

Community-Led, Peer-Led and Other Innovative Service Delivery Models for Syphilis

Summary

Effective syphilis responses depend not only on the availability of testing, treatment and prevention tools, but also on how and where those services are delivered. Traditional clinic-based models remain central to Australia's response but do not reach all populations equally. Community-led, peer-led and outreach approaches have demonstrated value in improving access to testing, prevention and care, particularly among populations that may not engage with mainstream healthcare services. Building on existing HIV and community health infrastructure, alongside emerging innovations in testing and service integration, presents an opportunity to expand the reach and effectiveness of the syphilis response. Realising this potential will require sustained investment, supportive policy settings and stronger integration across services.

Why traditional service models are not enough

Traditional healthcare services are not always accessible or appropriate for everyone. Clinic-based models often rely on individuals proactively seeking care, attending appointments and navigating referral pathways. For some populations, including people who use drugs, people experiencing housing instability, migrants, international students and highly mobile populations, this can create significant barriers to engagement.

Specialist sexual health services across many jurisdictions are also operating at or near capacity, while restricted opening hours, geographic distance and out-of-pocket costs can limit access through primary care. For some individuals, referral from one service to another can result in disengagement, delayed treatment and missed opportunities for prevention.

These challenges highlight the importance of service delivery models that are flexible, accessible and capable of meeting people where they are.

The value of alternative service delivery models

Traditional clinic-based models do not work for everyone. Community-led, peer-led and nurse-led approaches can help address barriers by providing more flexible, accessible and culturally appropriate pathways to prevention, testing and care.

Peer workers often have established trust, shared lived experience and strong connections with the communities they serve. This can reduce stigma, increase comfort discussing sexual health and improve engagement with health services.

Australia has a strong foundation of community infrastructure developed through decades of the HIV response. Organisations representing people living with HIV, LGBTIQ+ communities, people who use drugs, sex workers and Aboriginal and Torres Strait Islander communities have developed trusted relationships, engagement mechanisms and service delivery expertise that can support the syphilis response.

Community-based testing and prevention initiatives have demonstrated that services can be effectively delivered outside traditional healthcare settings. These approaches may be particularly valuable for people who are hesitant to engage with mainstream services or experience difficulties attending appointments.

Nurse-led services can also strengthen access, particularly in regional, rural and community settings. When supported by appropriate clinical governance, referral pathways and workforce development, these models can expand service reach while maintaining continuity of care.

Leveraging and building on existing community infrastructure may enable more rapid and cost-effective expansion of syphilis services than developing entirely new systems and programs.

Meeting people where they are

Delivering testing and prevention services in settings already accessed by priority populations can reduce barriers associated with stigma, transport, clinic opening hours and healthcare system navigation. These outreach approaches bring services directly into communities and settings where people live, work, socialise or access other forms of support.

Potential settings include:

- Peer-led community organisations
- Community events and outreach settings
- Sex-on-premises venues
- Alcohol and other drug (AOD) services
- Housing and homelessness services

These approaches bring prevention, testing and referral pathways into settings that people already access and trust. These models can facilitate earlier diagnosis, increase testing uptake and strengthen connections to follow-up care.

Integrated and emerging models

There are opportunities to integrate syphilis testing, treatment and prevention into services that many priority populations already access. Potential settings include AOD services, reproductive health and family planning services, women's health services, vaccination services and accommodation and homelessness services.

Integration can increase the reach of testing, treatment and prevention services by engaging people through settings they already access, while also reducing missed opportunities for care.

Emerging diagnostic technologies may further expand opportunities for community-based service delivery. Improved point-of-care tests and future self-testing options have the potential to support testing outside traditional clinical settings and increase accessibility for people who experience barriers engaging with mainstream healthcare services.

Existing initiatives such as community HIV testing services, self-testing distribution programs and vending machine projects provide a potential foundation for expanding community-based syphilis testing as new technologies become available.

What is needed to scale these models?

While community-led, peer-led and other alternative service delivery models have demonstrated promise, several barriers continue to limit broader implementation.

Funding and policy reform

Many services operate with limited or short-term funding, restricting their ability to scale successful models, maintain workforce capacity and expand their reach. Fragmented funding arrangements across HIV, sexual health, hepatitis, alcohol and other drugs, and community health sectors can also reduce opportunities for coordinated responses. More integrated funding and planning approaches could support collaboration, reduce duplication and improve efficiency.

Workforce reform

Current regulatory arrangements can limit the ability of nurses and other healthcare workers to independently provide testing and treatment in some settings. Supporting expanded scope of practice and innovative workforce models could improve access, particularly in regional, rural and other underserved communities.

Integration and continuity of care

Community-based testing models are most effective when they are supported by clear referral pathways and strong connections to clinical services. Ensuring individuals can move seamlessly between testing, diagnosis, treatment and follow-up is critical to maintaining continuity of care and preventing loss to follow-up.

Recommendations

1. Expand community-led, peer-led and nurse-led models

Invest in community-led organisations and alternative service delivery models, including peer-led, nurse-led and outreach approaches, to improve access to testing, prevention and care.

2. Build on existing community infrastructure

Leverage the expertise, trust and service delivery platforms developed through Australia's HIV, harm reduction and community health responses.

3. Enable scale-up through policy and funding reform

Address regulatory and funding barriers that restrict the implementation and scale-up of community-based and non-traditional service models.

4. Support integration and future testing models

Strengthen referral pathways and continuity of care, while supporting the future integration of point-of-care and self-testing technologies into community-based, peer-led and outreach services as they become available.