements such as requiring people to attend the consult alone, that any interpreting service is independent and external, opting for videoconferencing over the phone so that it is easier to determine if the person is alone and if there is coercion. For culturally and linguistically diverse communities, there is also a recognised need for specific cultural awareness training relating to pregnancy choices and abortion care (Singh et al).

A model of care that is designed with country SA service availability should be developed to support the service. The risk of adverse events from EMA appropriately prescribed is very small. There were 5.4% of people who had a complication following a medical termination of pregnancy (a category which includes abortions in all trimesters, but predominately early medical abortion). Of those with a complication the vast majority were due to retained products of conception, with small numbers due to uterine infection or bleeding. Despite this low risk, being within 1 hour of medical assistance is recommended, which should be considered in where in relation to service availability a person takes the medication.

In order to increase cost-effectiveness this model should adopt a task sharing model with registered nurses and nurse led model with nurse practitioners.

Critical to this model is an ongoing exemption to the 12-month rule for telehealth access, which was recently announced in the federal budget.

Opportunity for engagement with other stakeholders

Policy reform

The *SA Health Termination of Pregnancy Policy 2022* is out of date. In Appendix 1: Access section 3.1 a, there is no longer a need for medical credentialling/ registering to prescribe MS-2 Step. Further, section 5 requires SA Health services providing termination of pregnancy to have access to ultrasound for accurately dating (and ensuring an intra-uterine pregnancy). This should be refined to also include a time limit on the provision given this is critical to the quality and safety of EMA provision.

Prevention and Health Promotion

There appears to be a lack of general awareness among clinicians about the best practice recommendations for STI screening, and a lack of exposure to EMA prescribing. All avenues for reaching the general practice workforce should be used to provide ongoing information about training opportunities, best practice guidelines and network opportunities for providers. This is inclusive of training programs for General Practice Registrars and those undergoing rural generalist training.

The proposed website outlined above is a critical way to provide high quality, curated and targeted information to the population. In addition to general information, it can be the means to provide an online testing service, with associated instructions for how to test and the portal for accessing reproductive health services via telehealth if appropriate.

Community education is an ongoing need in sexual and reproductive health. In addition to school-based education there should be opportunities for people to access trusted information relating to broader sexual health matters as well as contraception and abortion access if required. The proposed website can support this, but it may also be important to use other media sources such as YouTube, Instagram or TikTok to provide accessible information.

Opportunities to provide low or no-cost condoms to people at higher risk of infection with an STI should be sought. This could be through PHC, Community Health Centres, or Higher Education Institutions, for example. Consideration should also be made for ready condom access and information availability for organisations that support young people.

Broader availability of long-acting reversible contraception options should be promoted for general practice, and consideration of funding the training to allow increased uptake.

Opportunity and recommendations - Aboriginal health

Through the consultation process, the same access barriers are in place for Aboriginal people in SH and RHS. It is the case that choice of service delivery is critical, with some people preferring to seek care from their local health service and others preferring to go elsewhere.

The literature described barriers to STI care such as Aboriginal cultural norms that require the separation of genders and traditional kinship systems that prevent some staff and patients interacting. A lack of male workers, concerns about maintaining client confidentiality, and high staff turnover were further barriers identified. In terms of strategies to enable STI testing, the study identified opportunities to test outside of the clinic and using adult health checks (Hengel et al). It is noted that it is common practice in Aboriginal Health Services in SA to include STI testing in the Adult Health Check.

A recent systematic review of barriers and enablers for young Aboriginal people in accessing sexual health services found barriers in the geographic location of services, inconsistent service provision, shame and differing levels of knowledge about the effects of STIs. Enablers included incorporating STI testing into other targeted initiatives, providing self-testing kits and achieving high levels of cultural competency (Ubrihien et al).

Aboriginal Health Services in SA have been involved for some time in supporting abortion access and have more recently been adapting to the changes in the laws for termination. Any work to improve access across SA to EMA should explicitly consider the needs of the local Aboriginal Health Service in the regional model approach.

In addition to the recommendations for the general community, the following are specifically considered for Aboriginal Health Services:

Practice guidelines

The CARPA Standard Treatment Manual has advice for STI checks in men, and young people, and additionally the Minymaku Kutju Tjukurpa – Women's Business Manual which has STI checks for women. This additionally includes contraception and pregnancy options.

Aboriginal Health Practitioner training

Certificate 4 for Aboriginal Health Practitioner (AHP) training includes an elective subject for STI care, unplanned pregnancy and abortion access. Aboriginal Maternal and Infant Care workers go on to further training after Certificate 4, so many but not all will have completed the sexual and reproductive health module.

There is a shortage of trained AHP in sexual health care in South Australia, more so in country areas. There are barriers in access to training such as inability to leave the community to do the training or being unable to afford training even if it is free. A model described in the consultation process, available in different contexts, includes a funded traineeship. This would involve people applying for a role, in this instance STI/BBV worker in an Aboriginal Community Controlled Health Organisation, and as part of the role the training is supported and funded to attain the necessary AHP qualifications.

AHP scope of practice

The consultation process identified that in many instances, AHP are not working to their full scope of practice relating to STI control. This should be further explored to understand the barriers to this limited scope of practice.

Need for partnerships in the local service area for EMA

Given the practice of EMA care requires other services such as ultrasound access, it is important that Aboriginal Health Services develop local partnerships to support the care provision. A case study from Pangula Mannamurna is presented below to demonstrate an effective approach to regional care:

About 12 months ago Pangula staff made the decision to offer EMA to their clients as a service from the clinic. This was a significant decision for their clients, as the region of Mount Gambier does not currently have public pregnancy termination access, with all clients requiring referral to Adelaide (Pregnancy Advisory Centre), or Warrnambool Victoria, for care.

To establish the service, it was confirmed that there was a GP prepared to prescribe the MS 2-Step treatment. Furthermore, the clinic midwife negotiated, on behalf of clients, bulk billed ultrasounds from the local private provider, which are arranged in a timely manner. The referral includes the notation "? MS 2-Step" to point out to the radiographer the indication, ensuring empathy of service delivery at the time of appointment. Once confirmed and commenced the local pharmacies then dispense the MS 2 –Step medication. Follow up care is mainly led by the clinic midwife, with the GP and local Obstetrician involved if and when indicated. The care delivered in the clinic is a partnership model that has been formed between the clinic midwife and prescribing GP, with close midwifery follow up and support for the client. The need for confidentiality is paramount throughout this process and is achieved through limiting the number of staff involved in the care.

Broader SH and RH service support

There appears to be a major gap in the ability of some Aboriginal Health Services to provide IUD insertion and removal. There are gaps in access to training in the procedure that can be sourced locally. A regional approach where a number of staff can be trained locally with a visiting trainer is needed, with the clinical part of the training able to be conducted (with consent) using a local patient list.

STI testing can be supported by an active campaign to de-stigmatise STI testing. This includes various merchandise such as t-shirts for staff, posters, videos for the televisions in the waiting room which encourage clients to talk about sexual health matters to staff. Visible and encouraged access to condoms is also recommended.

Safe spaces for women

There have been models of safe spaces for Aboriginal women to conduct women's business in a private, confidential manner. For example, the Port Augusta Well Women's House (closed in 2019) was a place where Aboriginal women could come together for comprehensive women's wellness. This space has been closed for some years.

Many EMA prescribing doctors will only provide the service in a regional centre. This means for women who are living remotely that they will need to travel and be accommodated to receive the service, and for some days after taking the abortion medications. A residential Women's Space in selected regional towns (for example, Port Augusta and Ceduna) would provide a safe space for women to receive abortion services. It would extend beyond abortion services to other health needs for women importantly, such that confidentiality is maintained (the service is not known only as an abortion service which would risk confidentiality).

Education in schools

There is currently no Aboriginal-specific sexual and reproductive health education in schools in SA. While many Aboriginal students in Department of Education schools would receive education by teachers trained in the mainstream SHINE SA Relationships and Sexual Health Curriculum, it is not tailored to Aboriginal young people specifically and is not provided by Aboriginal educators.

From 2010-2016 there was a program in schools for Aboriginal young people called Yarning On, developed and run through SHINE SA and originally funded by the Federal Government. This program's Federal funding ceased in 2013 and was continued by state funding until 2016 when it ended due to withdrawal of funding. Yarning On included two programs, the Investing in Aboriginal Youth Program and Aboriginal Focus Schools Program. An evaluation of the program, conducted by Flinders University found the programs had built significant capacity among individuals, organisations and communities to promote sexual health, wellbeing and safety for Aboriginal young people. There should be serious consideration for reinstating this program in the long term, as capacity building in this area requires repeated, sustained interactions, and with each new cohort of young people.

There is a community-based Aboriginal education program through SHINE SA, with two Aboriginal Community Educator/AHPs running the program.

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*Literature review methods EMA:

1. Medline OVID search through the University of Adelaide Library
2. Terms used and limits: early medical abortion (keyword), limit to year from 2010
3. Reviewed 174 titles, further in-depth review on 23 selected
4. Additionally searched the reference list of all 23 included papers.

*Literature review methods STI:

1. Medline OVID search through the University of Adelaide library:
    a. Terms used: (Sexually transmitted diseases (MESH) or sexually transmitted infections (keyword)) and health services.

       OR Sexually transmitted diseases (MESH) and reproductive health services

    b. Limit to years from 2010 and in English
    c. Reviewed 357 titles and abstracts, finding 16 papers to review.
2. Reviewed the contents of the BMJ journal Sexually Transmitted Infection for the last 3 calendar years (from January 2020), finding an additional 12 papers
3. Reviewed the WHO website.

Appendix 1: Consultation summary

	Who was consulted	Purpose	Type	Number of people
	Country PHN	Lead organisation		
	SHINE SA	Lead organisation	Executive Aboriginal Educator	2
1	Aboriginal Health Council of SA	Peak body for Aboriginal Health Services	Health peak body Aboriginal and Torres Strait Islander	2 meetings: STI/BBV team (4 staff) CEO
2	Communicable Disease Control Branch	State lead for STI control under the *Public Health Act*	Public health system	2
3	LHNs in country SA	Major service providers in country SA	Public health system	EFNLHN: Medical Project Officer
5	Chief Nurse	Lead for nursing and midwifery in SA	Nursing and Midwifery Lead for SA	1
6	Prison Health Service	Opportunity for screening and treatment while in-carcerated, rural sites	Public health services	1 Nurse lead
7	Office for the Commissioner for Children and Young People	Substantial consultation of the community	Policy, advocacy	1
8	Commissioner for Aboriginal Children and Young People	Substantial consultation of the community	Policy, advocacy, Aboriginal and Torres Strait Islander	1
9	Regional Support Unit	Oversees public health services to country SA	Public health system	1 Medical Officer
10	Chair SASBAC/ CPHO	STI and BBV control chair and CPHO	Public health system	1 Medical Officer
11	Chair of the TOP implementation group	MS2Step implementation chair	Public health system	1

Who was consulted		Purpose	Type	Number of people
12	Co-convenor of the SA Abortion Coalition	Understands the EMA landscape in SA and best practice internationally	Community	1
13	Adelaide Sexual Health Centre	Specialist clinical STI services for SA	Public health system	3 Medical Officers
14	Australian College of Rural and Remote Medicine	Peak body for rural GP services in SA	Medical	1 Medical Officer
15	SA Medical Imaging	Advice on availability of imaging for dating scans	Public health system	2
16	SIN	Peak body for sex workers in SA	Community	2
17	Aboriginal Health Services, multiple	Key PHC service delivery in regional areas of SA	Community health, Aboriginal and Torres Strait Islander	Pangula Mannamurna 1 Port Lincoln Aboriginal Health Service 1
18	Family Planning Alliance Australia	Peak body	Community, advocacy	1
19	Pregnancy Advisory Centre	Key and major service provider for TOP in SA	Medical, public health service	3 Medical, Nursing, Strategy
20	Children by Choice	TOP access	Community, advocacy	1
21	RFDS	Remote PHC services	Medical, community	2 Medical, 1 Nursing
22	Guardian CYP	Understanding of views of young people under Guardianship of the CEO, DCP	Policy, advocacy	1
23	EMA provider in country area	Yorke Peninsula region	Medical (GP)	1

Appendix 2: Nurse prescribing and funding

Models for prescribing (Nursing and Midwifery Board)

1. Autonomous: prescribing within scope of practice without the approval or supervision of another health professional but working collaboratively in a team.
2. Supervised: the prescriber has been educated to prescribe and has limited authorisation to prescribe. Prescribing occurs under the supervision of another authorised health professional. Supervision guidelines are established for the organisation tailored to the clinical governance frameworks, policies and procedures of the organisation.
3. Structured prescribing arrangement: prescriber has a limited authorisation to prescribe, and does so under a guideline, protocol or standing order.

Nurse Practitioners

Currently Nurse Practitioners (NP) are authorised to independently order investigations, make diagnoses and prescribe medications within their scope of practice (as above, this is Autonomous prescribing). From a sexual and reproductive health perspective, this includes the ability to prescribe antibiotics and MS-2 Step, and further, these medications when prescribed by a Nurse Practitioner are covered by the Pharmaceutical Benefits Scheme.

Nurse Practitioners are able to bill Medicare for the investigations, medication and also for their work in a fee for service model. The rebate for a standard consult is:

In order to do this a NP must (Department of Health and Aged Care) :

- Complete approved education
- Be recognised as a nurse practitioner by Services Australia
- Be registered with the Nursing and Midwifery Board of Australia
- Have a Medicare Provider number
- Enter into a collaborative arrangement with a medical practitioner.
- To prescribe PBS medicines NP must also be approved as an authorised PBS prescriber.

Endorsed midwives

Currently endorsed midwives are authorised to independently order investigations, make diagnoses and prescribe medications within their scope of practice (as above, this is Autonomous prescribing). From a sexual and reproductive health perspective, this includes the ability to prescribe antibiotics and MS-2 Step, and further, these medications when prescribed by a midwife are covered by the Pharmaceutical Benefits Scheme.

Endorsed midwives are able to bill Medicare for the investigations, medication and also for their work in a fee for service model.

In order to do this a midwife must (Services Australia):

- Be a midwife with a relevant AHPRA endorsement
- Complete approved education
- Have a Medicare Provider number
- Enter into a collaborative arrangement with a medical practitioner.
- To prescribe PBS medicines midwife must also be approved as an authorised PBS prescriber.

There are a large range of item numbers for midwives, including telehealth numbers.

Registered Nurses (RN)

RN who are not also a NP or midwife are not able to prescribe in the autonomous model in SA.

For EMA prescribing there is no legal barrier within the *Termination of Pregnancy Act* to prescribing, however there is through Section 18 of the *Controlled Substances Act 1984*. This section requires that:

- Only medical practitioners, dentists and nurse practitioners can prescribe any medication, or
- Under section 94 of the Health Practitioner Regulation National Law endorse the practitioner registration as being qualified to prescribe a medicine, or
- The practitioner is authorised to prescribe by regulation of the *Controlled Substances Act*.

Practice nurses are able to bill Medicare for services on behalf of a medical practitioner in limited circumstances. These include health assessment follow up, chronic disease monitoring and support and antenatal services. Practice nurse cannot prescribe items under the pharmaceutical benefits scheme which effectively precludes them from prescribing, despite the possibility of a supervised or structured prescribing model.

Appendix 3: Number of STI cases notified by calendar year and Local Health Network (LHN) of residence, South Australia, 1 January 2016 to 31 December 2023

LHN*	Notifiable condition	Calendar year of onset							
		2016	2017	2018	2019	2020	2021	2022	2023
Barossa Hills Fleurieu	Chlamydia	470	464	443	450	403	431	450	510
	Gonorrhoea	46	72	72	82	88	62	87	104
	Infectious syphilis	<5	≥5	≥5	≥5	≥5	≥5	≥5	≥5
Eyre and Far North	Chlamydia	186	171	283	235	236	234	183	246
	Gonorrhoea	166	163	246	257	185	313	232	296
	Infectious syphilis	≥5	≥5	≥5	≥5	≥5	≥5	<5	≥5
Flinders and Upper North	Chlamydia	135	148	158	122	99	124	89	168
	Gonorrhoea	25	24	63	60	54	56	74	88
	Infectious syphilis	<5	≥5	≥5	<5	≥5	<5	<5	≥5
Limestone Coast	Chlamydia	150	152	141	143	162	152	181	181
	Gonorrhoea	15	11	25	15	21	8	10	16
	Infectious syphilis	<5	<5	≥5	≥5	<5	<5	<5	<5
Riverland Mallee Coorong	Chlamydia	155	196	174	166	154	142	157	206
	Gonorrhoea	11	25	7	27	35	12	30	43
	Infectious syphilis	<5	<5	≥5	≥5	<5	<5	≥5	<5
Yorke and Northern	Chlamydia	114	123	158	151	115	114	115	142
	Gonorrhoea	8	15	11	25	18	9	20	17
	Infectious syphilis	<5	<5	<5	<5	<5	<5	<5	<5
Total Country SA LHNs	Chlamydia	1210	1254	1357	1267	1169	1197	1175	1453
	Gonorrhoea	271	310	424	466	401	460	453	564
	Infectious syphilis	16	36	57	32	27	35	36	42

Note: Data for all infections/diseases were extracted from the SA Health Notifiable Infectious Disease Surveillance (NIDS) system on 15 April 2024. Data are presented by date of calculated onset, which reflects the earliest recorded date associated with a notification; for STIs this normally defaults to the specimen collection date. For conditions with fewer than five notifications per year in any LHN, counts are not disaggregated geographically. Please note that surveillance data are subject to continuous revisions.

*There were a total of 433 notifications (<1%) with an invalid or undisclosed postcode.

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