

Box 1: Interview questions related to use of a centralised system for STI contact tracing.

| Question prompt |
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| <p>A National Investigation and Tracing Centre has been set up for COVID-19 that supports public health units to do contact tracing.</p> <ul style="list-style-type: none">• Do you think it would be useful to have a centralised workforce like this to help with STI partner notification?• What do you think would be good about a centralised service for partner notification and what problems or risks do you think there might be?• What are your thoughts about the logistics of passing people's contact details and diagnoses to another service while maintaining trust and confidentiality?• What do you think the key considerations are for a centralised service to work well for Māori, Pacific peoples and gay and bisexual men? |

Table 1: Characteristics of participants interviewed as key informants (n=12).

| Characteristics | n |
|--|---|
| Region of residence | |
| Auckland | 4 |
| Rural North Island | 1 |
| Wellington | 6 |
| Christchurch | 1 |
| Role | |
| Sexual health physician (SHDr) | 2 |
| Sexual health nurse, nurse specialist (SN) | 3 |
| General practitioner/public health physician (GP/PH) | 2 |
| Manager (M) ^a | 3 |
| Public health researcher (PHR) | 2 |
| Population expertise ^b | |
| Sexual health service attendees | 5 |
| Primary care patients ^c | 2 |
| Māori | 3 |
| Pasifika | 1 |
| Men who have sex with men (MSM) | 4 |
| People with or at risk of HIV | 3 |

^a Managers included people working in sexual health, HIV and contact tracing

^b Some people are included in more than one category

^c Primary care: inclusive of family planning

Table 2: Theme 1: potential benefits of a centralised STI contact tracing system.

| Potential benefits | Illustrative quotes |
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| <p><i>Efficiency, consistency and clarity:</i> Participants suggested that a centralised system would provide a systematic approach with adoption of standard national guidelines and would save clinics from establishing and staffing individual systems. A national free phone number for patient queries that is always staffed would be beneficial.</p> | <p><i>Guidelines around how it's done, what can be done, what can't be done, to make sure that patient confidentiality and privacy is maintained. It can be a bit of a minefield, you know, to go down and we're not all setting up our own individual training. So there's one standardised system for the whole country. (M2)</i></p> |
| <p><i>Specialised training:</i> Currently, clinicians receive very little or no training in contact tracing and the legal and practical boundaries are not always clear.</p> | <p><i>It could have advantages, because you're kind of sharing the same workforce. Specialised, specially trained people doing it. (SN2)</i></p> |
| <p><i>Improve capacity of clinical services:</i> A national service would require less clinician time and relieve pressure on already stretched sexual and public health services.</p> | <p><i>The challenge is nobody has the capacity to do it. GPs don't. I understand in most regions the PHUs don't even see it as part of their work to do STI contact tracing. (M3)</i></p> |
| <p><i>Trust and acceptability:</i> Public awareness of the national model used for COVID-19 contact tracing may facilitate acceptance and trust of a national STI contact tracing system.</p> | <p><i>I mean, the whole nation has got experience of the contact tracing network for COVID ... maybe they would have more trust in such a system now from the experience from COVID. (M2)</i></p> |
| <p><i>Anonymity:</i> Some people prefer that a contact tracer does not know them personally.</p> | <p><i>No relationship is actually very beneficial because you're not known to the family ... we've learned that some people don't want to be linked back to their GP. (M1)</i></p> |
| <p><i>Mobile populations:</i> A national approach could provide services for highly mobile populations more effectively than a local approach.</p> | <p><i>I think the other limitation is, each DHB [District Health Board] has their own contact tracing system and so there's no national reference point of, you know, like people are, particularly among MSM, sexual contacts are quite mobile. (M3)</i></p> |
| <p><i>Potential to provide a national picture of transmission networks:</i> Ability to collate and analyse national-level data would facilitate timely auditing and improvements.</p> | <p><i>We need to get a clearer picture of what's happening and how successful different strategies are and how we can improve those strategies and kind of improve contact tracing. (SN2)</i></p> |

Table 3: Theme 2: concerns and considerations for a centralised STI contact tracing system.

| Concerns and considerations | Illustrative quotes |
|--|---|
| <p><i>Lack of trust, privacy and confidentiality concerns:</i> Suspicion from both patients and clinicians about third-party involvement and possible privacy breaches. This could be mitigated by providing explanation of the privacy and confidentiality arrangements and raising public awareness to build confidence in a national service.</p> | <p><i>There's a kind of trust model between the provider and the person. So I would see a potential barrier if it was central, you've then got a hand over. (SHDr1)</i></p> <p><i>We've [the NITC] also had a number of incidents where the trust has been so high that families have contacted us voluntarily to say things are not quite as they should. (M1)</i></p> |
| <p><i>Appropriate training and skills:</i> It is critical that staff employed as contact tracers are appropriately trained, have good communication skills and understand and respect the communities they are interacting with.</p> | <p><i>Having someone that both is skilled enough to know what's required to be done, but to be done in a way that is going to support the mana and hold the integrity of that person up ... you're not going to learn that from a book, you're going to learn it from knowing the community. (GP/PH2)</i></p> |
| <p><i>Immediacy:</i> The pathway and time required to link with an external provider for contact tracing may not always be appropriate. Some circumstances require swift intervention.</p> | <p><i>A pregnant woman who turned up in hospital ready to give birth who's had no antenatal care, and they have got syphilis. That needs to be dealt with there and then—you wouldn't want to be passing that on to a contact tracing team. It needs to be done immediately. (SN1)</i></p> |
| <p><i>Continuity of care and links with local services:</i> A national service might not have local knowledge and relationships that allow cases to be linked to services in a timely way. Potential suspicion of an unknown provider may decrease engagement.</p> | <p><i>There's no real connection to the community. And, if I will be diagnosed here, for example, and then someone calls me from a random call centre, following up on my contacts, it might not go down so well. (SN2)</i></p> |
| <p><i>Sensitivity and stigma around STIs:</i> Individual and societal attitudes towards COVID-19 are quite different to STIs. Normalising and destigmatising STIs is crucial.</p> | <p><i>It's way more sensitive than COVID-19 as a breaking bad news thing because of the implications of what that news means and the stigma associated with it. (GP/PH2)</i></p> |
| <p><i>Cultural safety and considerations for priority populations:</i> It is critical that the social and cultural norms of Māori, Pasifika and GBM are understood and met.</p> | <p>Addressed in theme 3.</p> |