HEALTH EQUITY MATTERS
HIV. LGBTIQA+. COMMUNITIES.

Normalising Testing Pilot Project

Clinician-initiated testing for HIV, hepatitis B, hepatitis C and syphilis

Report July 2026

Prepared by:

Andrea Kindinger MGH
Senior Project Officer
Health Equity Matters

Harrison Sarasola MPH
Manager HIV and Community Health Programs
Health Equity Matters

Dr James Gray
Principal Director, Australia Program
Health Equity Matters

Zoe Sever
HIV Program Manager
ASHM

Dr Anthony K J Smith
Research Fellow
Centre for Social Research in Health, UNSW Sydney

HEALTH EQUITY MATTERS
HIV. LGBTIQA+. COMMUNITIES.

ashm | CSRH Centre for Social Research in Health

Table of contents

Acknowledgement of Country	02
Acknowledgements	03
Foreword	05
Key terms	06
Introduction	07
Scope of this report	09
Project aim and objectives	10
Project governance	11
Key considerations: Developing a clinician-initiated testing model for HIV, hepatitis B, hepatitis C and syphilis	12
The clinician-initiated testing model	15
Clinician recruitment	17
Implementation of the pilot	31
Evaluation of the model	32
Key learnings	40
Conclusion	43
References	44

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

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 this land of many Countries.

Sovereignty was never ceded and these lands always were and always will be Aboriginal land.

Acknowledgements

Health Equity Matters acknowledges the hard work and leadership of Habib Taouk, who initiated this project. Habib was instrumental in laying the groundwork during the early stages, including establishing the steering committee and commencing consultations. Thank you for your contribution to this important project.

Health Equity Matters acknowledges its valued Normalising Testing project partners. We thank Professor Martin Holt and Dr Anthony K J Smith from the Centre for Social Research in Health for their research expertise and leadership in the evaluation of the project, and Jessica Michaels and Joe Givan at ASHM for their clinical expertise and partnership. These collaborations are grounded in trust and a shared commitment to strengthening Australia's HIV response.

Health Equity Matters extends its sincere thanks to the pilot steering committee members and their organisations for their support and contribution to this project, as well as to our implementation partners, clinical partners, expert consultants and sector partners who worked in close collaboration with the HIV and Community Health Programs team to deliver this pilot successfully. We also acknowledge Hepatitis Australia for their support in incorporating hepatitis B and hepatitis C into the revised model. Projects of this nature are only possible through strong collaboration and partnership across Australia's HIV response, and we extend our deepest gratitude to all those who contributed to this work.

Health Equity Matters also acknowledges the dedication of Justin Salerno and Breandax Lim for their contributions to the evaluation of the pilot. Through their work conducting clinician interviews, they provided valuable insights that helped shape understanding of the model's implementation and impact.

Finally, Health Equity Matters wishes to sincerely thank each of the general practitioners who participated by implementing the clinician-initiated testing model in their practice. Each clinician contributed significant time, effort and professional expertise to this pilot. Without their commitment, this pilot would not have been possible. The clinicians listed below have provided consent to be acknowledged by name:

- Dr Cassy Workman, ARi
- Dr Mustafa Ebrahimjee, Albert Road General Practice
- Dr Mark O'Reilly, East Sydney Doctors and Taylor Square Private Clinic
- Dr Wei-May Su, East Sydney Doctors
- Clinicians at East Sydney Doctors, Taylor Square Private Clinic and Bondi Road Doctors
- Dr Tania Monjila, Harvey Medical Group
- Dr Thanh Hien Pham, Ledang Family Medical Centre
- Dr Darren So, Monash University Health Service Clayton
- Dr Beng Eu, Prahran Market Clinic
- Dr Joanne Wong
- Dr Con Hatzis, Prahran Market Clinic
- Dr Fred Jayawardene, Prahran Market Clinic
- Dr Andrew Lang, Prahran Market Clinic
- Dr Rebecca Overbury, Prahran Market Clinic
- Dr Belinda Ford, Streetdoctor Health 360
- Dr Anna Chaney, View Street Medical
- Dr Fergus McCabe, View Street Medical
- Dr Belinda Wozencroft, View Street Medical
- Dr Suzette Finch
- Dr Arti Inamdar
- Dr Alyisha Tan
- Dr Angus Taylor
- Dr Eveline Tjandramulia
- Dr Farhan Ulhaq

Project team

Joe Givan MPH
Senior Project Officer

Zoe Sever MSMed (SRH)
HIV Program Manager

Prof Martin Holt PhD FRSN
NHMRC Leadership Fellow
UNSW Sydney

Dr Anthony K J Smith
Research Fellow
UNSW Sydney

Andrea Kindinger MGH
Senior Projects Officer

Harrison Sarasola MPH
Manager, HIV and Community Health

Dr James Gray
Principal Director, Australia Program

Funding acknowledgement

This project was funded by the Australian Government through the Australian Centre for Disease Control. Health Equity Matters acknowledges this support and the Australian Government's ongoing commitment to strengthening Australia's response to HIV, hepatitis B, hepatitis C and syphilis.

Suggested citation

Kindinger, A., Sarasola, H., Gray, J., Sever, Z., & Smith, AJK. (2026). Normalising testing pilot project: Clinician-initiated testing for HIV, hepatitis B, hepatitis C and syphilis. Report July 2026. Health Equity Matters. https://www.healthequitymatters.org.au/impact-areas/australia/testing

Foreword

Since its inception more than 40 years ago, Australia's HIV response has been based on a partnership between affected communities, clinicians, researchers, advocates and government.

This partnership has delivered one of the fastest-declining rates of transmission in the world and – led by the Ninth National HIV Strategy – Australia now has a clear and achievable pathway towards virtual elimination of new HIV transmissions by 2030.

However, barriers to realising this ambitious vision and ensuring no communities are left behind persist. Key challenges include reducing late diagnoses, addressing inequities in care and minimising missed testing opportunities within general practice.

The Normalising Testing Pilot Project aims to address this challenge, in line with the Ninth National HIV Strategy's priority on innovative testing approaches. Led by Health Equity Matters, it is, to our knowledge, the first national pilot of a clinician-initiated testing model for HIV, hepatitis B, hepatitis C and syphilis in Australian general practice. It embeds testing into routine bloodwork and offers it to everyone, regardless of risk profile or demographics. The model ensures explicit and informed consent appropriate to the Australian medicolegal context and aims to reduce stigma relating to testing for HIV and other bloodborne pathogens.

The results of the pilot are encouraging. Clinicians found the model broadly acceptable and valued its capacity to normalise conversations about HIV and sexual health, prompt opportunistic vaccination, and support more confident discussions about treatment options. The report concludes that the clinician-initiated testing model is feasible and acceptable within general practice settings, and that it can be effectively implemented as a universal and targeted strategy to improve testing uptake. It suggests avenues for future research and consideration, most notably the potential value of targeting the model to settings where testing is not already a component of routine general practice care, such as outer-metropolitan, regional and remote communities where barriers to testing persist.

This project was made possible thanks to the support of a number of key partners and agencies. We thank the Australian Government for funding the pilot via the Australian Centre for Disease Control; Joe Givan at ASHM for their clinical expertise; Professor Martin Holt and Dr Anthony Smith at the Centre for Social Research in Health, UNSW for leading the evaluation; the members of the pilot steering committee; and Hepatitis Australia for their support in optimising this model to also include hepatitis B and hepatitis C. Above all, we thank the general practitioners who participated in the pilot and gave their expertise and time to this important work. This support and collaboration helped ensure the pilot's success and has brought Australia a step closer to our goal of achieving virtual elimination of HIV.

Dash Heath-Paynter
Chief Executive Officer, Health Equity Matters

Key terms

Opt-out testing:	'Opt-out' HIV testing is provider-initiated testing where a person in a clinical setting understands that testing is routinely performed for all clients unless they decline it (ASHM, 2024). Opt-out testing sometimes operates under an 'assumed consent' model, in which clinicians do not routinely initiate discussions about testing with every client, relying on the opt-out testing model being advertised and publicised within the service (Chadwick & Hill-Tout, 2024). Opt-out HIV testing is used in the international literature to describe approaches involving verbal discussion or assumed consent.
Clinician-initiated testing:	A provider-initiated approach to diagnostic testing that is conceptually equivalent to opt-out testing involving verbal discussion, where testing is offered routinely to every client and performed unless the client declines. In this project, clinician-initiated testing was used in lieu of opt-out testing to distinguish against assumed consent models, and to better emphasise the importance of clear, explicit communication to support informed consent – that is, testing was discussed with every client (Carter zet al., 2025).
Informed consent:	This project used the Australian Commission on Safety and Quality in Health Care definition of informed consent, based on the 2020 version[1], which was current during the project's development and implementation. "Informed consent is a person's decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention that is made: • Following the provision of accurate and relevant information about the healthcare intervention and alternative options available; and • With adequate knowledge and understanding of the benefits and material risks of the proposed intervention relevant to the person who would be having the treatment, procedure or other intervention" (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2020, p. 1).
Universal testing:	Involves offering HIV testing to an entire population (Baggaley & Hollingsworth, 2020), regardless of symptoms or risk behaviour.

[1] The ACSQHC revised its definition of informed consent in 2026. The substantive requirements of informed consent are unchanged in the revised definition and do not affect this report's findings or conclusions. The new version can be found here: https://www.safetyandquality.gov.au/sites/default/files/2026-05/informed-consent-fact-sheet-clinicians.pdf

Introduction

Australia has made significant progress in its HIV response through sustained investment, strong partnerships and a commitment to evidence-based prevention, testing and treatment.

The Ninth National HIV Strategy 2024-2030 (Australian Centre for Disease Control, 2024) builds on this foundation and sets a clear national goal of the virtual elimination of domestic HIV transmission by 2030. Achieving this goal will require continued innovation in HIV testing approaches that reduce late diagnoses, address inequities and minimise missed testing opportunities within routine healthcare, particularly in general practice settings.

Nationally, HIV testing in general practice typically occurs when clinical risk factors are identified, an approach known as 'risk-based' testing. It is also commonly described as 'opt-in' testing. These risk assessments draw on epidemiological trends and behaviour-based indicators to identify populations at higher risk of HIV. Beyond risk-based pathways, testing in clinical settings also occurs at specific clinical touchpoints, such as antenatal screening, and as a routine component of accessing specialist reproductive services. It is also offered during travel assessments and occupational health assessments.

Client-initiated testing (where the client requests a test for HIV) and current risk-based testing models (offered by the clinician) may lead to missed opportunities for testing and diagnosis. Client-initiated testing relies on an individual's awareness of HIV risk, health literacy and willingness to request testing, which can be limited by anticipated stigma, low perceived risk and lack of knowledge (Bolsewicz et al., 2015). Similarly, risk-based HIV testing depends on the clinician making an accurate risk assessment, which may be constrained by time pressures in consultations, clinician discomfort in raising sexual health and clients' reluctance to disclose sensitive information (Hocking et al., 2008; Owen & Magraith, 2025). As a result, both approaches can fail to identify individuals who do not perceive themselves to be at risk or who do not fit traditional risk profiles, contributing to delayed diagnoses and ongoing gaps in testing coverage. This remains a significant challenge in Australia's HIV response, reflected in persistently high rates of late diagnosis, with 38% of all new HIV notifications diagnosed late in 2025 (King et al., 2025).

Clinician-initiated testing (where the clinician offers HIV testing to all clients) addresses these limitations by applying a routine, universal approach to testing. This reduces reliance on risk assessment and disclosure and removes the need for clients to actively request testing, thereby supporting more consistent and equitable testing practices across communities. This approach is endorsed in ASHM's National HIV Testing Policy (ASHM, 2020), provided that informed consent is central to its application in the Australian clinical context. Evidence from international studies has demonstrated the effectiveness and acceptability of opt-out HIV testing across a range of clinical contexts, including high levels of client acceptability, reduced time to diagnosis and improved re-engagement to care among individuals previously disengaged from services. In general practice settings in the UK, opt-out testing has been shown to be acceptable to clients (Glew et al., 2014). A study in the Netherlands found that opt-out testing increased HIV testing uptake in an outpatient sexual health service (Heijman et al., 2009). Evidence from a modelling study in France found that introducing routine HIV screening in general healthcare settings reduced late diagnoses by shortening the timeframe from HIV acquisition to diagnosis, leading to higher mean CD4 counts at diagnosis (Yazdanpanah et al., 2010). Flash et al. (2015) demonstrated that an opt-out testing program in a United States emergency department improved re-engagement and retention in care among individuals who had previously been diagnosed but were no longer engaged in clinical services.

Building upon these findings, the Normalising Testing Pilot Project was developed in direct response to Australia's national priority for innovative testing approaches. Led by Health Equity Matters, the pilot was designed to evaluate a clinician-initiated HIV testing model implemented nationally in general practice, representing the first national pilot of its kind to our knowledge. During model development, the scope was expanded to include hepatitis B, hepatitis C and syphilis, recognising overlapping epidemics, shared barriers to testing and opportunities to strengthen preventive care through a combined testing approach. By embedding testing into routine consultations where blood tests are already being performed, the model sought to move beyond reliance on risk-based testing, support informed consent, reduce stigma and normalise HIV, hepatitis B, hepatitis C and syphilis testing as part of everyday care.

Clinician-initiated testing has the potential to engage people in opportunistic testing who are consistently missed by traditional, risk-based testing approaches. The findings of this pilot demonstrate that the impact of this model is likely to be greatest in settings where HIV testing has historically been less routine, reinforcing the importance of targeted recruitment and implementation in regions and practice environments where clinician engagement in HIV testing is lower. When directed to these settings, clinician-initiated testing shows potential to locate previously undiagnosed infections and reduce late diagnoses, including among people who do not perceive themselves to be at risk. Beyond diagnosis, the model supported broader preventive care, prompting opportunistic vaccination and enabling more frequent and confident discussions about PrEP, Doxy-PEP and other prevention strategies. This pilot demonstrates that clinician-initiated testing has the potential to be a feasible, acceptable and impactful intervention in general practice that strengthens equitable access to testing, supports broader preventive care and can help to normalise HIV and sexual health discussions, thereby reducing stigma associated with HIV testing and sustaining momentum toward a future free from domestic HIV transmission.

Scope of this report

This report documents the delivery and outcomes of Health Equity Matters' Normalising Testing Pilot Project, an initiative designed to implement and evaluate a novel clinician-initiated testing model for HIV, hepatitis B, hepatitis C and syphilis in general practice settings (often described as an opt-out testing model). It outlines the project context and provides the rationale underpinning the development of the clinician-initiated testing model. The report then presents an overview of the clinician recruitment process and describes experiences of implementing the model in general practice. It concludes by presenting the evaluation findings and key learnings, considering their implications for Australia's HIV response and highlighting the value of targeted implementation of clinician-initiated testing in appropriate practice settings.

Project aim and objectives

Aim

The Normalising Testing Pilot Project aimed to develop, implement and evaluate a routine clinician-initiated HIV, hepatitis B, hepatitis C and syphilis testing model in general practice settings nationally over a six-month period. Central to this initiative was the use of qualitative methods to assess the model's acceptability among general practitioners and its potential to improve equitable testing access, particularly among communities reporting lower rates of testing despite elevated risk of HIV, hepatitis B, hepatitis C and syphilis.

The overarching aims of this project were to:

- Develop a 'normalised' (routine) clinician-initiated testing model to support increased testing for HIV, hepatitis B, hepatitis C and syphilis.
- Determine the acceptability of the model among general practitioners involved in the model's implementation.

Objectives

1. **Develop a clinical model for clinician-initiated HIV testing, to be implemented in general practice settings,** in partnership with clinicians and community, clinical and research partners.

2. **Recruit and onboard general practitioners** to pilot the clinician-initiated testing model in their practice.

3. **Pilot the clinician-initiated testing model** by implementing it in the general practice settings of recruited clinicians.

4. **Evaluate the implementation of the clinician-initiated testing model** through qualitative interviews with clinicians to assess their experiences and develop insights into the feasibility and acceptability of the model in general practice.

5. **Document key learnings** to inform future program development.

Project governance

Clinical partners

Health Equity Matters partnered with ASHM to provide clinical oversight and expert guidance for the project. ASHM led the development of the clinical protocol and supported the recruitment of clinicians to participate in the program.

Steering committee

To ensure the clinician-initiated testing model was clinically appropriate, ethically sound and responsive to the complexity of Australia's HIV response, Health Equity Matters established a steering committee comprising Health Equity Matters members and affiliate members, alongside clinical, research and community experts from across Australia. The steering committee provided expert guidance to senior project staff throughout the pre-implementation, implementation and evaluation phases of the pilot, and was actively consulted during the development and refinement of both the model and the clinical protocol. This guidance was instrumental in supporting project staff to strengthen the integrity and implementation feasibility of the final model and to navigate the complex implementation environment of general practice.

Guidance from the steering committee also prompted consultation with medicolegal experts to examine informed consent and the appropriateness of a clinician-initiated testing model within an Australian consent framework. These conversations were instrumental to the development of the clinician-initiated testing model. Steering committee members are listed in Table 1, below.

Table 1. Normalising Testing Pilot Project steering committee members

Name	Organisation
Dr Beng Eu	Prahran Market Clinic, University of Melbourne
Brent Clifton	National Association of People with HIV Australia
Dr Anthony K J Smith	Centre for Social Research in Health, UNSW Sydney
Joe Givan	ASHM
Jessica Michaels	ASHM
Sharmila Radha Krishnan	WAAC
Cherie Hazelwood	East Sydney Doctors
Dr Chris Lemoh	Department of Medicine at Monash Health, Monash University
Peter Locke	Thorne Harbour Health
Rocky Byrne	Queensland Council for LGBTI Health
Dr Phillip Keen	Kirby Institute, UNSW Sydney

Evaluation partners

Health Equity Matters partnered with Professor Martin Holt and Dr Anthony K J Smith from the Centre for Social Research in Health, UNSW Sydney, to conduct an evaluation of this pilot.

Key considerations:
Developing a clinician-initiated testing model for HIV, hepatitis B, hepatitis C and syphilis

In this section, we describe the development of the model, key considerations and emergent challenges that were managed.

We describe the iterative development process, including consultation with partners and clinical experts, analysis of epidemiological evidence and consideration of legal and ethical requirements. Together, these elements informed a model that is responsive to the Australian clinical context and grounded in informed consent, clinical practicality and the aim of normalising testing within general practice.

Inclusion of hepatitis B, hepatitis C and syphilis

The project was funded to focus on HIV testing. However, early discussions during the model-design process explored whether the clinician-initiated testing model should also include testing for hepatitis B, hepatitis C and syphilis. Although distinct from HIV, testing for these pathogens involves an equivalent blood draw. In addition, hepatitis B testing can lead to the identification of candidates to be offered vaccination screening. Overall benefits to incorporating the tests together as part of opportunistic testing were also identified, including increased testing uptake, reduced missed opportunities for testing and diagnosis and the support of more holistic delivery of care.

The potential benefits of including hepatitis B, hepatitis C, and syphilis testing were weighed against the risk of overcomplicating the process, the additional support that clinicians might require and the cost implications of expanding the model. As part of this process, Health Equity Matters staff met with Hepatitis Australia to discuss the proposed protocol and model in more detail and to assess their acceptability.

Epidemiological data were also reviewed to inform decision-making. Analysis of Australian surveillance data across HIV, hepatitis B and hepatitis C identified overlapping population-level patterns of inequity (MacLachlan & Cowie, 2025; King et al., 2024a), including a disproportionate impact among multicultural communities and people born overseas – most notably in relation to hepatitis B, for which over two-thirds of cases occur among overseas-born individuals (MacLachlan & Cowie, 2025). These findings supported the inclusion of hepatitis B and hepatitis C in the model.

Epidemiological trends over the previous decade demonstrated a sustained and concerning increase in syphilis notification rates across Australia (King et al., 2024b). This evidence supported the inclusion of syphilis alongside HIV and viral hepatitis within the clinician-initiated testing model. During the implementation of the pilot, Australia's Chief Medical Officer, Professor Michael Kidd AO, formally declared syphilis a Communicable Disease Incident of National Significance (Australian Government Department of Health, Disability and Ageing, 2025), further reinforcing the appropriateness and timeliness of its inclusion in the model.

Informed by this evidence, Health Equity Matters worked in partnership with ASHM and Hepatitis Australia to further develop and refine the clinician-initiated testing model to incorporate testing for hepatitis B, hepatitis C and syphilis alongside HIV.

Legal and ethical considerations of a clinician-initiated testing approach in the Australian context

Early consultations with both steering committee members and general practitioners engaged in early concept testing highlighted concerns around the compatibility of an 'opt-out' testing model within Australia's medicolegal framework. In the Australian medical context, 'opt-out' testing tends to be received with caution, with some clinicians associating it with passive or incomplete consent processes. While opt-out HIV testing programs that rely on assumed consent have demonstrated success in the United Kingdom ("Opt-out HIV testing in the UK," 2023), important aspects of Australia's consent framework needed to be considered. According to the ACSQHC's guidelines (2020), informed consent must be obtained before blood tests are conducted.

These guidelines explain that informed consent involves providing clients with sufficient information about a proposed test, including its purpose, benefits and any material risks to support informed decision-making (ACSQHC, 2020). Although the current National HIV Testing Policy promotes opt-out testing, a recent legal analysis (published during this project's implementation) has suggested that this policy does not remove practitioner requirements to establish consent for medical procedures (including testing) that are required under general law (Carter et al., 2025). The authors recommended framing the practice as 'provider-initiated testing', and, to avoid legal risks to the clinician, that all practitioner legal duties be met, including obtaining direct, verbal provider-patient consent prior to any medical procedure, such as HIV testing.

The current National HIV Testing Policy stipulates that informed consent requires that the client understands that an HIV test is being conducted, the reason for testing, and the potential implications of not being tested (ASHM, 2020). This makes clear that any opt-out testing approach in Australia must ensure that informed consent is obtained, rather than relying on passive or assumed processes.

Consultation with medicolegal experts on informed consent requirements

Health Equity Matters consulted with medicolegal experts to clarify informed consent requirements for clinician-initiated HIV, hepatitis B, hepatitis C and syphilis testing in the Australian clinical and medicolegal context. The advice confirmed that informed consent serves a dual purpose: protecting clients' legal and ethical rights and safeguarding clinicians from negligence when conducting clinical care (Carter et al., 2025).

The advice clarified that informed consent comprises two core elements. The first relates to ensuring that the client is adequately informed, meaning they understand what is being proposed, including the nature and purpose of the tests being ordered. The second element relates to consent itself, which concerns physical contact made with a client, such as performing a venepuncture blood test. Consent must therefore be both legally valid and genuinely informed, so that what the client consents to clearly aligns with what actually occurs in practice.

Practical implications for clinician-initiated testing

This advice informed the design and implementation of the clinician-initiated testing model. The following key elements were provided to participating clinicians to support implementation in line with Australian informed consent requirements:

- the need to clearly communicate that a venepuncture blood test is being performed
- the need to clearly communicate the specific purpose of the blood test, including that testing for HIV, hepatitis B, hepatitis C and syphilis will be included.

Clinicians were encouraged to use their professional judgement in how they communicated this information, with an emphasis on ensuring that clients clearly understood the nature of the testing. For example, overly vague language (e.g., 'a whole bunch of tests') may not provide clients with sufficient clarity about what is being included.

The guidance also highlighted that formal questions such as 'do you consent?' are not required where informed consent is otherwise demonstrated.

In line with this, clinicians were reminded that consent may be expressed in different ways, including:

- explicitly, such as verbally agreeing, nodding or signing paperwork
- implicitly, such as proceeding to have blood collected after the clinician has clearly explained the tests.

To assist clinicians in implementing the model in a manner consistent with Australian informed consent requirements, a script was developed in consultation with practising clinicians (see below).

'Today, I will be ordering a blood test for you. I will be adding a test for HIV, hepatitis B, hepatitis C and syphilis, unless you don't want these included. I am doing this for everyone who gets any blood test in my practice.'

The script, while not prescriptive, was designed to support clear, explicit communication by ensuring that clients understood that a venepuncture blood test was being performed and that testing for HIV, hepatitis B, hepatitis C and syphilis would be included as part of that test. Rather than framing testing as an 'opt-in' process, the script suggested language such as 'unless you don't want these included,' which aligns with informed consent requirements and affirms client choice. Importantly, the script also sought to minimise the potential for clients to feel singled out or targeted by emphasising the routine nature of the tests – stating explicitly that they are offered to everyone attending the clinic for a blood test. In this way, the script operationalised informed consent in a manner that is legally robust, clinically practical and consistent with the underlying aim of normalising HIV testing within general practice. Finally, the model was deliberately reframed and described as 'clinician-initiated' testing, rather than 'opt-out' testing, to more accurately reflect the central role of clinician judgement, clear communication and informed consent within the Australian clinical setting.

Cost considerations for Medicare-ineligible clients

The inclusion of clients who are ineligible for Medicare was a further consideration arising from the advice and the broader consent framework informing the model. In the Australian context, HIV disproportionately affects people who are overseas-born and people from migrant and multicultural communities (King et al., 2025), many of whom experience limited or inconsistent access to Medicare-funded health care. The decision was made to include Medicare-ineligible clients, with clinicians advised to follow standard practice when testing these clients for HIV, hepatitis B, hepatitis C and syphilis. This decision was consistent with standard general practice approaches, helped support equitable delivery of clinician-initiated testing and reduced the risk of inadvertently excluding communities experiencing higher disease burden or structural barriers to care.

Together, these considerations shaped the design and framing of the clinician-initiated testing model. Consultation with medicolegal experts and engagement with clinicians confirmed the need for clear, explicit consent embedded within the model. To support this, suggested scripts were developed to ensure consent was legally robust and feasible in practice. A critical enabler of clinician engagement was reframing the approach as 'clinician-initiated' rather than 'opt-out', which helped to mitigate clinician concerns about consent. These adaptations strengthened clinician confidence, addressed initial hesitation and removed a key barrier to implementation, supporting broader engagement. As a result, the final model is responsive to the Australian clinical context, grounded in informed consent and could be practically integrated into routine care.

The clinician-initiated testing model

This section outlines the clinician-initiated testing model, including the eligibility criteria, the step-by-step process for implementation in general practice, and the supporting clinical protocol.

It describes how eligibility was defined to support safe, appropriate and consistent use of the model, how testing is incorporated into routine consultations where blood tests are already being performed, and how the protocol provides practical guidance to clinicians across all stages of testing. Together, these components illustrate how clinician-initiated testing can be implemented in practice to support routine testing for HIV, hepatitis B, hepatitis C and syphilis.

Eligibility for the model

Client eligibility for implementation of the clinician-initiated testing model was defined to support safe, appropriate and consistent implementation of the testing model in general practice. The eligibility criteria were developed in consultation with the project's steering committee and clinical partners and informed by medicolegal experts to ensure alignment with Australian informed consent requirements and routine clinical practice.

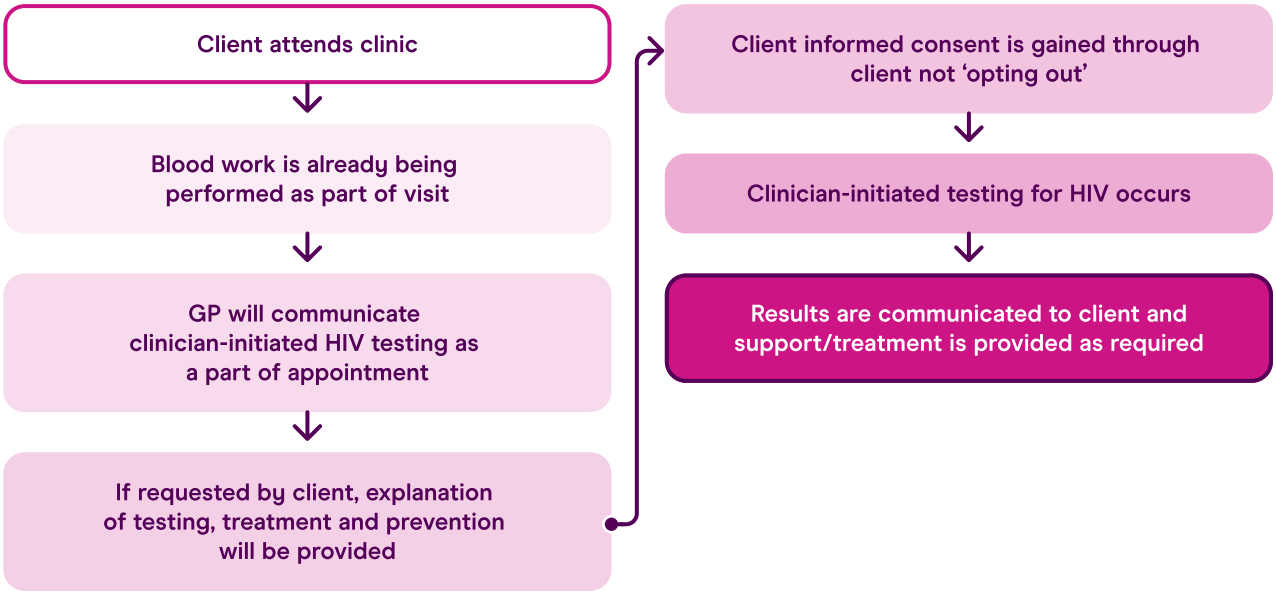
Clients were eligible for inclusion in the model if they met the following criteria:

- were aged 18 to 75 years old
- had not been tested for HIV in the previous six months
- were already having a blood test performed as part of their clinical care
- had provided informed consent to the testing for HIV, hepatitis B, hepatitis C and syphilis.

The clinician-initiated testing model is implemented during routine general practice consultations and follows a clear, step-by-step process (Figure 1). It centres on clinician judgement and informed consent, integrating HIV, hepatitis B, hepatitis C and syphilis testing into standard blood-testing practices where eligibility criteria are met. The process is outlined below:

- A client attends a routine general practice consultation.
- The clinician assesses whether the client meets the eligibility criteria for the clinician-initiated testing model.
- If the eligibility criteria are met, the clinician advises the client that testing for HIV, hepatitis B, hepatitis C and syphilis will be included as part of the client's routine blood test.
- Informed consent is obtained by the clinician before testing proceeds. Clients may decline any or all of the additional tests.
- Where consent is provided, testing is conducted and results are communicated to clients in line with standard clinical follow-up processes.

Figure 1. Implementation of the clinician-initiated testing model in general practice



Clinical protocol

The clinical protocol for the Normalising Testing Pilot Project was developed by ASHM in partnership with Health Equity Matters, drawing on input from the project's steering committee and clinical partners. The protocol provides participating clinicians with practical guidance for implementing the clinician-initiated testing model in general practice, covering all stages of the testing process from eligibility assessment and informed consent through to the communication of results and referral to support services. The protocol encompasses testing for HIV, hepatitis B, hepatitis C and syphilis, consistent with the scope of the clinician-initiated testing model.

The protocol was developed iteratively, with each version reviewed and refined in response to feedback from clinical partners and steering committee members. This process was informed by a review of existing clinical guidelines, including ASHM's decision-making tools for HIV, syphilis, hepatitis B and hepatitis C, which are embedded within the protocol as reference resources for clinicians. The protocol was designed to complement, rather than replace, each clinic's existing testing procedures, with the expectation that clinicians would adapt the guidance to align with their usual practice.

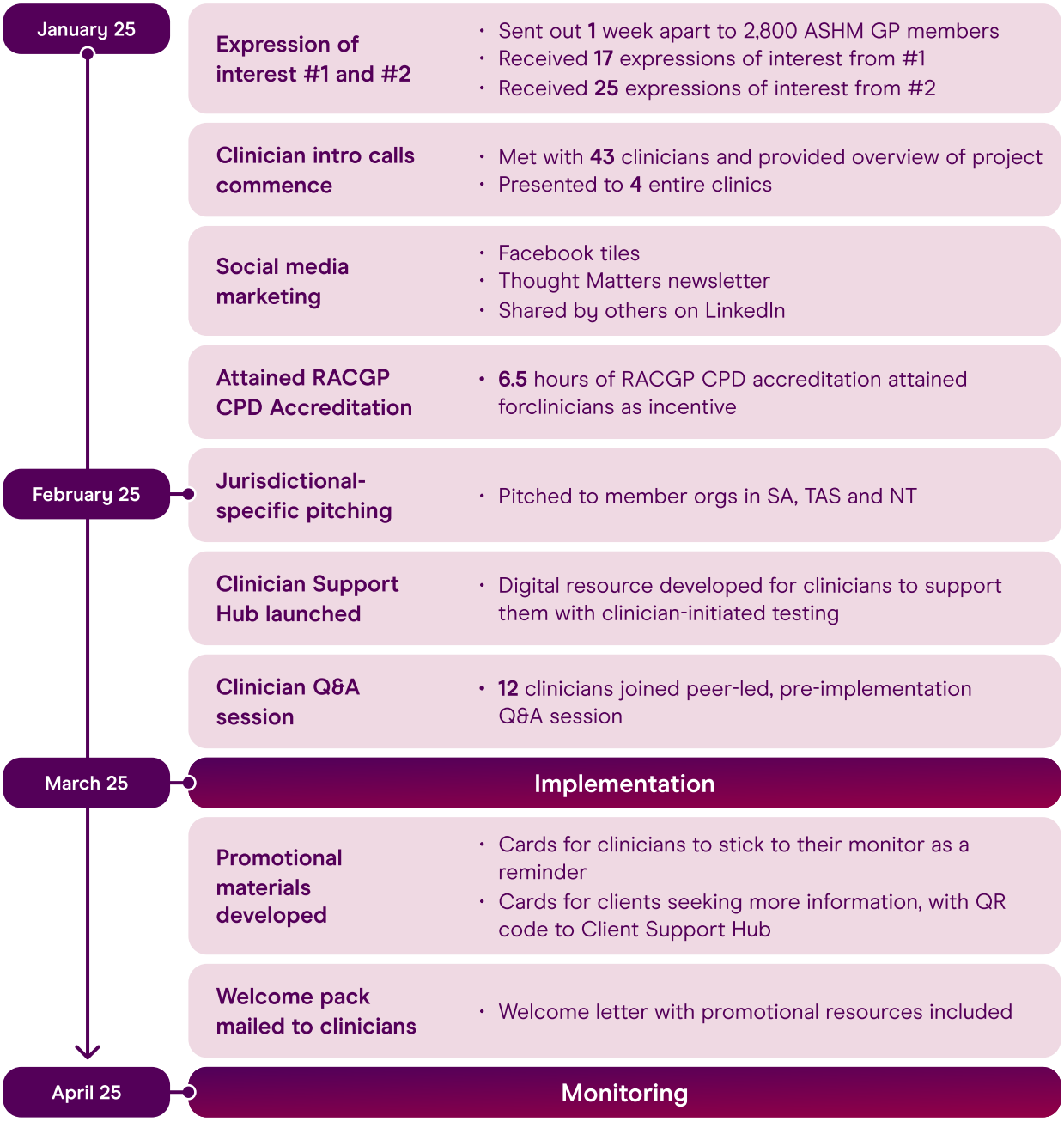
The clinical protocol was made available to participating clinicians as part of their onboarding and is publicly accessible via the Health Equity Matters website. The protocol can be found here.

Clinician recruitment

In this section, we describe the approach to clinician recruitment in the Normalising Testing Pilot Project, outlining the multiple channels used to maximise reach and engagement.

We detail how each recruitment pathway was implemented and the outcomes achieved from each approach (Figure 2). We present how this diversified recruitment approach supported the recruitment of clinicians across a range of practice settings and jurisdictions and led to the successful engagement of 55 clinicians (clinicians recruited) across 22 practices nationally.

Figure 2. Clinician recruitment activities and timeline for the Normalising Testing Pilot, January to April 2025.



Expression of Interest via ASHM membership

General practitioners were recruited to implement the clinician-initiated testing model through the dissemination of two EOI emails to the ASHM membership network. The EOIs were sent to approximately 2,800 clinicians across Australia.

The project team adopted a clinician-led health promotion approach in the development of the EOIs, using clear, concise and engaging language which was co-created with clinicians engaged through the project's steering committee. Additionally, the project ensured that both clinicians and clients featured in all advertising materials and that the images were reflective and representative of the cultural expertise and diversity that exists within both Australian general practice and our broader community. This was an intentional choice to signal that this pilot would benefit communities not historically understood to be 'at risk' of HIV and clinicians supporting multicultural clients.

The EOI included two response options at the end of the text: 'Yes, I would like to express interest' and 'Not interested'. Recognising that clinicians held mixed views about 'opt-out' testing approaches, the project team included the 'Not interested' option to capture insights into potential barriers to engagement, particularly in the event of low EOI uptake. Selecting either option directed clinicians to a corresponding landing page.

Landing page 1: 'Yes, I would like to express interest' form

Interested clinicians were directed via this link to a landing page to complete an expression of interest form requesting the following information:

- **Clinician details** including title, pronouns, clinician name, email address, phone number, clinic name, position title, state or territory location
- **Communities that the clinician supports**, such as Aboriginal and/or Torres Strait Islander People, culturally or linguistically diverse communities or multicultural people, university or international students, LGBTIQA+, fly-in-fly-out (FIFO) workers, people living with one or more of the following conditions: HIV, hepatitis B, hepatitis C, syphilis, or an 'other' option with a request to specify
- **Appointment scheduler** to book a 15-minute introductory call with a project representative, with the option of attending via Microsoft Teams or phone
- **A skills matrix questionnaire** for clinicians to self-assess their confidence in discussing various aspects of sexual health testing with clients, including:

    1. Confidence in discussing HIV with clients
    2. Confidence in discussing hepatitis B with clients
    3. Confidence in discussing hepatitis C with clients
    4. Confidence in discussing syphilis with clients
    5. Confidence in discussing current HIV prevention methods (UVL, PrEP, PEP, condoms)
    6. Confidence in initiating conversations around testing for the above blood-borne viruses (BBVs)/ sexually transmitted infections (STIs).

Details on clinician confidence at the point of EOI submission are provided later in this section.

Personal details were collected to enable follow-up with clinicians and to understand their geographic distribution. Information on the client communities that clinicians supported was gathered to ensure diverse representation across the cohort of recruited clinicians. The skills matrix questionnaire was used to assist project staff in identifying whether individual clinicians required additional or tailored support.

Following submission of the EOI form, clinicians received an Outlook calendar invitation for the scheduled 15-minute introductory call with a Health Equity Matters project staff member.

The table below summarises the number of submissions received for each EOI.

Table 2. Number (n=42) of submissions received for each expression of interest

Expression of interest	Date sent	Submissions received
First	21 January 2025	17
Second	31 January 2025	25
Total		**42**

Landing page 2: 'Not interested' form

Clinicians who were not interested in participating in the pilot were given the option to select this link and were directed to a landing page containing a form designed to capture their reasons for declining participation. No submissions were received via the 'Not interested' form.

Other recruitment pathways

Health Equity Matters project staff undertook additional forms of clinician recruitment outside of the EOIs issued through ASHM membership.

Health Equity Matters membership engagement

Project staff engaged with state and territory member organisations to support the referral of affiliated general practitioners to the program. This supported the recruitment of five clinicians in Western Australia and introductory meetings with clinicians in Tasmania and the Northern Territory, although these meetings did not result in the recruitment of clinicians to the project.

Referral through a public health unit

Engagement was undertaken with public health units in South Australia and the Northern Territory to support the referral of general practitioners to the program. No clinicians participated in the pilot from these regions.

Referral by a participating clinician

Clinicians were referred to the program by other enthusiastic participating clinicians who were already enrolled in the pilot.

Whole-clinic presentations

Health Equity Matters project staff were invited to deliver presentations to whole clinics by enthusiastic clinicians already enrolled in the pilot.

Social media advertising

A social media tile was developed by Health Equity Matters' in-house communications team to promote the program to clinicians through Facebook and LinkedIn channels (Figure 3). The tile included a QR code linking to the expression of interest form, enabling clinicians to register their interest and book an introductory call with Health Equity Matters project staff. The idea emerged following discussions with an enthusiastic clinician who, while not eligible to participate in the pilot due to working in a prison setting, responded positively to the project due to thoughtful engagement and expressed a strong interest in sharing the project with their broader clinical networks and professional connections.

Figure 3. Social media promotional tile developed to support clinician recruitment for the Normalising Testing Pilot.



The social media tile was viewed 647 times on Facebook, reaching 298 devices. A total of 21 click-throughs to the Expression of Interest landing page were generated across Facebook and LinkedIn (Figure 4).

Figure 4. Social media engagement metrics for the recruitment of clinicians to the Normalising Testing Pilot.

647
Views
The social media tile was viewed 647 times on Facebook

298
Devices Reached
The social media tile was reached by 298 devices

21
Click-Throughs
The social media tile resulted in 21 click-throughs to the landing page

Introductory calls with clinicians

Following submission of an expression of interest form, Health Equity Matters project staff conducted scheduled 15-minute introductory calls with individual clinicians. These calls were designed to build rapport, provide clear and practical information about the project and accommodate clinicians' busy schedules. The calls addressed the following topics:

- background and rationale for the project
- project overview
- client eligibility for clinician-initiated testing
- step-by-step guide of clinician-initiated testing in practice
- importance of informed consent in the context of clinician-initiated testing
- support and incentives available to clinicians
- timeline.

In the period from January to March 2025, Health Equity Matters project staff met 43 clinicians for introductory calls across all Australian states and territories.

During this period, project staff presented to two public health units in South Australia and the Northern Territory. They also delivered presentations to four clinics in Western Australia and New South Wales.

Table 3 provides the final number of clinicians recruited and the method of recruitment.

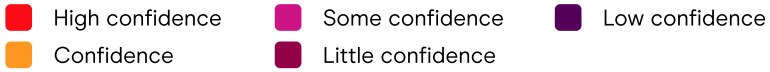
Table 3. Final number (n=55) of clinicians recruited by recruitment pathway

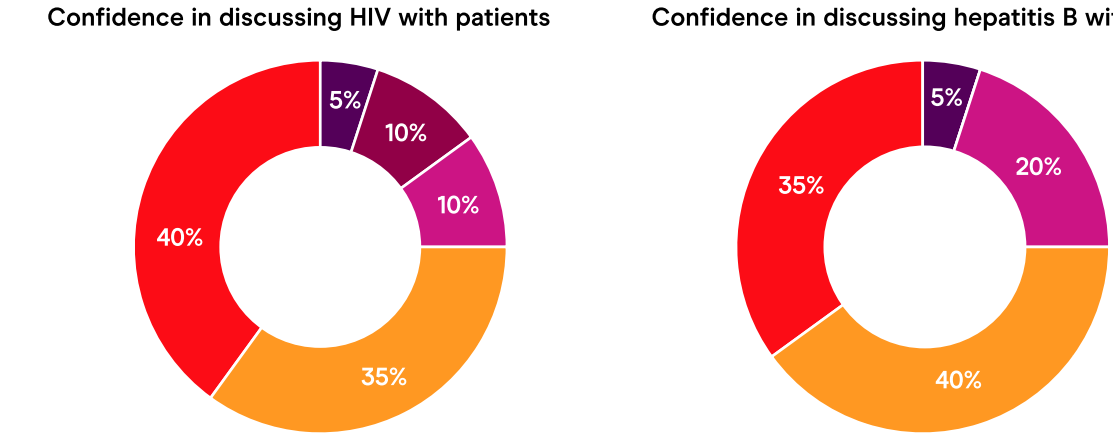
Method of recruitment	Clinicians recruited
ASHM expression of interest	20
Referral by a participating clinician	8
Whole clinic presentations	27
Total	**55**

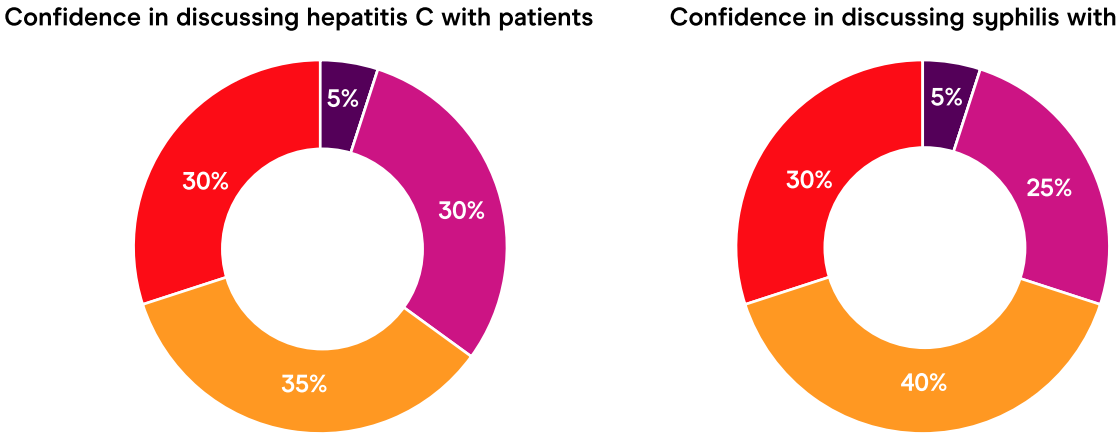
Clinician confidence at the point of EOI submission

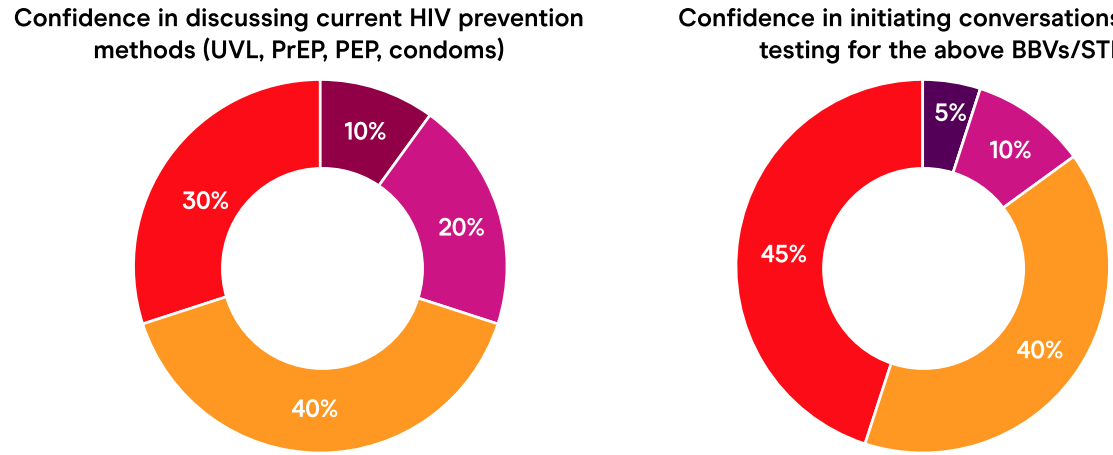
To understand baseline clinician confidence, self-reported confidence in HIV, hepatitis B, hepatitis C and syphilis testing was assessed at the point of EOI submission, prior to implementation. The results in Figure 5 summarise the responses of the 20 clinicians recruited to the pilot via the EOI.

Figure 5. Self-reported clinician confidence at baseline (EOI submission) across HIV, hepatitis B, hepatitis C and syphilis testing, HIV prevention, and initiation of BBV/STI testing conversations (n=20)









Health Equity Matters used these findings to design tailored support for clinicians, as described in the following sections. At the point of EOI submission, clinicians reported moderate to high confidence across all assessed areas. Confidence was highest for discussing HIV, hepatitis B and initiating BBV and STI testing, while confidence in hepatitis C and syphilis was more variable, suggesting these areas may benefit from targeted support. Confidence in current HIV prevention methods (U=U, PrEP, PEP and condoms) remained generally high, although a small proportion of respondents reported lower confidence. These findings indicate a strong baseline confidence in HIV-related discussions among participating clinicians, which provides important context for understanding the implementation of the model and the experiences reported in the Results and Key Learnings sections of this report.

Clinician onboarding and support

Clinician onboarding

Memorandum of understanding

Clinicians confirmed their participation by reading and signing a memorandum of understanding (MoU) provided by Health Equity Matters. The MoU was a non-binding agreement that outlined roles and responsibilities of Health Equity Matters and the participating clinician or practice.

Clinicians who signed and returned the MoU were onboarded into the program. No barriers to onboarding were reported, indicating strong acceptability of this approach among participating clinicians.

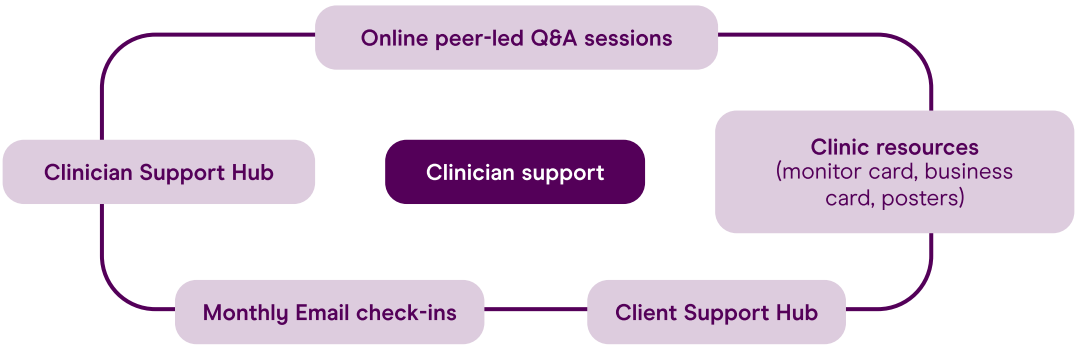
Clinician support

Although clinicians recruited to the pilot through the EOI reported moderate to high confidence in sexual health conversations, consistent with the self-assessment findings provided in the preceding section, the literature consistently shows that clinician confidence remains a key determinant of HIV testing (Bolsewicz et al., 2015; Leblanc et al., 2016). Where confidence is lower or knowledge gaps exist, clinicians may rely on or revert to risk-based approaches, which can lead to missed testing opportunities (Bagchi & Davis, 2020). Health Equity Matters therefore worked in collaboration with ASHM to develop a comprehensive support package for participating clinicians. While designed to support implementation of the clinician-initiated testing model in practice, the package also aimed to strengthen and sustain clinician confidence and capability in HIV, hepatitis B, hepatitis C and syphilis testing, treatment and prevention, including discussions related to HIV diagnoses.

The clinician support package comprised the following components:

- **Clinician Support Hub:** an online platform providing clinical guidance, implementation resources and access to accredited professional development opportunities.
- **Client Support Hub:** an online resource to support client understanding of clinician-initiated testing, consent processes and available state and territory support services.
- **Clinic resources:** practice materials designed to prompt and normalise clinician-initiated testing, including:
    - monitor cards
    - business cards
    - posters.
- **Online peer-led drop-in Q&A sessions:** peer-facilitated sessions run by an experienced clinician and designed to provide clinicians with a supportive forum to discuss practical implementation issues, seek guidance from peers and share questions and insights from practice.
- **Monthly email check-ins:** regular project communications to support clinicians throughout implementation, provide reminders, monitor progress and offer an opportunity to ask questions or seek support.

Figure 6. Overview of clinician support provided in the Normalising Testing pilot project.



Clinician Support Hub

The Clinician Support Hub was an online resource developed by Health Equity Matters in collaboration with ASHM and reviewed by the steering committee to support general practitioners participating in the pilot. It brought together key clinical and implementation resources, including:

- the clinical protocol
- practical guidance on client conversations
- information on RACGP Continuing Professional Development (CPD) accreditation available as an incentive within the program.

The hub also provided tools and information to support HIV testing, including ASHM's clinical decision-making tools for HIV, hepatitis B, hepatitis C and syphilis, treatment and prevention, as well as links to state and territory-specific support services for clinicians.

In addition, the hub provided access to resources to support the delivery of diagnoses, including NAPWHA's Making a Good Diagnosis training tool and online resources developed by ASHM. Collectively, these resources were designed to build clinician confidence and provide accessible, ongoing support throughout the implementation of the clinician-initiated testing model.

Client Support Hub

The Client Support Hub was an online resource developed by Health Equity Matters to support clients who were offered clinician-initiated testing as part of the pilot. The hub provided clear and accessible information about HIV, hepatitis B, hepatitis C and syphilis testing, including consent, privacy considerations and what to expect from testing. It also included links to national, state and territory-based support services for clients seeking further information or support. The Client Support Hub was designed to complement clinical consultations by supporting client understanding and informed decision-making.

Clinic resources

Health Equity Matters developed three clinic resources to support clinicians during the implementation phase of the pilot. These resources included a monitor card, business card and poster. Clinicians who were onboarded into the program were mailed a 'welcome pack' containing these resources for use in their clinical practice. The design of these resources was guided by a pragmatic approach to implementation, recognising the time constraints and competing priorities within general practice (Leidel et al., 2015). Simple, visible and accessible materials were selected to support clinicians, act as prompts to conduct testing and enable clear, concise communication with clients without adding significant workflow burden.

1. Monitor card

Monitor cards were developed as a visual prompt to remind clinicians to perform clinician-initiated testing. The cards measured 15.5cm × 4.5cm and included a sticker on the reverse, allowing them to be affixed to a desk monitor (Figure 7). Each card also featured a QR code that clinicians could scan to access the Clinician Support Hub.

The monitor cards were referenced by some clinicians during the evaluation interviews and were reported to be effective as a reminder.

Figure 7. Monitor cards developed to provide clinicians with a visual reminder to perform clinician-initiated testing. The QR code links to the Clinician Support Hub.

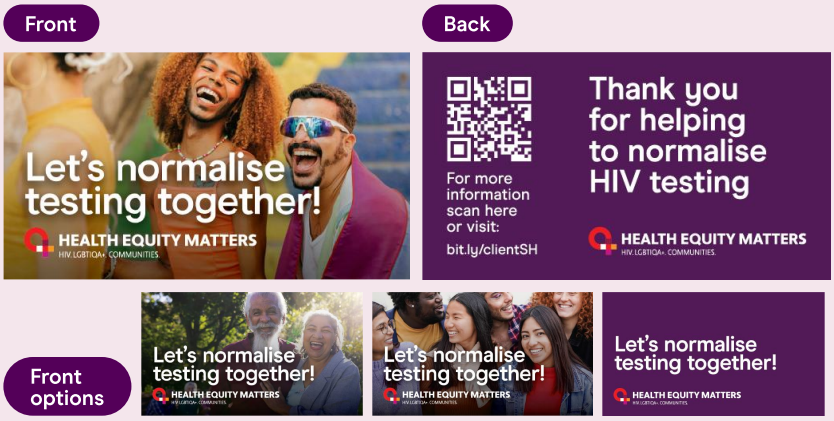


2. Business card

Business cards were developed as a resource for clinicians to share with clients who were seeking more information about the program. Four designs were produced. Three featured images representing diverse communities, including LGBTIQA+ people as well as young and older people and communities who might not typically consider themselves 'at-risk' for HIV, hepatitis B, hepatitis C and syphilis (Figure 8). This approach was intentionally adopted to support normalisation and inclusive representation. The fourth design did not include an image. The reverse of each card included a QR code that clients could scan to access the Client Support Hub.

During the evaluation interviews, clinicians reported that the business cards were helpful for clients seeking additional information and supported a natural segue into clinician-initiated testing and broader sexual health discussions. Clinicians also noted that placing the business cards on their desks acted as an additional visual prompt to perform clinician-initiated testing, demonstrating the value of simple, low-burden resources in supporting implementation within the time-pressured and competing demands of everyday general practice.

Figure 8. Business cards developed to support client information-seeking and engagement with clinician-initiated testing. The QR code links to the Client Support Hub.



3. Poster

Health Equity Matters developed a poster as an additional visual resource to support the implementation of clinician-initiated testing within general practice. The poster was designed to be displayed in clinical rooms and waiting areas to inform clients that testing for HIV, hepatitis B, hepatitis C and syphilis may be offered by their clinician as part of their routine care.

The poster was designed to present clinician-initiated testing as a standard and optional component of a general practice consultation, reinforcing that testing is offered broadly and that clients can choose whether to proceed. Clear, plain language was used to support client understanding and reduce potential anxiety related to testing discussions. The poster also included a QR code linking directly to the Client Support Hub.

Feedback on the posters was similar to that received on the business cards, indicating that they supported the initiation of conversations about clinician-initiated testing, while also acting as a visual reminder for clinicians to offer testing.

Figure 9. Poster developed for display in clinic rooms to inform clients about clinician-initiated testing. The QR code links to the Client Support Hub.



Online drop-in peer-led Q&A sessions

In collaboration with ASHM, two online drop-in Q&A sessions were delivered for clinicians at the pre-implementation and mid-implementation stages of the pilot. The sessions were peer-led by Dr Beng Eu, a general practitioner and Co-Director of a Melbourne-based practice.

These sessions enabled clinicians to connect with peers, receive project updates and engage in open discussion. The peer-led format allowed clinicians to ask questions and seek practical advice from an experienced colleague, with input from ASHM and Health Equity Matters.

Areas covered during the pre-implementation session included:

- informed consent
- client eligibility for the model
- support available to clinicians
- what to do if a client records a positive result
- how to navigate client questions.

Areas covered during the mid-implementation session included:

- optional strategies to support clinicians in remembering to offer clinician-initiated testing such as guidance on setting up pathology tests as a 'Favourite' in Best Practice and MedicalDirector clinical practice software
- clarification of the data being collected as part of the pilot (qualitative data only, with no quantitative data collection)
- instructions on how to download reports on the number of tests ordered in Best Practice and MedicalDirector for clinicians interested in assessing whether their testing for HIV, hepatitis B, hepatitis C and syphilis had increased during the pilot.

During the mid-implementation session, clinicians reported that the project was progressing well and that most clients were receptive to clinician-initiated testing, with support resources such as monitor cards and QR-code business cards proving particularly useful. They also noted increased hepatitis B vaccination and more frequent discussions about sexual health, PrEP and other vaccinations. Clinicians observed some variation in client responses across settings and identified inconsistent pathology test coding as a practical barrier. At this mid-implementation stage, these findings suggest the model was functioning as intended, supporting both testing and preventive care, while highlighting system-level factors that may affect consistency of delivery.

The evaluation results indicate that the peer-led Q&A sessions were highly valued by clinicians at both pre-implementation (n = 12) and mid-implementation (n = 8) stages. Strong ratings for usefulness and overall quality suggest these sessions supported confidence and practical implementation. This highlights the value of structured, peer-led support across multiple stages to sustain engagement and meet evolving clinician needs.

Table 4. Evaluation results for the Normalising Testing pre-implementation and mid-implementation online peer-led Q&A sessions for clinicians

	Pre-implementation session (out of 5)	Mid-implementation session (out of 5)
How would you rate the overall quality of this session?	4.4	4.7
How useful was this session to you and your participation in the pilot?	4.8	4.3
How useful do you feel the training materials provided to you are (support hub, protocol)?	4.4	4.5
How effective was the trainer in presenting the material covered in this session?	4.8	4.5
Overall average	**4.6**	**4.5**

Monthly email check-ins

During the six-month implementation phase of the pilot, Health Equity Matters project staff emailed participating clinicians monthly to check in and monitor progress with implementing the model. These check-ins were undertaken to ensure clinicians felt supported throughout the implementation phase and to provide an opportunity to raise feedback or implementation-related issues.

Many clinicians reported that they sometimes struggled to remember to offer clinician-initiated testing, but noted that the clinic resources provided, including monitor cards, business cards and posters, were helpful reminders. The monthly emails were also reported to serve as a reminder for clinicians to initiate testing. However, it is important to note that delays were experienced in hearing back from clinicians, and engagement tended to taper as the six-month pilot period progressed. This likely reflects the realities of clinician capacity and competing priorities within busy general practice settings, as well as the limited leverage of incentives beyond initial recruitment.

Clinician incentives

RACGP CPD Accreditation

In developing clinician support resources, Health Equity Matters and ASHM were deliberate in their focus on creating support resources that were high quality and would be genuinely valuable to clinicians in their professional practice. The aim was to enhance clinicians' knowledge and confidence across testing, treatment and prevention, to strengthen their capacity to support priority populations effectively and to provide guidance in navigating the complexities of delivering a new diagnosis. This approach was grounded in a commitment to offering support that contributed meaningfully to clinicians' ongoing professional development, and to recognising the time, expertise and commitment they brought to the pilot. In recognition of this contribution, the Normalising Testing Pilot Project secured RACGP CPD accreditation as an incentive for participating clinicians. The pilot was accredited for a total of 6.5 CPD hours (Activity number: 1154970). Details of the CPD accreditation are outlined below.

Learning objectives

1. Increase confidence in testing and treatment of HIV
2. Increase confidence in managing a diagnosis of HIV
3. Increase confidence in the testing, treatment and management of syphilis, hepatitis B and hepatitis C
4. Demonstrate the application of a clinician-initiated HIV, hepatitis B, hepatitis C and syphilis testing model to improve testing outcomes for clients
5. Evaluate and measure the acceptability of a clinician-initiated HIV, hepatitis B, hepatitis C and syphilis testing model

Approved activities

2	3	1.5
Educational activities	Reviewing performance	Measuring outcomes

Table 5. RACGP CPD-accredited activities for the Normalising Testing Pilot Project, including activity descriptions and estimated completion time

Type of CPD activity and description	Normalising Testing activity	Estimated CPD time for completion
1. Pre-implementation quality improvement survey	**Reviewing Performance:** 6-question quality improvement survey embedded within the Expression of Interest aimed at understanding your confidence around testing, clinical care and prevention of HIV, hepatitis B, hepatitis C and syphilis prior to implementation of the project.	15 minutes
2. Digital support resources	**Reviewing Performance:** Training staff on resources from the welcome pack. Digital support materials including project documentation and resources around patient informed consent, testing, treatment and prevention of HIV, hepatitis B, hepatitis C and syphilis.	1.5 hours
3. Q&A pre-implementation drop-in sessions	**Educational Activity:** Voluntary Q&A drop-in sessions led by our clinical partner ASHM that will give you an opportunity to have any questions answered or discuss anything prior to project implementation.	1 hour
4. Create clinical processes and train staff on clinical protocol and resources	**Reviewing Performance:** Each clinic to adapt and create their own Clinical Protocols, train staff on testing and implement normalising testing into practice.	1 hour
5. Mid-implementation debriefing sessions	**Educational activity:** Voluntary mid-implementation peer-led debriefing sessions led by our clinical partner ASHM that will allow you to meet with your peers to ask questions and receive support.	1 hour
6. Post-implementation quality improvement survey	**Reviewing Performance:** Voluntary 7-question quality improvement survey aimed at understanding your confidence around testing, clinical care and prevention of HIV, hepatitis B, hepatitis C and syphilis following completion of the project.	15 minutes
7. Evaluation interview assessing acceptability of the clinician-initiated testing model	**Measuring Outcomes:** Each clinic evaluates their model after 6 months. Voluntary qualitative interviews designed to evaluate acceptability of the clinician-initiated testing model aimed at contributing towards a body of evidence around clinician-initiated testing in general practice across Australia.	1.5 hours

Clinicians could also complete an additional 4.5 hours of CPD through pre-accredited ASHM training modules, recommended for those seeking further support and professional development.
These modules were accessible via the ASHM Training Modules section of the Clinician Support Hub and included the following:

- Clinical Extensions of HIV – 1.5 hours
- Clinical Extensions of hepatitis B – 2 hours
- Clinical Extensions of hepatitis C – 1 hour.

Acknowledgement in publication

In recognition of their time, expertise and contribution to the implementation of the clinician-initiated testing model and the evaluation of its acceptability, participating clinicians were offered the opportunity to be acknowledged in publications arising from the Normalising Testing pilot project.
This acknowledgment was intended as a further expression of appreciation for clinicians' willingness to engage in a pilot that involved reflecting on and adapting their clinical practice. Clinicians were able to choose whether they wished to be included in the acknowledgements.

Implementation of the pilot

Implementation of the pilot commenced on Monday, 3rd March 2025 and concluded on Friday, 5th September 2025.

A total of 55 clinicians were recruited across 22 clinics in New South Wales, Victoria, Western Australia and Queensland. One clinician withdrew approximately two months into the pilot. As a result, the final implementation cohort comprised 54 clinicians across 21 clinics. A breakdown by state and territory is shown in Table 6, below.

Table 6. Final number of clinicians (n=54) and clinics (n=21) included in implementation, by state and territory

State/territory	Clinicians included in implementation (n)	Clinics included in implementation (n)
New South Wales	28	6
Victoria	15	8
Western Australia	9	5
Queensland	2	2
Total	**54**	**21**

Evaluation of the model

Evaluation design

The Normalising Testing Pilot Project concluded with a structured evaluation to capture clinician experiences of implementing the clinician-initiated testing model. At the end of implementation, clinicians were contacted to confirm completion of their involvement, provide consent for acknowledgement and receive evaluation information. Clinicians were then invited to participate in qualitative interviews about their experiences. Interviews were conducted over a four-month period by trained project staff. All interviews were audio-recorded, transcribed and securely stored to inform the evaluation findings.

Ethics approval for the qualitative semi-structured interviews was provided by the UNSW Human Research Ethics Review Committee (iRECS4349). Prospective participants were emailed an invitation letter with a copy of the Participant Information Statement and Consent Form and told that participation in an interview was voluntary and that research findings would be anonymised. If they agreed to participate in an interview, they were asked to sign a digital consent form and invited to participate in an audio-recorded interview via Zoom. All audio recordings, fieldnotes, consent forms, and transcripts were stored on a password-protected UNSW server accessible only to the research team and Health Equity Matters staff.

There were three research questions guiding the design and analysis of this study:

1. What are the clinical practice experiences of a clinician-initiated HIV, hepatitis B, hepatitis C and syphilis testing model?
2. What benefits and challenges emerge from clinician-initiated HIV, hepatitis B, hepatitis C and syphilis testing in primary care?
3. How can clinician-initiated HIV, hepatitis B, hepatitis C and syphilis testing in primary care be optimally implemented?

Qualitative semi-structured interviews

As part of the evaluation of the clinician-initiated testing model, qualitative interviews were conducted with clinicians who implemented the model in general practice settings. The purpose of the interviews was to explore clinicians' experiences of clinician-initiated HIV testing, including its acceptability, feasibility, perceived impacts and opportunities for improvement.

Interviews followed a semi-structured interview guide to ensure consistency across participants while allowing flexibility to explore issues specific to individual practice contexts. Each interview commenced with an introduction outlining the purpose of the evaluation, confirming informed consent and explaining the recording and transcription process. All interviews were audio-recorded, transcribed and de-identified prior to analysis and participants were given the opportunity to ask questions before the interview commenced.

Interview questions were organised across several thematic areas including:

- clinician background and practice context
- experiences of implementing the clinician-initiated testing model
- use of support resources including the Clinician Support Hub and clinic resources
- benefits and challenges of implementing the clinician-initiated testing model
- considerations for sustainability and future implementation.

Data analysis

Interview data were analysed following thematic analysis principles, in which deidentified interview transcripts were systematically read and inductively coded, and themes were developed to capture patterns of meaning across the dataset. The analysis aimed to address both the research questions (above) while also being grounded in the experiences of participants. The analysis considered the context in which participants reported implementing the model, the acceptability of the model, and the benefits and challenges of the model that they discussed for themselves and for clients. A draft analysis was discussed by the research team before further refinement.

Results

Demographics of participating clinicians

A total of 14 GPs were interviewed (see Table 7), with an even balance between cisgender women and men, representing 11 different general practice clinics from capital cities in Victoria, NSW, and WA, with one participant working in an inner-regional location. Most participants (n=10) held specialised prescriber status to prescribe treatments for HIV or hepatitis B, or both.

Interviews were undertaken between September 2025 and January 2026 via videoconferencing, lasting between 19 and 46 minutes (mean average of 34.5 minutes).

Table 7. Participant demographic characteristics

Participants	Number
Gender	Cis woman (n=8) Cis man (n=6)
Clinics	Clinic F (n=3) Clinic K (n=2) Clinic A (n=1) Clinic B (n=1) Clinic C (n=1) Clinic D (n=1) Clinic E (n=1) Clinic G (n=1) Clinic H (n=1) Clinic I (n=1) Clinic J (n=1)
Years working in general practice	11+ years (n=11) 6-10 years (n=1) 3-5 years (n=1) Up to 2 years (n=1)
s100 prescriber status (specialised prescriber status for HIV or hepatitis B)	HIV prescriber (n=4) HIV and HBV prescriber (n=4) HBV prescriber (n=2) Not an s100 prescriber (n=4)
State	Victoria (n=8) NSW (n=4) WA (n=2)
Australian Statistical Geography Classification by Postcode	Major City (n=13) Inner Regional (n=1)

Participants reported working with a diverse range of client populations (e.g., people of all ages and local community members), but some participants reported specific demographics of clients they saw a higher proportion of in their clinic (see Table 8).

Table 8. Clinic characteristics

Primary clinic*	Clinicians and s100 prescriber status^	Client population#
Clinic A	HIV and Hep B s100 prescriber (n=1)	Aboriginal and Torres Strait Islander peoples; people who are homeless and migrant communities
Clinic B	No s100 prescribing status (n=1)	Migrant communities
Clinic C	HIV and Hep B s100 prescriber (n=1)	Aboriginal and Torres Strait Islander peoples; people living with HIV
Clinic D	No s100 prescribing status (n=1)	University health practice (students and staff only); migrant communities
Clinic E	Hep B s100 prescriber (n=1)	Gay, bisexual, and other men who have sex with men; migrant communities
Clinic F	HIV s100 prescriber (n=3)	LGBTIQA+ people; people living with HIV; migrant communities; people with complex mental health care needs
Clinic G	No s100 prescribing status (n=1)	People from regional areas
Clinic H	Hep B s100 training (n=1)	Migrant communities
Clinic I	No s100 prescribing status (n=1)	LGBTIQA+ people
Clinic J	HIV and Hep B s100 prescriber (n=1)	Gay, bisexual, and other men who have sex with men; migrant communities
Clinic K	HIV s100 training (n=1) HIV and Hep B s100 training (n=1)	LGBTIQA+ people; people who are homeless; people with complex mental health care needs

* Some clinicians reported working at multiple clinics; one primary clinic was designated.
^ s100 prescriber status refers to specialised training to prescribe HIV, hepatitis B, and/or hepatitis C treatments.
# Summary description of any specific demographics of client populations that clinicians at the clinic reported working with.

Implementing and adapting the model

Most participants reported successfully implementing the model as described in the protocol, but noted small differences in the ways they adapted the suggested wording in the clinical protocol:

> **'I would say, "would you like us to do some general screening today, which includes things like diabetes and cholesterol checks?" And then I would say, "And it's our normal practice that we include bloodborne virus testing as well, so that includes testing for HIV, hepatitis C, hepatitis B, and syphilis."'**
>
> (P04 Clinic A)

Some participants reported tailoring the wording based on their perception of the client's English comprehension or familiarity with the health system:

> **'Some people, I could tell, had more familiarity with those concepts, so I sort of rushed through those. Other people probably had to be explained in more detail. Obviously, there'll be differences in backgrounds of language or people who perhaps they're very good English speakers, but are perhaps navigating a very foreign health environment and healthcare environment in a different language, [which] can be very difficult, and trying to adjust my language on that can... but I do that every day anyway.'**
>
> (P06 Clinic D)

A few participants reported that the model did not differ much from their usual practice in which they frequently offered routine bloodborne virus and sexual health consultations to clients. However, these participants also reported that the resources accompanying the model (posters, business cards) helped prompt conversations or provided a framework for offering testing:

> **'Lots of our appointments are related to sexual health anyway, but I do have the [model business] cards here, so it's kind of a reminder to bring it up as well. So, when people were doing other kind of monitoring blood tests, there was some kind of frame of how to approach the discussion as well, so that was kind of handy just to have that prompt.'**
>
> (P05 Clinic F)

Finally, a few participants reported resistance or inconsistency with routinely implementing the model. For one participant this was due to other health workers being involved in discussing tests with clients, which made it difficult for them to consistently offer testing. Another participant reported reluctance and inconsistency with offering testing based on their assessment of the client's risk and enthusiasm. And a final participant reported that it was inappropriate to offer testing to all clients due to particular sensitivities:

> **'I would be conscious that a lot of my client demographic also would have potentially had traumatic histories. Having discussions about sexual health can be a delicate conversation to have as well, but is also a necessary conversation. So you're not necessarily going to do sexual health screening every single time, because it's not a safe or appropriate thing to do.'**
>
> (P13 Clinic K)

Improving healthcare through testing, prevention, and normalised discussions

Participants were asked to reflect on benefits they had observed in implementing the model, which included an overall increase in HIV, hepatitis B, hepatitis C and syphilis testing. Although no participants reported an HIV diagnosis during implementation, some reported a small number of hepatitis B, hepatitis C, or syphilis diagnoses, leading to treatment. In addition to testing, participants commonly described identifying many clients in need of hepatitis B vaccination, leading to administering vaccination.

Beyond the direct benefits of testing, diagnosis, and vaccination, participants discussed how offering testing through the model led to other benefits to holistic care, including opportunistic discussions about other aspects of sexual health and offering prevention:

> **'It fostered discussion about sexual health and STI prevention. For example, after having these discussions and then informing the clients of the results, it led to clients ending up on PrEP who hadn't thought that they were PrEP-eligible, as well as Doxy-PEP discussions, and talking about vaccination for mpox'**
>
> (P03 Clinic F)

These benefits were observed even in the context of clients declining HIV, hepatitis B, hepatitis C and syphilis testing, as P05 explained that it signalled they were an appropriate clinician to raise other sensitive sexual health topics in future consultations:

> **'I think loads of the people that have agreed to it were actually a lot more aware of what the tests are, what they're for, and how the frequency of those tests work, what symptoms to look out for. And even whenever they decided against [testing], it plants a bit of seed of: "I can bring this up later." So I've noticed that people have come back and said, for example, "I am having issues with erections", or "I've had sex in the last couple weeks and I'm worried about an STI". I don't think that would have been discussed otherwise.'**
>
> (P05 Clinic F)

It was also noted that the opportunity to 'normalise' conversations about HIV, hepatitis B, hepatitis C and syphilis was an important benefit of the model that was appropriate and beneficial for primary care:

> **'We tested a lot of patients that would not have otherwise gotten tested, and the ones who mentioned to me, "I don't think I've ever had this test done", it normalised it to a lot of people. Some of these people would have only heard of HIV in the context of the AIDS and didn't know any different. That was quite helpful in destigmatising. And I find that if these conversations are had with, your usual doctor, then there's already this good therapeutic relationship. So when I'm talking about something that in general, it would be beneficial for them to get tested, I would be there to support them through the rest of the follow-up. Having that already established relationship was useful.'**
>
> (P09 Clinic G)

Some participants observed that this opportunity to offer testing and destigmatise HIV, hepatitis B, hepatitis C and syphilis was only possible through the universal application of the model, and would raise problematic dynamics if offering testing based on perceived risk factors:

> **'It's nice saying, "I'm offering this to everybody" rather than, "you're from sub-Saharan Africa". That was actually an advantage, that it was being offered to everybody, and not because of the colour of your skin or where you were born.'**
>
> (P08 Clinic F)

Improved client-clinician rapport, communication skills, and confidence discussing HIV, hepatitis B, hepatitis C and syphilis

Some participants explained how implementing the model led to opportunities to deepen trust and rapport with patients, improve their clinical communication skills, or develop their confidence discussing HIV, hepatitis B, hepatitis C and syphilis with patients. For example, P04 described benefits for their confidence and their clinical follow-up skills:

> **'I became more confident with offering testing for everybody, so I wasn't so selective in who I was offering it to. I'm really happy that I took part in the study. It's certainly made me think about my phraseology in offering testing, and also made me more cognisant of good follow-up of results afterwards too, making sure I could track patients down to deliver the results.'**
> (P04 Clinic A)

Participants also described how the model facilitated more in-depth and personal conversations with patients, enabling stronger therapeutic relationships and a deeper understanding of patients' lives and experiences. P03 described how these conversations created opportunities to build more meaningful connections with patients:

> **'And [another] benefit was getting to know some patients better. [...] [the model] deepened the connection between me and [a couple of patients], because once we're talking about these things then suddenly, you know, you're talking about their more personal matters, and their relationship status, and if they're single, and what their sexual activities are, so I guess it deepened the interconnection with between me and some of these patients.'**
> (P03, Clinic F)

P12 reflected on the benefit of the model in supporting more holistic and preventive sexual health care, with clients responding positively to opportunities to consider broader sexual health and wellbeing within routine consultations:

> **'Look, it probably prompted some conversations anyway about, like, sexual safety and regularity of STI screening and it did open that conversation up a bit [...] patients appreciate having a like, preventive and holistic view, so I think most patients were happy to at least have it considered.'**
> (P12, Clinic J)

Managing time and complex conversations with clients as a key challenge

Most participants described the testing model as unproblematic to offer to most clients, and a practice for which clinicians became more confident in delivering over the course of the implementation period. However, some explained that the additional time taken in consultations was problematic for general practice, and sometimes distracted away from the purpose of the client's visit:

> **'I think the biggest challenge was time, and that's probably going to be a common response, I would imagine. General practice is busy, where consultations are tight in terms of time. I think the biggest challenge was the time during consultations to bring this up and address any sort of questions or concerns. Before you know it, that takes time away from whatever the client was there for.'**
> (P03 Clinic F)

Participants reported that they were less likely to offer the testing model if the consultation was already lengthy or if the client was attending with an acute problem in which offering HIV, hepatitis B, hepatitis C and syphilis testing seemed inappropriate:

'I think for clients presenting with acute problems, it becomes a little bit less suitable. I can think of some scenarios where clients are presenting with abdominal pain, and although technically, yes, you're asking them to do bloods, I think it becomes a little bit hard, because there's a lot of other things you're wanting to cover in that consult, along with a detailed history and physical exam. In that scenario, I found it difficult to fit [the model] in and I didn't always do it.'

(P09 Clinic G)

Several participants reported that they sometimes forgot to implement the model, particularly due to busy and time-sensitive general practice consultations. P11 reflected that their habit of offering HIV, hepatitis B, hepatitis C and syphilis testing reduced over time because after the initial few months, they had tested most of their clients already:

'I found that in the first few months it was easier, and it dropped off I think because I was getting to the point where I'd already tested people. And then I was in a bit less of a habit of testing people, because it wasn't just test everyone, because a lot of people had already been tested within that one-year period.'

(P11 Clinic I)

The complexity of discussing HIV, hepatitis B, hepatitis C and syphilis required sensitive discussion with some clients, adding to the length of the consultation:

'It can be confronting for clients. With an older client, for example, it's like, "oh, that's a disease that doesn't affect me, why would you think I might have HIV?" I found younger people would generally be more open to it, a bit more casual and relaxed. And that's probably because HIV doesn't dominate the news as being a death sentence anymore, and people have got a much more positive relationship with HIV. [...] Hepatitis, syphilis, you know, it's talking about people's sexual lives and people can be a little bit surprised if you suggest that they get tested.'

(P08 Clinic F)

P02 worked with a larger proportion of migrant clients, for whom there was additional concerns about how a bloodborne virus diagnosis may impact on work and life in Australia, requiring careful and sensitive discussion and education:

'If the client is resistant, I need to explain, so it becomes a longer consult. More than expected, you know? [...] Some clients do not understand. They're afraid they will lose their job.'

(P02 Clinic E)

Lingering concerns about appropriateness and cost-effectiveness

While most participants found the model acceptable for most of their clients, some discussed unresolved concerns about its appropriateness based on the presenting consultation. For example, P12 found it difficult to justify why they would offer HIV, hepatitis B, hepatitis C and syphilis testing to all clients receiving a blood test:

> **'I spend a lot of time sort of justifying what tests I am doing, in terms of why we're doing this, and why we're not doing other tests. The occasional client comes in and says, "I want to be tested for everything", and you sort of have to say, "That's not how this works." [...] There are populations that potentially [the model is] less relevant for as well... and it shouldn't be this complicated to just like, routinely add a blood test, but... it worked sometimes, but just felt a bit wrong for the consultation a few times.'**
>
> (P12 Clinic J)

This concern about the appropriateness of the model was also apparent for P08 who believed the model was unsuccessful because it did not result in any diagnoses:

> **'It was kind of frustrating that there weren't any extra diagnoses made. All the results came back normal. There was never any kind of validation of doing the test: "oh, yes, I'm kind of so glad that I've been offering this to people, and we've picked up an extra case of syphilis". It was kind of like, "why am I doing this?" And so, for a while there, I kind of stopped ordering them, because it just was no longer in the forefront of my mind, it didn't seem to have any merit, and so I stopped and lost interest in it, being totally honest.'**
>
> (P08 Clinic F)

A few participants similarly queried the cost-effectiveness of the model in terms of whether the effort of implementing the model and its cost was worthwhile. Others queried whether there would be issues with Medicare (Australia's public medical billing system) if the model was upscaled, and whether there was appropriate data to economically justify upscaling the model.

Some participants suggested improvements to scale up the model to improve acceptability and effectiveness, including more advertisements in waiting rooms or social media to inform clients (and reduce the burden of consultation time), embedding reminders in electronic health records or when printing pathology requests, or offering incentives or Medicare billing items:

> **'I think if we can encourage Medicare to introduce some sort of item, billing item number, so if, so I think, unfortunately, sometimes money can make a difference in there, if you have a particular item number assigned to this task only testing for HIV and other diseases, so more GPs will be inclined to offer this to the clients and improve testing.'**
>
> (P07 Clinic B)

Key learnings

This section explores the many important learnings that emerged from piloting a national clinician-initiated testing model for HIV.

Medicolegal clarity and governance were foundational to clinician uptake

Medicolegal risk, governance frameworks and the centrality of client care were the primary determinants of clinician willingness to adopt the model. During both the development and pre-implementation phases, the project's ability to explicitly address the medicolegal and care requirements of general practitioners was a critical prerequisite for engagement.

A key cross-cutting insight was that clinician uptake was strongly influenced by whether the intervention was perceived as appropriate, feasible and aligned with best practice and legal requirements.

Early engagement indicated some uncertainty about how 'opt-out' testing aligned with informed consent, including concerns that it may imply a lack of explicit consent. This perception acted as a barrier and underscored the importance of framing. By clearly communicating how consent would be obtained and reframing the approach as 'clinician-initiated' testing, the project was able to address this barrier and increase clinician willingness to engage.

Key factors included:

Strategic reframing: Shifting the terminology from 'opt-out' to 'clinician-initiated' testing to clearly distinguish the model from passive consent frameworks, ensuring it aligned with Australian medicolegal requirements for active, informed consent when bloodwork is ordered.

Necessity of verbal consent: Direct verbal communication and active client acknowledgement.

Proactive response to governance concerns: Consulting with experts in medicolegal governance and maintaining rigorous ethics oversight throughout the pre-implementation process helped demonstrate to clinicians that the model was robust, appropriate, and safe to implement within their specific practice contexts.

Co-creation with clinical expertise: Engaging deeply with the steering committee and participating sites to ensure clinical protocols were fit for purpose, reflecting real-world clinician expectations rather than theoretical ideals.

Preservation of clinical discernment: Ensuring the model served as a supportive framework that respected, rather than superseded, the clinical judgment of individual practitioners regarding client suitability and timing enabled space for clinicians to explore using the model without feeling mandated or obligated to continue it, irrespective of experienced outcome.

Key learnings

Implementation of clinician-initiated testing was broadly acceptable, with caveats

As highlighted in the qualitative evaluation results section of this report, and based on informal feedback provided during the implementation process, clinician-initiated testing was deemed broadly acceptable, with some caveats.

Clinicians described value in the model's ability to support them to normalise conversations around testing for HIV, hepatitis B, hepatitis C and syphilis as well as around client sexual health more broadly. Additional benefits described include an increase in:

- opportunistic vaccination for hepatitis B and broader vaccination discussions, including for mpox
- discussions regarding preventive health such as PrEP (for HIV) and Doxy-PEP (for syphilis and chlamydia)
- broader and more holistic sexual health discussions, including about sexual function and fulfillment
- increased rapport with clients, including greater openness and trust and appreciation for the holistic approach to their health and wellbeing.

Opportunities to update and challenge outdated or stigmatised understandings about HIV and HIV risk were also described. Additionally, application of the model supported clinicians to demonstrate a neutral and normalised approach to testing which did not make assumptions about a person's risk, thereby avoiding stereotyping and potential damage to client confidence and trust. Clinicians reported that the availability of the clinic materials helped to reinforce that they were not singling out any particular patient and were in fact offering testing to all patients.

Notably, this acceptability was observed within a cohort of clinicians who reported moderate to high baseline confidence in HIV and sexual health discussions, which likely supported engagement with the model and its successful implementation over the six-month pilot. This highlights the need to extend the model to clinicians and practice settings where HIV testing is less routinely undertaken. Barriers to HIV testing are well documented and include clinician hesitancy, reliance on risk-based assessment and individual beliefs or values (Leidel et al., 2015). In these contexts, the universal framing of clinician-initiated testing can reduce barriers by removing reliance on risk-based judgement and normalising HIV testing as part of routine bloodwork, enabling clinicians to offer testing without requiring risk-based justification.

As with any new approach, there were also logistical and motivational challenges described that future application of the model would need to consider. These included:

- The additional time required to engage clients in a conversation about sexual health and HIV, particularly for clients who held additional concerns or sensitivities around HIV and sexual health broadly.
- The increased labour and time required to undertake additional testing, including interpretation of results and confirmation testing requirements.
- Normalising testing may not immediately lead to diagnoses, which can challenge clinicians' perceptions of its appropriateness and cost-effectiveness when the value of testing is not immediately evident, and may reduce sustained adoption over time.

A further important consideration relates to clinical location. While this pilot demonstrated that the model was broadly acceptable among metropolitan general practitioners, particularly those already engaged through ASHM and with s100 prescribing experience, its applicability in regional and remote settings requires further exploration. General practitioners in these contexts play a critical role in community healthcare but often operate within more constrained environments, including workforce shortages, high staff turnover, limited access to specialist services and increased service demands (Cosgrave et al., 2019). Future implementation will need to be adapted to reflect these realities, with more targeted, context-specific recruitment approaches to support equitable reach across diverse settings. In particular, tailored supports and appropriate financial incentives are likely to be important for facilitating both initial engagement and sustained participation.

Key learnings

CPD facilitated recruitment, but additional incentives were required to sustain engagement

The inclusion of RACGP CPD accreditation played a clear role in supporting early clinician engagement in the pilot. By aligning participation with recognised professional development requirements, the program offered a credible and tangible incentive that acknowledged clinicians' time and contributed directly to their ongoing professional obligations.

However, CPD accreditation alone did not incentivise sustained engagement throughout the implementation phase. Clinicians reported that as the pilot progressed, competing clinical priorities, time pressures and workflow constraints became more prominent, and engagement declined in the absence of additional reinforcements such as the occurrence of a positive diagnosis or a quantitative update on the progress of the pilot. This indicates that while CPD can support initial participation, it is not sufficient as a standalone mechanism to maintain ongoing behaviour change in general practice.

Sustained engagement in future implementation would likely require a combination of supports that extend beyond CPD, such as the integration of the clinician-initiated testing model into clinical systems and workflows, providing financial incentives and introducing reinforcement throughout implementation, such as progress feedback, interim recognition or incremental incentives, or supporting 'clinic champions', to support sustained clinician engagement.

Flexibility in evaluation sampling and clinician engagement was required

Evaluation sampling was initially designed to be purposeful, with the aim of avoiding over-representation from individual sites and ensuring coverage across participating locations. However, due to slower-than-anticipated uptake of evaluation interviews, these sampling parameters were revised, and invitations were extended to all participating clinicians.

Under the original approach, clinical leads at sites with multiple participating clinicians were asked to nominate one to two clinicians to take part in the evaluation. This approach resulted in limited uptake, with feedback indicating a preference for direct contact with participating clinicians. In response, evaluation invitations were sent directly to clinicians, which streamlined engagement and supported broader participation.

This experience highlighted the importance of flexibility in evaluation design and the need to avoid additional processes that can discourage or delay clinician participation. It also reinforced the significant time pressures faced by general practitioners and demonstrated the value of keeping engagement simple and direct. Overall, direct communication with clinicians proved to be a more effective and efficient approach to supporting evaluation participation.

Conclusion

The findings of this pilot demonstrate that a clinician-initiated testing model for HIV, hepatitis B, hepatitis C and syphilis is both feasible and acceptable within general practice and can be effectively implemented as a universal and targeted strategy to improve testing uptake.

In addition to increasing testing, the model supported broader preventive care by enabling opportunistic vaccination for hepatitis B, increasing sexual health discussions about other vaccinations including mpox, and facilitating more frequent and confident discussions about HIV and STI prevention strategies, including PrEP and Doxy-PEP. It also contributed to strengthened clinician-client rapport. Together, these outcomes demonstrate the model's value in delivering more holistic, proactive sexual health care beyond testing and diagnosis alone.

Given that the clinicians recruited to the pilot were predominantly based in metropolitan settings where HIV, hepatitis B, hepatitis C and syphilis testing is already occurring at higher rates (Australian Centre for Disease Control, 2023), and no HIV diagnoses were reported by the subset of clinicians that participated in the evaluation, with only a small number of hepatitis B, hepatitis C and syphilis diagnoses recorded, the findings from this pilot indicate that the added value of this model is likely to be greatest in settings where testing is not routinely embedded into care. Expanding testing in outer-metropolitan, regional and remote areas is a priority of the HIV Taskforce Report, where barriers to accessing sexual health services persist. Variable and limited service availability, variable clinician confidence and systemic stigma can discourage people from accessing testing and reduce clinicians' willingness to offer it (Australian Centre for Disease Control, 2023).

In these contexts, clinician-initiated testing provides a clear mechanism to shift practice by embedding testing into routine bloodwork, rather than relying on client request or risk-based assessment. This reduces reliance on subjective judgement and enables clinicians to offer testing more consistently across a broader patient population, including those who may not otherwise be identified as requiring testing. As such, targeted implementation in these settings is likely to deliver the greatest impact by expanding reach, engaging patients who would not otherwise be tested, and addressing persistent gaps in testing coverage. This is particularly important given the ongoing challenge of late HIV diagnoses in Australia.

Importantly, a clinician-initiated approach reduces reliance on clinician judgement about perceived client risk and instead positions testing as a standard component of care, supporting more consistent, equitable and non-stigmatising delivery. In doing so, it has the potential to address structural and perceptual barriers that contribute to the persistence of 'never-testers,' including both clients who have never been offered testing and clinicians who may not routinely raise it.

Through the normalisation of HIV testing, this model has the potential to expand access, engage previously unreached communities and support earlier diagnosis. In alignment with the Ninth National HIV Strategy 2024-2030, these outcomes are critical to reducing late diagnoses, identifying the remaining undiagnosed population and sustaining momentum toward the virtual elimination of domestic HIV transmission in Australia by 2030.

References

Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). (2024). HIV testing policy update: Opt-out testing. https://ashm.org.au/initiatives/hiv-testing-policy-update-opt-out-testing/

Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). (2020). National HIV testing policy. https://testingportal.ashm.org.au/files/ASHM_National%20HIVTestingPolicy_2020_HIV_.pdf

Australian Centre for Disease Control. (2023). HIV Taskforce Report. https://www.cdc.gov.au/sites/default/files/2025-12/hiv-taskforce-report.pdf

Australian Centre for Disease Control. (2024). Ninth National HIV Strategy 2024–2030. https://www.cdc.gov.au/system/files/2025-10/ninth-national-hiv-strategy-2024-2030_0.pdf

Australian Commission on Safety and Quality in Health Care. (2020). Informed consent in health care: Fact sheet for clinicians. Internet Archive. http://web.archive.org/web/20251114131038/https://www.safetyandquality.gov.au/sites/default/files/2020-09/sq20-030_-_fact_sheet_-_informed_consent_-_nsqhs-8.9a.pdf

Australian Government Department of Health, Disability and Ageing. (2025, August 7). Chief Medical Officer's statement declaring syphilis a Communicable Disease Incident of National Significance. https://www.health.gov.au/news/cmo-statement-syphilis-cdins

Bagchi, A. D., & Davis, T. (2020). Clinician barriers and facilitators to routine HIV testing: A systematic review of the literature. Journal of the International Association of Providers of AIDS Care, 19. https://doi.org/10.1177/2325958220936014

Baggaley, R. F., & Hollingsworth, T. D. (2020). How universal does universal test and treat have to be? The Lancet HIV, 7(5), e306–e308. https://doi.org/10.1016/S2352-3018(20)30031-X

Bolsewicz, K., Vallely, A., Debattista, J., Whittaker, A., & Fitzgerald, L. (2015). Factors impacting HIV testing: A review – perspectives from Australia, Canada, and the UK. AIDS Care, 27(5), 570–580. https://doi.org/10.1080/09540121.2014.986050

Carter, D. J., Kagan, D., Storer, D., & Mulcahy, S. (2025). Clinician-initiated opt-out HIV testing and the law. Sexual Health, 22(6), SH25083. https://doi.org/10.1071/SH25083

Chadwick, D., & Hill-Tout, R. (2024). HIV medicine editorial: Opt-out HIV testing in the UK: Approaching the endgame? HIV Medicine, 25(2), 165–167. https://doi.org/10.1111/hiv.13555

Cosgrave, C., Malatzky, C., & Gillespie, J. (2019). Social determinants of rural health workforce retention: A scoping review. International Journal of Environmental Research and Public Health, 16(3), 314. https://doi.org/10.3390/ijerph16030314

Flash, C. A., Pasalar, S., Hemmige, V., Davila, J. A., Hallmark, C. J., McNeese, M., Miertschin, N., Ruggerio, M. C., & Giordano, T. P. (2015). Benefits of a routine opt-out HIV testing and linkage to care program for previously diagnosed patients in publicly funded emergency departments in Houston, TX. Journal of Acquired Immune Deficiency Syndromes, 69(Suppl. 1), S8–S15. https://doi.org/10.1097/QAI.0000000000000578

Glew, S., Pollard, A., Hughes, L., & Llewellyn, C. (2014). Public attitudes towards opt-out testing for HIV in primary care: A qualitative study. British Journal of General Practice, 64(619), e60–e66. https://doi.org/10.3399/bjgp14X677103

Heijman, R. L. J., Stolte, I. G., Thiesbrummel, H. F. J., van Leent, E., Coutinho, R. A., Fennema, J. S. A., & Prins, M. (2009). Opting out increases HIV testing in a large sexually transmitted infections outpatient clinic. Sexually Transmitted Infections, 85(4), 249–255. https://doi.org/10.1136/sti.2008.033258

Hocking, J. S., Parker, R. M., Pavlin, N., Fairley, C. K., & Gunn, J. M. (2008). What needs to change to increase chlamydia screening in general practice in Australia? The views of general practitioners. BMC Public Health, 8(1), 425. https://doi.org/10.1186/1471-2458-8-425

King, J., McManus, H., Kwon, J. A., Gray, R. T., & McGregor, S. (2024a). HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2024 – Hepatitis C. The Kirby Institute, UNSW Sydney. https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual-Surveillance-Report-2024-HCV.pdf

References

King, J., McManus, H., Kwon, J. A., Gray, R. T., & McGregor, S. (2024b). HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2024 – Sexually transmissible infections. The Kirby Institute, UNSW Sydney. https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual_Surveillance_Report_2024_STI_1.pdf

King, J., Kwon, J. A., McManus, H., Gray, R. T., & McGregor, S. (2025). HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2025. The Kirby Institute, UNSW Sydney. https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual_Surveillance_Report_2025_HIV.pdf

Leblanc, N. M., Flores, D. D., & Barroso, J. (2016). Facilitators and barriers to HIV screening: A qualitative meta-synthesis. Qualitative Health Research, 26(3), 294–306. https://doi.org/10.1177/1049732315616624

Leidel, S., McConigley, R., Boldy, D., Wilson, S., & Girdler, S. (2015). Australian health care providers' views on opt-out HIV testing. BMC Public Health, 15, 888. https://pubmed.ncbi.nlm.nih.gov/26369954/

MacLachlan, J., & Cowie, B. (2025). Prevalence and epidemiology of hepatitis B. B Positive. https://hepatitisb.org.au/prevalence-and-epidemiology-of-hepatitis-b/

Opt-out HIV testing in the UK (2023). The Lancet HIV, 10(6), e351. https://doi.org/10.1016/S2352-3018(23)00117-0

Owen, L., & Magraith, K. (2025). Could it be HIV? Using clinical indicator-guided HIV testing in general practice. Australian Journal of General Practice, 54(6), 413–416. https://doi.org/10.31128/AJGP-02-24-7161

Yazdanpanah, Y., Sloan, C. E., Charlois-Ou, C., Le Vu, S., Semaille, C., Costagliola, D., Pillonel, J., Poullié, A.-I., Scemama, O., Deuffic-Burban, S., Losina, E., Walensky, R. P., Freedberg, K. A., & Paltiel, A. D. (2010). Routine HIV screening in France: Clinical impact and cost-effectiveness. PLOS ONE, 5(10), e13132. https://doi.org/10.1371/journal.pone.0013132