NACCHO
National Aboriginal Community Controlled Health Organisation

ashm

Report

Second National Roundtable on Congenital Syphilis:

Tackling the syphilis outbreak to eliminate congenital syphilis

16th March 2026 – Sydney

NACCHO and ASHM acknowledge the Traditional Owners of the lands on which this roundtable was held, the Gadigal people of the Eora Nation. We recognise Aboriginal and Torres Strait Islander peoples' continuing connection to land, waters and community. We pay our respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples in attendance.

NACCHO and ASHM would like to thank the Australian Centre of Disease Control for providing funding for the Second National Roundtable on Congenital Syphilis.

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Executive summary

The Second National Congenital Syphilis Roundtable was held on 16 March 2026 in Sydney. Jointly convened by the National Aboriginal Community Controlled Health Organisation (NACCHO) and ASHM Health, the Roundtable brought together more than 80 senior representatives from federal and state governments, Aboriginal Community Controlled Health Organisations (ACCHOs), professional colleges, research institutions, and frontline clinical services. The forum functioned as a national policy and systems platform to accelerate coordinated action towards the elimination of congenital syphilis in Australia, building directly on the recommendations of the 2024 First National Congenital Syphilis Roundtable.

Australia is currently experiencing an unprecedented outbreak of syphilis. Congenital syphilis — transmitted from a pregnant person to their baby —represents one of the most serious and preventable consequences of this outbreak. The burden falls disproportionately on Aboriginal and Torres Strait Islander communities due to the determinants of health. Every case of congenital syphilis represents a failure of the health system to reach a pregnant person in time with testing, treatment, and care. The urgency of the current situation demands coordinated, sustained, and well-resourced action across all levels of the health system.

Key themes and findings

Roundtable discussions, expert presentations, and workshopping sessions identified eight interconnected priority areas for action. Collectively, these highlight that the pathway to eliminating congenital syphilis requires simultaneous progress across governance, clinical care, workforce, data, medicines supply, and community engagement.

Governance: Partnership-based governance models —exemplified by Western Australia and the Northern Territory —that embed shared decision-making between government and ACCHO sector organisations, with continuous quality improvement (CQI) mechanisms, have demonstrated effectiveness and should be replicated across all jurisdictions.

Antenatal Care Access: Significant structural, social, and systemic barriers —including domestic and family violence (DFV), housing instability, alcohol and other drug use, stigma, geographic remoteness, and lack of culturally safe services —continue to prevent many pregnant people from accessing or remaining in antenatal care. Community-led, culturally safe models of care, including Birthing on Country programs and ACCHO-led services, are proven to improve engagement and must be sustainably expanded.

Perinatal and Neonatal Care: Standardised Neonatal Management Plans for all pregnant people diagnosed with syphilis are urgently needed to prevent fragmented care and missed diagnoses and treatment. Significant data gaps also exist regarding the outcomes of infants born to people with syphilis, requiring expanded cascade of care surveillance.

Testing: A "no wrong door" approach to syphilis testing must be implemented across emergency departments, urgent care clinics, alcohol and other drug services, and correctional settings. National antenatal syphilis testing guidelines have not been consistently adopted at the facility level, and this must be urgently addressed.

Workforce: Workforce challenges —including instability, recruitment and retention pressures, and constrained scope of practice —have persisted since the first Roundtable. Expanding

scope of practice, embedding syphilis content into professional training, and sustaining Aboriginal and Torres Strait Islander Health Worker and Health Practitioner-led models of care are essential to meeting demand.

Data and Surveillance: Current surveillance systems are inadequate to consistently identify gaps across the testing and care continuum. Priority actions include strengthening Aboriginal and Torres Strait Islander identification in pathology datasets, transitioning antenatal syphilis testing to mandatory reporting within the National Perinatal Data Collection (NPDC), and improving data-sharing with private pathology providers.

Medicines Supply: Recurrent shortages of benzathine benzylpenicillin-G (BPG) —the only recommended treatment for syphilis during pregnancy and breastfeeding —continue to undermine the outbreak response. Improved demand forecasting, expanded Pharmaceutical Benefits Scheme (PBS) listing, and proactive inventory management are required as a matter of urgency.

Communication and Stigma Reduction: A national, coordinated communication strategy is needed to raise community awareness of syphilis, normalise testing, and reduce stigma. Both mass-media campaigns and targeted, locally delivered community initiatives are required to reach the health workforce and priority populations, including Aboriginal and Torres Strait Islander people, women of reproductive age, and people from culturally and linguistically diverse backgrounds.

Proposed actions

This report presents over 25 proposed actions, classified as short-term (achievable within 12 months) or long-term (requiring sustained investment and systems reform). These proposed actions are intended to inform the 2026 review and update of the National Syphilis Response Plan (Plan). NACCHO and ASHM strongly emphasise that the updated Plan must be accompanied by defined responsible parties, clear timeframes, and accountability mechanisms. The elimination of congenital syphilis in Australia is achievable —but only through sustained, coordinated, and well-resourced effort across governments, health services, and communities.

Background of the Second National Congenital Syphilis Roundtable

The Second National Congenital Syphilis Roundtable was jointly convened by NACCHO and ASHM as a national policy and systems forum to accelerate coordinated action towards the elimination of congenital syphilis in Australia. This Roundtable built on the recommendations of the 2024 National Congenital Syphilis Roundtable.

The aim of the Roundtable was to develop recommendations to achieve the elimination of congenital syphilis in Australia.

The objectives were to:

- identify the structural and operational barriers limiting progress to the elimination of congenital syphilis in Australia
- leverage successful jurisdictional and community-led approaches to preventing and

managing syphilis
- strengthen workforce, data and governance systems
- build consensus on priority actions that can be activated within the next 12 months
- develop a clear roadmap for coordinated national implementation efforts across jurisdictions and sectors.

The program (Appendix 1) was designed to support progress towards identifying persistent barriers and developing practical solutions, underpinned by sustained, intersectoral collaboration.

Purpose of the Roundtable report

This report outlines the key themes and suggested action items that emerged from the Roundtable. Recommendations will be considered as part of the 2026 review and update of the Plan.

NACCHO and ASHM strongly emphasise the importance of the updated the Plan being supported by defined actions, responsible parties and appropriate timeframes to enable accountability and timely progress in the outbreak setting.

To reflect urgency and sequencing, proposed actions in this report are classified as:

- **short-term:** Actions achievable within the next 12 months
- **long-term:** Actions requiring sustained investment and systems reform beyond 12 months.

At the conclusion of the roundtable, participants requested a third congenital syphilis roundtable to be convened in approximately 18 months to review progress against recommendations and maintain momentum. The current outbreak and resulting declaration of a Communicable Disease Incident of National Significance (CDINS) underscores the urgency for action and the need to ensure that agreed priorities are translated into timely and effective implementation activities.

Roundtable discussions and actions

Strengthened governance structures

Presentations from the Northern Territory and Western Australia showcased the strength of governance arrangements based on partnerships between government and ACCHO sector organisations.

These models have been assessed as effective because they included collaborative decision-making between government and community, CQI mechanisms and processes, and robust data collection and sharing. Collaborative governance models can support an all-of-system approach and should be considered for replication across jurisdictions.

Proposed actions	
SHORT-	Through the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS), support jurisdictions to implement governance arrangements

TERM	based on partnerships with the NACCHO affiliate in their jurisdiction, with a focus on congenital syphilis, including case assessments and CQI mechanisms and processes.

Access to and engagement in antenatal care

Timely and consistent engagement with antenatal care is one of the most critical levers for preventing congenital syphilis. Roundtable discussions highlighted that significant structural, social, and systemic barriers continue to prevent many pregnant people —particularly those from priority populations —from accessing or remaining engaged with antenatal care. Addressing these barriers is essential to the syphilis response.

Barriers to antenatal care access and engagement

Participants identified a range of factors that reduce access to and engagement in antenatal care, including:

- domestic and family violence (DFV), which creates unsafe conditions and prevents women from presenting to health services or disclosing health concerns
- homelessness and housing instability, which disrupts continuity of care and limits access to transport and services
- alcohol and other drug (AOD) use, which intersects with health system engagement and continuity of care
- stigma associated with syphilis diagnosis, STI testing, and drug use, which deters people from presenting to mainstream health services
- lack of culturally safe care environments, particularly for Aboriginal and Torres Strait Islander women and those from culturally and linguistically diverse (CALD) backgrounds
- geographic remoteness and limited availability of antenatal services in regional and remote areas
- insufficient integration of antenatal care with other services accessed by priority populations, such as AOD services, homelessness services, and correctional facilities.

Antenatal syphilis testing

Despite changes to antenatal syphilis testing recommendations across national guidelines — including the Living Evidence for Australian Pregnancy and Postnatal Care guidelines, Communicable Diseases Network Australia Series of National Guidelines, and Australasian STI Management Guidelines —these changes have not been implemented consistently across clinical settings.

Reasons identified for inconsistent implementation include:

- hospital or facility-based guidelines not reflecting updated national testing recommendations.
- healthcare workers not being aware of the changes to testing guidelines.

Culturally safe and flexible models of care

Participants emphasised that culturally safe and flexible models of care are essential to

support engagement and improve outcomes for people facing these intersecting risk factors. Aboriginal and Torres Strait Islander Health Worker and Health Practitioner-led models of care were highlighted as central to improving cultural safety, strengthening community trust and engagement, and improving patient outcomes. Community-led models of care —such as those delivered through the ACCHO sector —have been conclusively demonstrated to be effective and should be supported and expanded.

Birthing on Country programs and initiatives such as those led by Waminda were noted as important examples of how culturally grounded, community-controlled care can improve engagement and continuity. These programs support women to remain connected to care throughout pregnancy and the postnatal period.

Referral pathways and disengagement risk

Participants noted that current system design can inadvertently increase disengagement risk. For example, the need to refer patients to hospital-based services for BPG treatment —due to limited primary care access —introduces delays and burdens that may lead to disengagement from care. Strengthening the capacity of primary care and community settings to provide comprehensive antenatal care, including syphilis treatment, is therefore essential to keeping people connected with services.

Proposed actions	
SHORT-TERM	All jurisdictions to ensure that health service guidelines align with national antenatal syphilis testing recommendations. These changes should be communicated to staff and reflected in appropriate patient-facing resources.
SHORT-TERM	Identify and address gaps in antenatal syphilis management, care and data, including for infants born to pregnant people diagnosed with syphilis.
LONG-TERM	Expand and sustain investment in culturally safe, community-led models of antenatal care, including Birthing on Country programs and ACCHO-led models, to reduce structural barriers to engagement for priority populations.
LONG-TERM	Invest in health promotion activities targeted at priority populations —including Aboriginal and Torres Strait Islander people, women of reproductive age, and people experiencing DFV, homelessness or AOD use —to raise awareness of the importance of early and continuous antenatal care and syphilis testing.
LONG-TERM	Work with professional colleges and accrediting bodies —including those representing obstetricians, midwives, paediatricians and GPs —to embed standardised congenital syphilis protocols in professional training and continuing education.

Perinatal care: neonatal and postnatal considerations

Roundtable discussions surfaced a range of issues specifically relating to perinatal care —spanning the antenatal, neonatal and postnatal periods. These are presented in a dedicated section given their clinical and operational specificity and the need for coordinated,

multidisciplinary responses across maternity, neonatal and community health services.

Neonatal management

The need for clear and consistent Neonatal Management Plans for all individuals who test positive for syphilis during pregnancy was raised as a critical gap. Participants stated that standardised neonatal planning is essential to support timely clinical decision-making and ensure coordinated care across antenatal, maternity, neonatal and community health services.

Without such plans, there is a risk of fragmented care, delayed diagnosis of congenital syphilis in newborns, and missed opportunities for treatment. Paediatric Infectious Diseases specialists and neonatologists were noted as key partners in developing and implementing standardised neonatal management protocols.

Cascade of care for infants

Significant data gaps exist in relation to the testing and care received by infants born to people with syphilis. Expanding cascade of care work to capture this population is essential to understanding the full burden of congenital syphilis and identifying where system improvements are needed.

Proposed actions	
SHORT-TERM	Develop and implement clear, standardised Neonatal Management Plans for all pregnant people diagnosed with syphilis, to ensure coordinated care across antenatal, maternity, neonatal and community health services.
SHORT-TERM	Expand cascade of care surveillance to capture testing, treatment and outcomes for infants born to people with syphilis, to inform targeted system improvement.

Normalise and expand testing everywhere

Mechanisms to support a 'no wrong door' approach continue to be identified as opportunities to normalise and expand syphilis testing. The implementation of opportunistic syphilis testing protocols across priority settings —including emergency departments, urgent care clinics, alcohol and other drug services and correctional settings —was identified as a key priority in the response to syphilis.

An impactful keynote delivered by Dr Dawn Casey PSM, CEO of NACCHO, highlighted the disproportionate impact of syphilis on Aboriginal and Torres Strait Islander people. The keynote emphasised the leadership of the ACCHO sector in responding to the syphilis outbreak, including through initiatives such as the Enhanced Syphilis Response (ESR)/BBVSTI Program and community-led models of care, which have been conclusively proven to be effective. Dr Casey underscored the importance of collective responsibility and partnership, noting that effective outbreak response requires coordinated action across all parts of the health system.

Quote	"We [the ACCHO sector] know we can't do it alone, and nor should other primary health care services, have to fight the outbreak alone."

—Dr Dawn Casey PSM, CEO of NACCHO

Proposed actions	
SHORT-TERM	All jurisdictions to ensure that health service guidelines align with national syphilis testing recommendations. These changes should be communicated to staff and reflected in appropriate patient resources.
SHORT-TERM	All jurisdictions to implement and support opportunistic syphilis testing protocols across priority settings, including emergency departments, urgent care clinics, alcohol and other drug services and correctional settings.
SHORT-TERM	Investigate the opportunity to implement reflex syphilis testing on all genital ulcer swabs to reduce missed diagnostic opportunities.
SHORT-TERM	Include syphilis testing within established point-of-care and BBVSTI testing initiatives, with a focus on primary care and correctional settings (e.g. HIV, Hepatitis C, respiratory testing programs).
LONG-TERM	Commit to ongoing investment in innovative diagnostics and test and treat services and programs to support expanded and sustained testing.
LONG-TERM	Expand health promotion activities to normalise syphilis testing across priority settings and community contexts.

Strengthen workforce capacity

Participants reported that workforce challenges have remained largely consistent across services and settings since the first roundtable held in 2024. Ongoing issues were raised in relation to workforce stability, recruitment and retention, and sustained pressures on capacity. Despite the declaration of the CDINS, participants noted that workforce constraints continue to affect service delivery and limit the ability of services to respond flexibly and at a pace that meets emerging and evolving needs.

A core theme that emerged was the need to expand scope of practice across roles to enable health professionals to work to their full scope. Participants emphasised the importance of supporting upskilling opportunities, alongside enabling reforms such as changes to legislation, Medicare Benefits Schedule arrangements and provider numbers, and organisational policies. Ensuring clinicians can safely and effectively work to their full scope within appropriate governance frameworks was seen as critical.

The importance of working within multidisciplinary teams was evident, with participants highlighting the value of Aboriginal and Torres Strait Islander Health Worker and Health Practitioner-led models of care. These models were seen as central to improving cultural safety, strengthening community trust and engagement, and improving outcomes for Aboriginal and Torres Strait Islander people.

Healthcare worker awareness of the syphilis outbreak was also identified as a priority, noting that many clinicians across a range of settings remain unaware of the current outbreak, updated testing guidelines and the declaration of the CDINS.

Roundtable participants also discussed opportunities presented through engagement with professional societies and accrediting bodies. Collaborations between professional colleges to enable resource sharing and partnership activities were identified as an opportunity to raise awareness amongst diverse healthcare providers. A collaboration with Australian Health Practitioner Regulation Agency (AHPRA) to implement a short, mandatory CDINS-focused education module integrated into annual practitioner registration requirements for all health professionals was also discussed.

Proposed actions	
SHORT-TERM	Continue to explore opportunities to expand STI testing capability to a broader primary care workforce, including through scope-of-practice reforms and enabling legislative and policy changes.
SHORT-TERM	Explore opportunities to build partnerships with professional colleges and accrediting bodies to raise awareness of syphilis and embed STI/BBV content in professional training and continuing education (pre- and post-vocational).
LONG-TERM	Work with AHPRA to develop and integrate a mandatory CDINS-focused education module into annual practitioner registration requirements for relevant health professionals.`
LONG-TERM	Sustain investment in Aboriginal and Torres Strait Islander Health Worker and Health Practitioner-led models of care as a critical component of the long-term syphilis response workforce strategy.

Strengthen Australia's data and surveillance infrastructure

Participants reinforced the urgent need for improved data and surveillance systems to underpin the syphilis response, with a shared view that current evidence is inadequate to consistently identify gaps across the testing and care continuum. There was a strong emphasis on the need to better understand who is missing out on testing and care, and why, particularly across priority populations.

Conversations throughout the day highlighted the need for clear, routinely monitored syphilis data collection. Key data points identified as requiring strengthened monitoring included:

- syphilis testing coverage among women aged 15–44 years
- timing and number of tests, and guideline-based retesting rates
- data disaggregated by key priority groups, including Aboriginal and Torres Strait Islander people

Significant limitations were noted in existing datasets, including the inability to distinguish between the number of tests and the number of individuals tested (due to de-identification), and gaps in testing positivity data —particularly from private pathology. These gaps were seen as limiting targeted action and system improvement. Engaging both public and private pathology providers to enable more effective and timely data sharing was identified as an important step.

Recent progress in the inclusion of an antenatal syphilis testing data item within the National Perinatal Data Collection (NPDC) was welcomed. However, it was also acknowledged that this data item is currently being scoped for inclusion in the Perinatal National Best Endeavours Data Set , and that transitioning it to core, mandatory reporting should be a priority action following the piloting phase.

There was strong agreement that rapid action is required to improve Aboriginal and Torres Strait Islander identification in pathology datasets, recognising that this is a longstanding and unresolved priority. Strengthened Indigenous identification was seen as critical not only for the syphilis response, but for supporting progress towards equity and Closing the Gap across all communicable diseases.

Quote	"There is a need for stronger data and evidence, and to better understand where the gaps in our evidence base are."

—Zoe Wainer, Director-General of the Australian Centre for Disease Control

Proposed actions	
SHORT-TERM	Strengthen national monitoring and accountability of antenatal syphilis testing, including through the NPDC.
SHORT-TERM	Investigate the inclusion of Aboriginal and Torres Strait Islander identification status in all BBV and STI pathology request forms and datasets, to develop a feasible plan for implementation across public and private laboratories.
SHORT-TERM	Engage the Public Health Laboratory Network to develop a coordinated approach to working with public and private pathology providers to enable effective and timely data sharing, improving the quality and completeness of syphilis surveillance data.
LONG-TERM	Transition the antenatal syphilis testing data item from best-endeavours to mandatory reporting within the NPDC, following the piloting phase, to ensure consistent national data on antenatal syphilis testing coverage.

Strengthen Australia's medicines supply system

Recurrent shortages of BPG were raised as a core barrier to an effective syphilis outbreak response in Australia. This issue was seen as particularly critical given that BPG is the only recommended treatment for syphilis during pregnancy and breastfeeding. Ongoing supply disruptions were described as undermining timely treatment and clinician confidence.

A case study presented at the roundtable illustrated the devastating impact of receiving alternate, non-first-line therapies, serving as a powerful reminder of the real-world consequences of BPG supply instability on morbidity and mortality in Australia.

Challenges related to differing supply arrangements across healthcare settings were raised. Current PBS and doctors' bag arrangements were noted to limit access to BPG in private

general practice, creating barriers for GPs to initiate treatment in community settings. In contrast, hospital-based services were reported to have more consistent access and support, at times making referral to secondary care a more feasible option than treatment in primary care. Reliance on such referral pathways was described as introducing additional barriers for patients, including delays to treatment, increased burden associated with travel and a risk of disengagement from care.

Insights provided by the Therapeutic Goods Administration (TGA) indicated that existing forecasting approaches may no longer accurately reflect true demand for BPG. Prolonged and recurrent shortages over the past decade mean historical usage data may be significantly underestimating need, highlighting the importance of updated forecasting methodologies to support a more stable medicines supply system.

Proposed actions	
SHORT-TERM	Explore opportunities to strengthen the supply of BPG, including communication around the use of 19A products and proactive inventory management by health services.
SHORT-TERM	Establish six-monthly reporting on BPG demand and usage to the TGA to support improved demand forecasting and supply planning.
LONG-TERM	Advocate for additional PBS-listed products to improve BPG access across healthcare settings, including private general practice.

National communication and stigma reduction strategy

There was broad support for targeted, national mass-media public health campaigns to raise community awareness of syphilis, normalise and promote testing, and reduce stigma. The recent National Lung Cancer Screening campaign was cited as a positive example of what can be achieved through coordinated national messaging.

In addition, locally delivered, smaller-scale campaigns and community-based events were seen as important complements, particularly in improving reach to people who may not be regularly engaged with healthcare services.

A consistent view was that messaging should be tailored and culturally appropriate, with a clear focus on priority populations. This was noted to include:

- Aboriginal and Torres Strait Islander people
- women of reproductive age
- fathers-to-be
- young men
- people from CALD backgrounds.

Proposed actions	
SHORT-TERM	Review evaluations of existing national marketing campaigns (e.g. Beforeplay, ASHM Health workforce campaigns) to identify communication gaps, including awareness of CDINS.
LONG-TERM	Utilise evaluation findings to design a national marketing and communication strategy that addresses identified gaps and supports sustained community awareness of syphilis.

Conclusion and next steps

The Second National Congenital Syphilis Roundtable reaffirmed that Australia possesses the knowledge, the clinical tools, and the community leadership needed to eliminate congenital syphilis —however translating this potential into outcomes requires a step-change in the pace, coordination, and accountability of the national response. The CDINS declaration provides both the mandate and the urgency for action.

The Roundtable surfaced persistent, well-documented barriers that have not yet been sufficiently resolved: inconsistent adoption of updated testing guidelines at the facility level; recurrent shortages of BPG that undermine clinician confidence and timely treatment; inadequate data and surveillance systems that obscure where the most critical gaps lie; workforce constraints that limit the ability of services to respond at pace; and the ongoing underinvestment in the culturally safe, community-controlled models of care that have proven most effective in reaching priority populations. These are not new problems —they are systemic failures that require systemic solutions.

The actions outlined in this report span eight priority domains —governance, antenatal care access, perinatal and neonatal care, testing, workforce capacity, data and surveillance, medicines supply, and communications These actions should be formally considered in the 2026 review and update of the Plan, and NACCHO and ASHM Health strongly emphasise that the updated Plan must include defined responsible parties, clear timeframes, and robust accountability mechanisms to ensure implementation progress can be meaningfully tracked.

A central and recurring message throughout the Roundtable was the indispensable role of the ACCHO sector and Aboriginal and Torres Strait Islander Health Workers and Health Practitioners in driving an effective, culturally grounded response. As Dr Dawn Casey PSM, CEO of NACCHO, made clear, the ACCHO sector cannot do this alone —and nor should any part of the health system be expected to. The response requires genuine, sustained partnership across governments, peak bodies, professional colleges, community organisations, and frontline services. Collective responsibility is not a platitude in this context; it is a clinical and public health imperative.

NACCHO and ASHM Health are committed to continued advocacy on behalf of the communities most affected by congenital syphilis, and to supporting the implementation of the actions agreed at this roundtable. In recognition of the ongoing need for monitoring and momentum, participants called for a third national congenital syphilis roundtable to be

convened in approximately 12–18 months. This forum will provide a critical opportunity to review progress against recommendations, identify emerging gaps, and sustain the collaborative impetus that has been built across two national roundtables.

NACCHO and ASHM Health thank all participants who attended and contributed to the Roundtable, and acknowledge the generous support of the Australian Centre for Disease Control and the Australian Government Department of Health, Disability and Ageing. The expertise, candour, and commitment demonstrated by attendees—representing more than 50 organisations from across the country—is a testament to the depth of Australia's congenital syphilis response community and the collective determination to protect the lives of women, newborns and their families.

The current CDINS declaration underscores the urgency for action. Agreed priorities must be translated into timely and effective implementation activities. Eliminating congenital syphilis in Australia is achievable—but requires sustained, coordinated effort across all sectors.

Appendices

Appendix 1: Program

08:30	**Coffee and registration**	
09:00	Welcome	Jessica Michaels
09:05	Welcome to Country	Michael West
09:15	**Introduction and setting the scene**	Dr Nathan Ryder
Session theme: Leveraging success: tools and strategies for the future		
09:30	**Keynote address:** The experience and successes of the Aboriginal Community Controlled Health sector before and after the CDINS declaration	Dr Dawn Casey
09:45	**Keynote address:** What's next now that the CDINS has been declared?	Prof Michael Kidd
10:00	**Keynote address:** The role of the CDC in the syphilis response	Prof Zoe Wainer
10:15	**Case study 1:** Success in the response to date: WA Health CQI approach	Prof Donna Mak, Dr Caitlyn White, Ms Kim Gates & Dr Daniel Hunt
10:30	**Case study 2:** Success in the response to date: NT Incident Management Team	Dr Kelly Hosking, Dr John Boffa & Sinon Cooney
10:45	**Group discussion:** Reflections from the case studies	Dr Nathan Ryder and all
11:05	**Morning tea**	
Session theme: Overcoming barriers to best practice		
11:20	**Impact of BPG shortages**: The impact on communities and the workforce	Dr Kelly Hosking
11:35	**Short, medium- and long-term solutions to BPG shortages**: What levers do we have for change?	Dr Tahli Fenner & Dr Marwa Ahmed
11:50	**Testing data:** What do we have, and what do we need?	Dr Skye McGregor
12:10	**Group discussion**: What data gaps are delaying our progress?	Dr Skye McGregor and all
12:30	**Lunch**	

Session theme: Improving access to testing and care for diverse communities		
13:15	**Panel session:** Models of Care and lessons learnt – Facilitated by Dr Megan Campbell Sinon Cooney – Improving access to culturally safe care for Aboriginal and Torres Strait Islander People Rhiannon Villiers – Syphilis prevention, testing and care in Homeless Health Care Melanie Briggs – Delivering Culturally Safe Antenatal Care Dr John Boffa – Models of care for Medicare-ineligible&partners Nicole Christy – Prioritising syphilis prevention, testing and care in alcohol and other drug services Dr Sara Whitburn – Ensuring syphilis testing and care in Primary Care	
14:15	**Table discussion:** What do we need to do to improve access to testing and care for diverse communities?	Dr Megan Campbell
Session theme: Enabled environments and intersectoral collaboration		
14:45	**The role and impact of the sexual health workforce in ACCHOs:** Reflecting on successes and challenges	Dr Megan Campbell
15:00	**Unlocking impact:** Enabling nursing and midwifery scope of practice reform	Prof Alison McMillan
15:15	**Panel session:** Success and opportunities to support a diverse workforce - Facilitated by Jessica Michaels Dr Lousie Owen – RACP Dr Sara Whitburn – RACGP Prof Cath Chamberlain – CATSINaM Dr Stephen Gourley – ACEM Dr Irene Kourtis – ASID Dr Stephanie Bond – RANZCOG	
16:00	**Group discussion:** What actions must be prioritised to support the workforce?	Jessica Michaels
16:15	**Afternoon tea**	
16:30	**Wrap up**	

Appendix 2: List of attendees

Name	Role	Organisation
Stephen Gourley	Immediate Past President	ACEM
Kelley Lennon	Chief Midwife	ACoM
Shawn Clackett	Director	ACT Health
Kath Keenan	Public Health Medical Officer	AH&MRC
Katina D'Onise	Senior Public Health Medical Officer	AHCSA
Bianca Mark	Manager, STI and BBV Program	AHCSA
Kim Gates	Executive Manager, Health & Wellbeing	AHCWA
Caitlyn White	Public Health Medical Officer	AHCWA
Kelly Kildea	Senior Policy Adviser	AIDA
Miranda Cumpston	Guidelines Program Manager	ALEC, Monash
Barbara Molanus	Sexual Health Coordinator	AMSANT
Alice Kett	Strategic Lead	ANMF Federal
Martyn Kirk	Leader, Department of Applied Epidemiology	ANU
Cherie Bennett	Nursing Policy and Advocacy Lead	ASHM
Alexandra Lipa	Senior Project Officer	ASHM
Sarah Maunsell	Sexual Health Program Manager	ASHM
Molly Stannard	Project Manager	ASHM
Jessica Michaels	Deputy Chief Executive Officer	ASHM
Candice Holland	Member, Board of Directors	ASID
Irene Kourtis	Chief Executive Officer	ASID
Allannah Munro	Primary Health Care Manager	ATSICHS
Seba Bourne	Aboriginal and Torres Strait Islander Health Worker	ATSICHS Mackay
Zoe Wainer	Director-General	Australian CDC
Mandy Charlton	Director of STI Section	Australian CDC
Clare Bradshaw	Program And Policy Officer	Australian CDC
Lachlan Bannister	Data Analysis and Policy Officer	Australian CDC
Stephanie Williams	Assistant Director-General	Australian CDC
Olivia Tierney	Senior Midwifery Advisor to CNMO	Australian DoHDA

Name	Role	Organisation
Caleb Hardy	EA to Chief Medical Officer	Australian DoHDA
Michael Kidd	Chief Health Officer	Australian DoHDA
Alison McMillan	Chief Nurse & Midwifery Officer	Australian DoHDA
Melinda Turner	First Assistant Secretary of First Nations Health Division	Australian DoHDA
Tahli Fenner	Assistant Secretary	Australian DoHDA
Jason Asselin	Head, Surveillance & Data Linkage	Burnet Institute
Daniel Hunt	Chair	BVSTIAC
John Boffa	Acting Chief Executive Officer	CAAC
Catherine Chamberlain	Chief Midwifery Officer	CATSINaM
Stephanie Bond	Gynaecologist, Sexual Health Physician	DOH Victoria
Elizabeth Birbilis	A/Manager BBV/STI	DOH Victoria
Louise Owen	Director, VIC Statewide Sexual Health Service	DOH Victoria
Mihaela Ivan	A/Deputy Chief Health Officer Communicable Diseases	DOH Victoria
Rhiannon Villiers	Registered Nurse	Homeless Healthcare
Sinon Cooney	Chief Executive Officer	Katherine West Health Board Aboriginal Corporation
Nicole Christie	Nurse Unit Manager	Kirketon Road Centre
Karl Briscoe	Chief Executive Officer	NAATSIWHP
Dawn Casey	Chief Executive Officer	NACCHO
Megan Campbell	Medical Advisor	NACCHO
Monica Kempster	Director, Sexual Health and BBVs	NACCHO
Kate Alexander	National Coordinator, ESR Program	NACCHO
Bianca Prain	Director, Public Health Programs	NSW Health
Christine Selvey	Medical Epidemiologist	NSW Health
Kelly Hosking	Director, Sexual Health and Blood Borne Viruses	NT Health
Vicki Krause	Director, CDC	NT Health
Manoji Gunathilake	Head, Sexual Health and BBV Unit	NT Health
Timothy Ford	Paediatric Infectious Diseases Specialist	Perth Children's Hospital

Name	Role	Organisation
Melinda Hassall	Advanced Public Health Officer, CDB	Qld Health
Elena McLeish	CNC, QSSS	Qld Health
Annie Preston-Thomas	Public Health Medical Officer, Cairns PHU	Qld Health
Sara Whitburn	Chair, Sexual and Reproductive Health Special Interest Group	RACGP
Tom Rees	Manager, STI and BBV Section	SA Health
Mish Pony	Chief Executive Officer	Scarlet Alliance, Australian Sex Workers Association
Daile Kelleher	Chief Executive Officer	Sexual and Reproductive Health Australia
Adam Bartlett	Staff Specialist	Sydney Children's Hospital
Karin English	Senior Medical Advisor	Tasmanian DOH
Marwa Ahmed	Assistant Director	TGA
Skye McGregor	Epidemiologist	The Kirby Institute
Rebecca Guy	Head, Surveillance Evaluation and Research Program	The Kirby Institute
Belinda Hengel	Research Fellow	The Kirby Institute
James Ward	Director	UQ Poche Centre for Indigenous Health
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