Integrating testing for sexually transmissible infections into routine primary care for Aboriginal young people: a strengths-based qualitative analysis

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Abstract

Objectives: This paper examines factors that enabled successful integration of testing for sexually transmissible infections into routine care in Aboriginal Community Controlled Health Services.

Methods: This paper reports analysis of qualitative interview data recorded with 19 purposively sampled key informants in New South Wales, Australia, representing six Aboriginal Community Controlled Health Services and five government health bodies supporting those services. The analysis explicitly adopted a strengths-based approach.

Results: Participants reported a strong belief that routine screening overcomes shame and increases engagement with sexual health screening. Incorporating sexual health screening into general medical consultations increases the capture of asymptomatic cases. The Medicare Benefits Schedule 715 Adult Health Check was highlighted as an ideal lever for effective integration into routine care.

Conclusion: Integration of testing for sexually transmissible infections into routine care is widely perceived as best practice by senior stakeholders in Aboriginal healthcare in NSW. Findings support continued work to optimise the MBS 715 as a lever to increase testing.

Implications for public health: Identifying accessible strategies to increase testing for sexually transmissible infections in Aboriginal Community Controlled Health Services can reduce disparities in notifications affecting Aboriginal young people.

Key words: sexual health, Aboriginal health, young people, sexually transmissible infection, routine care

This paper explores expert perspectives on strategies that integrate testing for sexually transmissible infections (STIs) into routine primary care for Aboriginal young people in New South Wales (NSW), Australia. In most cultural contexts around the world, sexual health is a sensitive matter, creating challenges for effective screening and treatment. The importance of equitable access to sexual healthcare for young people has been recognised globally.[1] There is consensus in the literature from neo-colonial states such as Australia, New Zealand, the US and Canada that culturally safe sexual healthcare is vital to the wellbeing and development of Indigenous youth in the face of health inequities, including over-representation in STI notifications.[2] This paper adds new insights to this literature with the aim of extending our understanding of what works to make sexual health a more integrated and normalised dimension of health and wellbeing for Aboriginal Australians.

Reducing the disproportionate impact of STIs on the health of Aboriginal young people in Australia is a priority in state and national public health strategies.[3-5] STIs such as chlamydia and gonorrhoea are often asymptomatic and, if not detected and treated, can lead to complications such as pelvic inflammatory disease, chronic pelvic pain, ectopic pregnancy and infertility.[6] While syphilis is easily treated with antibiotics, it can progress to serious late-stage disease involving organ damage and neurological disorder if undetected and left untreated.[7] Additionally, untreated syphilis during pregnancy can cause stillbirth and birth defects.[8]

There is strong evidence that delivery of preventative health within a primary healthcare setting such as Aboriginal Community Controlled Health Services (ACCHS) can improve health outcomes for Aboriginal populations.[9] The primary healthcare setting, including ACCHS, is recognised as playing a vital role in STI prevention and management, particularly with clinical approaches focussed on screening to identify asymptomatic infections.[10] Aboriginal community members report finding ACCHS more accessible and culturally appropriate than mainstream services,[11] indicating the need to learn from and invest in robust services that support community needs.

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Grounded in a history of Aboriginal agency and self-determination, ACCHS have played a central role in the provision of holistic, culturally appropriate healthcare to Aboriginal communities for more than 45 years.[12] Indigenous-specific primary healthcare services controlled by local Indigenous communities have been established to meet similar needs in other countries with a history of colonisation.[13] Today, ACCHS across Australia are estimated to deliver more than 2.5 million episodes of care to Aboriginal community members each year.[14] Aboriginal community members identify ACCHS as providers of safe and accurate information about sexual health.[15] Many ACCHS deliver healthcare that has been assessed as meeting best practice standards in high-income nations,[16] as well as providing preventative care that is equal if not superior to that delivered in mainstream general practice settings.[17] Aboriginal people who use ACCHS view holistic understandings of healthcare and strong relationships with community to be strengths of the community-controlled model.[16]

Epidemiological context

STI notifications in Aboriginal populations in Australia occur at a higher rate in young people aged 15–29 years than in the corresponding age bracket in the non-Indigenous population.[18] The most common STI diagnosis in Aboriginal young people across Australia is chlamydia, followed by gonorrhoea and syphilis.[19] HIV prevalence in the Aboriginal population remains low,[20] but the HIV notification rate for Aboriginal people has increased in recent years while simultaneously decreasing in the non-Indigenous Australian-born population.[18]

A systematic review and meta-analysis concluded that most studies on STI prevalence in Aboriginal populations have been conducted in remote regions, which have recorded the highest notification rates of STIs for more than two decades.[21] Additionally, two-thirds of studies reviewed in a scoping review of qualitative literature on the sexual health of Aboriginal young people were conducted in regional, rural or remote regions.[22] There is little health research focussing on Aboriginal populations in New South Wales,[23] despite the largest number of Aboriginal people in Australia living in New South Wales compared to other Australian states and territories.[24]

The BBV & STI Research, Intervention and Strategic Evaluation Aboriginal Systems Projects (BRISE ASP)

This paper reports a secondary analysis of interview data collected as part of the BBV & STI Research, Intervention and Strategic Evaluation Aboriginal Systems Project (BRISE ASP) in 2016. The BRISE Program undertakes policy-relevant research to support the NSW Ministry of Health STI and BBV strategy implementation. BRISE ASP was developed to support strategic directions for STI and BBV strategies for Aboriginal populations in New South Wales during the 2014–2019 funding round. As part of BRISE ASP, The Kirby Institute and the Centre for Social Research in Health (CSRH) conducted interviews with key informants from ACCHS or government Local Health District (LHD) settings in New South Wales.

The key informants who contributed interviews to BRISE ASP represent a group of experts who are hard to access and experience considerable demands on their time. While a brief report was published from these data in 2018, this secondary analysis has been conducted in 2021 to generate more in-depth understanding of the insights from these professionals regarding the specific question of how to integrate STI testing into routine care in ACCHS settings. Limited qualitative literature has been published with key informants from New South Wales ACCHS in the time since this data was collected and the issues discussed by key informants in this dataset remain relevant and timely.

Methods

The aim of this analysis is to identify the factors that stakeholders working in public health and community-controlled health services believe work to support the successful incorporation of testing for STIs into routine care for Aboriginal young people, particularly in community-controlled settings.

Governance, ethics approval and informed consent

BRISE ASP was overseen by an advisory group consisting of representatives from ACCHS, LHDs, the NSW Ministry of Health, the Kirby Institute and CSRH, as well as one Aboriginal medical doctor. Four members of the advisory group were Aboriginal. The BRISE ASP advisory group met quarterly during the project.

The members of the original BRISE ASP advisory group who remained in their positions were consulted and endorsed this secondary analysis. Four members of this group are Aboriginal. Maintaining the Aboriginal membership of the original committee was prioritised by the research team. In the instance where an Aboriginal member of the committee was no longer able to sit on the committee, another Aboriginal representative of their organisation was engaged to replace them.

This secondary analysis received ethics approval through the Aboriginal Health and Medical Research Council of NSW ethics committee (HREC 1735/20).

All participants provided extended consent for use of their data. The research team for this paper includes key members of the BRISE ASP research team, including the researcher who conducted the interviews.

Sample

Using a stratified purposeful sampling frame,[25] BRISE ASP purposively selected key informants based in one of six ACCHS or one of five LHDs involved in supporting those ACCHS. All participants had experience in the delivery of STI and BBV programs for Aboriginal communities in New South Wales, as well as clinical and public health expertise in STI and BBV prevention. The sample consisted of senior ACCHS and LHD staff from across New South Wales, representing six ACCHS and five LHDs.

Purposive sampling ensured representation of different Aboriginal populations and diversity of ACCHS. The ACCHS selected included regional, remote and metropolitan ACCHS, as well as ACCHS that both had and had not received STI/BBV funding from the NSW Ministry of Health. Only LHDs that provided services to the same geographical region as a participating ACCHS were invited to participate. Both Aboriginal and non-Aboriginal key informants participated in interviews, as well as both men and women. These characteristics are not reported in the analysis alongside data quotes to protect confidentiality, given the small number of people working in this sector.

Strengths-based approach

This paper explicitly adopted a strengths-based approach to its subject matter and analysis. The Lowitja Institute describes 'deficit discourse' as discussions about disadvantage

that narratively frame Aboriginal people as inherently deficient and problematic.[26] Problematising Aboriginality as itself a causative factor in ill health suggests blame for health disparities should be placed on Aboriginal people and communities rather than on systemic factors such as racism.[27] A deficit-focussed epidemiological framing camouflages the strengths of Aboriginal people and communities within both research and policy, thereby reinforcing and normalising continued use of deficit discourse in the design of programs and services intended to reduce health disparities.[28] Explicit acknowledgement of the desire to overcome a deficit discourse and adopt a strengths-based approach can provide alternative strategies to address health disparities experienced by Indigenous peoples.[29] In line with the strengths-based approach taken by the original BRISE ASP, this project continues to centre the strengths, assets and capabilities of ACCHS and ACCHS staff.

Data collection

The dataset consists of transcripts of interviews with 19 participants across 15 interviews of 30–60 minutes in length. Three interviews were completed in one group, with the remainder completed individually. Interviews were conducted by phone between June and December 2016. The researcher who conducted the interviews (CN) is also a co-author of this secondary analysis. This researcher is non-Indigenous and engaged extensively with the Aboriginal advisory group to develop the interview guide.

During interviews, key informants discussed the factors that influenced the development, implementation, and sustainability of successful programs on which they had worked, with a focus on which elements most contributed to their success. Themes covered in the BRISE ASP interview guide included governance; community consultation; resourcing; collaboration and external support; intervention type (for example quality improvement, health promotion, marketing); partnerships with other services; and sustainability.

Thematic analysis

We completed an inductive thematic analysis using NVivo – a computer software package for managing qualitative data and analysis. The researcher leading the thematic analysis (HM) is an Aboriginal woman from New South Wales, with expertise in sexual health promotion for Aboriginal people. We followed the model outlined by Braun and Clarke[30] that guides researchers to systematically identify and organise patterns of meaning in the interview data, first into distinctive codes and then into overarching themes.[31] As outlined by Braun and Clarke,[30] we then reviewed candidate themes and sub-themes and developed a thematic map of the analysis (see Figure 1). Throughout the coding and analysis process, potential themes were collaboratively discussed among the whole research team, which included investigators from the original BRISE ASP. The thematic map was also circulated to the BRISE ASP advisory group, and their feedback was incorporated into the final analysis.

Results

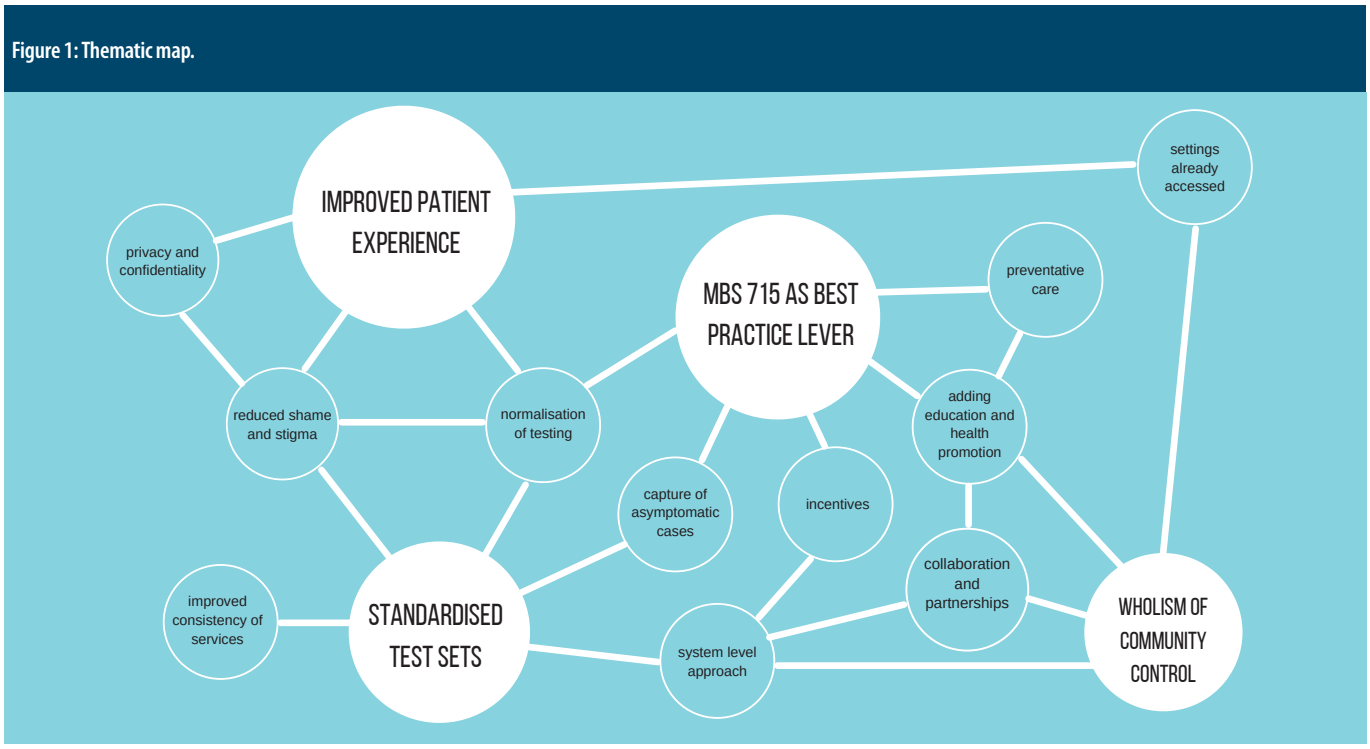
Participant characteristics are shown in Table 1.

All interview data that focused on the integration of STI testing into routine practice represented this as a valuable goal. Embedding STI testing into routine care was seen to reduce the shame and

Table 1: Participant job title.

ACCHS participants (n = 8)	Practice Manager	4
	Health Manager	1
	Program Manager	1
	Aboriginal Sexual Health Worker	1
	Registered Nurse	1
LHD participants (n = 11)	Program Manager	2
	Clinical Nurse Consultant	2
	Director	2
	Sexual Health Physician	2
	Program Manager	2
	Nurse Unit Manager	1

Figure 1: Thematic map.



embarrassment associated with discussing sexual matters, particularly for young people, and as an effective strategy to reduce the stigma associated with sexual health. Linking STI testing to other routine tests which are less stigmatised – such as blood pressure or blood sugar – was also supported by participants:

> *It's not, you know, "We're picking on you because we think you look a bit, you know, dodgy," sort of thing … Thinking you look like you need testing. Getting it so that that's a norm … We test everybody just like we, you know, we'll do your blood pressure and your blood sugar. Then we like, you know, we wanna test for STIs because that's a normal thing.* – Participant 7 (ACCHS)

Privacy and confidentiality were also identified as concerns for patient access to sexual healthcare that could be minimised by incorporating sexual healthcare into general medical consultations. Protecting patient privacy in small communities where patients are likely to be well known to ACCHS staff was identified as particularly important:

> *If you go in and make an appointment to see a doctor and it's just for a general health issue, it's less embarrassment factor than if you have to walk in there and ask for an STI test and your auntie's at reception.* – Participant 10 (LHD)

A perceived benefit of making STI testing part of routine care was identifying asymptomatic cases who present to ACCHS for reasons other than sexual healthcare. Increasing screening of asymptomatic patients who may not request an STI test was viewed as a particularly challenging aspect of delivering healthcare in the ACCHS setting, but also as vital to providing appropriate early intervention for young people in the Aboriginal communities in which participants worked. Participants felt that the inclusion of STI tests in routine medical consultations that had been organised for other purposes was relatively frictionless for patients and facilitated much higher testing rates than relying on patients to request an STI test:

> *So, when we're talking about chlamydia, I spend a lot of time talking about young women and young heterosexual men, and how you can, you know, if someone comes in for a medical certificate for a cold, just sort of say, "Oh, you're 18. What we usually do every year for people up to the age of 25 is do a urine test for chlamydia. Here's a bottle. Why don't you just go off and do it?"* – Participant 3 (LHD)

Participants described the relationships that ACCHS had with their local communities as an asset. Incorporating STI screening into services and settings patients already access for general healthcare was perceived as particularly effective in rural areas where ACCHS are typically used by a higher proportion of the local population and was seen as accessible from both the patient end and the provider end:

> *Although they often think there's not many young people there, when you run the numbers, there usually are some of the young people attending the service. They're attending the service for all of their healthcare needs which includes prevention health and then so inserting STI and BBV testing into that with a bit of assistance is really not that difficult.* – Participant 6 (LHD)

One of the strongest recommendations across the dataset was the use of standardised test sets, inclusive of chlamydia, gonorrhoea, syphilis, HIV and trichomoniasis where appropriate, offered as part of routine health consultations. This was perceived as an ideal strategy for avoiding the stigma and bias associated with risk-based assessment, while still capturing individuals at higher risk. It should be noted that risk-based assessment continues to be recommended for viral hepatitis.[32,33] Several participants identified the Medicare Benefits Scheme Item Number 715 Aboriginal and Torres Strait Islander Peoples Health Assessment (hereafter referred to as the MBS 715 and also referred to by some participants as a 'health check') as an ideal lever for embedding an annual screen using standardised test sets into routine healthcare. The MBS 715 (discussed in more detail later) is an annual routine preventative health screen targeted at Aboriginal and Torres Strait Islander people attending primary healthcare services that is attached to practice-level incentives via Australia's universal health insurance program, Medicare.[34]

> *When you're sitting down with a man who's having sex with men, doesn't consider himself gay, he's married to a woman, you know, he mightn't have that sort of disclosure that one would think, you know. Like, and he'll, you know, be denying that to anybody… it just takes that personalising away so you don't need that disclosure like to make that decision whether you can test or not. So, if you're saying, "Oh, look, you're here for an adult health check [MBS 715]. Part of that adult health check is we do a full screen just to make sure you're all right."* – Participant 11 (ACCHS)

The MBS 715 was also seen as an optimal entry point to annual STI screening for young patients who may have recently become sexually active, but who were unlikely to present for the purpose of requesting an STI test. This youth demographic was perceived to have additional needs for health promotion and education, as well as screening. Some participants described the MBS 715 as an opportunity to incorporate sexual health education and health promotion into routine care alongside STI testing. This holistic approach – the incorporation of preventive healthcare and health promotion into comprehensive health assessments – was highlighted by several participants as a strength of the ACCHS system that was not as likely to be provided to young Aboriginal people attending mainstream general practice.

> *They didn't advertise it as STI screening; they advertised it as health checks targeting a target group – and I think it was 15 to 21 years. And that's how they got people in the door. When they got them in the door, they did things like, "Oh we just, we're gonna do your blood pressure. We're gonna do your temp and your weight. And while you're here we're gonna get you to pee in this jar" … And then they started the discussion. "Are you sexually active?" you know. "Have you got access to condoms?"* – Participant 9 (ACCHS)

From the provider perspective, the incorporation of standardised test sets into the MBS 715 was also believed to improve the consistency of services. Participants explained that terminology used to request sexual health screening varied between clinicians and pathology requests for STI tests may not be inclusive of all major STIs unless the correct language is used. The use of standardised test sets – and particularly systematised standardisation via technological solutions such as auto-populating pathology requests via the patient management system – was suggested as a successful strategy to ensure consistency in testing across the service.

> *If someone just puts in STI testing that they might not get everything … One thing we did, and we've had good success at getting all the tests that we need, is completely re-writing and trying to encourage GPs not to use certain naming conventions but to, to use the ones that we've devised so that we get exactly what we ask for.* – Participant 4 (ACCHS)

Embedding STI testing into routine care via inclusion in the MBS 715 was viewed as an effective strategy to improve service performance. Making comprehensive STI

screening a routine part of every annual MBS 715 delivered within an ACCHS lifted testing rates across the service and contributed to increased performance against STI testing Key Performance Indicators (KPIs). Some participants believed that the linking of the MBS 715 to financial incentives from Medicare gave it further appeal for broad implementation within ACCHSs, as a primary healthcare practice such as an ACCHS receives an incentive payment for each MBS 715 completed with an Aboriginal person. The normalisation of STI testing as a routine part of the MBS 715 reduced barriers to uptake on both the patient and provider end and the Medicare incentives acted as a motivator for system-level change. Several participants described a whole-of-service approach to encouraging the annual delivery of an MBS 715 to each eligible patient within the service, with this high MBS 715 uptake then facilitating the easy provision of a routine annual STI test to a broader cohort of patients.

> *The 715 is really the key to it all both because you're integrating the testing into other preventative health which is easier for clinicians … and more acceptable to patients. But it also makes it sustainable from a funding perspective because there's sufficient money from that. From my understanding from talking to managers of community-controlled services, they can utilise that quite substantial amount of money to deliver quite good programs.* – Participant 6 (LHD)

This systematic approach was also raised as central to the success of delivery of holistic care in the context of collaboration between ACCHS staff from different disciplines. Several participants identified collaboration between doctors, nurses, and Aboriginal Health Practitioners in the delivery of the MBS 715 as a common feature of high performing ACCHS, while other participants emphasised the importance of Aboriginal Health Practitioners in ensuring the smooth engagement of Aboriginal young people with clinical services.

> *That Aboriginal health worker takes them into a separate room. They do all the build-up, you know, start the health check [MBS 715]. They talk to them, and they would actually ask would they like an STI screen there. Knockback is really low. Most people say yes. So then they actually move them into the doctor. Move them in there. Sometimes that Aboriginal health worker actually goes with them, if they want, to support them … And then they come back to the Aboriginal health worker who will then organise … their appointment for pathology, whatever, X-rays, they'll just do all that for them.* – Participant 8 (LHD)

Many participants emphasised the fact that these services "don't look at sexual health differently". Participants demonstrated a shared understanding that treating STIs as equivalent to other aspects of routine healthcare contributed to the success of these high-performing services. This also allowed staff from different disciplines – including doctors, nurses and Aboriginal Health Practitioners – to work in partnership to deliver best practice, holistic healthcare that was inclusive of routine STI testing.

Discussion

Key informants strongly supported integrating STI testing into routine care for Aboriginal young people in New South Wales. This analysis supports several key findings from previous research.[10,35-37] Participants clearly identified that the offering of STI testing to all young people attending a service as part of routine healthcare was an effective mechanism to circumvent shame and stigma that can act as a barrier to testing. Systematic efforts to normalise STI testing within services were recognised as drivers of increased acceptability and uptake among the target population. Participants strongly recommended incorporating standardised STI test sets into the MBS 715 as a best practice strategy for integrating STIs into routine care within the ACCHS setting.

Our participants not only recognised the extent to which patients value the holistic approach to healthcare taken by ACCHS but felt that this holistic approach was vital to sustaining practice change that facilitated successful integration of STI testing into routine care. Previous research has emphasised the crucial role of acceptance by the community in mobilising Aboriginal community members to seek out and engage with health services[11,15] and this is also reflected in the literature examining Indigenous community-controlled healthcare in other countries.[2] This was also expressed by our participants, with several citing the strong relationships ACCHS had with their local community as an asset for engaging that community with healthcare and specifically with healthcare related to STIs. The benefits of strong relationships between the ACCHS and the local community were particularly emphasised in the context of regional and remote settings, which have historically recorded the highest STI notification rates[21] and hence most require a comprehensive and effective response from local healthcare services.

A scoping review identified that the role of culture underpinning all aspects of healthcare provision is the most significant distinction between ACCHS and mainstream health services for Aboriginal people accessing healthcare.[13] Previous literature has also identified the importance of Aboriginal staff in providing respectful, culturally safe care,[16] which was reflected in comments by our participants about Aboriginal staff at high performing ACCHS. Community-controlled healthcare services run by and for the Aboriginal community are more likely to be culturally safe and free of racism than mainstream services[11] and experiencing racism is itself predictive of poor health outcomes for Aboriginal people.[38]

The majority of clients (92%) who access ACCHS services do so for reasons other than accessing STI and BBV testing,[39] highlighting the need to increase routine and opportunistic screening to detect asymptomatic infections. In line with our findings, in-depth interviews with clinicians in other settings have found support for normalising STI testing via embedding screening programs into routine primary care.[35] Our analysis also aligns with findings from in-depth interviews with young women that have strongly supported age-based STI screening, as opposed to testing based on clinician risk assessment, as a strategy to normalise and destigmatise testing for STIs.[36] International research has found that annual screening for bacterial STIs is most acceptable to patients when framed as routine preventative healthcare offered to all patients based on age rather than targeted at individual risk behaviour[40] and that questioning about risk behaviour for the purposes of HIV testing is perceived as shaming and racist by Indigenous patients in other countries.[41] A systematic review of interventions to increase STI screening in primary care settings found that the interventions with the greatest impact were those that provided an accessible and systematised mechanism to offer an STI test to all eligible young people,[42] which was believed to be best practice by participants in our study.

Preventative care for Aboriginal people in Australia is incentivised in ACCHS and GP settings by the MBS 715 Aboriginal

and Torres Strait Islander Peoples Health Assessment, which is the only routine health assessment in Australia that includes young people as a target population. The National Guide to a Preventative Health Assessment for Aboriginal and Torres Strait Islander People[34] recommends inclusion of sexual and reproductive healthcare in an MBS 715 for Aboriginal young people aged 30 and under, alongside lifestyle factors such as smoking, physical activity, assessment of social and emotional wellbeing, vaccination, and routine blood work including serum lipids, kidney function and fasting plasma glucose. While uptake of the MBS 715 has increased in the past decade, delivery continues to vary considerably between regions and between practices.[43] Aboriginal young people are more likely to receive an MBS 715 in an ACCHS compared to a mainstream general practice setting,[44] and our analysis demonstrates that ACCHS in New South Wales have leveraged the MBS 715 to integrate both STI testing and sexual health promotion into routine care.

Previous research has found a positive association at the service level between delivery of an MBS 715 and a comprehensive STI test inclusive of chlamydia, gonorrhoea and syphilis.[39] The systematised incorporation of standardised pathology requests into the MBS 715 was strongly recommended by our participants as a strategy to increase the comprehensiveness of STI tests conducted in ACCHS and ensure broad testing of Aboriginal young people for all major STIs. This is of particular importance to Aboriginal young people in the context of the over-representation of this population in syphilis notifications in regions affected by the ongoing syphilis outbreak that began in northern Australia. The use of opt-out standardised test sets has been found to increase the inclusion of syphilis in other settings with other priority populations at elevated risk of syphilis.[45] The need to increase STI testing among asymptomatic Aboriginal young people in order to reduce community prevalence has also been recognised[21] and modelling has shown that annual sexual health screening has the potential to decrease STI rates if 60% or more of the target population are tested.[46] Inclusion of routine discussion of sexual and reproductive health in the MBS 715 has been recommended as a culturally safe approach in recent qualitative literature.[15] While research specifically focussed on the use of the MBS 715 in young Aboriginal people is limited, there is some evidence[39] to support the use of the MBS 715 as a mechanism to increase STI testing for patients who attend ACCHS for other purposes, and this analysis also supports this recommendation. The strong endorsement of our participants for use of the MBS 715 to normalise annual STI screening in young people supports advocacy for incentivised annual health assessments for adolescents more broadly, particularly considering a successful trial of comprehensive adolescent health assessments in mainstream general practice in Victoria.[47]

Limitations

This paper was conducted as a secondary analysis of an existing dataset: the data was not collected with this specific focus on the issue of integrating STI testing into routine care, although this was a topic of interest in that broader study. While Aboriginal key informants were represented in the sample, Aboriginal status was not collected at the time of interview and thus it was not possible to compare viewpoints of Aboriginal key informants with viewpoints of non-Aboriginal key informants. Additionally, the data analysed in this paper were collected prior to the COVID-19 pandemic and may not reflect the post-pandemic context in ACCHS settings in New South Wales. Despite these limitations, study findings remain highly relevant to the delivery of sexual healthcare in New South Wales ACCHS.

Recommendations and future research

The findings of this analysis are relevant to the ongoing syphilis outbreak occurring in Aboriginal communities across Australia[48-50] and the need to ensure that sexual health testing is inclusive of syphilis testing. Findings may inform public health policy and sexual health practice in New South Wales and other parts of Australia, as well as other postcolonial settings with Indigenous populations affected by health inequities. This may ultimately reduce the risk posed to New South Wales Aboriginal communities by the syphilis outbreak in neighbouring states.

Future qualitative research with key informants from New South Wales ACCHS and supporting government services would strengthen the evidence base supporting recommendations made in this paper. While the issues discussed in this dataset are long-term and remain relevant five years after data collection, there is value in revisiting this setting in a post-COVID context. The research team recommends that additional research continue to adopt a strengths-based approach and focus on the successes and assets of high-performing ACCHS, as well as centring Aboriginal voices. The research team strongly recommends that research in this setting should be Aboriginal-led.

Conclusion

Integration of STI testing into routine care is widely perceived as best practice by senior stakeholders within both ACCHS and LHDs in New South Wales. Findings support continued work to optimise the MBS 715 as an optimal lever for increasing STI testing among Aboriginal people in New South Wales.

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