HEALTH EQUITY MATTERS
HIV. LGBTIQA+. COMMUNITIES.

Better Practice Incubator: Peer-led HIV Contact Tracing Pilot

Report June 2026

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Health Equity Matters pays its respects and acknowledges the Traditional Owners and Custodians of the unceded lands on which this and our other domestic work takes place. We acknowledge Elders past and present and extend our respect to Aboriginal and Torres Strait Islander peoples across the many Countries of which Australia is comprised.

Sovereignty was never ceded. Always was and always will be Aboriginal land.

Artwork credit: ENOKI (Dja Dja Wurrung, Yorta Yorta)

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Foreword

Australia is moving steadily closer to its vision of virtually eliminating HIV transmission. The ninth National HIV Strategy identifies the conception of innovative approaches to HIV testing, treatment, prevention, and stigma reduction as a priority for Australia if we are to achieve this vision.

Through funding from the Australian Centre for Disease Control, Health Equity Matters has been able to deliver several pilot projects that provide the sector with opportunities to trial and understand
new measures that might positively impact the national response.

The organisation's Peer-led Contact Tracing project is a direct response to this priority and is one of these projects. It places Australia's peer workforce at the centre of the contact tracing process, offering significant value to Australia's HIV response, and a window into incorporating peers in the delivery of contact tracing for the control of other infectious diseases.

Current responsibility for contact tracing rests with the diagnosing clinician or, where available, specialist state health services. Our project broadens this model by leveraging the skills and lived experience of Australia's HIV peer workforce to support HIV contact tracing. This enables people newly diagnosed with HIV with the opportunity to engage with peers in contact tracing conversations.

In Australia, HIV is predominantly transmitted through sexual contact between gay and bisexual men, and trans men. Increasingly new HIV infections are among communities of gay and bisexual men, and trans men from culturally and linguistically diverse backgrounds. Using peers to lead contact tracing will ensure critical information about HIV can be provided to people newly diagnosed with HIV in culturally appropriate language and more candid conversations can occur with sexual contacts. This supports our efforts to target people who are at higher risk of HIV with information about testing and access to care.

We thank the Australian Government for supporting Health Equity Matters to pilot this innovative project and we look forward to sharing the insights from the project with sector partners.

Dash Heath-Paynter
Chief Executive Officer

Acknowledgements

Health Equity Matters acknowledges the hard work and leadership of Valerie Arsenova, who was instrumental in the initiation and implementation of this project. Thank you, Val, for your enduring contribution to this important work.

Health Equity Matters also wishes to acknowledge and thank each of the peers involved in this pilot, and to extend this thanks to our members and affiliate members who readily engaged with and supported this work. Each of the peers contributed significant time, effort, and professional and lived expertise to the pilot, enabling its successful design and implementation. Thank you.

Health Equity Matters extends its thanks to the pilot steering committee members, implementation partners, clinical partners and sector partners who worked in deep collaboration to bring this pilot to fruition. Work of this nature would not be possible without strong partnership from across Australia's HIV response, and we extend our deepest thanks to all involved.

Finally, Health Equity Matters wishes to thank its project partners, Professor Mark Stoové and Dr Michael Traeger from Burnet Institute, and Cherie Bennett and Joshua Borja from ASHM, whose many contributions to this project led to successful implementation. Thank you.

Project Partners





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1.0
Introduction

Australia's Ninth National HIV Strategy stands as a global benchmark for a successful, partnership-based response to HIV, with the central vision of achieving the virtual elimination of HIV transmission by 2030.

While Australia has achieved many of its goals and is moving closer to realising this vision, inequities in the nation's HIV response persist and must be addressed if this ambition is to be fulfilled.

Historically, the Australian HIV response has successfully leveraged peer-led models to improve engagement in testing, treatment, and psychosocial support. Peers — individuals with lived experience of HIV or deep community connections — bring a unique perspective, understanding and cultural authority that greatly facilitates trust building with community members accessing peer-led sexual health services. They operate from a shared community lens, reducing the power imbalance inherent in clinical interactions and providing a safe space to navigate sensitive conversations. Yet despite the success of peer-led models in other areas, the application of peer-led approaches to the specific domain of contact tracing has remained largely unexplored in Australia.

Recognising this gap, Health Equity Matters initiated the Peer-led HIV Contact Tracing Pilot. Launched in June 2025, this six-month initiative sought to assess the feasibility and acceptability of a model in which trained peers support newly diagnosed individuals to identify and notify partners. The pilot was designed to test whether a peer-led approach could offer a more culturally safe, less intimidating alternative to traditional clinical contact tracing, thereby improving outcomes.

The journey to implementation was not linear. The pilot began with an ambitious vision of an end-to-end peer model, in which peers would be responsible both for identifying contacts and conducting the notification calls. However, rigorous consultation with a national steering committee comprising clinicians, public health experts, and community leaders identified several complex risks associated with this model. These included the potential for intimate partner violence, and the identification of complex cases requiring public health unit escalation. To mitigate concerns about the model's ability to navigate these risks effectively, the scope was adjusted and the model was significantly refined. The final model retained the peer's critical role in supporting the ***index client*** to identify ***contacts***, but removed the peer's direct role in notifying them, with this step reserved for specialist public health units to ensure safety and legal compliance.

The pilot was successfully implemented across eight clinical sites in New South Wales, Victoria, and Western Australia. While the number of referrals was lower than anticipated, the two clients who engaged with the service received a supportive, non-judgmental experience, with peers successfully identifying multiple ***contacts*** for both. Critically, the pilot illuminated several challenges which exist within collaborations of this nature, particularly regarding data security, governance, and employment law.

This report documents the development, implementation, and evaluation of this novel pilot. It moves beyond simple metrics to explore the operational, ethical, and strategic lessons learned. By examining the challenges faced at each of the project's milestones, the report aims to provide a model that can be adapted and expanded across community and government health settings. We argue that while the pilot was small in scale, its implications are significant: a peer-led contact tracing model is not only possible but holds value to Australia's HIV response.

2.0
This Report (scope)

This report documents and evaluates Health Equity Matters' Peer-led HIV Contact Tracing Pilot. It outlines the background and rationale for the project and describes its three key outcomes:

1. Development of the peer-led contact tracing model.
2. Development of a peer workforce model.
3. Implementation of the pilot.

The report then examines the implementation challenges encountered during the pilot and reflects on the key learnings identified through the process. Finally, it considers the implications of the findings for Australia's HIV response and identifies opportunities for future pilot programs to leverage and build upon the insights presented. Access to the results of the acceptability evaluation which was completed as part of this project will be made available separately to this report and once a peer review has been conducted.

Despite the strong commitment of clinicians and public health teams to supporting partner notification, the experience of contact tracing can vary considerably across Australia's health system. Many HIV diagnoses occur within general practice and primary care settings where clinicians may see relatively few cases and may have limited time or specialist support available to facilitate detailed contact tracing discussions. In addition, the roles and responsibilities of clinicians, public health units and sexual health services in supporting contact tracing differ across jurisdictions, creating variability in how individuals experience the process. These structural factors do not reflect a lack of commitment by clinicians, but rather the realities of a complex and resource-constrained health system.

Within this context, there may be value in complementary models that provide additional support to both individuals newly diagnosed with HIV and the clinicians supporting them. Peer-led approaches have long been recognised as a cornerstone of Australia's HIV response, contributing to improved trust, engagement and culturally safe communication around sensitive health issues. A peer-led contact tracing model has the potential to support more client-led conversations, provide additional time and space for individuals to discuss partners and risk, and help reduce some of the discomfort that can arise when discussing sexual history. Such a model may also support clinicians by providing an additional pathway through which patients can access informed, empathetic and culturally responsive support during the contact tracing process.

Contact tracing identifies individuals who may have been exposed to HIV and enables them to be supported to access testing and care. It also provides opportunities to offer prevention information and treatment support for those who are diagnosed. However, partner notification can present challenges. Shame and fear of stigma may discourage individuals from notifying partners themselves. Many clinicians report limited time or confidence in conducting detailed contact tracing discussions, while public health authority involvement can sometimes generate mistrust, leading some individuals to feel reluctant to disclose sensitive sexual history information.

Effective contact tracing therefore requires highly nuanced, culturally appropriate and sensitive approaches. When undertaken effectively, it can help reduce undiagnosed HIV in the community, particularly among people who test infrequently. In response to these challenges, Health Equity Matters explored the potential for a peer-led model of contact tracing. Peers may include people with HIV, individuals from similar communities, or people with shared identities based on sexuality, gender, age, cultural background or migration experience. Within healthcare settings, peer workers can help foster a comfortable, non-judgemental and empathetic environment for individuals navigating a new diagnosis. Shared lived experience or community connection may reduce some of the discomfort associated with discussing a positive diagnosis or past sexual history.

This pilot sought to build on the innovative and impactful peer-led work that occurs across a range of clinical and non-clinical settings within the Health Equity Matters membership. While the model of peer-led contact tracing for HIV remains relatively novel, particularly within general practice settings, the pilot sought to leverage the strong history of partnership between community organisations and clinicians to explore the feasibility and acceptability of a peer-led contact tracing model to support people newly diagnosed with HIV.

3.0
Project Background and Rationale

Receiving a new HIV diagnosis can be a challenging and overwhelming experience for many people. An often-described reason for this is the number of conversations that occur alongside receiving a diagnosis.

These discussions may include starting treatment, understanding the implications of the diagnosis, and navigating the emotional and social impact of living with HIV. Some of these conversations can be particularly challenging, including discussions about contact tracing and partner notification.

HIV is a nationally notifiable disease in Australia. Following diagnosis, clinicians are required to notify public health authorities and discuss partner notification and contact tracing with the individual diagnosed. This involves a clinician discussing previous sexual history with the individual and working with them to identify partners who may potentially be at risk and therefore considered contacts. Identified contacts may then be notified by the individual themselves, by the treating physician, or, following referral, by the relevant state-based public health team with specialist capacity to undertake partner notification. Notification often occurs at the time of diagnosis; however, it may also occur during subsequent clinical appointments, depending on the needs and readiness of the individual.

While significant efforts have been made by clinicians to facilitate a positive, low-resistance and client-led experience of the contact tracing process, adverse or stigmatising experiences can still occur. These experiences are frequently reported within general practice settings, although they have also been described within more specialised HIV and sexual health services.

Peer-led models have demonstrated strong effectiveness within Australia's HIV response, and the meaningful engagement of peers has played a critical role across areas historically considered the domain of clinicians and health professionals. Peer-led service delivery has been shown to improve engagement with healthcare services and support individuals to navigate sensitive health conversations. This occurs for several reasons, including increased cultural understanding and safety, greater levels of trust when discussing sensitive topics related to sexuality and sexual practices, and the cultural authority peers can bring through shared lived experience or community connection. In some cases, individuals may perceive clinicians primarily through their role as healthcare or government workers, whereas peers may be viewed first through a shared community lens

An external peer-led approach may also facilitate a lower level of perceived risk for individuals on temporary, student or working visas. Concerns around confidentiality, disclosure and potential visa implications have been reported as barriers to accessing HIV testing, care and support. Peer-led engagement can help reduce some of these concerns by providing individuals with a trusted and culturally responsive point of contact.

Health Equity Matters and NAPWHA, together with their member organisations and affiliates, employ a highly skilled and experienced peer workforce operating across both clinical and non-clinical settings. Exploring the feasibility and acceptability of peer-led contact tracing therefore presents an opportunity to expand Australia's investment in peer-led approaches to HIV prevention, care and support.

This pilot comes at a significant time in Australia's HIV response. As Australia moves closer towards its goal of the virtual elimination of new HIV transmissions, inequities within the response are becoming increasingly visible. Late diagnosis, delayed commencement of treatment, and lower rates of treatment initiation and retention in care contribute to higher rates of transmission among some communities and remain a source of preventable morbidity and mortality for people with HIV – particularly among communities who experience structural and social marginalisation on the basis of culture, ethnicity, language spoken, migration experience, gender identity and other intersecting factors.

4.0
Project Aim and Objectives

Aim:

Health Equity Matters' Peer-led HIV Contact Tracing Pilot aimed to assess the feasibility and acceptability of a peer-led contact tracing model to support people newly diagnosed with HIV to identify and notify partners who may have been exposed to HIV.

Objectives:

1. **Develop a model for peer-led HIV contact tracing** in consultation with clinicians, community organisations and research partners.
2. **Establish partnerships with participating clinical services** to pilot the peer-led contact tracing model.
3. **Recruit and train a peer workforce** to deliver confidential and culturally appropriate support to people navigating partner notification following an HIV diagnosis.
4. **Pilot the peer-led contact tracing model** within participating clinical settings to explore its operational feasibility and integration with existing partner notification processes.
5. **Evaluate the implementation of the model**, including its feasibility, acceptability and operational considerations, and document key learnings to inform future program development.

Key Terms

'Health Care Provider'	Used to reference general practitioners, primary care providers, nurses and other medical professionals providing sexual health services specific to contact tracing for HIV.
Index	The formal term used to reference the client who has just received a new HIV diagnosis. The contact tracing conversation occurs first with this person. This report avoids using 'index' solely to describe a client accessing the service — we use 'index client' instead.
Contact	Used to reference identified sexual partners of the index client who may also be at risk of HIV transmission.

5.0
Project Governance

At the start of the project, Health Equity Matters assembled a project steering committee made up of experts from its members and affiliate organisations, sexual health and contact tracing specialists and clinicians from across Australia's HIV response.

The steering committee's role was to provide expert guidance to senior project staff throughout the life of the pilot. This included during the initial stages, when discussions were focused on creating a suitable peer-led contact tracing model. The committee also contributed heavily to pre-implementation, implementation and evaluation discussions, and was regularly consulted during the creation and refinement of the model, and of clinical and peer protocols. Guidance received from steering committee members was instrumental in supporting project staff to navigate the complex implementation environment that this project operated within.

Project Steering Committee members included:

Name	Organisation
Professor Dr. Jason Ong	Director, Melbourne Sexual Health Centre
Brent Clifton	Deputy Director, National Association of People with HIV Australia (NAPWHA)
Dr Christopher Lemoh	Infectious disease and general physician
Troy Sinkovic	Operations Manager, Testing Services, ACON
Melissa Warner	Chief Executive Officer, Queensland Positive People (QPP)
Sharmila Radha Krishnan	Manager, Clinical & Therapeutic Services (WAAC)
Jane Hooker	Manager, BBV/STIs | Communicable Disease, Victorian Department of Health

Evaluation Partners:

Health Equity Matters partnered with Professor Mark A Stoové and Dr Michael Traeger from Burnet Institute to undertake and lead the evaluation of the pilot.

Clinical training and protocol creation partners:

Health Equity Matters partnered with Cherie Bennett and Joshua Borja from ASHM on the refinement of our clinical protocol and on the development and delivery of the training provided to the pilot's Peer Contact Tracers.

6.0
Outcome One: Development of the peer contact tracing model

6.1 Current Contact Tracing Protocol

In Australia, the management of HIV is governed by each state and territory's respective HIV management guidelines. Additional to jurisdiction-based management guidelines, healthcare providers are also able to access the Australian contact tracing guidelines authored by ASHM.

Contact tracing forms a core pillar of the effective management of HIV in Australia and involves the supporting health care provider working with the client receiving a new HIV diagnosis to identify any previous sexual partners who might also be at risk of HIV transmission. These ***contacts***, once identified, are contacted by either the supporting health care provider or relevant public health unit. ***Contacts*** are advised that they have recently been in contact with a person who has received an HIV diagnosis and are encouraged to seek testing for HIV. Supporting health care providers then help these ***contacts*** access testing for HIV.

Contact tracing conversations often occur at time of diagnosis as required by HIV management guidelines. However, health care providers with contact tracing experience report that the timing and success of these conversations often depends on client trust, client capacity at time of diagnosis and reassurance that the process will be confidential and appropriately sequenced. Thus, while the topic of contact tracing is typically broached with clients at time of diagnosis, subsequent conversations may be required to identify and liaise with ***contacts***.

6.2 Initial Peer Contact Tracing model

At the project's inception in January 2024, it was envisaged that peer contact tracers would be responsible for the full contact tracing process. This involved two key steps:

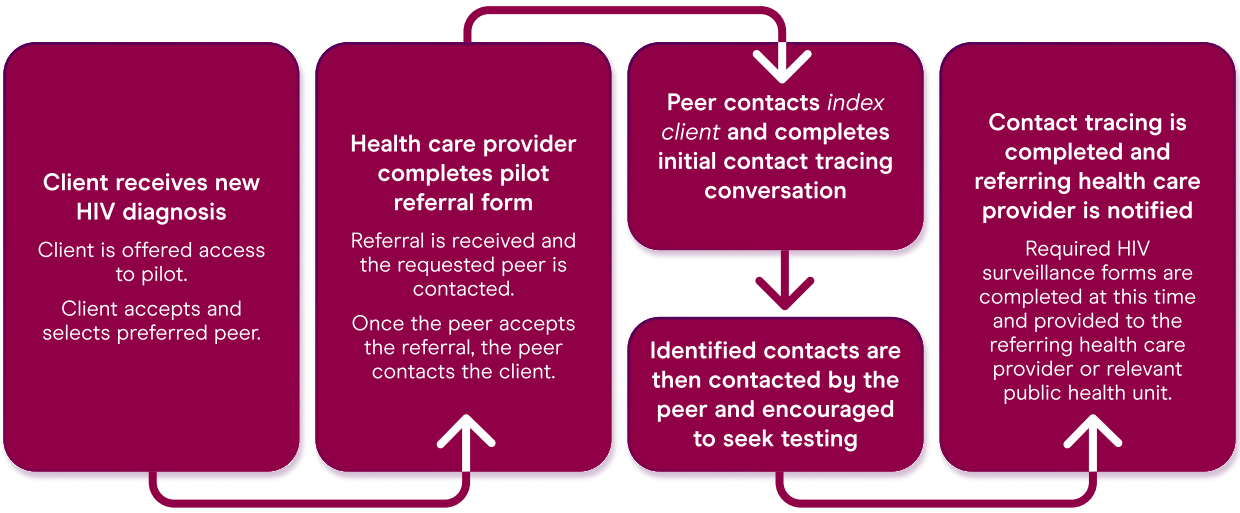
Step 1. **An initial contact tracing appointment.**

Involved peers holding an initial appointment with the ***index client*** to identify potential ***contacts***.

Step 2. **Contacting identified contacts.**

Peers would then contact identified ***contacts*** to encourage them to seek testing.

Figure 1: Initial Peer Contact Tracing Model



7.0 Outcome Two: Peer Workforce Model

7.1 Peer roles and responsibilities

Peers act as the primary contact for clients accessing the pilot service and are responsible for the following:

- Conducting peer contract tracing appointments with people referred to the service via telephone or secure videoconferencing.
- Providing an empathetic, safe, confidential and respectful contact tracing experience for clients accessing the service — drawing on lived experience as a peer to support the rapport-building process.
- Supporting clients in the identification of potential ***contacts***.
- Ensuring accurate and timely entry of appointment data (including identified ***contacts***) and communicating any additional relevant information relating to the safe and compliant running of the pilot.

Peers were also responsible for providing clients accessing the pilot with information about available support services in their local state or territory, such as peer-led organisations for people with HIV or additional community-specific health information. While peers were not required to provide peer support outside the scope of contact tracing, we note that clients did ask lived experience related questions which peers were well positioned to answer on the basis of being peers themselves.

7.2 Who is regarded as a 'peer'

Previous attempts to establish a national framework to define what constitutes a 'peer' or 'peer worker' include NAPWHA's Peer Support Standards 2020 (Ogier, 2020). However, as Krulic et al. (2025) note, conceptions of who constitutes a 'peer' are often mediated by a range of factors, including culture, gender and sexuality, or—in the case of this pilot—HIV status.

During the pilot's development, steering committee members, NAPWHA and its members and Health Equity Matters members and affiliates proposed that a 'peer' in this context should be a person living with HIV. Unfortunately, this definition was not feasible and presented the pilot with two significant limitations: the capacity of Australia's HIV peer workforce to support the pilot, and access to peers who were able to provide peer support through a shared lived experience of culture, gender or other intersectional experiences facing clients likely to be referred to the service.

Capacity limitations

Australia's HIV-positive peer workforce, while well engaged, skilled and impactful, remains small and operates on limited funding. Peer workers currently engaged across the membership of Health Equity Matters and NAPWHA have substantial workloads and very limited availability. Ultimately this led to challenges in the pilot's ability to engage available peers.

How this pilot defines who constitutes as a 'peer'

To respond to these challenges, it was determined that, for a person to be deemed a 'peer', a worker needed to demonstrate either:

- experience in and aptitude for providing HIV-related peer support, peer navigation or peer education for people with HIV.
- experience working within peer spaces (both clinical and non-clinical) to support people living with or receiving a new diagnosis of HIV.

This definition enabled project staff to engage peers who brought significant professional and lived expertise to the pilot.

8.0
Outcome Three: Implementation of the pilot

Implementation of the pilot commenced on 6 June 2025 and was originally scheduled to conclude on 30 November 2025. This timeline was subsequently extended to 30 April 2026 to allow for additional client referrals and to accommodate the complexities of the recruitment and onboarding phases.

Seven participating sites were engaged across three states. Four were located in New South Wales, with two in Victoria and one in Western Australia (following the model adjustment).

Table 2: Record of Implementation sites

State/Territory	Service Name	Service Type
Victoria	Melbourne Sexual Health Centre	Sexual Health Centre
Victoria	Prahran Market Clinic	Private clinic
New South Wales	Bondi Road Doctors	Private clinic
New South Wales	East Sydney Doctors	Private clinic
New South Wales	Taylor Square Private Clinic	Private clinic
New South Wales	North Sydney Local Health District	Local Health District run sexual health service
Western Australia	M-Clinic	Community Health Clinic

A note on the above table: One clinic based in Queensland was due for onboarding to the pilot but later needed to disengage before implementation due to site specific assessment procedures and the cost/benefit of undertaking these procedures—this clinic is omitted as a result.

8.1 Recruitment of participating clinical services

Shortly after the pilot's conceptual commencement in January 2024, initial mapping conversations began to identify appropriate sites. This process was formalised by late February 2024, with the first recruitment drives occurring in late February and early March.

Initial recruitment focused on direct engagement, often via email, with sexual health services reporting high caseloads of new HIV diagnoses. It was during this first wave that the project encountered significant clinician resistance to the proposed model.

Table 1: Post-Training Evaluation Responses

Metric	Strongly Agree / Very Confident	Agree / Confident
Confidence: Peer Support	2 (50%)	2 (50%)
Confidence: Contact Tracing Process	2 (50%)	2 (50%)
Confidence: Assess Transmission Risk	4 (100%)	0 (0%)
Confidence: Active Listening	4 (100%)	0 (0%)
Confidence: Manage Emotions & Referrals	2 (50%)	2 (50%)
Speakers Effectively Communicated	3 (75%)	1 (25%)
Pace of Delivery	2 (50%)	2 (50%)
Encouraged Participation	4 (100%)	0 (0%)

RedCap Training Module

Health Equity Matters Project staff created an online, pre-recorded RedCap training module outlining the correct operational procedures to ensure a safe, confidential and effective contact tracing process using the specially created RedCap peer-led contact tracing platform.

6.3 Model Revision

During pre-implementation, significant concerns were raised by project steering committee members and sites that were interested in participating in the pilot. In response, the team made significant changes to the pilot model to enable implementation. These changes are outlined below.

Removal of step 2 from the peer contact tracing process

As the project moved closer to implementation and training materials were finalised, steering committee members who were themselves responsible for leading specialist public health contact tracing teams expressed concerns about the depth and suitability of planned training. Key concerns related to whether the planned training would be sufficient to ensure that peers could effectively respond to the complexity and challenges that often result from notification of identified ***contacts***, while maintaining their own personal wellbeing. Steering committee members noted that for public health units, intensive and ongoing training occurs before a clinician can notify identified ***contacts***. Health Equity Matters noted that it was confident in the training and capacity of our peers to undertake these calls — given that many currently work in high-complexity peer roles that involve navigating trauma. However, due to genuine resource limitations affecting the pilot's ability to respond to the types of escalations described by clinicians (such as intimate partner violence or potential harm to minors) it was decided that in the interest of both client and peer safety and care this part of the model would be removed.

Differing levels of comfort with the model led to unique workflows for each state and territory engaged in the pilot

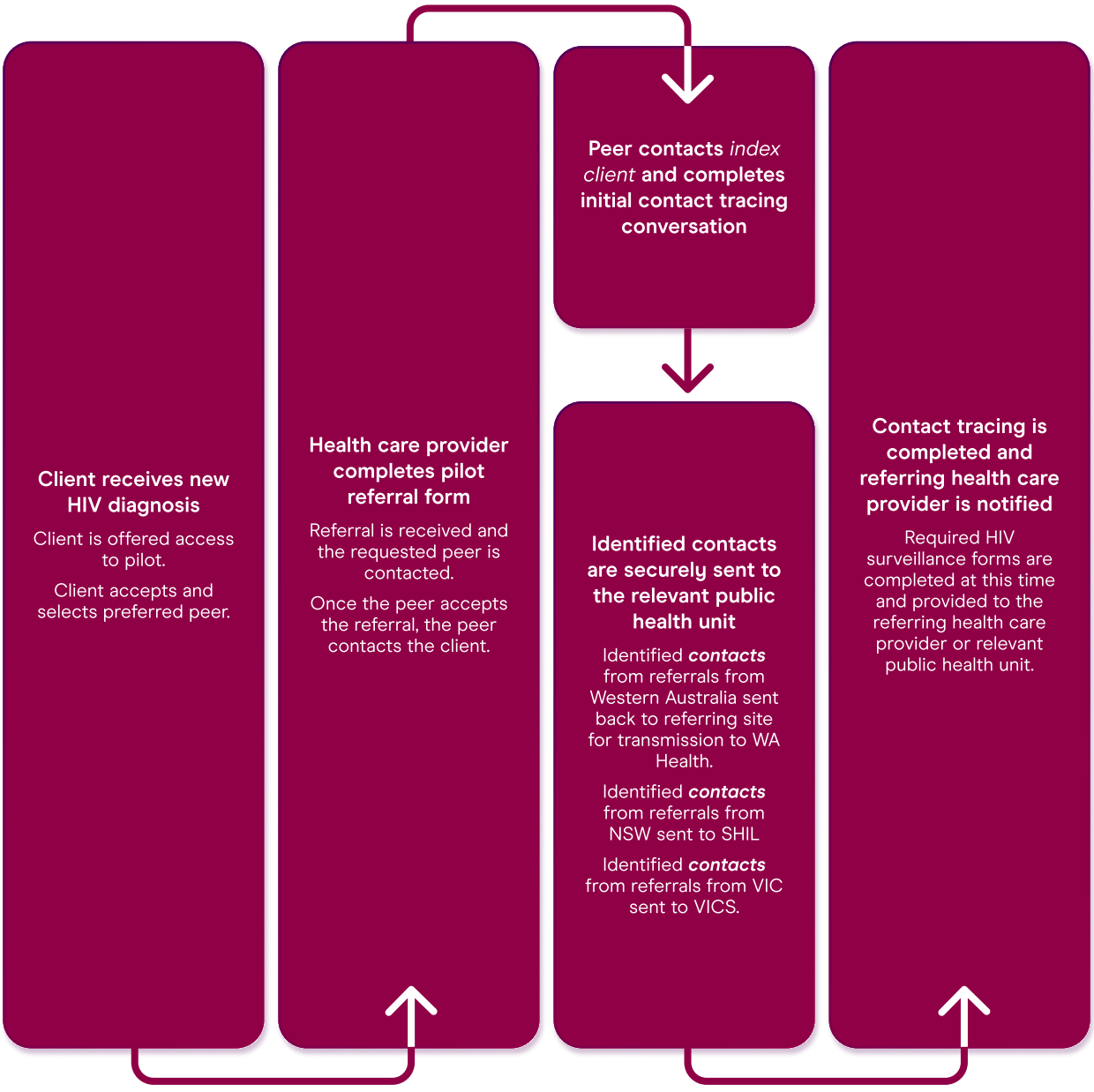
Initial pre-implementation conversations with state and territory health ministry counterparts, public health clinics and sexual health units responsible for contact tracing revealed differing levels of comfort with and confidence in the proposed peer contact tracing model. Concerns included unease with asking peers to navigate the complexity of calls with identified ***contacts*** (VIC), concerns about client data transmission and reporting to state infectious disease management bodies (SA), internal approval timeframes (QLD) and concerns about the reproduction of existing service provision (NSW). Securing the support and involvement of these stakeholders required the model to be tailored in response to the concerns raised by each. We note that we were only successful in progressing involvement with our counterparts in New South Wales, Victoria and Queensland because of these changes. Specific changes to the model included:

- Victorian and New South Wales specialist contact tracing units (VICS and SHIL) requested that any ***contacts*** identified within their jurisdiction be securely sent to their services to enable their specialists to complete the contact tracing process.
- Queensland counterparts requested no amendment to the planned model.
- South Australian counterparts raised multiple concerns about the pilot model and protocol. Project staff attempted to address many of the concerns raised; however, detailed discussions revealed that a number of concerns arose from state-based governance and management of HIV in South Australia. As a result, it was determined that these concerns could not be overcome within the timeframes of the pilot.

6.4 Final Model

After in-depth consultation and model refinement with interested state and territory stakeholders, the below model was agreed upon for implementation in participating sites in Western Australia, Victoria and New South Wales.

Figure 2: Final Peer-led Contact Tracing Model



6.5 System implementation of the peer-led contact tracing model

The privacy, security and protection of client data was a critical focus of Health Equity Matters' peer contact tracing model. To protect client data at each stage of the client's journey, several systems and protocols were implemented. Many of these measures incorporated existing data security measures employed throughout state and territory health departments — identified as part of broad consultation. Additional layers of protection were also applied to these processes on the advice of IT specialists. We outline each system and its use in the client journey below.

Reducing the amount of collected client information:

Only client data which was necessary to the contact tracing process was collected by the pilot service. This balanced the clinical and public health needs required by current contact tracing processes, while ensuring that only minimal data collection occurred. Information about the nature of data collected and how this was treated was accessible to clients at time of referral in the Pilot Privacy Statement (see Appendix A).

RedCap:

A secure web application commonly used in medical and clinical research. Servers were Australian based and use of the service was compliant with relevant state and federal privacy law. The model utilised a custom configuration of RedCap to enable the secure sending and management of referrals to the service. Clinicians would complete a referral to the service using a custom RedCap client referral form. Once received, all referrals were then managed within RedCap until the peer contact tracing appointment had been concluded.

Individual user profiles were created within RedCap to ensure that peers and Health Equity Matters staff only held access to data relevant to their role in the model. Researchers at no time had access to client data. Data provision to our research partners is outlined within the Evaluation component of this report.

Encrypted messaging:

In addition to a raft of security additions made in consultation with IT specialists, Health Equity Matters also used encrypted messaging to ensure the security of data transmitted to specialist contact tracing services.

Password-protected peer contact tracing reports:

At the end of the peer contact tracing appointment, Health Equity Matters staff were responsible for transmitting either a custom contact tracing report or completed state health surveillance form to their state health counterparts to enable the completion of follow-up with identified ***contacts***. These forms were password secured and transmitted using encrypted messaging.

Secure call conferencing:

Peers were provided with user accounts managed by Health Equity Matters and housed within our existing IT environment. All contact tracing appointments occurred using pre-configured software which facilitated both secure calls and video conferencing if preferred by clients.

These steps, in conjunction with internal processes, meant that access to Health Equity Matters' peer contact tracing pilot was secure and largely a 'closed loop' system. While it was possible to implement the pilot securely using the systems provided, interfacing with state and territory health partners could have been improved considerably if greater system interoperability existed between services and across jurisdictions. In the absence of this interoperability, however, the pilot demonstrated an ability to facilitate the safe management of client data.

7.3 Recruitment

It was initially envisaged that peers would be recruited using an external job posting. However, after exhaustive efforts to navigate Australian employment law (***see section 8.5: Governance, Legal and Ethical Challenges and Considerations***), this approach was deemed infeasible. Instead, the project used an internal recruitment process that engaged peers from across the membership.

Peers were recruited from Health Equity Matters' and NAPWHA's membership via a recruitment drive and an internal expression of interest (EOI). This was followed by a formal recruitment process involving behavioural questioning and standard employment pre-checks. At the conclusion of this process, the project had successfully engaged six peers. Two peers ceased involvement prior to implementation due to limited capacity, as described in 7.2.

7.4 Specialist peer contact tracing team

Collectively, the peers engaged in this pilot had over 25 years of experience working in LGBTIQA+ health and the Australian HIV response, with specialist skills in complex client support and case management among their many areas of expertise. While there were limits to some of the intersectional experiences our peers were able to support, broadly speaking, the peer team had a strong combination of professional and lived experience that was supportive of a wide range of community experiences.

7.5 Peer-led training modules and support resources

Peers engaged in the pilot had extensive professional experience working in clinical and non-clinical settings and supporting complex client engagements. As a result, baseline HIV and sexual health knowledge was high, as was confidence (indicated by pre-training evaluation measures). To build on this strong foundation, the pilot implemented two online training modules, which were mandatory for peers participating in the pilot.

The first module was an online, facilitated, peer-led contact tracing workshop led by pilot clinical partners Cherie Bennett and Joshua Borja from ASHM. The second training module consisted of a pre-recorded RedCap database training session developed by Health Equity Matters project staff, focusing on the administrative process of running a peer-led contact tracing session. Finally, to facilitate peer access to all relevant peer-led contact tracing documentation, training modules, referral pathways and other additional supports for peers, Health Equity Matters project staff created a Peer Resource Hub which was accessible online to pilot peers. Detailed information about the provided training modules is outlined in the following.

ASHM Peer-led Contact Tracing Training Module

In close collaboration with ASHM and clinical peer contact tracing experts engaged through the project's steering committee, a comprehensive three-hour online training session was created and run by Cherie Bennett and Joshua Borja from ASHM. The training session focused on explaining the peer-led contact tracing process, client eligibility criteria, referral pathway process and the responsibilities of peers conducting contact tracing. Training included reinforcement of core skills such as active listening, effective questioning and navigating and responding to strong client emotions during the contact tracing process. The training also reinforced the scripting and protocol processes that ensured strong client confidentiality. Access to the training documentation can be found here.

Peers were asked to complete an optional post-training evaluation form communicating their confidence across the learning objectives and skills covered by the training. Results show that, at the end of training, peers felt confident and very confident across each of the learning areas covered by the training, indicating that the training provided was largely helpful in supporting peers to feel confident to undertake peer contact tracing.

8.2 Initial clinical reception

Among the sexual health clinics approached by the project in this first wave, initial feedback indicated a hesitation to engage. This hesitation stemmed from concerns regarding the 'reportable' nature of HIV contact tracing and HIV management more broadly, as well as potential risks to continuity of care. We note that these concerns were a persistent barrier to engagement that featured frequently in later onboarding conversations. These concerns are discussed at length in the section describing the project's key learnings. Government-run sexual health services also noted that they already employed highly trained staff, suggesting that they may have considered the pilot to offer little value to their existing operations. Other clinics (particularly public health clinics) communicated significant logistical and governance challenges which would need to be overcome before they could participate in the pilot. These included the potential need to complete site-specific assessments and internal ethics and approvals processes before engaging. This posed a particular challenge that often acted as a barrier to engagement — particularly given the project's short delivery schedule. Despite three months of sustained recruitment efforts, attempts to engage sexual health clinics and sites with high caseloads were largely unfruitful.

8.3 Member concerns raised

Members also raised concerns about the suitability of the proposed model early in the pre-implementation process. Key concerns included:

- **Training adequacy:** Members wanted to see a clearer structure and contact tracing training package.
- **Safeguards for peers:** Members requested explicit safeguards to be included in the model to ensure engaged peers had access to adequate support resources and appropriate escalation pathways — particularly for clients experiencing domestic partner violence or for clients experiencing acute mental distress.
- **Role clarity:** Members needed further clarification about the nature of peer-led contact tracing positions, including how this role would operate in concert with existing peer-led services. Additionally, members requested further information about the engagement model and additional information about how peers would be employed/engaged in the project.

Subsequently, several Health Equity Matters members and affiliates requested further refinement and adjustment to the pilot model before they would endorse participation.

8.4 Initial extension and subsequent project overhaul

In March 2024 the project applied for and was granted an extension to the planned timelines. The application for an extension reflected challenges identified during pre-implementation that needed to be addressed prior to recruitment of participating sites, and member engagement and endorsement. At this time an internal review of the project logic, model and communications was launched to address the concerns raised by clinicians and members approached to participate in the pilot.

8.5 Governance, legal and ethical challenges and considerations

Throughout the implementation of this project several significant governance, legal and ethical challenges and considerations were identified and overcome. Many of these issues are well documented within public health literature as structural barriers to successful public health initiative implementation. In this section we briefly describe these challenges and considerations along with the steps taken to overcome them.

8.5.1 Governance
(Privacy, Data Security, Interoperability)

Privacy and Confidentiality Protocols

The topic of client privacy and confidentiality featured throughout consultations in the pre-implementation phase of the pilot. Concerns commonly related to how the pilot would ensure client privacy and confidentiality. Examples of these concerns included:

- **Management of conflicts of interest:** Given the small size of the LGBTIQA+ community and its proximity to HIV, concerns were raised about how the program would prevent peers being connected to someone they knew or, if this occurred, what steps would be taken to manage related risk. Additionally, concerns were raised by NAPWHA members about the impact of involvement of their peers in the project and the barriers this may create for clients seeking to access peer-based services later run by those same peers. It was noted that many clients may wish to distance themselves from people involved in earlier aspects of their diagnosis (including peer contact tracers). Concerns were also raised that this might lead to clients avoiding future engagement with peer contact tracers in non-contact tracing settings — creating a barrier to accessing ongoing peer support.
- **Client privacy:** Questions were raised about how the pilot would support peers, clinicians and Health Equity Matters project staff to ensure that client privacy was protected throughout the pilot. Specifically, questions were raised about when, where and how privacy concerns would be discussed with clients, particularly those with significant anxiety about disclosure of their diagnosis.

Data-security and patient data management concerns

Data security and the governance of client data transmission emerged as a primary barrier during pre-implementation, particularly among government-run sexual health services. Despite comprehensive communication regarding the project's robust data protection protocols, concerns regarding the interoperability and security of peer-managed data remained a significant barrier to clinician engagement. This is consistent with literature identifying clinicians' obligations to their patients as an important consideration in their willingness to engage with service innovation (Wiersma et al., 2025).

Closely linked to data security was a significant misunderstanding regarding ethical oversight. Many clinical stakeholders indicated that their engagement with the pilot would be conditional on it gaining formal ethics approval for data transmission, conflating the pilot's status as a 'service improvement initiative' with the rigorous requirements of a clinical trial. This conflation created a perception of unmitigated risk where none existed within the project's governance framework.

8.5.2 Legal
(Protected Attributes, Employment Model, National Employment law requirements)

Protected Attributes and Anti-Discrimination Law

Initially, the project intended to recruit peers through an external recruitment process, including a public job advertisement. However, based on HR advice obtained by Health Equity Matters early in the pre-implementation phase, before a job posting could be created targeting LGBTIQA+ people with HIV, Health Equity Matters was required to seek exemptions from a number of state, territory and federal anti-discrimination laws under which these attributes are legally protected.

The substantial work required to prepare and submit formal exemption requests led to significant delays to peer recruitment. These delays were compounded by a lack of clarity over which states required exemptions. By May 2025, it was determined that external recruitment would not be feasible, and that internal recruitment would be required to meet the planned May deadline to commence recruitment.

Employment Model

Administration resource was required to establish casual roles in different states. Additionally, numerous complexities regarding salary levels existed within the project.

8.5.3 Ethical
Multi-site Ethics, Peer Safeguarding and debriefing)

Multi-site Ethics approval requirements and site-specific assessments (SSAs)

Sexual health clinics often required site-specific assessments to be performed before engaging in the project. This often resulted in the clinic disengaging from further conversations about the pilot. Common reasons for disengagement included:

- The service not having the capacity to support the SSA process.
- The cost of undertaking a site-specific assessment preventing further engagement.
- Project time constraints meant that the six-month process that might be required to obtain SSA approval for some sites ruled out their participation entirely.

Additional to these challenges were the research ethics implications. For each new SSA required, additional ethics revisions would need to be requested in line with the research ethics protocol governing the project. Every effort was made to close these gaps. For example, project officers adjusted model budgeting to enable the project to cover some of the costs associated with required SSAs. Project officers also tried to front end conversations about the SSA process to better map service requirements and then plan further conversations accordingly. Despite these efforts, the financial, time and capacity constraints presented by the SSA requirement meant that engagement in the pilot was untenable for many services. Future collaborations must better account for this process and enable significantly longer time to better support stronger engagement with public sexual health clinic engagement.

As noted by Taylor et al. (2026), while strong ethics processes are critical to ensure the safety of clinical health research, the resource requirements and lead time associated with ethics requirements such as SSAs can create significant barriers to delivery. While the pilot was not a clinical research project, the implementation hurdles presented by ethics requirements and specifically site-specific assessments did reduce test sites' ability to engage. It is therefore important that these barriers are addressed in future applications of the model in similar clinical settings.

Peer safety and wellbeing

During creation of the project's peer protocol (operation manual), steering committee members and wider consultation partners expressed a strong desire that it include robust supports for peer contact tracers. Consequently, Health Equity Matters ensured that peers — where required — had access to both informal debriefing with project staff, and specialist clinical debriefing opportunities accessed through the organisation's employee assistance program. These measures were deemed appropriate and in line with existing peer support mechanisms offered by member and affiliate member peer-led services. Additionally, Health Equity Matters staff ran a series of peer check-in sessions throughout the implementation period that allowed peers to share their experiences and provide one another with further support.

8.6 Evaluation partnership and methodology

Burnet Institute led the evaluation of this pilot initiative. A qualitative process evaluation was undertaken to explore implementation of the peer-led HIV contact tracing pilot, including barriers and facilitators to delivery, contextual influences, stakeholder perceptions, and implications for future scalability. The process evaluation was informed primarily by the UK Medical Research Council (MRC) framework for process evaluations of complex interventions, focusing on three key domains: implementation, context, and mechanisms of impact. Elements of the Consolidated Framework for Implementation Research (CFIR) were also considered to support exploration of organisational, legislative, and health-system factors influencing implementation.

Data sources included semi-structured interviews with nine key stakeholders involved in program design, implementation, and delivery, alongside administrative process data from client referrals. Interview participants included a Health Equity Matters program manager, four peer contact tracers, a sexual health clinician involved in steering and protocol development, a clinician involved in diagnosing and referring clients into the program, a public health unit stakeholder involved in protocol development and oversight, and a clinician from a service that declined participation in the pilot. Interviews explored experiences of implementation, perceived acceptability of the model, governance and legislative considerations, workforce and operational challenges, and views regarding future implementation. Interview transcripts and notes were reviewed to identify recurring themes relating to implementation processes, barriers and facilitators, stakeholder perceptions, and contextual influences on delivery of the intervention. Findings were interpreted using domains from the MRC process evaluation framework.

8.7 Project timeline and key milestones

The project was initially intended to be completed by June 2025. As the model was developed and additional complexities were identified, an extension of 12 months to June 2026 was requested and provided.

Consequently, several sexual health physicians insisted on undergoing extensive internal technical and governance reviews before proceeding. Given the pilot's compressed delivery schedule, these mandatory internal processes could not be completed within the project timeline, rendering engagement impossible

IT Interoperability limitations

As previously mentioned, clinicians held concerns about the transmission, storage and management of client data. While great effort went into addressing these concerns, for many clinicians the prospect of client data existing outside of pre-approved systems and protocols presented too significant a compliance risk and ultimately led to low uptake of the pilot among these stakeholders. Ironically, the high variability among internal IT systems and compliance processes across each of these stakeholders often prevented system integration or system bridging options from being explored. A lack of IT health system interoperability between NGO, clinical and government health organisations is a well-documented barrier to the implementation of digital health initiatives (AIHW, 2024; Krahe et al., 2024), particularly with respect to clinical health system interoperability with community health service provision.

Intimate partner violence and mandatory reporting escalation protocols

Steering committee members with contact tracing experience noted that the process commonly surfaced instances of intimate partner violence and potential risk to minors, and raised concerns about the training, support and processes that would be required for peers to address these instances. It was subsequently determined that the model was not equipped to manage such 'complex cases', so the eligibility criteria were revised to identify and exclude these cases from the pilot. Complex client needs of this kind highlight an important requirement of digital health models such as the peer-led contact tracing model: models must be suited to both the setting and the specific clinical needs of the client (Newton et al., 2024; Parmar et al., 2022; Wiersma et al., 2025). Once the model was adjusted to support clinicians to identify clients with complex needs and exclude them from the pilot, clinicians indicated they were more comfortable with supporting the project.

9.0
Key Learnings

Development of a peer-led contact tracing model for HIV is not only achievable, but also acceptable and sustainable

This pilot has demonstrated that — despite many complexities and challenges — it is possible to develop a novel, peer-led approach to HIV contact tracing in Australia that is acceptable to peers, clinicians and community members benefiting from the service. However, implementation requires time, resourcing, buy-in and collaboration between public and private health leaders.

Despite the low number of referrals to the service, we demonstrated that — with the right settings — peers were able to successfully implement and conduct contact tracing discussions. Peers were also successful in creating a supportive peer environment and successfully supported their clients to identify several potential ***contacts***.

Adjustments to the model made in response to clinician concerns meant that it was not possible to demonstrate the capacity of peers engaged in the pilot to undertake the full spectrum of activities that make up 'end-to-end' peer contact tracing for HIV, including follow-up with identified ***contacts***. However, it is important to note that across Australia's HIV response peers and peer workers carry out a wide range of complex client-related support work, much of which is already completed in partnership with clinicians working within Australia's HIV response. Clinician concerns about the suitability and readiness of peers engaged in the pilot to respond to specific instances of complexity (such as intimate partner violence or non-compliance with health orders) are valid. However, we submit that the majority of peers engaged in this work already deal with issues of similar complexity within their substantive roles.

Promisingly, this model demonstrates that — despite limited resources, time and pre-existing infrastructure — NGOs can operate within existing systems to establish and run a peer-led contact tracing service for HIV in concert with mainstream peer contact tracing services.

Finally, models such as this present high value in the context not only of Australia's changing HIV epidemic, but also more recent public health outbreaks which have required a near-immediate response, such as mpox and COVID-19. Investment in the creation of testing models that enable rapid deployment and mobilisation of Australia's community health services and workforce to bolster public contact tracing efforts represents great value to Health Equity Matters members and affiliate members, as well as to Australia's HIV and public health responses broadly. Investing in the governance, resourcing, and operational partnerships needed to enable similar models could potentially strengthen Australia's broader public health capacity.

Clinical acceptability is fundamental for uptake of novel health services such as peer-led contact tracing

Our model received a mixed response from clinicians. Those resistant to the model were primarily concerned about patient care and safety, citing doubts about peer capability and training to undertake contact tracing. Additional concerns included patient data and privacy, management of complex client needs, and the risk of clients being lost to follow-up. Among services with existing specialist contact tracing teams, there was confusion about the necessity of the model given their in-house expertise.

Conversely, engagement with the pilot was most often secured through the trust, rapport, and relationships that project staff had developed with clinicians over time, along with sustained conversation to address concerns that had deterred others. Clinicians are critical partners to innovation and operate within high-risk, complex, and regulated environments. The influence that individual clinicians hold over the success of medical innovations and collaborations such as this pilot cannot be overstated.

Ricciardelli & Ricciardelli (2026, pp. 3–4) support this finding, noting that clinical leadership is critical to the adoption and structural reorganisation required to facilitate innovation and changes to existing practice. This reflects our experience directly: clinicians who supported the pilot often took on an informal role as its promoters within their service. Without this leadership, many of the sites successfully recruited would not have been onboarded.

A key learning, then, is the importance of clinicians as leaders of clinical innovation and change. Any future implementation of this model must be acceptable, valuable, and responsive to the specific technical, regulatory, interpersonal, and operational concerns of clinicians to ensure successful adoption.

A national peer-led contact tracing service is feasible but setting and integration matters

While several services approached during this pilot declined to participate, citing the model's incomplete end-to-end coverage as offering limited value, or noting that existing arrangements were preferable, the more significant barriers to uptake were structural rather than conceptual. Concerns about risk, governance, and interoperability featured consistently in stakeholder objections. Had it been possible to adequately address these concerns, stronger engagement and higher referrals would likely have resulted.

Despite these barriers, the pilot demonstrates that peers, when provided with adequate time, training, support and infrastructure, can deliver contact tracing effectively. Both clients referred to the service received quality support, and the peer successfully facilitated contact tracing conversations that led to the identification of several ***contacts***. While these numbers are neither representative nor generalisable, they indicate that peer-led contact tracing is feasible and may be preferred by some people newly diagnosed with HIV when the option is available. We posit that this preference likely reflects the positionality of peers as non-government, non-institutionally aligned workers, a distinction that may be particularly important for individuals who fear government management of their status or who hold mistrust in government-aligned institutions (Megnin-Viggars et al., 2020).

Provided with appropriate regulatory settings, infrastructure, and ongoing support, peer-led contact tracing could represent a scalable and highly mobile capability within Australia's HIV response. However, the pilot's experience underscores that where this model sits structurally will largely determine its viability. In the following, we discuss two potential integration pathways we consider viable.

8.8 Referrals to the service

In total the service received two referrals during implementation. Both appointments were successful in supporting clients to identify potential ***contacts***. Eight ***contacts*** were identified through the service.

Both referrals were sourced from the same clinic and were completed within 24 hours of the referral being received (including reporting tasks).

One client agreed to support the evaluation of the service, the other did not.

Referrals to the service were lower than our initial forecasts, which relied on current case numbers at participating clinics and broader epidemiological trends. We describe possible reasons for this in Section 9: Key Learnings.

Appendix A
Privacy Statement

Health Equity Matters Peer Contact Tracing Pilot
Project Information & Privacy Statement

Project Information

About Contact Tracing

Contact tracing involves you or your clinician contacting people you have identified as potentially being at risk of HIV transmission. These individuals will be notified that they have been in contact with someone who has tested positive for HIV and they will be referred to get tested. No information related to you will ever be shared during this process.

In some cases, your clinician or physician may need further support to complete contact tracing. In these instances, your clinician may gain support from specialist public health contact tracers who are trained and better resourced to reach and notify people you are concerned about.

Health Equity Matters' Peer-led Contact Tracing

Peer Contact Tracing is a 6-month 'pilot' service created by Health Equity Matters and is funded by the Australian Government. The service provides clients with the option of selecting a professional community health worker (called a peer) to support you in conducting the contact tracing process.

In your peer contact tracing support session, your peer will create a safe and supportive space; they will explain the contact tracing process to you before asking you some questions to help them support you in identifying people you may have had sexual contact with and need to be tested. These people can then be contacted anonymously and supported to seek testing.

Important!

At no point will any of the information you provide us with be disclosed to the people you have identified in your appointment. Your privacy will be kept in the strictest confidence.

Once we have identified who you would like contacted, Health Equity Matters project staff will create a password-protected report to send back to your referring clinician to contact the people you have identified.

For individuals based in Victoria

We offer this service in partnership with Victoria's specialist contact tracing unit (VICS). When using our service, we provide your contact information and the information you have provided us about your contacts to enable the VICS team to complete the contact tracing process. Use of our service requires your consent to share your contact information with this team, so they can contact you if they require further information.

For more information, please see **collection of your personal information**.

Program Evaluation

This service is being evaluated by our partners at the Burnet Institute.

People who use the service have the option to participate in an evaluation of the program; however, this is completely optional and is not required to access or use this service.

At the end of your peer contact tracing appointment, your peer will ask you if you would like to be contacted by a member of the research team to share your feedback. If you would like to take part, please say yes. If you would not like to take part, please say no.

If you would like to participate, your first name and phone number will be given to a member of the research team. If you would not like your real name to be shared, please let us know, and we can use your preferred pseudonym. Once confirmed, a member of the research team will call you to ask you about your experience with the service. This phone call would take approximately 30 minutes.

No specific information about your use of this service would be shared with the researchers.

Michael Traeger, Research Fellow, and **Bernadette Ryan**, Qualitative Research Assistant, HIV & STI Prevention Group, will be conducting these interviews.

Privacy Statement

Who is collecting your personal information?

Your personal information is being collected by the Health Equity Matters Limited (ABN 91 708 310 631) ("**Health Equity Matters**" or "**we**").

Collection of your personal information

To be able to access our peer contact tracing service, we need to obtain some personal and medical information from you.

We collect your data:

1. When your clinician refers you to the service.
2. At the time of your contact tracing appointment with our peers.

We collect your data when you consent to using the service. You may request to access this information at any time, and it will be provided to you. You can also request to have this information deleted at any time, and unless we are required to retain this information by law, we will action your request within 14 business days. Please send your request to harrison.sarasola@healthequitymatters.org.au if you would like this to occur.

Types of information collected

During the initial referral to the service (completed by your clinician):

- Your name or an agreed-upon alias
- Your date of birth
- Your best contact number
- Your pronouns
- Your eligibility to use the service (see criteria below)
- Confirmation from your clinician that the service has been explained to you and that you consent to using the service
- Other clinical information required to support the contact tracing process (such as contact tracing time period, e.g., the last 3 months)

During the contact tracing appointment with the peer:

- The names and contact details of people with whom you had sexual contact and who may require notification.
- Information about any discussed risk events, such as:
  - where and when the event took place
  - who was involved
  - other information that might support the contact tracing process

10.0 Implications for the HIV Response

This pilot holds several potential implications for Australia's HIV response. These include:

1. A state-based model for peer-led contact tracing for HIV is viable, acceptable, secure and holds much value to Australia's HIV response. However, further investment is needed to identify the specific settings that are required to better support implementation and adoption of this model.

2. Australia has an extremely capable, talented and multidisciplinary peer workforce. However, its ability to support clinical practice — specifically contact tracing — is under-recognised. Peers engaged in this pilot were able to provide peer support, access to community health services and culturally responsive care while remaining effective in performing the required contact tracing processes. Increased investment in peer-led initiatives presents high value.

3. Clinicians are a crucial partner in Australia's HIV response and often operate within complex health, risk and governance settings. Australia's community health organisations must seek to understand and map out these environments and the considerations they present to clinicians if they are to be successful in promoting service improvement initiatives such as peer-led contact tracing.

4. Australia's divergent HIV epidemic and other emergent public health epidemics are likely to require a rapidly scalable contact tracing workforce. However, this need not be confined to nursing or clinical staff alone. Our model demonstrates that with the right training, governance, operational and systems settings, peers are capable of supporting contact tracing efforts. However, a number of governance and operational challenges remain that mean a state-led application of this model would be better positioned to respond to these challenges and ensure successful adoption and uptake.

11.0
Future Directions

Future efforts to explore peer-led contact tracing are recommended. We suggest that — from an operational and logistical perspective — collaboration between Health Equity Matters members and the state health agencies responsible for contact tracing offers the most promising avenue for successfully delivering such initiatives.

We also acknowledge that for some states and territories, limited funding and resourcing of peer-led initiatives across sexual health services broadly means that peer workforces are significantly smaller. In these instances, we urge state governments to consider how they might collaborate, resource and support Health Equity Matters members to first build and then maintain professional peer workforces. Health Equity Matters would endorse state-led efforts to increase peer-workforce capacity among our members and would suggest that our federal health partners could also contribute a significant amount of expertise and value to these conversations.

Finally, an opportunity exists for deeper cross-sector collaboration between NGOs and state-health agencies. Health Equity Matters members have demonstrable experience in successfully delivering high-quality, effective and tailored health services that present unique value to marginalised communities in clinical and non-clinical settings. The success of these partnerships is due to the mutual respect, understanding and appreciation for the value, experience, perspectives and professional expertise each party brings to the conversation. These partnerships are also often resourced appropriately and are structured to ensure maximum benefits to the communities they seek to support. They contribute significant capacity and value to state and federal health responses. This model demonstrates an opportunity for a novel pathway to further collaboration between our sectors. We recommend that federal and state health leaders work with Health Equity Matters and its members to investigate and invest in potential future applications of this model.

NGO–clinical partnership:

Peer-led contact tracing could be embedded within LGBTIQA+ or community health NGOs, with access to clinical supervision, clinical systems access and clear escalation pathways. This would preserve the culturally safe, non-institutional setting that appears supportive of the model's acceptability, while ensuring clinical governance requirements around risk, data security, and mandatory reporting are met through formalised partnership arrangements. For smaller jurisdictions with limited staffing capacities (both within community health and public health services), this approach presents great benefit but would require resourcing and strong partnership with state health partners to enable successful implementation

Mainstream contact tracing service integration:

Australia is home to some of the world's most capable contact tracing teams and comprehensive surveillance systems. Australians should be proud of the quality of support provided by state health services.

Creating an integrated, state and federally endorsed peer-led contact tracing model within existing contact tracing services offers a number of potential benefits. As some supporting partners noted, state health services already engage staff from the communities they support to ensure contact tracing teams are able to respond to the cultural complexities which underpin health-seeking behaviours, particularly around sensitive sexual health-related events such as a new HIV diagnoses or the communication of a potential HIV exposure. However, we note that a number of small states/territories are subject to significant funding challenges that mean it is not always possible to hire staff from affected communities. Equally, communities experiencing high levels of marginalisation and stigma require tailored services and specific employment conditions which might not always be possible within existing state health services.

Alternatively, existing state-based contact tracing services could seek to strengthen recruitment, engagement and retention of workers who themselves belong to communities most affected by HIV — including people with HIV from these communities. This would enable increased integration of peer workers within mainstream public health and sexual health settings, improving existing contract tracing services' capacity to support and respond to affected communities in culturally informed ways.

However, this option would require mainstream health services to consider the settings and support needed for marginalised communities, particularly people with HIV, to thrive. Engaging with communities with lived experience of intersecting marginalisation and disconnection from, or distrust of, mainstream health services will require state-based contact tracing services and community health organisations to invest in fostering culturally tailored and supportive environments.

Governance, system and process interoperability remains a significant barrier to innovation within Australia's HIV response

Across the development, pre-implementation and implementation phases of this pilot, significant time and effort was invested in understanding and mapping the differences in how contract tracing and HIV management are approached across jurisdictions. These differences were often made clear when we asked contact tracing teams and clinicians engaging in contact tracing how this guidance was operationalised within their service or jurisdiction. Different reporting requirements, compliance concerns, capacity limitations (particularly access to specialist contact tracing support) and other structural and operational differences across jurisdictions suggest that a state-based implementation of this model would have a higher likelihood of successful adoption.

Australia's federal health authorities are well positioned to initiate and lead conversations around a potential state-based implementation of this model. The system-wide knowledge and perspectives, cross-jurisdictional relationships and existing information channels available to federal health agencies would lend the authority, resourcing and overarching support needed to help bridge many of the interoperability challenges that exist between NGOs and their state-based health counterparts.

Appendix B
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Eligibility criteria

Before referring you to our service, your clinician will determine if the service is suitable. they will do this by completing the following eligibility criteria:

Criteria 1: Client has recently been diagnosed with HIV.
Criteria 2: Client is above the age of 18.
Criteria 3: Client hasn't had unprotected sex (condomless with someone not on PrEP/condom broke/presence of blood) within the last 72 hrs and requires immediate contact tracing so that they can access PEP.
Criteria 4: Client understands the process and can give informed consent to have their details shared with the peer contact tracer and has access to a private phone.
Criteria 5: Client is not showing signs of high mental distress, thoughts of self-harm or suicidal ideation.
Criteria 6: Client has not expressed any concerns regarding the mental health of any partners, domestic and family violence, child abuse, or partners who are pregnant or recently gave birth.
Criteria 7: Client is not a risk to others or themselves.

The scope of this service is limited to peer support within the context of contact tracing. If your clinician thinks you would benefit from immediate or more comprehensive support, they might not be able to refer you to our service.

Why do we collect your personal information?

Contact tracing requires us to understand who you might have had sexual contact with and who needs to be notified about potential transmission risk.

Collected data will be used solely for the purpose of undertaking the contact tracing process and to support your clinician or specialist health unit to complete the required reporting procedures as required by state and territory laws/procedures.

To help us access the effectiveness of the service and identify areas of improvement, aggregated and de-identified data will be used for the service evaluation. This will help us enhance the quality of the provided service in the future while protecting your privacy.

How will my data be kept secure?

During your use of the service, the data we collect will be directly entered by your clinician into a secure medical records system called REDCap. This is a system that is used extensively for health research and is highly secure.

Access to your information will only be granted to your selected peer, your treating physician and the project manager at Health Equity Matters. The project manager is responsible for coordinating your appointment and providing your clinician and specialist contact tracers with the information they require to complete the contact tracing process.

Health Equity Matters staff and peers are also governed under a strict code of conduct and privacy policy. Our Privacy Policy, available here, contains information about how you may

access the personal information we hold about you, how you may seek the correction of this information, how you can make a privacy complaint and how we will deal with your privacy complaint.

What would happen if we did not collect your personal information?

If we did not collect your personal information, we would not be able to contact you or provide you with the peer contact tracing service. Some information that is collected as part of the peer contact tracing service is also a requirement by law and is required to run the service to ensure compliance.

Who will we disclose your personal information to?

We will not disclose any personal, sensitive or medical information without your consent, except where it is necessary or required to do so in accordance with the law or for the purpose which your personal data is collected. Please see, types of data collected above.

Contact tracing requires Health Equity Matters to share information pertaining to the contact tracing process, such as the names and numbers of the people who you have identified as being potentially at risk for HIV transmission to your referring clinician.

How will my data be sent to my clinician/ public health units?

Collected data will be sent to the clinician/public health unit via a password protected file using encrypted email to ensure your data is protected. Encryption helps protect your personal information by converting it into a secure format that can only be accessed by authorised recipients. Only the referring clinician or the relevant public health officer will be able to view your information. All data handling procedures comply with strict privacy and data protection standards.

HEALTH EQUITY MATTERS
HIV. LGBTIQA+. COMMUNITIES.

Better Practice Incubator: Peer-led HIV Contact Tracing Pilot

Report June 2026

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HEALTH EQUITY MATTERS
HIV. LGBTIQA+. COMMUNITIES.

Health Equity Matters pays its respects and acknowledges the Traditional Owners and Custodians of the unceded lands on which this and our other domestic work takes place. We acknowledge Elders past and present and extend our respect to Aboriginal and Torres Strait Islander peoples across the many Countries of which Australia is comprised.

Sovereignty was never ceded. Always was and always will be Aboriginal land.

Artwork credit: ENOKI (Dja Dja Wurrung, Yorta Yorta)

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Foreword

Australia is moving steadily closer to its vision of virtually eliminating HIV transmission. The ninth National HIV Strategy identifies the conception of innovative approaches to HIV testing, treatment, prevention, and stigma reduction as a priority for Australia if we are to achieve this vision.

Through funding from the Australian Centre for Disease Control, Health Equity Matters has been able to deliver several pilot projects that provide the sector with opportunities to trial and understand
new measures that might positively impact the national response.

The organisation's Peer-led Contact Tracing project is a direct response to this priority and is one of these projects. It places Australia's peer workforce at the centre of the contact tracing process, offering significant value to Australia's HIV response, and a window into incorporating peers in the delivery of contact tracing for the control of other infectious diseases.

Current responsibility for contact tracing rests with the diagnosing clinician or, where available, specialist state health services. Our project broadens this model by leveraging the skills and lived experience of Australia's HIV peer workforce to support HIV contact tracing. This enables people newly diagnosed with HIV with the opportunity to engage with peers in contact tracing conversations.

In Australia, HIV is predominantly transmitted through sexual contact between gay and bisexual men, and trans men. Increasingly new HIV infections are among communities of gay and bisexual men, and trans men from culturally and linguistically diverse backgrounds. Using peers to lead contact tracing will ensure critical information about HIV can be provided to people newly diagnosed with HIV in culturally appropriate language and more candid conversations can occur with sexual contacts. This supports our efforts to target people who are at higher risk of HIV with information about testing and access to care.

We thank the Australian Government for supporting Health Equity Matters to pilot this innovative project and we look forward to sharing the insights from the project with sector partners.

Dash Heath-Paynter
Chief Executive Officer

Acknowledgements

Health Equity Matters acknowledges the hard work and leadership of Valerie Arsenova, who was instrumental in the initiation and implementation of this project. Thank you, Val, for your enduring contribution to this important work.

Health Equity Matters also wishes to acknowledge and thank each of the peers involved in this pilot, and to extend this thanks to our members and affiliate members who readily engaged with and supported this work. Each of the peers contributed significant time, effort, and professional and lived expertise to the pilot, enabling its successful design and implementation. Thank you.

Health Equity Matters extends its thanks to the pilot steering committee members, implementation partners, clinical partners and sector partners who worked in deep collaboration to bring this pilot to fruition. Work of this nature would not be possible without strong partnership from across Australia's HIV response, and we extend our deepest thanks to all involved.

Finally, Health Equity Matters wishes to thank its project partners, Professor Mark Stoové and Dr Michael Traeger from Burnet Institute, and Cherie Bennett and Joshua Borja from ASHM, whose many contributions to this project led to successful implementation. Thank you.

Project Partners





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1.0
Introduction

Australia's Ninth National HIV Strategy stands as a global benchmark for a successful, partnership-based response to HIV, with the central vision of achieving the virtual elimination of HIV transmission by 2030.

While Australia has achieved many of its goals and is moving closer to realising this vision, inequities in the nation's HIV response persist and must be addressed if this ambition is to be fulfilled.

Historically, the Australian HIV response has successfully leveraged peer-led models to improve engagement in testing, treatment, and psychosocial support. Peers — individuals with lived experience of HIV or deep community connections — bring a unique perspective, understanding and cultural authority that greatly facilitates trust building with community members accessing peer-led sexual health services. They operate from a shared community lens, reducing the power imbalance inherent in clinical interactions and providing a safe space to navigate sensitive conversations. Yet despite the success of peer-led models in other areas, the application of peer-led approaches to the specific domain of contact tracing has remained largely unexplored in Australia.

Recognising this gap, Health Equity Matters initiated the Peer-led HIV Contact Tracing Pilot. Launched in June 2025, this six-month initiative sought to assess the feasibility and acceptability of a model in which trained peers support newly diagnosed individuals to identify and notify partners. The pilot was designed to test whether a peer-led approach could offer a more culturally safe, less intimidating alternative to traditional clinical contact tracing, thereby improving outcomes.

The journey to implementation was not linear. The pilot began with an ambitious vision of an end-to-end peer model, in which peers would be responsible both for identifying contacts and conducting the notification calls. However, rigorous consultation with a national steering committee comprising clinicians, public health experts, and community leaders identified several complex risks associated with this model. These included the potential for intimate partner violence, and the identification of complex cases requiring public health unit escalation. To mitigate concerns about the model's ability to navigate these risks effectively, the scope was adjusted and the model was significantly refined. The final model retained the peer's critical role in supporting the ***index client*** to identify ***contacts***, but removed the peer's direct role in notifying them, with this step reserved for specialist public health units to ensure safety and legal compliance.

The pilot was successfully implemented across eight clinical sites in New South Wales, Victoria, and Western Australia. While the number of referrals was lower than anticipated, the two clients who engaged with the service received a supportive, non-judgmental experience, with peers successfully identifying multiple ***contacts*** for both. Critically, the pilot illuminated several challenges which exist within collaborations of this nature, particularly regarding data security, governance, and employment law.

This report documents the development, implementation, and evaluation of this novel pilot. It moves beyond simple metrics to explore the operational, ethical, and strategic lessons learned. By examining the challenges faced at each of the project's milestones, the report aims to provide a model that can be adapted and expanded across community and government health settings. We argue that while the pilot was small in scale, its implications are significant: a peer-led contact tracing model is not only possible but holds value to Australia's HIV response.

2.0
This Report (scope)

This report documents and evaluates Health Equity Matters' Peer-led HIV Contact Tracing Pilot. It outlines the background and rationale for the project and describes its three key outcomes:

1. Development of the peer-led contact tracing model.
2. Development of a peer workforce model.
3. Implementation of the pilot.

The report then examines the implementation challenges encountered during the pilot and reflects on the key learnings identified through the process. Finally, it considers the implications of the findings for Australia's HIV response and identifies opportunities for future pilot programs to leverage and build upon the insights presented. Access to the results of the acceptability evaluation which was completed as part of this project will be made available separately to this report and once a peer review has been conducted.

Despite the strong commitment of clinicians and public health teams to supporting partner notification, the experience of contact tracing can vary considerably across Australia's health system. Many HIV diagnoses occur within general practice and primary care settings where clinicians may see relatively few cases and may have limited time or specialist support available to facilitate detailed contact tracing discussions. In addition, the roles and responsibilities of clinicians, public health units and sexual health services in supporting contact tracing differ across jurisdictions, creating variability in how individuals experience the process. These structural factors do not reflect a lack of commitment by clinicians, but rather the realities of a complex and resource-constrained health system.

Within this context, there may be value in complementary models that provide additional support to both individuals newly diagnosed with HIV and the clinicians supporting them. Peer-led approaches have long been recognised as a cornerstone of Australia's HIV response, contributing to improved trust, engagement and culturally safe communication around sensitive health issues. A peer-led contact tracing model has the potential to support more client-led conversations, provide additional time and space for individuals to discuss partners and risk, and help reduce some of the discomfort that can arise when discussing sexual history. Such a model may also support clinicians by providing an additional pathway through which patients can access informed, empathetic and culturally responsive support during the contact tracing process.

Contact tracing identifies individuals who may have been exposed to HIV and enables them to be supported to access testing and care. It also provides opportunities to offer prevention information and treatment support for those who are diagnosed. However, partner notification can present challenges. Shame and fear of stigma may discourage individuals from notifying partners themselves. Many clinicians report limited time or confidence in conducting detailed contact tracing discussions, while public health authority involvement can sometimes generate mistrust, leading some individuals to feel reluctant to disclose sensitive sexual history information.

Effective contact tracing therefore requires highly nuanced, culturally appropriate and sensitive approaches. When undertaken effectively, it can help reduce undiagnosed HIV in the community, particularly among people who test infrequently. In response to these challenges, Health Equity Matters explored the potential for a peer-led model of contact tracing. Peers may include people with HIV, individuals from similar communities, or people with shared identities based on sexuality, gender, age, cultural background or migration experience. Within healthcare settings, peer workers can help foster a comfortable, non-judgemental and empathetic environment for individuals navigating a new diagnosis. Shared lived experience or community connection may reduce some of the discomfort associated with discussing a positive diagnosis or past sexual history.

This pilot sought to build on the innovative and impactful peer-led work that occurs across a range of clinical and non-clinical settings within the Health Equity Matters membership. While the model of peer-led contact tracing for HIV remains relatively novel, particularly within general practice settings, the pilot sought to leverage the strong history of partnership between community organisations and clinicians to explore the feasibility and acceptability of a peer-led contact tracing model to support people newly diagnosed with HIV.

3.0
Project Background and Rationale

Receiving a new HIV diagnosis can be a challenging and overwhelming experience for many people. An often-described reason for this is the number of conversations that occur alongside receiving a diagnosis.

These discussions may include starting treatment, understanding the implications of the diagnosis, and navigating the emotional and social impact of living with HIV. Some of these conversations can be particularly challenging, including discussions about contact tracing and partner notification.

HIV is a nationally notifiable disease in Australia. Following diagnosis, clinicians are required to notify public health authorities and discuss partner notification and contact tracing with the individual diagnosed. This involves a clinician discussing previous sexual history with the individual and working with them to identify partners who may potentially be at risk and therefore considered contacts. Identified contacts may then be notified by the individual themselves, by the treating physician, or, following referral, by the relevant state-based public health team with specialist capacity to undertake partner notification. Notification often occurs at the time of diagnosis; however, it may also occur during subsequent clinical appointments, depending on the needs and readiness of the individual.

While significant efforts have been made by clinicians to facilitate a positive, low-resistance and client-led experience of the contact tracing process, adverse or stigmatising experiences can still occur. These experiences are frequently reported within general practice settings, although they have also been described within more specialised HIV and sexual health services.

Peer-led models have demonstrated strong effectiveness within Australia's HIV response, and the meaningful engagement of peers has played a critical role across areas historically considered the domain of clinicians and health professionals. Peer-led service delivery has been shown to improve engagement with healthcare services and support individuals to navigate sensitive health conversations. This occurs for several reasons, including increased cultural understanding and safety, greater levels of trust when discussing sensitive topics related to sexuality and sexual practices, and the cultural authority peers can bring through shared lived experience or community connection. In some cases, individuals may perceive clinicians primarily through their role as healthcare or government workers, whereas peers may be viewed first through a shared community lens

An external peer-led approach may also facilitate a lower level of perceived risk for individuals on temporary, student or working visas. Concerns around confidentiality, disclosure and potential visa implications have been reported as barriers to accessing HIV testing, care and support. Peer-led engagement can help reduce some of these concerns by providing individuals with a trusted and culturally responsive point of contact.

Health Equity Matters and NAPWHA, together with their member organisations and affiliates, employ a highly skilled and experienced peer workforce operating across both clinical and non-clinical settings. Exploring the feasibility and acceptability of peer-led contact tracing therefore presents an opportunity to expand Australia's investment in peer-led approaches to HIV prevention, care and support.

This pilot comes at a significant time in Australia's HIV response. As Australia moves closer towards its goal of the virtual elimination of new HIV transmissions, inequities within the response are becoming increasingly visible. Late diagnosis, delayed commencement of treatment, and lower rates of treatment initiation and retention in care contribute to higher rates of transmission among some communities and remain a source of preventable morbidity and mortality for people with HIV – particularly among communities who experience structural and social marginalisation on the basis of culture, ethnicity, language spoken, migration experience, gender identity and other intersecting factors.

4.0
Project Aim and Objectives

Aim:

Health Equity Matters' Peer-led HIV Contact Tracing Pilot aimed to assess the feasibility and acceptability of a peer-led contact tracing model to support people newly diagnosed with HIV to identify and notify partners who may have been exposed to HIV.

Objectives:

1. **Develop a model for peer-led HIV contact tracing** in consultation with clinicians, community organisations and research partners.
2. **Establish partnerships with participating clinical services** to pilot the peer-led contact tracing model.
3. **Recruit and train a peer workforce** to deliver confidential and culturally appropriate support to people navigating partner notification following an HIV diagnosis.
4. **Pilot the peer-led contact tracing model** within participating clinical settings to explore its operational feasibility and integration with existing partner notification processes.
5. **Evaluate the implementation of the model**, including its feasibility, acceptability and operational considerations, and document key learnings to inform future program development.

5.0
Project Governance

At the start of the project, Health Equity Matters assembled a project steering committee made up of experts from its members and affiliate organisations, sexual health and contact tracing specialists and clinicians from across Australia's HIV response.

The steering committee's role was to provide expert guidance to senior project staff throughout the life of the pilot. This included during the initial stages, when discussions were focused on creating a suitable peer-led contact tracing model. The committee also contributed heavily to pre-implementation, implementation and evaluation discussions, and was regularly consulted during the creation and refinement of the model, and of clinical and peer protocols. Guidance received from steering committee members was instrumental in supporting project staff to navigate the complex implementation environment that this project operated within.

Project Steering Committee members included:

Name	Organisation
Professor Dr. Jason Ong	Director, Melbourne Sexual Health Centre
Brent Clifton	Deputy Director, National Association of People with HIV Australia (NAPWHA)
Dr Christopher Lemoh	Infectious disease and general physician
Troy Sinkovic	Operations Manager, Testing Services, ACON
Melissa Warner	Chief Executive Officer, Queensland Positive People (QPP)
Sharmila Radha Krishnan	Manager, Clinical & Therapeutic Services (WAAC)
Jane Hooker	Manager, BBV/STIs | Communicable Disease, Victorian Department of Health

Evaluation Partners:

Health Equity Matters partnered with Professor Mark A Stoové and Dr Michael Traeger from Burnet Institute to undertake and lead the evaluation of the pilot.

Clinical training and protocol creation partners:

Health Equity Matters partnered with Cherie Bennett and Joshua Borja from ASHM on the refinement of our clinical protocol and on the development and delivery of the training provided to the pilot's Peer Contact Tracers.

6.0
Outcome One: Development of the peer contact tracing model

6.1 Current Contact Tracing Protocol

In Australia, the management of HIV is governed by each state and territory's respective HIV management guidelines. Additional to jurisdiction-based management guidelines, healthcare providers are also able to access the Australian contact tracing guidelines authored by ASHM.

Contact tracing forms a core pillar of the effective management of HIV in Australia and involves the supporting health care provider working with the client receiving a new HIV diagnosis to identify any previous sexual partners who might also be at risk of HIV transmission. These ***contacts***, once identified, are contacted by either the supporting health care provider or relevant public health unit. ***Contacts*** are advised that they have recently been in contact with a person who has received an HIV diagnosis and are encouraged to seek testing for HIV. Supporting health care providers then help these ***contacts*** access testing for HIV.

Contact tracing conversations often occur at time of diagnosis as required by HIV management guidelines. However, health care providers with contact tracing experience report that the timing and success of these conversations often depends on client trust, client capacity at time of diagnosis and reassurance that the process will be confidential and appropriately sequenced. Thus, while the topic of contact tracing is typically broached with clients at time of diagnosis, subsequent conversations may be required to identify and liaise with ***contacts***.

6.2 Initial Peer Contact Tracing model

At the project's inception in January 2024, it was envisaged that peer contact tracers would be responsible for the full contact tracing process. This involved two key steps:

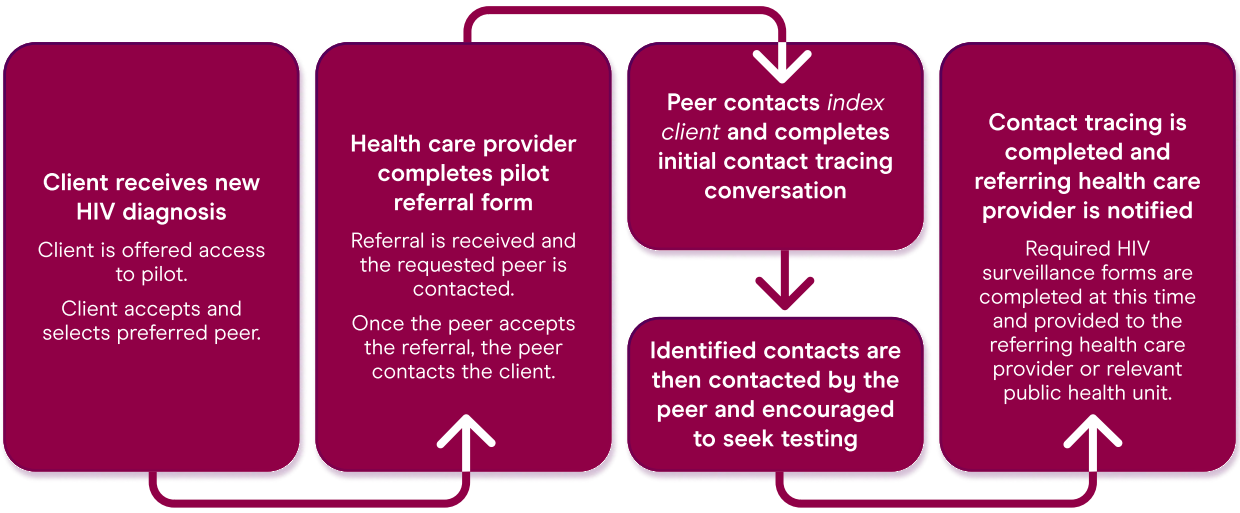
Step 1. **An initial contact tracing appointment.**

Involved peers holding an initial appointment with the ***index client*** to identify potential ***contacts***.

Step 2. **Contacting identified contacts.**

Peers would then contact identified ***contacts*** to encourage them to seek testing.

Figure 1: Initial Peer Contact Tracing Model



7.0 Outcome Two: Peer Workforce Model

7.1 Peer roles and responsibilities

Peers act as the primary contact for clients accessing the pilot service and are responsible for the following:

- Conducting peer contract tracing appointments with people referred to the service via telephone or secure videoconferencing.
- Providing an empathetic, safe, confidential and respectful contact tracing experience for clients accessing the service — drawing on lived experience as a peer to support the rapport-building process.
- Supporting clients in the identification of potential ***contacts***.
- Ensuring accurate and timely entry of appointment data (including identified ***contacts***) and communicating any additional relevant information relating to the safe and compliant running of the pilot.

Peers were also responsible for providing clients accessing the pilot with information about available support services in their local state or territory, such as peer-led organisations for people with HIV or additional community-specific health information. While peers were not required to provide peer support outside the scope of contact tracing, we note that clients did ask lived experience related questions which peers were well positioned to answer on the basis of being peers themselves.

7.2 Who is regarded as a 'peer'

Previous attempts to establish a national framework to define what constitutes a 'peer' or 'peer worker' include NAPWHA's Peer Support Standards 2020 (Ogier, 2020). However, as Krulic et al. (2025) note, conceptions of who constitutes a 'peer' are often mediated by a range of factors, including culture, gender and sexuality, or—in the case of this pilot—HIV status.

During the pilot's development, steering committee members, NAPWHA and its members and Health Equity Matters members and affiliates proposed that a 'peer' in this context should be a person living with HIV. Unfortunately, this definition was not feasible and presented the pilot with two significant limitations: the capacity of Australia's HIV peer workforce to support the pilot, and access to peers who were able to provide peer support through a shared lived experience of culture, gender or other intersectional experiences facing clients likely to be referred to the service.

Capacity limitations

Australia's HIV-positive peer workforce, while well engaged, skilled and impactful, remains small and operates on limited funding. Peer workers currently engaged across the membership of Health Equity Matters and NAPWHA have substantial workloads and very limited availability. Ultimately this led to challenges in the pilot's ability to engage available peers.

How this pilot defines who constitutes as a 'peer'

To respond to these challenges, it was determined that, for a person to be deemed a 'peer', a worker needed to demonstrate either:

- experience in and aptitude for providing HIV-related peer support, peer navigation or peer education for people with HIV.
- experience working within peer spaces (both clinical and non-clinical) to support people living with or receiving a new diagnosis of HIV.

This definition enabled project staff to engage peers who brought significant professional and lived expertise to the pilot.

8.0
Outcome Three: Implementation of the pilot

Implementation of the pilot commenced on 6 June 2025 and was originally scheduled to conclude on 30 November 2025. This timeline was subsequently extended to 30 April 2026 to allow for additional client referrals and to accommodate the complexities of the recruitment and onboarding phases.

Seven participating sites were engaged across three states. Four were located in New South Wales, with two in Victoria and one in Western Australia (following the model adjustment).

Table 2: Record of Implementation sites

State/Territory	Service Name	Service Type
Victoria	Melbourne Sexual Health Centre	Sexual Health Centre
Victoria	Prahran Market Clinic	Private clinic
New South Wales	Bondi Road Doctors	Private clinic
New South Wales	East Sydney Doctors	Private clinic
New South Wales	Taylor Square Private Clinic	Private clinic
New South Wales	North Sydney Local Health District	Local Health District run sexual health service
Western Australia	M-Clinic	Community Health Clinic

A note on the above table: One clinic based in Queensland was due for onboarding to the pilot but later needed to disengage before implementation due to site specific assessment procedures and the cost/benefit of undertaking these procedures—this clinic is omitted as a result.

8.1 Recruitment of participating clinical services

Shortly after the pilot's conceptual commencement in January 2024, initial mapping conversations began to identify appropriate sites. This process was formalised by late February 2024, with the first recruitment drives occurring in late February and early March.

Initial recruitment focused on direct engagement, often via email, with sexual health services reporting high caseloads of new HIV diagnoses. It was during this first wave that the project encountered significant clinician resistance to the proposed model.

Table 1: Post-Training Evaluation Responses

Metric	Strongly Agree / Very Confident	Agree / Confident
Confidence: Peer Support	2 (50%)	2 (50%)
Confidence: Contact Tracing Process	2 (50%)	2 (50%)
Confidence: Assess Transmission Risk	4 (100%)	0 (0%)
Confidence: Active Listening	4 (100%)	0 (0%)
Confidence: Manage Emotions & Referrals	2 (50%)	2 (50%)
Speakers Effectively Communicated	3 (75%)	1 (25%)
Pace of Delivery	2 (50%)	2 (50%)
Encouraged Participation	4 (100%)	0 (0%)

RedCap Training Module

Health Equity Matters Project staff created an online, pre-recorded RedCap training module outlining the correct operational procedures to ensure a safe, confidential and effective contact tracing process using the specially created RedCap peer-led contact tracing platform.

6.3 Model Revision

During pre-implementation, significant concerns were raised by project steering committee members and sites that were interested in participating in the pilot. In response, the team made significant changes to the pilot model to enable implementation. These changes are outlined below.

Removal of step 2 from the peer contact tracing process

As the project moved closer to implementation and training materials were finalised, steering committee members who were themselves responsible for leading specialist public health contact tracing teams expressed concerns about the depth and suitability of planned training. Key concerns related to whether the planned training would be sufficient to ensure that peers could effectively respond to the complexity and challenges that often result from notification of identified ***contacts***, while maintaining their own personal wellbeing. Steering committee members noted that for public health units, intensive and ongoing training occurs before a clinician can notify identified ***contacts***. Health Equity Matters noted that it was confident in the training and capacity of our peers to undertake these calls — given that many currently work in high-complexity peer roles that involve navigating trauma. However, due to genuine resource limitations affecting the pilot's ability to respond to the types of escalations described by clinicians (such as intimate partner violence or potential harm to minors) it was decided that in the interest of both client and peer safety and care this part of the model would be removed.

Differing levels of comfort with the model led to unique workflows for each state and territory engaged in the pilot

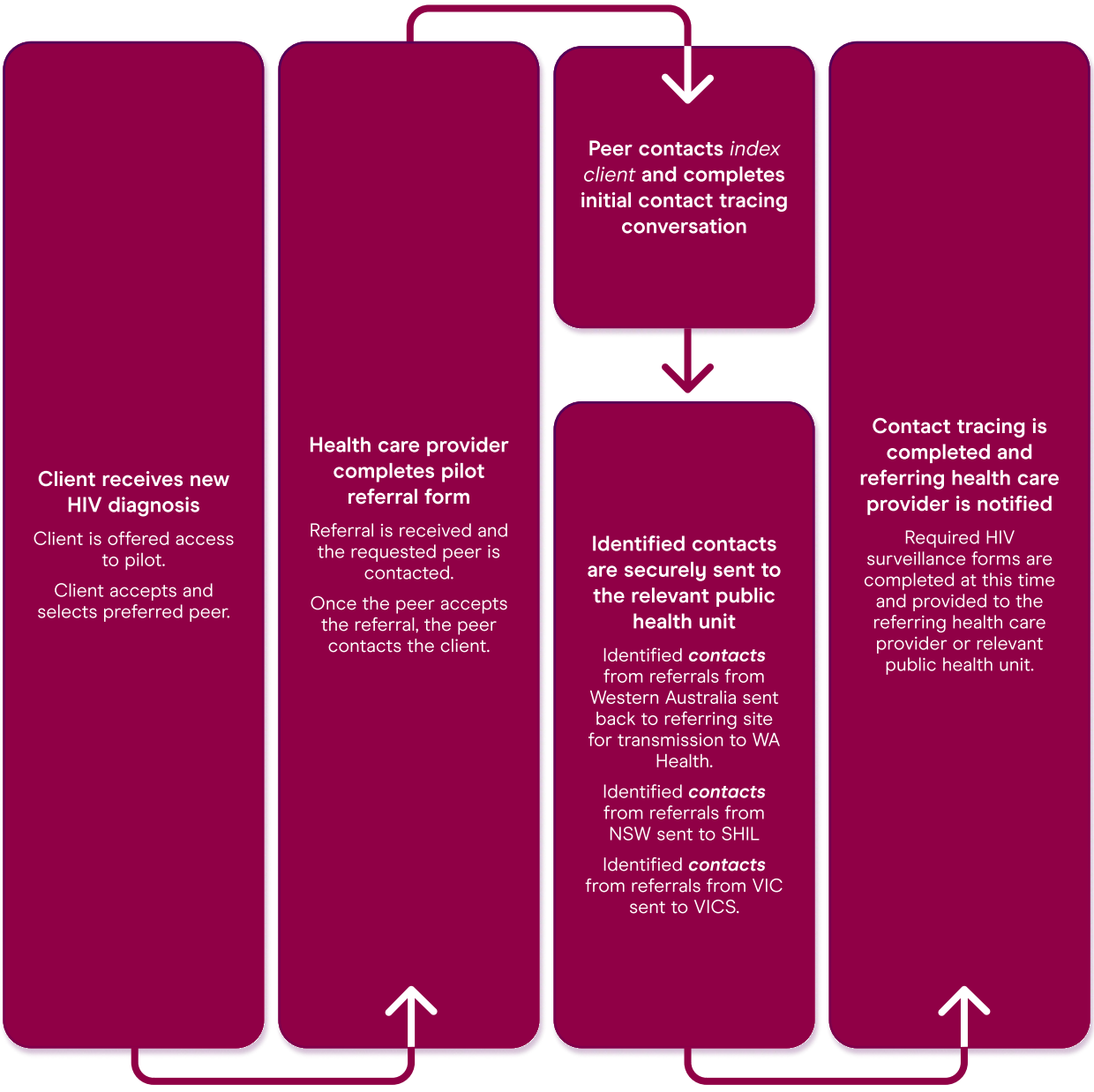
Initial pre-implementation conversations with state and territory health ministry counterparts, public health clinics and sexual health units responsible for contact tracing revealed differing levels of comfort with and confidence in the proposed peer contact tracing model. Concerns included unease with asking peers to navigate the complexity of calls with identified ***contacts*** (VIC), concerns about client data transmission and reporting to state infectious disease management bodies (SA), internal approval timeframes (QLD) and concerns about the reproduction of existing service provision (NSW). Securing the support and involvement of these stakeholders required the model to be tailored in response to the concerns raised by each. We note that we were only successful in progressing involvement with our counterparts in New South Wales, Victoria and Queensland because of these changes. Specific changes to the model included:

- Victorian and New South Wales specialist contact tracing units (VICS and SHIL) requested that any ***contacts*** identified within their jurisdiction be securely sent to their services to enable their specialists to complete the contact tracing process.
- Queensland counterparts requested no amendment to the planned model.
- South Australian counterparts raised multiple concerns about the pilot model and protocol. Project staff attempted to address many of the concerns raised; however, detailed discussions revealed that a number of concerns arose from state-based governance and management of HIV in South Australia. As a result, it was determined that these concerns could not be overcome within the timeframes of the pilot.

6.4 Final Model

After in-depth consultation and model refinement with interested state and territory stakeholders, the below model was agreed upon for implementation in participating sites in Western Australia, Victoria and New South Wales.

Figure 2: Final Peer-led Contact Tracing Model



6.5 System implementation of the peer-led contact tracing model

The privacy, security and protection of client data was a critical focus of Health Equity Matters' peer contact tracing model. To protect client data at each stage of the client's journey, several systems and protocols were implemented. Many of these measures incorporated existing data security measures employed throughout state and territory health departments — identified as part of broad consultation. Additional layers of protection were also applied to these processes on the advice of IT specialists. We outline each system and its use in the client journey below.

Reducing the amount of collected client information:

Only client data which was necessary to the contact tracing process was collected by the pilot service. This balanced the clinical and public health needs required by current contact tracing processes, while ensuring that only minimal data collection occurred. Information about the nature of data collected and how this was treated was accessible to clients at time of referral in the Pilot Privacy Statement (see Appendix A).

RedCap:

A secure web application commonly used in medical and clinical research. Servers were Australian based and use of the service was compliant with relevant state and federal privacy law. The model utilised a custom configuration of RedCap to enable the secure sending and management of referrals to the service. Clinicians would complete a referral to the service using a custom RedCap client referral form. Once received, all referrals were then managed within RedCap until the peer contact tracing appointment had been concluded.

Individual user profiles were created within RedCap to ensure that peers and Health Equity Matters staff only held access to data relevant to their role in the model. Researchers at no time had access to client data. Data provision to our research partners is outlined within the Evaluation component of this report.

Encrypted messaging:

In addition to a raft of security additions made in consultation with IT specialists, Health Equity Matters also used encrypted messaging to ensure the security of data transmitted to specialist contact tracing services.

Password-protected peer contact tracing reports:

At the end of the peer contact tracing appointment, Health Equity Matters staff were responsible for transmitting either a custom contact tracing report or completed state health surveillance form to their state health counterparts to enable the completion of follow-up with identified ***contacts***. These forms were password secured and transmitted using encrypted messaging.

Secure call conferencing:

Peers were provided with user accounts managed by Health Equity Matters and housed within our existing IT environment. All contact tracing appointments occurred using pre-configured software which facilitated both secure calls and video conferencing if preferred by clients.

These steps, in conjunction with internal processes, meant that access to Health Equity Matters' peer contact tracing pilot was secure and largely a 'closed loop' system. While it was possible to implement the pilot securely using the systems provided, interfacing with state and territory health partners could have been improved considerably if greater system interoperability existed between services and across jurisdictions. In the absence of this interoperability, however, the pilot demonstrated an ability to facilitate the safe management of client data.

7.3 Recruitment

It was initially envisaged that peers would be recruited using an external job posting. However, after exhaustive efforts to navigate Australian employment law (***see section 8.5: Governance, Legal and Ethical Challenges and Considerations***), this approach was deemed infeasible. Instead, the project used an internal recruitment process that engaged peers from across the membership.

Peers were recruited from Health Equity Matters' and NAPWHA's membership via a recruitment drive and an internal expression of interest (EOI). This was followed by a formal recruitment process involving behavioural questioning and standard employment pre-checks. At the conclusion of this process, the project had successfully engaged six peers. Two peers ceased involvement prior to implementation due to limited capacity, as described in 7.2.

7.4 Specialist peer contact tracing Team

Collectively, the peers engaged in this pilot had over 25 years of experience working in LGBTIQA+ health and the Australian HIV response, with specialist skills in complex client support and case management among their many areas of expertise. While there were limits to some of the intersectional experiences our peers were able to support, broadly speaking, the peer team had a strong combination of professional and lived experience that was supportive of a wide range of community experiences.

7.5 Peer-led training modules and support resources

Peers engaged in the pilot had extensive professional experience working in clinical and non-clinical settings and supporting complex client engagements. As a result, baseline HIV and sexual health knowledge was high, as was confidence (indicated by pre-training evaluation measures). To build on this strong foundation, the pilot implemented two online training modules, which were mandatory for peers participating in the pilot.

The first module was an online, facilitated, peer-led contact tracing workshop led by pilot clinical partners Cherie Bennett and Joshua Borja from ASHM. The second training module consisted of a pre-recorded RedCap database training session developed by Health Equity Matters project staff, focusing on the administrative process of running a peer-led contact tracing session. Finally, to facilitate peer access to all relevant peer-led contact tracing documentation, training modules, referral pathways and other additional supports for peers, Health Equity Matters project staff created a Peer Resource Hub which was accessible online to pilot peers. Detailed information about the provided training modules is outlined in the following.

ASHM Peer-led Contact Tracing Training Module

In close collaboration with ASHM and clinical peer contact tracing experts engaged through the project's steering committee, a comprehensive three-hour online training session was created and run by Cherie Bennett and Joshua Borja from ASHM. The training session focused on explaining the peer-led contact tracing process, client eligibility criteria, referral pathway process and the responsibilities of peers conducting contact tracing. Training included reinforcement of core skills such as active listening, effective questioning and navigating and responding to strong client emotions during the contact tracing process. The training also reinforced the scripting and protocol processes that ensured strong client confidentiality. Access to the training documentation can be found here.

Peers were asked to complete an optional post-training evaluation form communicating their confidence across the learning objectives and skills covered by the training. Results show that, at the end of training, peers felt confident and very confident across each of the learning areas covered by the training, indicating that the training provided was largely helpful in supporting peers to feel confident to undertake peer contact tracing.

8.2 Initial clinical reception

Among the sexual health clinics approached by the project in this first wave, initial feedback indicated a hesitation to engage. This hesitation stemmed from concerns regarding the 'reportable' nature of HIV contact tracing and HIV management more broadly, as well as potential risks to continuity of care. We note that these concerns were a persistent barrier to engagement that featured frequently in later onboarding conversations. These concerns are discussed at length in the section describing the project's key learnings. Government-run sexual health services also noted that they already employed highly trained staff, suggesting that they may have considered the pilot to offer little value to their existing operations. Other clinics (particularly public health clinics) communicated significant logistical and governance challenges which would need to be overcome before they could participate in the pilot. These included the potential need to complete site-specific assessments and internal ethics and approvals processes before engaging. This posed a particular challenge that often acted as a barrier to engagement — particularly given the project's short delivery schedule. Despite three months of sustained recruitment efforts, attempts to engage sexual health clinics and sites with high caseloads were largely unfruitful.

8.3 Member concerns raised

Members also raised concerns about the suitability of the proposed model early in the pre-implementation process. Key concerns included:

- **Training adequacy:** Members wanted to see a clearer structure and contact tracing training package.
- **Safeguards for peers:** Members requested explicit safeguards to be included in the model to ensure engaged peers had access to adequate support resources and appropriate escalation pathways — particularly for clients experiencing domestic partner violence or for clients experiencing acute mental distress.
- **Role clarity:** Members needed further clarification about the nature of peer-led contact tracing positions, including how this role would operate in concert with existing peer-led services. Additionally, members requested further information about the engagement model and additional information about how peers would be employed/engaged in the project.

Subsequently, several Health Equity Matters members and affiliates requested further refinement and adjustment to the pilot model before they would endorse participation.

8.4 Initial extension and subsequent project overhaul

In March 2024 the project applied for and was granted an extension to the planned timelines. The application for an extension reflected challenges identified during pre-implementation that needed to be addressed prior to recruitment of participating sites, and member engagement and endorsement. At this time an internal review of the project logic, model and communications was launched to address the concerns raised by clinicians and members approached to participate in the pilot.

8.5 Governance, legal and ethical challenges and considerations

Throughout the implementation of this project several significant governance, legal and ethical challenges and considerations were identified and overcome. Many of these issues are well documented within public health literature as structural barriers to successful public health initiative implementation. In this section we briefly describe these challenges and considerations along with the steps taken to overcome them.

8.5.1 Governance
(Privacy, Data Security, Interoperability)

Privacy and Confidentiality Protocols

The topic of client privacy and confidentiality featured throughout consultations in the pre-implementation phase of the pilot. Concerns commonly related to how the pilot would ensure client privacy and confidentiality. Examples of these concerns included:

- **Management of conflicts of interest:** Given the small size of the LGBTIQA+ community and its proximity to HIV, concerns were raised about how the program would prevent peers being connected to someone they knew or, if this occurred, what steps would be taken to manage related risk. Additionally, concerns were raised by NAPWHA members about the impact of involvement of their peers in the project and the barriers this may create for clients seeking to access peer-based services later run by those same peers. It was noted that many clients may wish to distance themselves from people involved in earlier aspects of their diagnosis (including peer contact tracers). Concerns were also raised that this might lead to clients avoiding future engagement with peer contact tracers in non-contact tracing settings — creating a barrier to accessing ongoing peer support.
- **Client privacy:** Questions were raised about how the pilot would support peers, clinicians and Health Equity Matters project staff to ensure that client privacy was protected throughout the pilot. Specifically, questions were raised about when, where and how privacy concerns would be discussed with clients, particularly those with significant anxiety about disclosure of their diagnosis.

Data-security and patient data management concerns

Data security and the governance of client data transmission emerged as a primary barrier during pre-implementation, particularly among government-run sexual health services. Despite comprehensive communication regarding the project's robust data protection protocols, concerns regarding the interoperability and security of peer-managed data remained a significant barrier to clinician engagement. This is consistent with literature identifying clinicians' obligations to their patients as an important consideration in their willingness to engage with service innovation (Wiersma et al., 2025).

Closely linked to data security was a significant misunderstanding regarding ethical oversight. Many clinical stakeholders indicated that their engagement with the pilot would be conditional on it gaining formal ethics approval for data transmission, conflating the pilot's status as a 'service improvement initiative' with the rigorous requirements of a clinical trial. This conflation created a perception of unmitigated risk where none existed within the project's governance framework.

Key Terms

'Health Care Provider'	Used to reference general practitioners, primary care providers, nurses and other medical professionals providing sexual health services specific to contact tracing for HIV.
Index	The formal term used to reference the client who has just received a new HIV diagnosis. The contact tracing conversation occurs first with this person. This report avoids using 'index' solely to describe a client accessing the service — we use 'index client' instead.
Contact	Used to reference identified sexual partners of the index client who may also be at risk of HIV transmission.

8.5.2 Legal
(Protected Attributes, Employment Model, National Employment law requirements)

Protected Attributes and Anti-Discrimination Law

Initially, the project intended to recruit peers through an external recruitment process, including a public job advertisement. However, based on HR advice obtained by Health Equity Matters early in the pre-implementation phase, before a job posting could be created targeting LGBTIQA+ people with HIV, Health Equity Matters was required to seek exemptions from a number of state, territory and federal anti-discrimination laws under which these attributes are legally protected.

The substantial work required to prepare and submit formal exemption requests led to significant delays to peer recruitment. These delays were compounded by a lack of clarity over which states required exemptions. By May 2025, it was determined that external recruitment would not be feasible, and that internal recruitment would be required to meet the planned May deadline to commence recruitment.

Employment Model

Administration resource was required to establish casual roles in different states. Additionally, numerous complexities regarding salary levels existed within the project.

8.5.3 Ethical
Multi-site Ethics, Peer Safeguarding and debriefing)

Multi-site Ethics approval requirements and site-specific assessments (SSAs)

Sexual health clinics often required site-specific assessments to be performed before engaging in the project. This often resulted in the clinic disengaging from further conversations about the pilot. Common reasons for disengagement included:

- The service not having the capacity to support the SSA process.
- The cost of undertaking a site-specific assessment preventing further engagement.
- Project time constraints meant that the six-month process that might be required to obtain SSA approval for some sites ruled out their participation entirely.

Additional to these challenges were the research ethics implications. For each new SSA required, additional ethics revisions would need to be requested in line with the research ethics protocol governing the project. Every effort was made to close these gaps. For example, project officers adjusted model budgeting to enable the project to cover some of the costs associated with required SSAs. Project officers also tried to front end conversations about the SSA process to better map service requirements and then plan further conversations accordingly. Despite these efforts, the financial, time and capacity constraints presented by the SSA requirement meant that engagement in the pilot was untenable for many services. Future collaborations must better account for this process and enable significantly longer time to better support stronger engagement with public sexual health clinic engagement.

As noted by Taylor et al. (2026), while strong ethics processes are critical to ensure the safety of clinical health research, the resource requirements and lead time associated with ethics requirements such as SSAs can create significant barriers to delivery. While the pilot was not a clinical research project, the implementation hurdles presented by ethics requirements and specifically site-specific assessments did reduce test sites' ability to engage. It is therefore important that these barriers are addressed in future applications of the model in similar clinical settings.

Peer safety and wellbeing

During creation of the project's peer protocol (operation manual), steering committee members and wider consultation partners expressed a strong desire that it include robust supports for peer contact tracers. Consequently, Health Equity Matters ensured that peers — where required — had access to both informal debriefing with project staff, and specialist clinical debriefing opportunities accessed through the organisation's employee assistance program. These measures were deemed appropriate and in line with existing peer support mechanisms offered by member and affiliate member peer-led services. Additionally, Health Equity Matters staff ran a series of peer check-in sessions throughout the implementation period that allowed peers to share their experiences and provide one another with further support.

8.6 Evaluation partnership and methodology

Burnet Institute led the evaluation of this pilot initiative. A qualitative process evaluation was undertaken to explore implementation of the peer-led HIV contact tracing pilot, including barriers and facilitators to delivery, contextual influences, stakeholder perceptions, and implications for future scalability. The process evaluation was informed primarily by the UK Medical Research Council (MRC) framework for process evaluations of complex interventions, focusing on three key domains: implementation, context, and mechanisms of impact. Elements of the Consolidated Framework for Implementation Research (CFIR) were also considered to support exploration of organisational, legislative, and health-system factors influencing implementation.

Data sources included semi-structured interviews with nine key stakeholders involved in program design, implementation, and delivery, alongside administrative process data from client referrals. Interview participants included a Health Equity Matters program manager, four peer contact tracers, a sexual health clinician involved in steering and protocol development, a clinician involved in diagnosing and referring clients into the program, a public health unit stakeholder involved in protocol development and oversight, and a clinician from a service that declined participation in the pilot. Interviews explored experiences of implementation, perceived acceptability of the model, governance and legislative considerations, workforce and operational challenges, and views regarding future implementation. Interview transcripts and notes were reviewed to identify recurring themes relating to implementation processes, barriers and facilitators, stakeholder perceptions, and contextual influences on delivery of the intervention. Findings were interpreted using domains from the MRC process evaluation framework.

8.7 Project timeline and key milestones

The project was initially intended to be completed by June 2025. As the model was developed and additional complexities were identified, an extension of 12 months to June 2026 was requested and provided.

8.8 Referrals to the service

In total the service received two referrals during implementation. Both appointments were successful in supporting clients to identify potential ***contacts***. Eight ***contacts*** were identified through the service.

Both referrals were sourced from the same clinic and were completed within 24 hours of the referral being received (including reporting tasks).

One client agreed to support the evaluation of the service, the other did not.

Referrals to the service were lower than our initial forecasts, which relied on current case numbers at participating clinics and broader epidemiological trends. We describe possible reasons for this in Section 9: Key Learnings.

Consequently, several sexual health physicians insisted on undergoing extensive internal technical and governance reviews before proceeding. Given the pilot's compressed delivery schedule, these mandatory internal processes could not be completed within the project timeline, rendering engagement impossible

IT Interoperability limitations

As previously mentioned, clinicians held concerns about the transmission, storage and management of client data. While great effort went into addressing these concerns, for many clinicians the prospect of client data existing outside of pre-approved systems and protocols presented too significant a compliance risk and ultimately led to low uptake of the pilot among these stakeholders. Ironically, the high variability among internal IT systems and compliance processes across each of these stakeholders often prevented system integration or system bridging options from being explored. A lack of IT health system interoperability between NGO, clinical and government health organisations is a well-documented barrier to the implementation of digital health initiatives (AIHW, 2024; Krahe et al., 2024), particularly with respect to clinical health system interoperability with community health service provision.

Intimate partner violence and mandatory reporting escalation protocols

Steering committee members with contact tracing experience noted that the process commonly surfaced instances of intimate partner violence and potential risk to minors, and raised concerns about the training, support and processes that would be required for peers to address these instances. It was subsequently determined that the model was not equipped to manage such 'complex cases', so the eligibility criteria were revised to identify and exclude these cases from the pilot. Complex client needs of this kind highlight an important requirement of digital health models such as the peer-led contact tracing model: models must be suited to both the setting and the specific clinical needs of the client (Newton et al., 2024; Parmar et al., 2022; Wiersma et al., 2025). Once the model was adjusted to support clinicians to identify clients with complex needs and exclude them from the pilot, clinicians indicated they were more comfortable with supporting the project.

Appendix B
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Appendix A
Privacy Statement

Health Equity Matters Peer Contact Tracing Pilot
Project Information & Privacy Statement

Project Information

About Contact Tracing

Contact tracing involves you or your clinician contacting people you have identified as potentially being at risk of HIV transmission. These individuals will be notified that they have been in contact with someone who has tested positive for HIV and they will be referred to get tested. No information related to you will ever be shared during this process.

In some cases, your clinician or physician may need further support to complete contact tracing. In these instances, your clinician may gain support from specialist public health contact tracers who are trained and better resourced to reach and notify people you are concerned about.

Health Equity Matters' Peer-led Contact Tracing

Peer Contact Tracing is a 6-month 'pilot' service created by Health Equity Matters and is funded by the Australian Government. The service provides clients with the option of selecting a professional community health worker (called a peer) to support you in conducting the contact tracing process.

In your peer contact tracing support session, your peer will create a safe and supportive space; they will explain the contact tracing process to you before asking you some questions to help them support you in identifying people you may have had sexual contact with and need to be tested. These people can then be contacted anonymously and supported to seek testing.

Important!

At no point will any of the information you provide us with be disclosed to the people you have identified in your appointment. Your privacy will be kept in the strictest confidence.

Once we have identified who you would like contacted, Health Equity Matters project staff will create a password-protected report to send back to your referring clinician to contact the people you have identified.

For individuals based in Victoria

9.0
Key Learnings

Development of a peer-led contact tracing model for HIV is not only achievable, but also acceptable and sustainable

This pilot has demonstrated that — despite many complexities and challenges — it is possible to develop a novel, peer-led approach to HIV contact tracing in Australia that is acceptable to peers, clinicians and community members benefiting from the service. However, implementation requires time, resourcing, buy-in and collaboration between public and private health leaders.

Despite the low number of referrals to the service, we demonstrated that — with the right settings — peers were able to successfully implement and conduct contact tracing discussions. Peers were also successful in creating a supportive peer environment and successfully supported their clients to identify several potential ***contacts***.

Adjustments to the model made in response to clinician concerns meant that it was not possible to demonstrate the capacity of peers engaged in the pilot to undertake the full spectrum of activities that make up 'end-to-end' peer contact tracing for HIV, including follow-up with identified ***contacts***. However, it is important to note that across Australia's HIV response peers and peer workers carry out a wide range of complex client-related support work, much of which is already completed in partnership with clinicians working within Australia's HIV response. Clinician concerns about the suitability and readiness of peers engaged in the pilot to respond to specific instances of complexity (such as intimate partner violence or non-compliance with health orders) are valid. However, we submit that the majority of peers engaged in this work already deal with issues of similar complexity within their substantive roles.

Promisingly, this model demonstrates that — despite limited resources, time and pre-existing infrastructure — NGOs can operate within existing systems to establish and run a peer-led contact tracing service for HIV in concert with mainstream peer contact tracing services.

Finally, models such as this present high value in the context not only of Australia's changing HIV epidemic, but also more recent public health outbreaks which have required a near-immediate response, such as mpox and COVID-19. Investment in the creation of testing models that enable rapid deployment and mobilisation of Australia's community health services and workforce to bolster public contact tracing efforts represents great value to Health Equity Matters members and affiliate members, as well as to Australia's HIV and public health responses broadly. Investing in the governance, resourcing, and operational partnerships needed to enable similar models could potentially strengthen Australia's broader public health capacity.

10.0 Implications for the HIV Response

This pilot holds several potential implications for Australia's HIV response. These include:

1. A state-based model for peer-led contact tracing for HIV is viable, acceptable, secure and holds much value to Australia's HIV response. However, further investment is needed to identify the specific settings that are required to better support implementation and adoption of this model.

2. Australia has an extremely capable, talented and multidisciplinary peer workforce. However, its ability to support clinical practice — specifically contact tracing — is under-recognised. Peers engaged in this pilot were able to provide peer support, access to community health services and culturally responsive care while remaining effective in performing the required contact tracing processes. Increased investment in peer-led initiatives presents high value.

3. Clinicians are a crucial partner in Australia's HIV response and often operate within complex health, risk and governance settings. Australia's community health organisations must seek to understand and map out these environments and the considerations they present to clinicians if they are to be successful in promoting service improvement initiatives such as peer-led contact tracing.

4. Australia's divergent HIV epidemic and other emergent public health epidemics are likely to require a rapidly scalable contact tracing workforce. However, this need not be confined to nursing or clinical staff alone. Our model demonstrates that with the right training, governance, operational and systems settings, peers are capable of supporting contact tracing efforts. However, a number of governance and operational challenges remain that mean a state-led application of this model would be better positioned to respond to these challenges and ensure successful adoption and uptake.

11.0
Future Directions

Future efforts to explore peer-led contact tracing are recommended. We suggest that — from an operational and logistical perspective — collaboration between Health Equity Matters members and the state health agencies responsible for contact tracing offers the most promising avenue for successfully delivering such initiatives.

We also acknowledge that for some states and territories, limited funding and resourcing of peer-led initiatives across sexual health services broadly means that peer workforces are significantly smaller. In these instances, we urge state governments to consider how they might collaborate, resource and support Health Equity Matters members to first build and then maintain professional peer workforces. Health Equity Matters would endorse state-led efforts to increase peer-workforce capacity among our members and would suggest that our federal health partners could also contribute a significant amount of expertise and value to these conversations.

Finally, an opportunity exists for deeper cross-sector collaboration between NGOs and state-health agencies. Health Equity Matters members have demonstrable experience in successfully delivering high-quality, effective and tailored health services that present unique value to marginalised communities in clinical and non-clinical settings. The success of these partnerships is due to the mutual respect, understanding and appreciation for the value, experience, perspectives and professional expertise each party brings to the conversation. These partnerships are also often resourced appropriately and are structured to ensure maximum benefits to the communities they seek to support. They contribute significant capacity and value to state and federal health responses. This model demonstrates an opportunity for a novel pathway to further collaboration between our sectors. We recommend that federal and state health leaders work with Health Equity Matters and its members to investigate and invest in potential future applications of this model.

Clinical acceptability is fundamental for uptake of novel health services such as peer-led contact tracing

Our model received a mixed response from clinicians. Those resistant to the model were primarily concerned about patient care and safety, citing doubts about peer capability and training to undertake contact tracing. Additional concerns included patient data and privacy, management of complex client needs, and the risk of clients being lost to follow-up. Among services with existing specialist contact tracing teams, there was confusion about the necessity of the model given their in-house expertise.

Conversely, engagement with the pilot was most often secured through the trust, rapport, and relationships that project staff had developed with clinicians over time, along with sustained conversation to address concerns that had deterred others. Clinicians are critical partners to innovation and operate within high-risk, complex, and regulated environments. The influence that individual clinicians hold over the success of medical innovations and collaborations such as this pilot cannot be overstated.

Ricciardelli & Ricciardelli (2026, pp. 3–4) support this finding, noting that clinical leadership is critical to the adoption and structural reorganisation required to facilitate innovation and changes to existing practice. This reflects our experience directly: clinicians who supported the pilot often took on an informal role as its promoters within their service. Without this leadership, many of the sites successfully recruited would not have been onboarded.

A key learning, then, is the importance of clinicians as leaders of clinical innovation and change. Any future implementation of this model must be acceptable, valuable, and responsive to the specific technical, regulatory, interpersonal, and operational concerns of clinicians to ensure successful adoption.

A national peer-led contact tracing service is feasible but setting and integration matters

While several services approached during this pilot declined to participate, citing the model's incomplete end-to-end coverage as offering limited value, or noting that existing arrangements were preferable, the more significant barriers to uptake were structural rather than conceptual. Concerns about risk, governance, and interoperability featured consistently in stakeholder objections. Had it been possible to adequately address these concerns, stronger engagement and higher referrals would likely have resulted.

Despite these barriers, the pilot demonstrates that peers, when provided with adequate time, training, support and infrastructure, can deliver contact tracing effectively. Both clients referred to the service received quality support, and the peer successfully facilitated contact tracing conversations that led to the identification of several ***contacts***. While these numbers are neither representative nor generalisable, they indicate that peer-led contact tracing is feasible and may be preferred by some people newly diagnosed with HIV when the option is available. We posit that this preference likely reflects the positionality of peers as non-government, non-institutionally aligned workers, a distinction that may be particularly important for individuals who fear government management of their status or who hold mistrust in government-aligned institutions (Megnin-Viggars et al., 2020).

Provided with appropriate regulatory settings, infrastructure, and ongoing support, peer-led contact tracing could represent a scalable and highly mobile capability within Australia's HIV response. However, the pilot's experience underscores that where this model sits structurally will largely determine its viability. In the following, we discuss two potential integration pathways we consider viable.

NGO–clinical partnership:

Peer-led contact tracing could be embedded within LGBTIQA+ or community health NGOs, with access to clinical supervision, clinical systems access and clear escalation pathways. This would preserve the culturally safe, non-institutional setting that appears supportive of the model's acceptability, while ensuring clinical governance requirements around risk, data security, and mandatory reporting are met through formalised partnership arrangements. For smaller jurisdictions with limited staffing capacities (both within community health and public health services), this approach presents great benefit but would require resourcing and strong partnership with state health partners to enable successful implementation

Mainstream contact tracing service integration:

Australia is home to some of the world's most capable contact tracing teams and comprehensive surveillance systems. Australians should be proud of the quality of support provided by state health services.

Creating an integrated, state and federally endorsed peer-led contact tracing model within existing contact tracing services offers a number of potential benefits. As some supporting partners noted, state health services already engage staff from the communities they support to ensure contact tracing teams are able to respond to the cultural complexities which underpin health-seeking behaviours, particularly around sensitive sexual health-related events such as a new HIV diagnoses or the communication of a potential HIV exposure. However, we note that a number of small states/territories are subject to significant funding challenges that mean it is not always possible to hire staff from affected communities. Equally, communities experiencing high levels of marginalisation and stigma require tailored services and specific employment conditions which might not always be possible within existing state health services.

Alternatively, existing state-based contact tracing services could seek to strengthen recruitment, engagement and retention of workers who themselves belong to communities most affected by HIV — including people with HIV from these communities. This would enable increased integration of peer workers within mainstream public health and sexual health settings, improving existing contract tracing services' capacity to support and respond to affected communities in culturally informed ways.

However, this option would require mainstream health services to consider the settings and support needed for marginalised communities, particularly people with HIV, to thrive. Engaging with communities with lived experience of intersecting marginalisation and disconnection from, or distrust of, mainstream health services will require state-based contact tracing services and community health organisations to invest in fostering culturally tailored and supportive environments.

Governance, system and process interoperability remains a significant barrier to innovation within Australia's HIV response

Across the development, pre-implementation and implementation phases of this pilot, significant time and effort was invested in understanding and mapping the differences in how contract tracing and HIV management are approached across jurisdictions. These differences were often made clear when we asked contact tracing teams and clinicians engaging in contact tracing how this guidance was operationalised within their service or jurisdiction. Different reporting requirements, compliance concerns, capacity limitations (particularly access to specialist contact tracing support) and other structural and operational differences across jurisdictions suggest that a state-based implementation of this model would have a higher likelihood of successful adoption.

Australia's federal health authorities are well positioned to initiate and lead conversations around a potential state-based implementation of this model. The system-wide knowledge and perspectives, cross-jurisdictional relationships and existing information channels available to federal health agencies would lend the authority, resourcing and overarching support needed to help bridge many of the interoperability challenges that exist between NGOs and their state-based health counterparts.

1. **Develop a model for peer-led HIV contact tracing** in consultation with clinicians, community organisations and research partners.

2. **Establish partnerships with participating clinical services** to pilot the peer-led contact tracing model.

3. **Recruit and train a peer workforce** to deliver confidential and culturally appropriate support to people navigating partner notification following an HIV diagnosis.

4. **Pilot the peer-led contact tracing model** within participating clinical settings to explore its operational feasibility and integration with existing partner notification processes.

5. **Evaluate the implementation of the model**, including its feasibility, acceptability and operational considerations, and document key learnings to inform future program development.

5. **Evaluate the implementation of the model**, including its feasibility, acceptability and operational considerations, and document key learnings to inform future program development.

4. **Pilot the peer-led contact tracing model** within participating clinical settings to explore its operational feasibility and integration with existing partner notification processes.

Step 1. **An initial contact tracing appointment.**

Involved peers holding an initial appointment with the ***index client*** to identify potential ***contacts***.

1. A state-based model for peer-led contact tracing for HIV is viable, acceptable, secure and holds much value to Australia's HIV response. However, further investment is needed to identify the specific settings that are required to better support implementation and adoption of this model.

2. Australia has an extremely capable, talented and multidisciplinary peer workforce. However, its ability to support clinical practice — specifically contact tracing — is under-recognised. Peers engaged in this pilot were able to provide peer support, access to community health services and culturally responsive care while remaining effective in performing the required contact tracing processes. Increased investment in peer-led initiatives presents high value.

3. Clinicians are a crucial partner in Australia's HIV response and often operate within complex health, risk and governance settings. Australia's community health organisations must seek to understand and map out these environments and the considerations they present to clinicians if they are to be successful in promoting service improvement initiatives such as peer-led contact tracing.

4. Australia's divergent HIV epidemic and other emergent public health epidemics are likely to require a rapidly scalable contact tracing workforce. However, this need not be confined to nursing or clinical staff alone. Our model demonstrates that with the right training, governance, operational and systems settings, peers are capable of supporting contact tracing efforts. However, a number of governance and operational challenges remain that mean a state-led application of this model would be better positioned to respond to these challenges and ensure successful adoption and uptake.