



Curtin University



# HIV AND MOBILITY IN AUSTRALIA: ROAD MAP FOR ACTION



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# Glossary

AAC	AIDS Action Council
AB-DGN	African and Black Diaspora Global Network
ACLAF	African Communities Leaders Advisory Forum
ACON	AIDS Council of New South Wales
AFAO	Australian Federation of AIDS Organisations
AIVL	Australian Injecting and Illicit Drug Users' League
ARCSHS	Australian Research Centre for Sex, Health and Society
ASHM	Australasian Society of HIV Medicine
ATRAS	Australian HIV Observational Database Temporary Residents Access Study
BRICS countries	Brazil, Russia, India, China and South Africa
CaLD	Culturally and linguistically diverse
CEH	Centre for Culture, Ethnicity and Health
CHOGM	Commonwealth Heads of Government Meeting
CW Government	Commonwealth Government
ECCQ	Ethnic Communities Council of Queensland
FASSTT	Forum of Australian Services for Survivors of Torture and Trauma
FP NSW	Family Planning NSW
GARP	Global AIDS Response Progress (formerly known as UNGASS)
ICASO	International Council of AIDS Service Organizations
ILO	International Labour Organization
IOM	International Organization for Migration
KWP	The Knowledge, The Will and The Power
LASS	Leicestershire AIDS Support Services
MACBBVS	Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections
MHSS	Multicultural Health and Support Service
MMRC	Metropolitan Migrant Resource Centre
MSHN	Multicultural Sexual Health Network
NAPWHA	National Association of People with HIV Australia
OECD	Organisation for Economic Cooperation and Development
PaKoMi Project	(Pa = Participation, Ko = Cooperation and Mi = HIV prevention in migrants) Project
PEACE	Personal Education and Community Empowerment (Relationships Australia SA)
PEPFAR	President's Emergency Plan for AIDS Relief
PLG	Parliamentary Liaison Group
RHeaNA	The Refugee Health Network of Australia
SiREN	Sexual Health and Blood-Borne Virus Applied Research and Evaluation Network
SHBBVP	Sexual Health and Blood-borne Virus Program
SWOP	Sex Workers Outreach Program
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Project
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations Refugee Agency
UNICEF	United Nations Children's Fund
WA	Western Australia
WAAC	Western Australian AIDS Council
WACHPR	Western Australian Centre for Health Promotion Research
WHO	World Health Organisation

# Other Acronyms

ACT	Australian Capital Territory
AIDS	Acquired Immune Deficiency Syndrome
ASAP	As soon as possible
ART	Antiretroviral treatment
BBV	Blood borne virus
DIDO	Drive-in drive-out
FIFO	Fly-in fly-out
GDP	Gross domestic product
GMSM	Gay and other men who have sex with men
GNI	Gross national income
HIV	Human Immunodeficiency Virus
ICT	Information communication technology
IDU	Injecting drug use
LGBTI	Lesbian, gay, bisexual, transgender and intersex
NGO	Non-government organisation
NSW	New South Wales
NSEP	Needle and Syringe Exchange Program
NT	Northern Territory
PLHIV	People living with HIV
PWID	People who inject drugs
Qld	Queensland
SA	South Australia
STI	Sexually transmitted infection
US	United States
WA	Western Australia

# Definitions

CD4	A type of white blood cell that protects the body from infection(s). <sup>1</sup>
Concentrated epidemic	The HIV prevalence rate is <1% in the general population, but >5% in at least one high-risk subpopulation, such as GSM, PWID, sex workers or the clients of sex workers. <sup>4</sup>
Contain and control	Traditional approach to public health and disease outbreak.
Diaspora; African and Black Diaspora	Populations outside their country of origin usually sustaining ties and developing links both with that country of origin and across countries of settlement/residence. <sup>2</sup> The African and Black Diaspora (ABD) are populations of Black Africans and their descendants who are dispersed through a mix of forced and willing migration and who may or may not maintain strong ties to their African origin. The ABD broadly encompasses populations of: recent migrants; second generation and multi-generational populations; refugee and asylum seekers; and mobile populations (e.g. temporary migrant workers).
Generalised epidemic	The HIV prevalence rate is >1% in the general population. <sup>4</sup>
Globalisation	'...the increasing economic and financial integration of economies around the world. It removes national boundaries from the financing, production, sale and distribution of goods and services and includes movement of technology, finance and labour.' <sup>3</sup>
Global South and Global North	The UN classifies the global North as having more developed regions, which includes Europe and Northern America, while the global South encompasses less developed regions including Africa, Latin America and the Caribbean, Asia (except Japan) and Oceania (except Australia and New Zealand). It is recognised this is just one way of conceptualising the process of development.
Low, middle and high income countries	Economies are divided according to the 2012 GNI per capita. The groups are: low income, \$1,035 or less; lower middle income, \$1,036 - \$4,085; upper middle income, \$4,086 - \$12,615; and high income, \$12,616 or more. <sup>4</sup>
Migrant	In this discussion paper the term 'migrant' refers to a person undergoing a semi-permanent or permanent change of residence which involves a change of his/her social, economic and/or cultural environment. <sup>2</sup> It includes individuals who migrate to Australia as 457 visa holders, migrant workers, international students, refugees and asylum seekers; but excludes travellers, tourists and business people. The UN defines migrant as an individual who has resided in a foreign country for more than one year irrespective of the causes, voluntary or involuntary, and the means, regular or irregular, used to migrate. <sup>4</sup>
Migration	A process of moving, either across an international border, or within a state which results in a temporary or (semi-) permanent change of residence. <sup>2</sup>
Mobile populations	People who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons. <sup>5</sup>
Mobility and movement	Human geographic mobility, which encompasses any kind of movement of people, regardless of length, composition and causes.
Multiculturalism	The cultural and ethnic diversity of Australia.
Priority populations/ populations at-risk of HIV	Examples of priority populations are GSM, sex workers, PWID, mobile populations and migrants.
Trans* people	Trans* is an abbreviation for transgender. Transgender is a term for people whose gender behaviour, expression or identity or behaviour is different from those typically associated with their assigned sex at birth. <sup>6</sup>
Treatment as prevention (TasP)	Used to describe HIV prevention methods that use antiretroviral therapy in PLHIV to decrease the chance of HIV transmission independent of CD4 cell count. <sup>7</sup>

“

*Uncertainty about how much the disease will spread – how soon and to whom remains the public discourse about AIDS. Will it, as it spreads around the world, remain restricted, largely, to marginal populations: to the so-called risk groups and then to large sections of the urban poor? Or will it become the classic pandemic affecting entire regions? Both views are in fact being held simultaneously.*

*Like the effects of industrial pollution and the new system of global financial markets, the AIDS crisis is evidence of a world in which nothing important is regional, local, limited; in which everything that can be circulated does, and every problem is, or destined to become, worldwide.....People circulate in greater numbers than before. And diseases.*

*From the untrammelled intercontinental air travel for leisure and business of the privileged to the unprecedented migrations of the underprivileged for villages to cities and legally and illegally from country to country – all this physical mobility and interconnectedness (with it consequent dissolving of old taboos, social and sexual) as is vital; to the maximum functioning of the advanced world...*

*But now that heightened modern interconnectedness in space, which is not only personal but social, structural, is the bearer of a health menace sometimes described as a threat to the species itself; and the fear of AIDS is of a piece with attention to other unfolding disasters that are the by-products of advanced society...AIDS is one of the dystopian harbingers of the global village, that future which is already here and always before us, which no one knows how to refuse.<sup>8</sup>*

”

**Susan Sontag ‘AIDS and its Metaphors’ (1988)**

# Executive Summary

In 1989, Australia became one of the first countries in the world to develop a formal strategy to address HIV/AIDS; many elements of the first strategy remain today. Australia adopted a human rights approach and prioritised mobilising affected communities, developing peer-based education, legal protection for people at-risk of and living with HIV, and a harm reduction approach regarding illicit drug use. As a result, Australia has avoided a generalised epidemic, with HIV transmission mainly concentrated amongst specific populations, gay and other men who have sex with men being the largest.

HIV diagnoses in Australia have been increasing among people travelling to and from high HIV prevalence countries. The Seventh National HIV Strategy (2014-2017) states people and their partners who travel to or from high HIV prevalence countries, as well as travellers and mobile workers as priority populations in Australia.

*The HIV and Mobility in Australia: Road Map for Action* discussion paper explores the links between HIV and mobility in Australia, in particular the increase in HIV diagnoses in the last five to ten years among people travelling to and from regions of high HIV prevalence. The paper is an outcome of the Western Australia (WA) HIV and Mobility Project. The project involved collaboration between the Western Australian Centre for Health Promotion Research (WACHPR) and the Australian Research Centre in Sex, Health and Society (ARCSHS), with support from the Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN).

The aims of the project were to:

- identify and review current programs and activities which have been implemented to respond to overseas-acquired HIV (in Australia and similar epidemics globally)
- develop a research and action agenda for priority populations to stimulate further discussion and support advocacy endeavours.

This discussion paper presents the findings of the project and proposes a 'road map for action' for HIV and mobility issues in Australia. While the project was initiated in response to the changing HIV epidemiology in WA, the proposed agenda for action is of national interest.

This paper has drawn on the published and grey literature<sup>A</sup>, and feedback collected from the sector<sup>B</sup> about HIV and mobility issues over the past twelve months, including the special sessions and meetings held at the 2013 Australasian HIV/AIDS Conference in Darwin and the 20th International AIDS Conference (AIDS 2014) in Melbourne.

<sup>A</sup> Grey literature is not formally published in sources such as books or journal articles and includes communications e.g. reports, discussion papers, government documents, theses, dissertations and conference proceedings.

<sup>B</sup> This discussion paper defines the sector as the sexual health and blood borne virus (BBV) sector.



## Consultation Process

The consultation process for the development of this paper offered a range of opportunities for stakeholder groups to provide feedback, as outlined below:

### 21–23 October 2013

2013 Australasian HIV/AIDS Conference – meeting convened with key stakeholders to discuss the scope of the WA HIV and Mobility Project and outputs of interest.

### 3 June 2014

Key stakeholders invited to provide feedback on an early draft of the discussion paper. Discussion paper revised for wider consultation.

### 18 July 2014

Draft discussion paper open for consultation, available through the SIREN website.

### 21–25 July 2014

Consultation promoted to AIDS 2014 delegates who expressed interest in issues associated with HIV and mobility and the discussion paper.

### 29 July 2014

Discussion paper presented at the 'HIV and Mobile Populations' seminar in Perth, WA and feedback encouraged from attendees.

### 21 August 2014

Consultation period extended and reminders sent to key stakeholders.

### 19 September 2014

Consultation period closed.

### 24 October 2014

Feedback incorporated and discussion paper finalised.

in some cases, and the associated lead-in times for advocacy and budgeting would need to be considered.

The categories and frameworks used to describe social groups of people, countries and epidemiological risk groups do not intend to amplify differences, minimise complexity or construct sets of mutually exclusive categories. A clear definition of mobility does not exist and the causal links between HIV and migration are also not well understood. Categories used in this paper offer only one means of presenting the concepts and issues relating to HIV and mobility, and to conceptualise populations at-risk, and risk behaviour in the context of developing a plan for action.

By proposing a series of interconnected strategies within each of these action areas, the road map is intended to support the move from rhetoric to action on HIV and mobility.

It is envisaged that the proposed road map will be discussed, considered and debated by stakeholders and affected communities and play a support role in guiding action within key areas of the National HIV Strategy. The associated implications for taking action need to be considered including advocacy required to secure CW and state government buy-in, and support for the implementation of priority actions, where appropriate.

Responses for mobile populations and HIV transmission require nuanced understanding of the dynamic nature of mobility and detailed understanding of the epidemiology of HIV and mobility. Sufficient resourcing from government, and mobilisation of peak bodies, community-based organisations and affected communities will be critical for effective implementation of responses. Population mobility will continue to affect characteristics of HIV epidemics globally. The development of harmonised interventions to prevent and manage HIV transmission within migrant and other mobile populations will progress Australia's goal of zero new infections by 2020, ensuring no one is left behind.

## PART 1. HIV and Mobility in Australia: Setting the Scene

Part One examines the historical context of HIV/AIDS, the links between HIV and people on the move, and the characteristics of HIV epidemiology related to mobility. Key concepts associated with globalisation, mobility and global health governance structures are presented. The paper also provides an overview of the HIV policies, frameworks, strategies and programs in Australia, and in countries with similar epidemics.

This paper intends to stimulate discussion and action amongst stakeholders with an interest in HIV and mobility issues. These include peak bodies, service providers, non-government organisations (NGOs), research centres, state and Commonwealth (CW) governments, and policymakers. It is expected the proposed areas for action and strategies will be considered by stakeholders and modifications made to the proposed 'road map for action'. CW government buy-in and support for these strategies will be necessary

## PART 2. HIV and Mobility in Australia: An Agenda for Action

Part Two presents a suggested a framework for action. The proposed road map for action was informed by:

- The Seventh National HIV Strategy (2014-2017)
- Frameworks and approaches successfully used in Australia
- Frameworks and approaches used with mobile populations and migrants in similar countries
- Relevant research from Australia and overseas
- Discussions with key stakeholders.

Ten principles were identified for developing a strategic approach to HIV management for mobile populations and migrants in Australia:

- Incorporate a human rights approach to reduce stigma and discrimination directed at mobile populations and migrants
- Reduce all barriers to testing and access to treatment
- Pay attention to the confluence between HIV and mobility
- Move beyond 'narrow protectionist policies'
- Commit resources to improve migrant health
- Continue to develop links and cooperative partnerships with affected communities locally and internationally
- Participate in and contribute to global health governance
- Create closer cooperation between Australia and the HIV policy, public health, treatment and support sectors in countries of origin and destination for Australian mobile populations and migrants
- Acknowledge that mobile population and migrants need more than information (even if it is translated).
- Know your epidemic(s)—continue surveillance and monitoring and develop evaluation strategies in conjunction with migrant populations.

These 10 principles are reflected in five key areas for action, linked to the priorities outlined in the Seventh National HIV Strategy (2014-2017). The road map proposes specific strategies to address each action area including primary responsibilities and timeframes.

# 1. International Leadership and Global Health Governance

### Overall Goals:

- Ensure Australia's population health response to HIV and mobile populations is contemporary and appropriate through participating in and contributing to international dialogue on cross border HIV responses
- The CW Government provides policy leadership to minimise rates of HIV as a result of mobility in the Pacific region and to ensure that Australian policies are consistent with this outcome
- The CW Government ensures that HIV and other health impacts are taken into consideration in non-health related international policy deliberations.

# 2. Commonwealth and State Leadership

### Overall Goals:

- The Australian HIV response enables an effective response to migrants and mobile populations that experience increased vulnerability to HIV acquisition or transmission, within a human rights framework
- The CW and state governments show strong leadership in relation to building overall community support and consensus to prioritisation of health services related to mobile populations and migrants
- The CW and state governments provide appropriate funding levels and resources
- There are coherent legal and policy responses to mobile populations and migration.



## 3. Community Mobilisation

### Overall Goals:

- Improve mobile population and migrant community awareness, health literacy, knowledge, attitudes and risk reduction behaviours around HIV in the context of living in Australia
- Develop partnerships between migrant groups, other community groups and the HIV sector to advocate for change and improvements in health and other service delivery
- Encourage leadership and peer advocacy within migrant and mobile populations and increase participation in the HIV response
- Encourage community consultation and empowerment through creative, flexible and ongoing engagement
- Develop social capital and resilience in migrant communities and mobile populations.

## 4. Development of Services for Mobile or Migrant Populations

### Overall Goals:

- Maximise the physical, psychological, sexual and social health and well-being of migrants and other mobile people living with HIV through the provision of high quality, tailored, clinical services
- Increase the uptake of sexual health testing, treatment, sexual health education and referral amongst migrants and mobile populations with an emphasis on early detection and treatment
- Increase the health literacy of migrants and mobile populations
- Improve the capacity for migrants and other mobile populations in maintaining risk reduction strategies
- Decrease discriminative attitudes to migrants and other mobile people with HIV
- Understand cultural, structural impacts of services on mobile populations and migrants.

## 5. Research, Surveillance and Evaluation

### Overall Goals:

- Provide high quality information to inform the strategic and policy response to mobile populations and migrants including:
  - Standardised surveillance for sub populations
  - Enhanced surveillance of where infections occur
  - Risk analysis for different groups
  - Cost benefit analysis of interventions and universal access to treatment
  - Evaluation of interventions for migrants and mobile populations
  - Evaluation of HIV screening for asylum seekers policy
  - Social research on migrant healthcare seeking behaviours, HIV knowledge and attitudes, and experiences of migrants living with HIV
  - Phylogenetic analysis of HIV transmission
  - Analysis of barriers to uptake, maintenance and effectiveness of treatment
  - Role and feasibility of treatment as prevention in migrant populations
  - Migration and HIV prevalence studies
  - Analysis of discrimination and stigma of migrants
  - Investigation of impacts of legislation on migrant health and access to HIV treatment.

# Part 1.

## HIV and Mobility in Australia: Setting the Scene



# A Changing Landscape

**As the HIV pandemic surely should have taught us, in the context of infectious diseases, there is nowhere in the world from which we are remote and no one from whom we are disconnected.<sup>9</sup>**

**IOM 'Emerging Infections' (1992)**

After crossing species, the Human Immunodeficiency Virus (HIV) originally progressed slowly until the 1970s when in many countries it took a foothold,<sup>10</sup> more efficiently transmitted between human hosts. This was due to factors including urbanisation and mass mobility brought about by globalisation.<sup>1, 11</sup>

The initial epidemic was simultaneously

recognised in different populations of gay and other men who have sex with men (GMSM) in the US and Europe, and the heterosexual population in Haiti. This was believed to have facilitated HIV transmission between the African epidemic and the US epidemic.<sup>1, 10, 11</sup> Sex between men in Haiti may also have been a factor in spreading the virus.<sup>1</sup>

When the HIV/AIDS (Acquired Immune Deficiency Syndrome) epidemic was recognised in Australia, many early cases were predominantly amongst GSMs who acquired HIV during trips abroad to areas of high HIV prevalence in the US and Europe, or who had sexual contact with visiting travellers and tourists in Australia.<sup>1</sup> A small number of heterosexual men and women acquired HIV in regions where generalised transmission was dominant, such as South East Asia and sub Saharan Africa, through sexual contact and injecting drug use (IDU).<sup>12</sup>

As the HIV epidemic grew in Australia, it continued to affect homosexually active men. There was a fear that the epidemic could spread into the 'broader community' via 'bridge' populations such as bisexual men, people who inject drugs (PWID) and sex workers.<sup>13</sup> However this was not the case. Highly successful, community-based programs were developed and implemented within priority groups including the so-called 'bridge' populations.<sup>13</sup> As the epidemic matured, 'risk behaviours' and 'risk environments and contexts' were added to the discourse including how these could be modified to reduce the risk of HIV acquisition.<sup>13</sup>

In 1989, Australia became one of the first countries in the world to develop a formal HIV/AIDS strategy;<sup>13</sup> many elements of the first strategy remain today. Australia adopted a human rights approach and prioritised mobilising affected communities, developing peer-based education, legal protection for people at-risk of and living with HIV, and a harm reduction approach regarding illicit drug use.<sup>13</sup> As a result, Australia has avoided a generalised epidemic, with HIV transmission mainly

concentrated amongst specific populations, GSMs being the largest.<sup>13</sup>

In the last five to ten years there has been a noticeable increase in HIV diagnoses of heterosexual people from high prevalence regions, particularly people from sub Saharan Africa, South East Asia and the Caribbean. These people have moved permanently to low HIV prevalence countries including Australia, the United Kingdom (UK), the US, Canada and European countries.<sup>14-16</sup>

This increase in HIV diagnoses approximates overall mobility and migration patterns from and to these countries. This trend has continued to grow despite migration controls in place in some countries, which impose restrictions on entry, stay and residence for people living with HIV (PLHIV).<sup>17, 18</sup> The majority of people acquired HIV in their place of birth (or in transit).<sup>19</sup> However there is growing evidence that people from migrant backgrounds acquired HIV in destination countries, including from other migrants with HIV.<sup>20-22</sup>

About 1% of Australian HIV diagnoses have occurred amongst people born in low prevalence countries (including Australia) exposed through heterosexual contact with people born in high prevalence countries.<sup>23</sup> This proportion may rise when Australian-born GSMs exposed through contact with GSMs born in high prevalence countries are included.

In addition to people coming to Australia with HIV, a proportion of Australian people acquired HIV while travelling (either for work or leisure) in high prevalence countries.<sup>23</sup> There is an increasing number of people who are semi-permanently and permanently moving and travelling from low prevalence countries, such as Australia, to high prevalence countries.<sup>24, 25</sup>

People travel for purposes including working in transnational corporations, working and volunteering in non-government organisations, leisure and tourism (also involving the intention of seeking sex), military and peacekeeping exercises, and retirement.<sup>26</sup> When people move to countries where they have limited access to the health system or the health system is underdeveloped, their contingency plan is to use the health system of their home country.<sup>24</sup>

Some of the key issues relating to HIV and mobility that may have contributed to an increase in diagnoses include: proximity to high prevalence countries and frequency of travel to such regions; the emergence of companies undertaking mining operations in high prevalence regions; risks for employees working in the minerals and energy sector particularly associated with fly-in-fly-out/ drive in-drive-out (FIFO/DIDO) work and potential flow-on effects in the community; and ineligibility for Medicare and treatments for certain visa holders.<sup>C, D</sup> These issues have been found to be of particular relevance to WA, however many of the above issues may pose similar challenges to other states.

<sup>C</sup> The Western Australian Health Department operational directive allows HIV physicians to seek authority for HIV treatment up to \$10,000 p.a. and other clinical services for PLHIV. The guidelines for HIV treatment provision of Medicare ineligible persons in WA are available at <http://www.health.wa.gov.au/circularsnew/attachments/699.pdf>

<sup>D</sup> Details on the Temporary Work (Skilled) (subclass 457) visa are available at <http://www.immi.gov.au/allforms/pdf/1154.pdf>

# An Epidemiological Snapshot

## Key Concepts

- Initial and ongoing responses to regional and country HIV epidemics have influenced the course of epidemics around the globe.
- Countries with structural responses including a human rights approach to HIV have been more successful than countries without such a structural approach.
- There is a strong correlation between the level of migration from high prevalence regions to low prevalence regions and the number of people diagnosed with HIV in these low prevalence regions. In Australia this trend has been seen in heterosexual men and women from sub Saharan Africa and women from South East Asia, particularly Thailand; other high income countries are experiencing the same issue.
- The presence of border controls does not make any difference to rates of overseas acquired HIV.
- Travellers or migrants to Australia acquiring HIV in other countries comprise about 20% of total new diagnoses in Australia.

middle income countries.<sup>5, 34</sup> However, within these regions are the BRICS countries (Brazil, Russia, India, China and South Africa) which are also undergoing huge political and social change, and economic growth.<sup>35</sup> These countries, as well as Thailand, have features of both generalised and concentrated epidemics. For example, there are recently recognised epidemics amongst GSM in predominantly heterosexual epidemics in sub Saharan Africa.<sup>36</sup>

It is clear that epidemics are not dichotomous and do not always fit neatly in to the definitions described above. The global AIDS epidemic is a patchwork of smaller epidemics resulting from interacting networks of transmission. More recently UNAIDS<sup>37</sup> has noted that the global epidemic comprises locations and populations with diverse and often interconnected features. There are many suggestions about why there is a marked difference between epidemics.<sup>34</sup> One suggestion may be that in low prevalence epidemics a more comprehensive response has been adopted including a human rights approach, legal and policy reform, community-based programs as well as strategies aimed at individuals.<sup>38</sup>

Table 1 provides some examples comparing the features of concentrated and generalised epidemics. It is acknowledged these examples are generalisations. For example, there are countries like Saudi Arabia that have almost non-existent HIV<sup>33</sup> but a very low gender equity.

## Generalised and Concentrated Epidemics

Since the beginning of the HIV/AIDS pandemic, key patterns have been identified.<sup>27, 28</sup> A **generalised**<sup>E</sup> HIV epidemic has been seen in countries and/or regions with predominantly heterosexual transmission, and with a population prevalence of over 1% of the population.<sup>29, 30</sup> A **concentrated**<sup>E</sup> HIV epidemic has been found in countries and/or regions which predominantly affected particular groups such as GSM, PWID and some sex workers and where the overall population prevalence of HIV was less than 1%.<sup>29, 30</sup> Australia has experienced the latter because its epidemic has remained concentrated within particular population groups, mainly GSM.<sup>31</sup>

The most significant generalised epidemic is in sub Saharan Africa,<sup>32</sup> where prevalence in some of these countries is as high as 28% of the population (Swaziland 28%, Botswana 22%, South Africa 19%),<sup>33</sup> and in some parts of South East Asia and the Caribbean (Bahamas 3.2%).<sup>32</sup> These regions also tend to include low and

<sup>E</sup> Please refer to list of definitions at the beginning of the document.

**Table 1: Examples comparing the features of concentrated and generalised epidemics<sup>27-30</sup>**

High, low and middle income countries with concentrated HIV epidemics with low overall prevalence of HIV	Low and middle income countries with generalised HIV epidemics with higher overall prevalence of HIV
People participate in democratic processes. There is attention to human rights which are protected by legislation and rule of law.	Variable participation in democratic process. Corruption, military rule, internal unrest may feature.
Gender equity.	Gender inequity.
Generally high gross domestic product (GDP) with relatively high spending on health care.	Low GDP per population with low spending on health care and low life expectancy.
Variable levels of poverty with a health and social services system in place in most countries.	High levels of poverty, conflict, famine.
Reasonably early attention to HIV epidemic—prioritised, funded, strategic.	HIV was not prioritised because of competing health issues and/or other priorities.
High access to HIV treatments. Early availability may have assisted in keeping HIV epidemics relatively contained from the mid-1990s.	Variable but improving access to HIV treatments.
Low prevalence amongst women and children with very low number of orphans.	High prevalence amongst women and children leading to high number of orphans.
Protection of the rights of PLHIV with attention paid to the impact of stigma and discrimination.	Variable protection of the rights of PLHIV. High levels of stigma and discrimination.
Promotion of condoms is related to the impact of religious organisations particularly the Catholic Church.	Promotion of condoms is related to the impact of religious organisations particularly the Catholic Church.
Variable approach to same sex relationships—gradual repeal of laws against homosexuality and enacting of rights for lesbian, gay, bisexual, transgender and intersex (LGBTI) people.	Some countries have repealed severe laws, others are in the process of becoming even more severe.
Variable legal approaches to sex work although most countries do not encourage it. (criminalised, regulated or some other sanctions).	In some circumstances sex work is a vital part of the economy and does not have attached stigma (i.e. Thailand).
Variable approach to substance use—some have declared a 'war on drugs', others have supported NSEPs (Needle and Syringe Exchange Program). Some countries are very opposed to harm reduction policies and thus have high levels of HIV related to sharing needles.	Vital part of the economy in terms of production and export of substances, but individuals who use drugs are marginalised.
Amongst high prevalence groups (GMSM) there is high turnover of sexual partners or concurrency. In at-risk groups overall there has been a high uptake of preventative mechanisms such as condoms and sterile injecting equipment when available.	In some countries there is acceptance of, and high levels of concurrent sexual relationships, acceptance of polygamy, and engagement of sex work services.





## Why is the Type of HIV Epidemic Significant?

The features of generalised and concentrated epidemics are important, as different prevention interventions are required for different epidemic types. Arguably, the reason there has not been a generalised spread of HIV in high income regions such as Australia is because early action occurred; at-risk communities were mobilised, and governments resourced at-risk groups.<sup>13</sup> In addition, there have been significant structural mechanisms put in place, such as access to health care and the means of protection for all groups, underpinned by legal frameworks and the protection of PLHIV or those at-risk of acquiring HIV.<sup>39</sup>

Australia needs to develop appropriate responses to meet the needs of emerging priority groups. It is therefore essential to understand how people leaving high prevalence epidemics have experienced responses to HIV in their home countries, and how they understand the HIV epidemic in Australia. People coming to Australia from high prevalence countries are at-risk because there is often a stark difference in HIV visibility to that of their country of origin. In many high prevalence countries HIV is on the news, billboards, TV, radio, and in the community. In Australia, most people who have AIDS are on antiretroviral treatment (ART) and HIV is not as visible to the community. Those from low prevalence countries, including Australians, travelling to high prevalence countries may be at-risk if they are unaware of higher HIV prevalence, and have not experienced generalised epidemics.

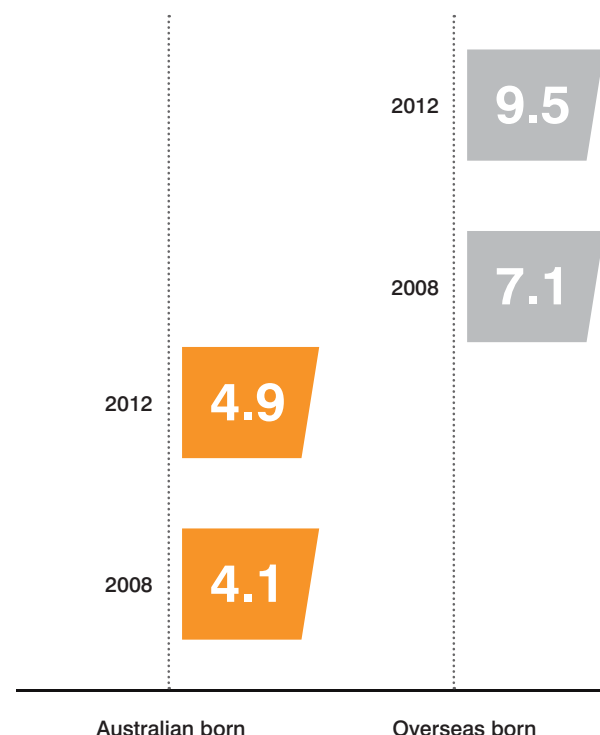
Furthermore, Australians, or people who have lived in Australia for a long time, have experienced a comprehensive HIV response including legal protections for PLHIV, access to health care and means of HIV protection. These are all within a policy framework of anti-discrimination reforms and the repeal of laws that have criminalised sex between men.<sup>13</sup> When Australians travel to other countries they may assume that responses to HIV are the same as they are in Australia.

## HIV Epidemiology in Australia

Australia's HIV epidemic is characteristic of a concentrated epidemic within specific risk groups. Between 2009 and 2013, 67% of those diagnosed with HIV in Australia were GSM compared with 25% diagnoses attributed to heterosexual people.<sup>40</sup> Sixty four per cent of those diagnosed with HIV in Australia in 2012 were homosexually active men, compared with 25% diagnoses attributed to heterosexual people.<sup>23</sup>

This pattern is not consistent throughout Australia. In the same period in WA, 40% of new diagnoses occurred among homosexually active men compared with 54% attributed to heterosexual contact.<sup>41</sup> The rate per 100,000 people of HIV diagnoses of Australian born people compared with overseas born people also differs, as shown in Figure 1.<sup>23</sup>

**Figure 1: HIV diagnoses in Australia (per 100,000)**



The population rate of HIV diagnoses in the sub Saharan African-born and Asian-born populations increased by 66% between 2008 and 2012 compared to the period between 2003 and 2007.<sup>23</sup>

In summary, of the total number of heterosexual diagnoses between 2008 and 2012 in Australia, 36% were either born-in, or were partners of people born-in, sub Saharan Africa and 17.8% were born-in or were partners of people (mostly women) born-in South East Asia.<sup>23</sup> In 2013, 46% heterosexual diagnoses were people born-in, or partners of people born-in, sub Saharan Africa.<sup>40</sup> The rate per 100,000 people of HIV diagnoses in Australians born-in high prevalence countries, where the likely route was heterosexual transmission, increased from 1.1 per 100,000 in 2004–2008 to 1.33 per 100,000 in 2009–2013.<sup>40</sup>



## A Case of Change HIV Epidemiology in WA

In the past ten years, WA has experienced a change in HIV epidemiology. New diagnoses are now split equally between homosexually active men and heterosexual men and women.<sup>42</sup> While three quarters of WA homosexually active men acquire HIV in Australia, over 70% of heterosexual people diagnosed with HIV were born and acquired HIV outside of Australia.<sup>42</sup> This trend has also been seen in other areas of Australia such as far north Queensland (Qld).

Since the mid-2000s, WA has diagnosed 288 heterosexual men and women with HIV, of whom 75% were born in sub Saharan Africa (n=119) and South East Asia (n= 97).<sup>42</sup> Seventy per cent of these new HIV diagnoses were also acquired outside of Australia with an equal distribution between men and women.<sup>42</sup> The majority acquired HIV overseas in their country of birth; however a small number acquired HIV in a country other than their birth; generally in another high prevalence country. At present a very small proportion of people from high prevalence countries who did not have HIV upon arrival in WA, have acquired it in Australia.

Since the beginning of the HIV epidemic in WA in 1983, 21% (n=433) of total HIV diagnoses have been amongst people born overseas and acquired HIV overseas and who had migrated to Australia semi-permanently or permanently; they were not tourists or visitors.<sup>42</sup>

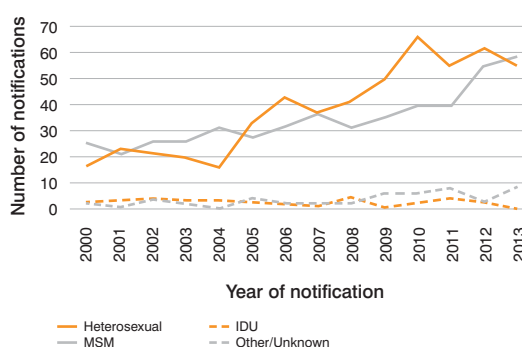
Since 2004, 149 homosexually active men born overseas have been diagnosed with HIV in WA, with 64% (n=95) of all cases being acquired in Australia.<sup>42</sup> Of the 54 men who acquired HIV outside of Australia, 37% (n=20) acquired HIV in South East Asia and 33% (n=18) acquired HIV in Europe.<sup>42</sup>

Since 2003, the majority of heterosexual men and women diagnosed with HIV at sexual health clinics have acquired HIV overseas.<sup>23</sup>

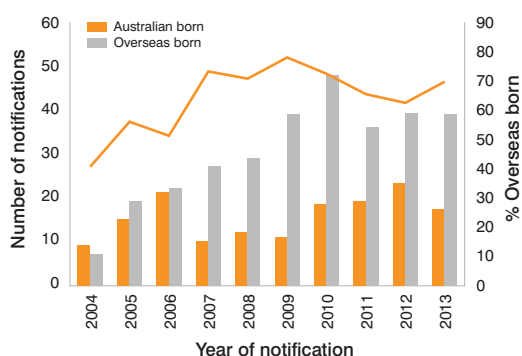
Since 2004, WA HIV epidemiology has shown that 77 Australian born heterosexual people have acquired HIV overseas of which 84% acquired HIV in either South East Asia (n=55) or sub Saharan Africa (n=10).<sup>42</sup> Among Australian born heterosexual people who acquired HIV overseas, men were significantly over-represented with 8.6 more men than women having acquired HIV overseas.

Since 2002, just over 400 homosexually active men have been diagnosed with HIV in WA with approximately 75% acquiring HIV in Australia.<sup>42</sup> Of the 100 men who acquired HIV outside Australia, 40% acquired HIV in South East Asia and 34% acquired HIV in Europe. Since 2004, 12% (n=45) of Australian born homosexually active men have acquired HIV overseas.<sup>42</sup>

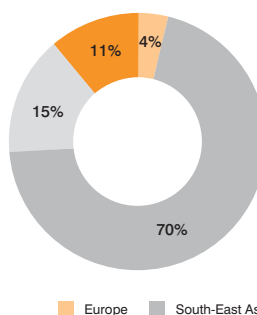
**HIV notifications by exposure group, WA residents 2000-2013<sup>42</sup>**



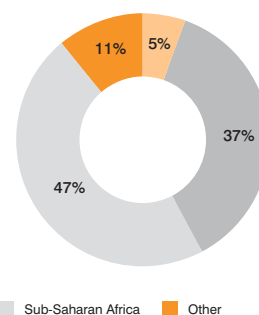
**Heterosexual HIV notifications by place of birth, WA residents 2004-2013<sup>42</sup>**



**Heterosexual HIV notifications, overseas-acquired by place of acquisition, WA residents 2004-2013<sup>42</sup>**



**Heterosexual HIV notifications, overseas born-overseas acquired, WA residents 2004-2013<sup>42</sup>**



## Overseas Acquired HIV

In countries with similar epidemics to Australia (concentrated epidemics rather than generalised epidemics), there has been a similar phenomenon observed, as shown in Figure 2.<sup>26, 43-49</sup>

Figure 2: Overseas acquired HIV

### Norway (2008)

109 (78%) of newly diagnosed people were from African countries.

### Canada (2008)

8.5 times higher incidence among people from endemic countries; 16% of new HIV infections attributed to people of endemic countries in 2008.

### Britain (2010)

HIV prevalence was 47 per 1,000 - 31 per 1,000 men, 64 per 1000 women and 21 per 1,000 pregnant women. HIV was acquired overseas by 6.5% of homosexually active men, 68.7% of heterosexual men and 32.7% heterosexual women. Africa and Asia were most common regions of acquisition for heterosexual people.

### US (2001-2007)

Estimated 12% of African-American diagnoses attributed to foreign born; High risk heterosexual contacts and late diagnoses; High prevalence countries most commonly reported: Central America, Caribbean, Africa and South America.

### France (2008)

48% overseas born; Rate per 100,000: 0.06% French born, 0.62% overseas born, 3.72% sub Saharan Africa born.

### Netherlands (2008)

60% of all newly diagnosed women were from sub Saharan Africa. Overall HIV prevalence is 0.02% among the general Dutch population, 0.4% among Caribbean migrants and 3.1% from sub Saharan Africa migrants.

### Germany (2008)

Large proportion of heterosexual acquired HIV diagnosed in migrants from sub Saharan Africa and to a lesser extent South East Asia (particularly Thailand).

### Belgium (2008-2010)

1,364 non-Belgian citizens diagnosed with HIV (62.3% were from sub Saharan Africa).

### Switzerland (2008-2010)

Between 16 and 23% of newly diagnosed HIV cases attributed to migrants from sub Saharan Africa, with the main transmission route being heterosexual.

### New Zealand (1996-2009)

3192 HIV diagnoses (10% of African descent).

# Globalisation and the Confluence of Social Change



**AIDS is both a product and cause of globalisation, linking the least developed and the most developed regions of the world. Despite attempts to close borders to its spread, as in the restrictions on entry of HIV positive people applied by many countries, the spread of the virus made a mockery of national sovereignty.<sup>50</sup>**



Denis Altman 'Global Sex' (2001)

## Key Concepts

- Globalisation has irrevocably changed the world economically and socially
- Globalisation and one of its consequences, mass mobility, has been a major factor in the HIV/AIDS pandemic.

Since the mid-1970s, world economies and communities have become increasingly interconnected because of global trade and commerce, financial markets, transnational corporations and information communication technology (ICT).<sup>51, 52</sup> Globalisation has meant that existing inequities have been reinforced or exacerbated and country borders have become increasingly porous.<sup>51, 53</sup>

While globalisation applies to economic structures, other impacts of globalisation have been acknowledged. These include sociocultural impacts such as the internet, global media interests, the advent of social media, cultural expression and music, transnational civil society organisations and international crime syndicates.<sup>51</sup> Cheap and accessible air travel for the masses has arguably facilitated, as well as resulted, from globalisation.<sup>51, 54</sup>

While globalisation coincided with the HIV/AIDS pandemic mainly because of mass mobility, there are a number of other factors that have both exacerbated the extent of the epidemic in some countries as well as been significant barriers to responding to it.

**Globalisation has meant that existing inequities have been reinforced or exacerbated and country borders have become increasingly porous**

## Colonisation and Religion

Many countries in the Global South<sup>F</sup> on the continents of Africa, South Asia and South East Asia, with a high HIV prevalence have a history of colonisation. Members

**Members of the former British Empire or the CW of Nations make up only one third of the world's population but two thirds of the world's HIV population<sup>55</sup>**

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A negative legacy of colonisation was the prevailing norms of the colonising country. Norms attached to sex and homosexuality and

the influence of religion led to high levels of stigma and discrimination in relation to homosexuality. For example, countries colonised by Great Britain inherited Victorian norms and laws regarding sex and homosexuality that continue to be embraced by colonised countries, long after independence.<sup>55</sup> Ironically, the colonising countries have repealed many of these outdated laws and introduced other protective laws, while former colonies have made laws even more severe. For example, the colonial legacy of British laws criminalising homosexuality still exists in CW countries despite repeal of similar laws in Britain itself.<sup>31, 55-57</sup>

When the impacts of HIV/AIDS gathered momentum, these prevailing laws, religious doctrines, attitudes and values became barriers to responses such as preventative education. In the US for example, conservative attitudes towards condoms and contraception saw increasing focus in many states on abstinence particularly in schools<sup>58</sup> and the federal government tied international donor funding for sexual and reproductive health and HIV programs to abstinence only policies.<sup>59</sup> Other programs in countries like Uganda encouraged abstinence in the first instance, which while demonstrating some successes, drew heavily on an approach to prevention that focused on monogamy and heterosexual relationships.<sup>59</sup> In addition, some post-colonial African countries were dealing with political upheaval and could not prioritise health, including HIV. The spread of HIV became generalised, driven by intra-country mobility mainly for work such as mining, agriculture, fishing and related industries including truck-driving and sex work.<sup>11, 60-62</sup>

## Social Change

Following World War II and prior to globalisation there was a high level of social change, which had a bearing on the future course of HIV/AIDS. For example, the sexual revolution in Western countries in the 1960s meant women could control their fertility, normalising sex outside marriage, especially in relation to pre-marital sexual relations.

Gay liberation (particularly for men) from the 1960s to 1970s in Western countries sought to extend the sphere of acceptable sexual expression to include male and female homosexuality.<sup>63</sup> 'Gay' culture, and practices such as the development of 'sex on premises venues' provided ideal conditions for HIV to spread.<sup>63</sup> The shift towards later marriage in most countries led to an increase in pre-marital sex, the prevalence of which was higher in high income countries<sup>6</sup> and higher in men than women.<sup>64, 65</sup>

A range of social, economic, political and environmental factors influenced individual behaviour, affecting HIV risk.<sup>27, 39</sup> Poverty has been implicated in HIV epidemics; however, it is important to consider context as both poverty and wealth can contribute to greater HIV vulnerability.<sup>65</sup> An established sex industry in countries such as Thailand was marketed to Westerners as an important part of the Thai economy. Sex workers and people who traded illicit substances from the Middle East and South East Asia were brought together through movement of people, led to ideal conditions for the spread of HIV.<sup>26</sup>

**Following World War II and prior to globalisation there was a high level of social change, which had a bearing on the future course of HIV/AIDS**



<sup>F</sup> Please refer to list of definitions at the beginning of the document.

<sup>G</sup> Please refer to list of definitions at the beginning of the document.

# People on the Move

According to Joint United Nations Programme on HIV/AIDS (UNAIDS)<sup>66</sup> the number of people who crossed international borders increased by 276% from 25 million people in 1950 to 940 million in 2010. Of those, half

**According to Joint United Nations Programme on HIV/AIDS (UNAIDS)<sup>66</sup> the number of people who crossed international borders increased by 276% from 25 million people in 1950 to 940 million in 2010.**

travelled for leisure, recreation and vacation, 15% for business and 27% travelled for other reasons such as visiting friends and relatives, religious or health care reasons.

By 2008, more than 200 million people were international migrants, and by the end of 2007 there were 16 million refugees, 26 million individuals displaced by conflict but did not cross borders, 25 million people displaced because of natural disaster, 20–30 million were irregular migrants and 2.4 million were trafficked.<sup>66</sup>

## The driving factors of mass mobility

Globalisation has led to mass movement and migration of people, demonstrating a range of benefits for individuals and communities. Movement occurs from rural to urban areas; mobility for employment, work or education; people escaping war (including civil wars) and conflict; and people seeking a better life.<sup>67, 68</sup>

There are global demographic shifts where population replacement rates in industrialised countries have decreased, but increased in low and middle income countries. This has led to labour surpluses in low and middle income countries and labour shortages in industrialised countries.<sup>46</sup>

To redress this imbalance and economic need, people have been encouraged to move for employment opportunities, as well as to take advantage of other economic and social aspects offered by high income countries. The existence of established CaLD (culturally and linguistically diverse) communities in host countries may also act as an incentive for people to move;<sup>46</sup> however mobility is bi-directional where people in high income countries can benefit from a lower cost of living, and the cultural and social experiences in low and middle income countries. There are also unpredictable factors influencing mobility related to natural, man-made and slow onset disasters.<sup>46</sup>

## Key Concepts

- Mobility has increased dramatically in the last thirty years in volume, speed, disparity and diversity, and there is no indication this will change.
- Mobility can be a risk factor for HIV acquisition, increase a person's vulnerability to HIV, exacerbate existing risk factors for HIV acquisition or drive HIV epidemics.
- Mass mobility has been responsible for the spread of many health conditions throughout the world.
- There are different types of mobility which are not mutually exclusive —permanent, semi-permanent and temporary. Within each category there are different motivations for mobility (employment, education, recreation, leisure and desire to experience different cultures, escaping war and conflict, family reunion) and different directions (from low and middle income countries to high income countries, and vice versa) some of which confer greater or less risk.
- The impact of migration in host communities is varied. There are strong associations between prevailing economic conditions and levels of unemployment and the attitudes towards migrants.
- At least one fifth of Australian migrants experience discrimination and other negative attitudes.





## Mass Mobility and the Impact on HIV Risk and Vulnerability

There is debate about how to conceptualise mobility.<sup>69, 70</sup> There is an overlap between different types of mobility, for example people who engage in 'tourist' activities while they are away for work, or backpackers who are employed in seasonal work. The level of HIV vulnerability

**Mobility facilitates opportunities for an individual's behaviour to change, potentially putting them at risk of HIV. This includes changes to alcohol consumption and other drug(s) intake, or sex such as engaging in concurrent sexual relationships**

may be influenced by push and pull factors, including different motivations for mobility; travel direction and destiny; the level of control over travel and pre travel; and transit and post travel factors.<sup>70-73</sup>

There is also debate about whether mobility is a risk factor of HIV acquisition, increases a person's vulnerability to HIV, exacerbates existing risk factors for HIV acquisition, or is a driver of HIV epidemics.<sup>69</sup>

### Mobility as a risk factor for HIV acquisition

Mobility facilitates opportunities for an individual's behaviour to change, potentially putting them at risk of HIV. This includes changes to alcohol consumption and other drug(s) intake, or sex such as engaging in concurrent sexual relationships.

Mobility may also create situations where individuals do not change their usual behaviour but are in a more risky circumstance such as a high HIV prevalence area<sup>74, 75</sup> and/or in situations where sexual health and safe sex are low on the list of priorities, or not accessible, such as for asylum seekers. These risks may be exacerbated as people are out of their comfort zone, personal resilience is reduced and their normal social supports are not available.<sup>76, 77</sup> When mobility is considered a risk factor it requires individuals to be responsible for modifying their own behaviour to reduce risk, or for countries to implement policies and strategies that reduce the risks for individuals associated with mobility.

### Increased vulnerability to HIV as a result of mobility

Vulnerability relates to the conditions under which people move (i.e. choice, documentation, between or within countries, language and cultural differences at destiny, trauma, displacement, transactional sex, economic circumstances or coercive sex) and the way people are treated pre-departure, during transit and at the destination.<sup>77</sup> This does not assume that people are at risk because of mobility, but that mobility makes some people more vulnerable to HIV acquisition, as access to health services and social support change during the mobility process.<sup>77</sup> Different people and groups are impacted differently; for example, migrants have varying access to health care and services depending on their citizen status. Many of the factors increasing a person's vulnerability can be modified by governments, the private sector, communities and other institutions.

### Exacerbation of existing risk factors for HIV acquisition

Mobility may exacerbate HIV vulnerability when combined with other already pre-existing risk factors for HIV. This relates to groups who may already be at increased risk of HIV acquisition such as GSM, trans\* people, sex workers or PWID and are mobile where normal supports are unavailable such as access to condoms or sterile equipment. Migration policies and laws that increase dependence on third parties in order to travel, discriminate against people travelling/working, or do not provide safe migration avenues for sex workers can also exacerbate risk factors. Intersecting marginalities with increased experiences of stigma, discrimination and HIV risk can also be exacerbated by mobility.

### Mobility as a driver of HIV epidemics

Mobility may speed-up or slow-down the spread of HIV in regions, countries, communities or social groups. Social drivers are complex, fluid, non-linear, and contextual. HIV infections do not happen randomly and are prone to clustering—some populations are more likely than others to experience a social structure in which risk factors intersect and cluster to potentiate HIV spread within a network.<sup>78</sup>

Table 2 provides a summary of some examples of the risk associated with mobility.<sup>65, 70-73, 78-82</sup>

It is acknowledged that there are many exceptions to the generalisations presented on the following page.

**Table 2: Examples of the risk associated with mobility<sup>H</sup>**

Lower vulnerability and/or risk of HIV acquisition	Higher vulnerability and/or risk of HIV acquisition
Mobility/migration/travel has been a choice.	Mobility has not been a choice and is related to post war, conflict or natural disaster.
Individual or family has had the time and capacity to plan and prepare their travel.	Departure has occurred in traumatic, chaotic and unplanned circumstances.
Individual or family has financial means.	Individual or family has little access to money.
Travel is properly documented i.e. passports, necessary visas, travel documents, money.	Travel is under-documented or undocumented.
Travel is traditional/ commonplace/traditional.	Travel is unusual and uncommon.
Travel is intra-country.	Travel crosses an international borders or borders.
Travel is for a short time.	Travel is a for a lengthy period.
Travel takes place with another person (couple) or a family group.	Travel is alone. Females are more vulnerable than males.
Similar culture, way of life, language of departure community and destination community.	Dissimilar culture, way of life, language of departure community and destination community.
Mobility/ travel is direct between departure and destination country.	Mobility/travel is through another country or otherwise indirect.
The social capital of the person at the point of departure such as interconnectedness, community engagement, social support, income, employment, education level, savings, health status.	Social determinants of health at the destination country such as levels of xenophobia, racism and discriminatory laws; levels of social connectedness and support for migrants; language and other services for cultural integration; existence of community support and access to spiritual connectedness; access to mainstream services and health care. <sup>83</sup>

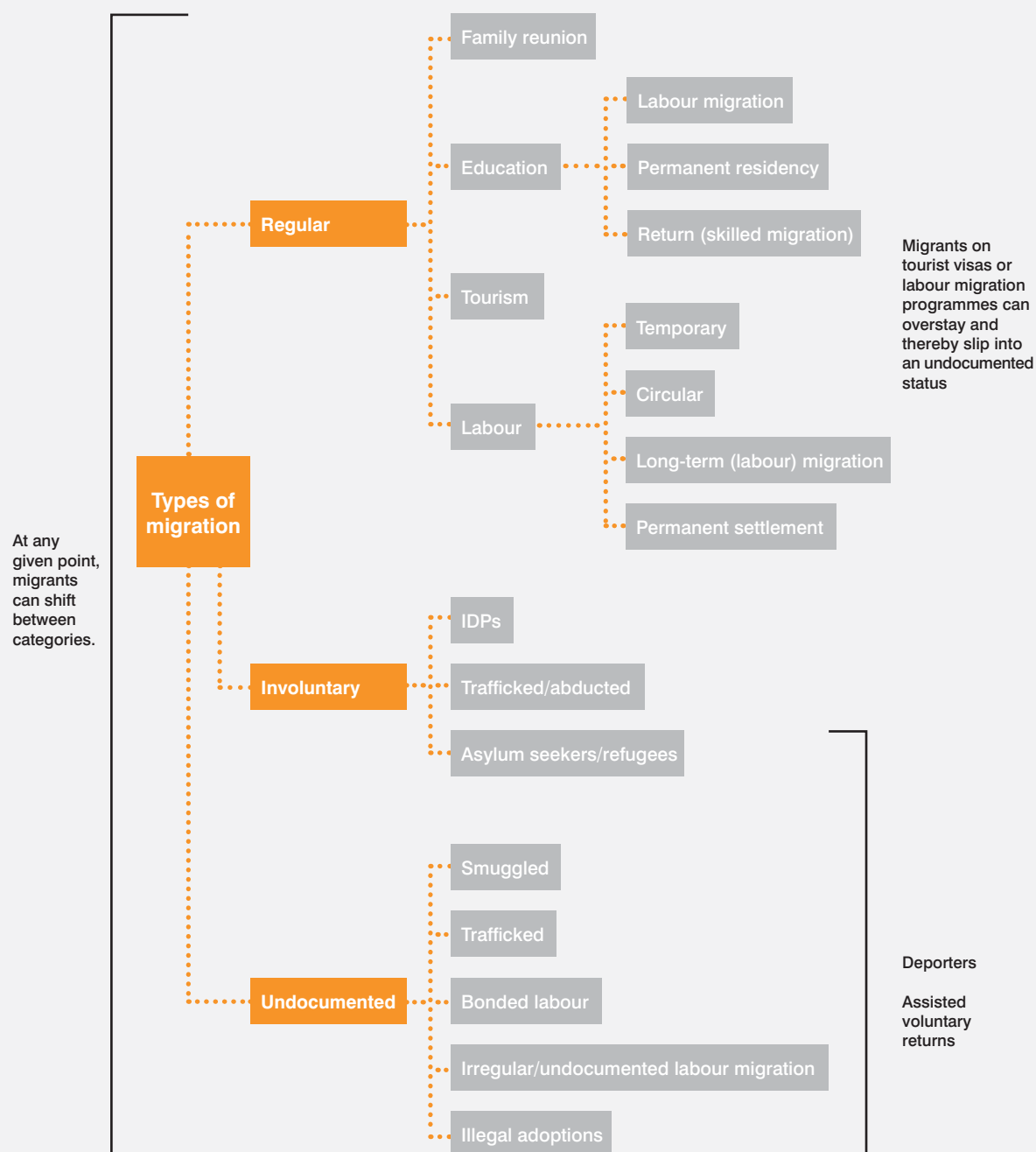


<sup>H</sup> Please refer to list of definitions at the beginning of the document.

## Types of Mobility

Types of mobility include permanent shift (migration), semi-permanent migration, temporary mobility, and constantly mobile. These types of mobility and their implications for HIV risk are described further below. The various types of migration are depicted in Figure 3.<sup>84</sup>

**Figure 3: Types of migration**





### Permanent shift (migration)

This type of mobility is usually related to people motivated to find a better life where their intent is to find a new home for one or more of the following purposes:

- employment and economic circumstances
- family reunion
- escaping war, civil war and conflict
- lifestyle and/or retirement.<sup>85</sup>

HIV increases have been associated with mobility from low and middle income regions to high income regions. It had previously been assumed that migrants arrived with HIV in the destination country; however there is now evidence from a number of countries that people may acquire HIV in their destination country, despite it being a low prevalence country.<sup>21, 86-88</sup>

Migrant vulnerability to HIV may emerge when the person living in the destination environment does not have social support; has difficulty accessing services; lives in poor or under-resourced areas, experiences language and other cultural barriers; experiences stigma and discrimination; and for those who may not seek health care for fear of losing their visa.<sup>68, 89</sup> This includes asylum seekers and refugees in the community on temporary protection visas who are in limbo between temporary and permanent migration status; or sex workers unable to access industrial rights or support mechanisms without fear of deportation.<sup>89, 90</sup>

### Semi-permanent migration

This type of mobility is related to people who reside for a number of years in a destination but have not 'permanently' moved away from their home and may include migration for:

- employment
  - military deployment in conflict and post conflict zones
  - civil society employment and aid work
  - transnational companies and industries
  - sex work
- education
- extended leisure and recreation
- lifestyle factors and desire to experience different cultures
- escaping war and conflict.<sup>22, 25, 91, 92</sup>

In circumstances where the mobility direction is from low and middle income countries to high income countries, risks and vulnerabilities relate to the context and environment in which people move to. There may also be lack of access to health care services for temporary visa holders such as 457 visa holders or international students in Australia.<sup>93</sup>

Migrants and people retiring semi-permanently to high prevalence countries may not have access to structural protections, such as access to health care services.<sup>24</sup> Risk taking may be a desired part of the overall experience in many cases, and risk mitigation strategies may vary from person to person.<sup>92</sup> Some individuals will plan by having travel insurance and pre-departure vaccinations.<sup>94</sup> Others will use in-situ risk mitigation strategies such as wearing bike helmets, not drinking tap water and using condoms.<sup>95</sup> However alcohol, or other drug use or having sex with travellers or locals can be desired as part of an experience and may be risky even if not intended.<sup>94-97</sup> This means that people must determine their own risk mitigation or reduction strategies, something that they may not be used to.

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People from high income regions may migrate permanently or semi-permanently to low and middle income regions because it is more affordable—another emerging trend likely to lead to greater HIV vulnerability.<sup>24</sup> These migrants may be older with higher level health care needs, which are not easily met in the destination countries. They may plan to access health insurance, health care and other support services in their home country, placing greater pressure on the health systems of both countries.<sup>24, 98</sup>



### Temporary mobility

This type of mobility relates to people who travel for shorter periods of time and may include travelling for:

- adventure tourism where high levels of personal risk-taking are planned. Usually individuals have means and are well-informed.<sup>92</sup>
- tourism with sexual intentions, where the primary motivation is to have sexual experiences. This is not limited to men—an increasing number of women travel for sex.<sup>99</sup>
- work, especially young tourists on working holiday visas, including people taking ‘gap years’ and backpackers wanting new experiences.<sup>100</sup>
- holidays where people want to relax and explore. Risk taking is moderated and determined by travel companions, features of the destination, use of alcohol and drugs, and economic means.<sup>101</sup>
  - for singles or individuals travelling in groups, depending on age and gender, the risk profile may vary from minimal to very high such as young people at ‘party destinations’ or men following sporting teams where alcohol consumption and peer pressure to take risks may be high.<sup>26, 102</sup>
  - for families or people travelling with their partners, HIV risk is generally minimal.

### Constantly mobile

People who are constantly mobile may include those who fly-in-fly-out (FIFO) or drive-in-drive-out (DIDO) for work or other workers which include:

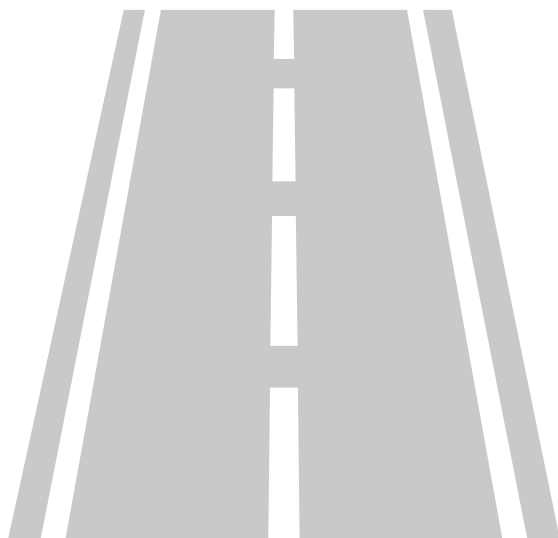
- individuals with jobs requiring them to be away from home for long periods of time, as well as those who are repeatedly mobile or in transit. Their professional activities may include periods of monotony interspersed with high stress, and peer pressure promoting a risk-taking culture. People who are constantly mobile may carry large amounts of money relative to their place of travel. This money can attract a range of services, including sexual services.<sup>68</sup>
- mobile sex workers generally conceal the purpose of their travel from authorities, at border migration control and while in the country. They are at-risk because they are marginalised and receive minimum social and legal protection due to criminalisation of sex work, criminal justice approaches to and conflation with trafficking, and lack of access to industrial rights mechanisms or supports without fear of deportation. This increases the risk of being threatened and harassed.<sup>103-106</sup>



## Migration to Australia

In Australia, migrant arrivals adding to the population have been outnumbering births on an annual basis since the 1990s. However in terms of mobility and migration there have been significant changes over the past thirty years:

- the composition of the permanent migration program has shifted from less than a third to more than two third skilled migrations; the program is designed to address skills shortages.
- the permanent migration program is moving towards a demand driven model, at a company level rather than at a governmental level.
- there has been an explosion in the growth of temporary migration (457 visas) which is consistent with globalised labour requirements.<sup>93</sup>



The Monash Institute for the Study of Global Movements and the Australian Multicultural Foundation, with Scanlon Foundation funding has been commissioned since 2007 to measure and report on social cohesion related to migration.<sup>107</sup> According to recent reports:

- there is strong support for those admitted under the 'skill' and 'family' streams of the Migration Program, the Humanitarian Program and for overseas students within the Australian community that is higher than in other comparable countries.
- the findings show strong levels of support for multiculturalism<sup>1</sup> and that it has been good for Australia.
- there is a large acceptance of previously stigmatised groups with less than 5% of respondents indicating negative feelings towards migrants from English-speaking countries and continental European backgrounds. However, at least one fifth of Australian migrants report they experienced discrimination and other negative attitudes.
- positive responses were not restricted to those usually the most favourable to cultural diversity—urban dwellers, highly educated, and young—but were consistently high within segments of the population; however in communities with high levels of ethnic diversity only 37% of respondents believed immigration had a positive impact on daily life. Of people from a non-English speaking background, 22% claimed they had experienced discrimination, which is almost double the national figure. The highest level of negative feeling, at almost 25%, was towards migrants from the Middle East.
- there is little correlation in public perception and actual changes in migrant intake. The two key factors bearing on Australian attitudes to immigration were the state of the labour market, particularly the level of unemployment and the political prominence of immigration issues.

A similar study in Britain released in January 2014, 'Perceptions and Reality Public Attitudes to Immigration' by the Ipsos MORI Social Research Institute shows that 43% of British people identified migration control as one of the top three issues for the UK, despite migration estimated at 7% of the UK population. This may be partly due to British people overestimating the numbers and types of migrants, and a perception that migrants put too much pressure on public services and unfairly access welfare payments (referred to as 'benefit tourism').<sup>108</sup>

<sup>1</sup> Please refer to list of definitions at the beginning of the document.

# Global and Local Responses

## Key Concepts

- Traditional 'contain and control' public health interventions at the border are inadequate in dealing with HIV.
- Many governments, including the Australian government, have included 'contain and control' measures as part of their repertoire in reducing the number of new HIV infections.
- These measures are inappropriate for the scale of the problem and breaches human rights that result.
- Global economic structures have paid little attention to health impacts of globalisation, inequitable health systems and other public health threats.
- Global health governance structures—UNAIDS, United Nations General Assembly Special Session (UNGASS) have an emphasis on ensuring that countries develop a response to HIV/AIDS. This has the unintended consequence of countries operating in isolation with few cross border programs.
- In Australia, insufficient resources have been directed to addressing migrant health issues and significant HIV policy barriers have not been removed such as testing when applying for permanent and temporary visas.
- Migrants who settle in a particular country can be accessed if programs are meaningful, have met their needs, and if disincentives to participate are removed or minimised.

## Global Health Governance

As a result of globalisation and mass mobility, global health governance structures, particularly those that deal with public health matters, have been inadequate in dealing with HIV/AIDS.

After the 'new world' was discovered, countries were colonised and travel by sea increased, and so did the threat of exotic, tropical diseases to European countries.<sup>109, 110</sup> In the mid-1800s, twelve European nations standardised and harmonised port of entry mechanisms to manage health threats.<sup>J</sup> Lengthy periods at sea, which gave illnesses and diseases an incubation period, meant diseases could therefore be detected on arrival. The advent of air travel however has meant that diseases can now spread around the world quickly before symptoms reveal themselves.

Global health governance mechanisms have not developed or kept pace.<sup>109</sup> It was not until 1945 that the United Nations (UN) Charter provided further guidance because of the mass movement of refugees after World War II.<sup>111</sup> In 1951, the World Health Organization developed international sanitary regulations that were only revised in 1981. These regulations 'ensure the maximum security against international spread of disease while maintaining minimum impact of the effort on international traffic and trade'.<sup>112</sup>

For highly infectious and fatal diseases which pose tangible threats to the general population, measures which contain disease spread and 'protect populations' through the restriction of movement have generally been accepted as appropriate courses of action. It was not until 2007 that a new set of regulations was agreed to by member states of the UN—the International Health Regulations (2005), originally developed in 1969. The focus of the new regulations was not to quickly tackle any outbreak at its source rather than control diseases at borders.<sup>113</sup> While HIV is a serious illness with fatal consequences if left untreated, it is not highly visible to the general population as it has a slow incubation period, few if any symptoms, is not contagious and involves private behaviour. It is also unamenable to traditional methods of cross border health control; other strategies are needed to prevent onward transmission.<sup>27</sup>

In 1987 the World Health Organisation (WHO) organised a special program on AIDS to direct and coordinate the global response to the pandemic, mobilising countries through a framework for common practices.<sup>114</sup> Other players have emerged more recently, arguably as a result of poor or ineffective global health governance structures. It is noteworthy for example that though two thirds of the world's population living with HIV live in CW countries, HIV has yet to feature in the CW Heads of Government Meeting (CHOGM).<sup>55</sup> Private philanthropists such as the Gates Foundation, Lowy Institute, transnational non-government organisations such as the Global Fund, the President's Emergency Plan For AIDS Relief (PEPFAR), Médecins Sans Frontières, Oxfam, Red Cross, Save the Children and Transnational Corporations have significant influence in intra-country and cross border health issues. Some of these new bodies are neither accountable to 'countries' or global health bodies such as WHO.<sup>115</sup>

<sup>J</sup> A result of the International Sanitary Conferences, convened from 1851-1938 prior to the establishment of the World Health Organization in 1948.



**Public authorities must attach prime importance to the human rights of migrants including the right to health. Legal frameworks are important to guarantee access to health services to protect migrants from discrimination and the effect of attitudes of politicians, media, professional and authorities<sup>77</sup>**



### **Policies, Frameworks, Strategies and Programs in Australia and Internationally**

The Australian government has included people travelling to Australia from high prevalence countries in six out of seven national HIV/AIDS strategies, however relatively few resources have been directed at the issue, and in general migrant health facilities are underdeveloped. In addition, significant policy barriers have not been removed. When applying for a permanent visa, migrants aged fifteen years or over are required to take a HIV test in Australia.<sup>116</sup> Migrants aged less than fifteen years are also required to take a HIV test if they are being adopted or have a history of blood transfusions or other clinical conditions.<sup>116</sup> When applying for a temporary visa in Australia, migrants who intend to work or study to become a doctor, nurse, dentist or paramedic are required to take a HIV test.<sup>116</sup> The Migration Health Requirement for permanent residency is a barrier for PLHIV.<sup>117</sup> The policy is often misunderstood, which stigmatises PLHIV and affected communities and impacts affected migrant communities' engagement in HIV prevention, care and support strategies.<sup>117</sup>

Internationally, governments are also grappling with this issue. For instance, three quarters of European member states have identified migrants as important sub-populations in their national HIV response and some have developed targeted prevention programs for migrants.<sup>46</sup> However, few countries monitor their response to HIV prevention among migrants and even fewer have any qualitative data to show the quality and scale of these targeted programs.<sup>46</sup>

If programs are to be effective they have to be accessible to people either while they are mobile, or alternatively when they are in a location or situation for long enough to access the program. Migrants who settle in a particular country can be accessed if programs are meaningful, have meet their needs, and if disincentives to participate are removed or minimised.

Various theoretical frameworks and models have informed HIV prevention responses in a variety of settings. Examples include:

- public health strategies and operational frameworks<sup>118</sup>
- targeting migrants in-situ mechanisms which influence behaviour<sup>88</sup>
- social plausibility as a way of conceptualising potential intervention strategies<sup>65</sup>

- community mobilisation, social cohesion, social capital and resilience<sup>65, 119, 120</sup>
- targeting mobile populations.<sup>79</sup>

Responses have included:

- global think tanks, meetings and instruments
  - examples include declarations,<sup>121, 122</sup> position papers,<sup>22</sup> technical reports,<sup>90, 123</sup> consultations,<sup>77</sup> policy and program reviews,<sup>44, 46</sup> and organisations.<sup>46, 124, 125</sup>
- cross border policy and service responses
  - to date the focus has been on harmonising surveillance and monitoring. There are few published examples of cross-border programs where the border is land based and most of the movement is by car, train and even foot.<sup>78, 126, 127</sup> Cross-border or regional programs and service delivery must remain a long-term goal for the global HIV sector.

- service delivery responses
  - many programs exist in low to middle income countries funded by governments from high income countries and philanthropic organisations.<sup>128-130</sup> While there are many innovative projects targeting mobile populations and migrants in high income countries, they tend to have a narrow impact, low participation and limited resource allocation.
- integrated and comprehensive programs
  - various programs have been implemented to date in Britain,<sup>131</sup> Israel,<sup>120</sup> Europe, Germany and Australia.

Table 3 summarises some examples of national programs and projects that have been implemented. Table 4 summarises some examples of the types of state-based programs and projects that have been implemented.

**Table 3: National programs and projects**

### National programs and projects

**Australian Federation of AIDS Organisations (AFAO)** is the national peak body for HIV community response.

AFAO has produced a number of relevant position papers, discussion papers, briefing papers, and the mapping of services targeting African communities, particularly about aspects of the African community in relation to HIV.<sup>117, 132</sup> They have also facilitated a number of state and national consultations.<sup>132</sup> AFAO manages an international project which is delivered in-situ in Thailand (<http://www.afao.org.au/what-we-do/international-program>) and is a member of the African and Black Diaspora Global Network (ABDGN) on HIV and AIDS. Please refer also to the African Australian Communities and HIV: Mapping HIV health promotion programs and resources report produced by AFAO([www.afao.org.au/library/resources](http://www.afao.org.au/library/resources))

See [www.afao.org.au](http://www.afao.org.au) for further details.

**Scarlet Alliance** is the national peak body representing peer-based sex worker programs.

The Scarlet Alliance Migration Project, staffed and managed entirely by migrant sex workers, was formally first funded in 2009. The project works to support evidence-based policy development, representation, training, capacity development of sex worker peer educators in delivering services to migrant sex workers, and produce translated information and resources for distribution to sex workers of Thai, Chinese and Korean language backgrounds. Scarlet Alliance also works with international sex worker programs, including a capacity building project in Papua New Guinea and an ongoing partnership with the *Empower Foundation* in Thailand to provide information and support for sex workers intending to work in Australia. Significant research with migrant sex workers has been undertaken and published by Scarlet Alliance,<sup>104, 133</sup> which is available on their website.

See [www.scarletalliance.org.au](http://www.scarletalliance.org.au) for further details.

**National Association for People Living With HIV/AIDS (NAPWHA)** is a national peak non-government organisation that represents PLHIV.

In 2014, NAPWHA published a report on *The Australian HIV Observational Database Temporary Residents Access Study (ATRAS)*, a study on HIV positive patients ineligible for Medicare. NAPWHA estimates that the number of Medicare ineligible HIV-positive temporary residents in Australia in care over the last two years is 450, of whom 141 are in the ATRAS study.<sup>134</sup> In collaboration with the National Centre in HIV Social Research at University of New South Wales, NAPWHA also conducted an audit into the experiences and effects of stigma on the lives of PLHIV. Although there were no specific findings for migrants or mobile populations, the results have general relevance for mobile populations and migrants.<sup>135</sup>

See [www.napwa.org.au](http://www.napwa.org.au) for further details.

**Australian Injecting and Illicit Drug Users' League (AIVL)** is the national peak organisation representing the state and territory drug user organisations and issues of national significance of people who use or have used illicit drugs.

AIVL received funding via AusAID in 2008 to undertake the Partnerships project in the Asian region. The project aimed to develop and maintain partnerships with peer-based drug user organisations in Asia to support effective regional responses to HIV. The project was extended in 2012 and AIVL has continued to support drug user networks in the Asian region.

See [www.aivl.org.au](http://www.aivl.org.au) for further details.



**Table 4: State-based programs and projects**

State-based programs and projects
<p><b>New South Wales (NSW)</b></p> <p><b>The Multicultural HIV and Hepatitis Service (MHAHS)</b> responds to HIV/AIDS and hepatitis C among CALD communities in New South Wales (NSW).</p> <p>MHAHS workforce development initiatives include capacity building and cultural sensitivity training to relevant agencies, and training for multicultural health and community workers. MHAHS works with different communities to develop culturally appropriate strategies. Health promotion multi-strategic initiatives targeting priority CaLD groups are also conducted by the MHAHS in partnership with key community and sector based agencies. In 2012, the MHAHS established a NSW African/Australian HIV network following successful engagement with African communities using innovative engagement methods, including sponsoring annual soccer tournaments and participation in ethnic radio.</p> <p>See <a href="http://www.mhahs.org.au">www.mhahs.org.au</a> for further details.</p> <p>The <b>AIDS Council of New South Wales (ACON)</b> is a NSW based health promotion organisation that specialises in HIV and LGBTI health.</p> <p>ACON hosts a specific project working with gay men in the Pacific and Thailand.<sup>136</sup></p> <p>See <a href="http://www.acon.org.au">www.acon.org.au</a> for further details.</p> <p><b>Family Planning NSW (FPA NSW)</b> is a not-for-profit organisation that provides reproductive and sexual health services in NSW. FPA NSW developed the <i>Safe in the Sack</i> Campaign designed to increase safer sex practices amongst backpackers visiting Australia (2004).</p> <p>See <a href="http://www.fpnsw.org.au">www.fpnsw.org.au</a> for further details.</p> <p>In NSW there is a massive push within the community to increase testing (with the estimations that 20% of PLWHIV are undiagnosed) and to target at risk populations. In the South Eastern Sydney Local Health District a nurse has been employed to increase testing in targeted areas of health.</p> <p>See <a href="http://www.health.nsw.gov.au/endinghiv">www.health.nsw.gov.au/endinghiv</a> for further details</p>
<p><b>Victoria (VIC)</b></p> <p>The <b>Multicultural Health and Support Service (MHSS) and the Centre for Culture, Ethnicity and Health (CEH)</b></p> <p>The Centre for Culture, Ethnicity and Health (CEH) provides information, training and support on cultural diversity and well-being. The Multicultural Health and Support Service (MHSS) program is provided by the Centre for Culture, Ethnicity and Health (CEH) to support Victorian migrant and refugee communities and service providers in the areas of STIs and BBVs.</p> <p>To facilitate a multi-sectoral approach to sexual health, the MHSS developed a Multicultural Sexual Health Network (MSHN). The MSHN brings together stakeholders from various sectors to discuss sexual health issues and strategies to ensure better health and well-being outcomes for multicultural communities. The network acts as a hub for information sharing, referral, enhanced coordination, service model development and multi-sectoral advocacy. The CEH created a manual to supplement training provided by the MHSS with regard to HIV and cultural competence of health workers. Other projects provided by the CEH include <i>Hip Hop for Health</i> workshops, which leverage the popularity of hip hop to engage with African and Arabic youth around sexual health issues. <i>Sister2Sister</i> was a program for young women that fostered a community and family approach to sexual and reproductive health and a family camp. Various regional community workshops have also been held by the CEH.</p> <p>See <a href="http://www.ceh.org.au">www.ceh.org.au</a> for further details.</p>
<p><b>Queensland (Qld)</b></p> <p><b>Ethnic Communities Council of Queensland (ECCQ)</b> is a not-for-profit, community-based peak body that represents CaLD communities in Qld. The ECCQ runs a HIV, Hepatitis C and Sexual Health program which aims to educate people of CaLD background on HIV, viral hepatitis and STIs and connect them to service providers.</p> <p>The program is based on a peer education model, where bilingual community health workers conduct presentations and workshops to community groups, information stalls at community events and shopping centres at targeted locations, language specific calendars and distribute printed resources.</p> <p>See <a href="http://www.eccq.com.au">http://www.eccq.com.au</a> for further details.</p>
<p><b>Western Australia (WA)</b></p> <p><b>The Metropolitan Migrant Resource Centre (MMRC)</b> is a non-profit community organisation that facilitates the settlement and participation of migrants in metropolitan Perth, WA). The MMRC regularly partners projects with the WA AIDS Council (WAAC) including World AIDS Day and community leaders' HIV training. The organisations also partnered on the Uthando Project to make dolls for HIV-affected children in South Africa. Activities have facilitated discussion among African community participants about HIV.</p> <p>A partnership was also formed for a theatre and drama based peer education project 'Sharing Stories', designed to communicate HIV and intergenerational conflict messages to people from CaLD communities in metropolitan Perth. Using interactive theatre and drama based strategies, the project was found to be a culturally appropriate means to engage migrant youth in sexual health education. In partnership with the WA AIDS Council (WAAC) the MMRC launched an innovative online cultural competency training program <i>Your Cultural Lens</i> in 2014. The training program is designed to contribute to the development of culturally appropriate sexual health services.</p> <p>See <a href="http://www.mmrcwa.org.au">www.mmrcwa.org.au</a> for further details.</p>

Table 4: State-based programs and projects (continued)

State-based programs and projects
<p><b>Western Australia (WA)</b></p> <p><b>Western Australian AIDS Council</b> is a WA community based organisation that works to promote health and well-being of people living with or at-risk of HIV, STIs and BBVs.</p> <p>The WAAC developed a sexual health project for backpackers <i>Safe in the Sack</i> which included mass media resources based on the Sydney Project, education sessions and events in youth hostels, condom distribution, and engagement with the youth travel industry and local pubs. The WAAC has undertaken a number of activities targeting HIV and Australian travellers. This includes research on sexual health risk taking behaviour, resource and website (<a href="http://www.sexinothercities.com.au">http://www.sexinothercities.com.au</a>) development and other social marketing activities e.g. Safe Sex No Regrets campaign (2008-2009).</p> <p>The WAAC has undertaken a range of work with the African and Black Diaspora, which includes:</p> <ul style="list-style-type: none"> <li>• supporting the Ethiopian Radio Service to produce short HIV-related radio programs</li> <li>• establishing the African Ambassador for HIV in Perth project</li> <li>• active membership of the AFAO African Project Reference Group</li> <li>• recruiting and up-skilling potential African HIV peer educators</li> </ul> <p>The WAAC has also funded research and undertaken a range of advocacy efforts around this issue both within the sector and with groups such as the Chamber of Minerals and Energy. The WAAC also conducted training and developed resources for travel medicine providers of travel vaccines and other pre and post travel health checks. The WAAC joined Barrick Gold for the Industry Development project, an online training module for workers travelling to high risk countries.</p> <p>See <a href="http://www.waids.com">www.waids.com</a> for further details.</p> <p><b>WA Department of Health</b> has delivered the Travel Safe campaign for many years. Recent iterations were <i>Going Overseas? Get it On</i>, a campaign aimed at male travellers and the <i>Could I be getting more than I came for?</i>, campaign aimed at backpackers (2012) to increase awareness of maintaining safe sexual practices when travelling or working overseas. The <i>Travel Safe</i> campaign was evaluated in 2009 along with Sex in Other Cities.</p> <p>The Department has supported the development of a cultural competency online training program (2014), and has funded a number of research and NGO strategies and research projects to explore issues surrounding HIV and Mobility.</p> <p>See <a href="http://www.health.wa.gov.au">www.health.wa.gov.au</a> for more details</p>
<p><b>South Australia (SA)</b></p> <p><b>Relationships Australia SA</b> is a not for profit, secular, community organisation whose objective is to relieve the suffering, distress and helplessness of vulnerable and disadvantaged people, so as to enhance their physical, social and emotional wellbeing.</p> <p>The Personal Education and Community Empowerment (PEACE) Multicultural Services program supports people from CaLD backgrounds to lead balanced, healthy lives. In response to the African women's high vulnerability to acquiring HIV, PEACE implemented an 'Empowering African Women' project comprising a series of six education sessions being delivered to African women aged seventeen to thirty years. PEACE also supports the African Communities Leaders Advisory Forum (ACLAF), a decision-making forum for community members to influence PEACE BBV and STI activities. PEACE Multicultural Services, Relationships Australia SA developed a travel safe booklet <i>Travelling Overseas? Then Plan Ahead</i>. Designed to provide guidance before, during and after travel, the resource also contained information on safe sex and safer injecting practices.</p> <p>See <a href="http://www.rasa.org.au">www.rasa.org.au</a> for further details.</p> <p><b>SA Health</b> developed a series of factsheets targeting international students in 2014. The factsheets were developed in partnership with the Department of Further Education, Employment, Science and Technology with contributions by Multicultural Youth SA Inc. Information included health cover, health service access, sexual health and emotional well-being.</p> <p>See <a href="http://www.sahealth.sa.gov.au">www.sahealth.sa.gov.au</a> for more details</p> <p><b>SA Sex Industry Network (SIN)</b> provides an outreach, peer education, information, support and safer sex supplies to migrant sex workers and sex workers from non-English speaking backgrounds.</p> <p>See <a href="http://www.sin.org.au/SINCaldProject">www.sin.org.au/SINCaldProject</a> for further details</p>
<p><b>Australian Capital Territory (ACT)</b></p> <p><b>The AIDS Action Council (AAC)</b> is a community-based health organisation that aims to reduce transmission and minimise personal and social impacts of HIV/AIDS via education and health promotion.</p> <p>The peer based sexual health project SWOP (Sex Workers Outreach Program) which is run by the AAC provides HIV and STI education to sex workers. Bilingual education officers are also used to provide outreach work to CaLD sex workers.</p> <p>See <a href="http://www.aidsaction.org.au">www.aidsaction.org.au</a> for further details.</p> <p><b>Companion House</b> works with newly arrived and longer term settlers who have sought refuge in Australia.</p> <p>Companion House work closely with bi cultural and bilingual workers and community elders to carry out their work. Gender based sex education classes are delivered by the ACT branch to recently arrived African migrant and young people with a refugee background who are of high school age.</p> <p>See <a href="http://www.companionhouse.org.au">www.companionhouse.org.au</a> for further details.</p>



**Table 4: State-based programs and projects (continued)**

State-based programs and projects
<p><b>Northern Territory (NT)</b></p> <p><b>The Refugee Health Network of Australia (RHeaNA)</b> is a network of health and community professionals with interest and/or expertise in refugee health.</p> <p>The Network draws members from every Australian state and territory and has a multidisciplinary focus and includes clinicians, experts, health service managers and researchers. As part of the NT Refugee Health Network, the subcommittee Everybody's Business was established to identify the sexual and reproductive needs of migrant and refugee communities. The committee is made up of government and non-government agencies that support migrant and refugee communities.</p> <p>See <a href="http://www.refugeehealthaustralia.org">www.refugeehealthaustralia.org</a> for more details.</p> <p>The <b>NT Department of Health</b> developed an HIV and travellers campaign.</p> <p>See <a href="http://www.health.nt.gov.au">www.health.nt.gov.au</a> for further details</p>

As shown in Table 4, there are some similarities and differences between the states. In NSW, Victoria, Western Australia and Queensland, there are dedicated multicultural health and support services or peak bodies supporting ethnic communities. A range of NGOs, state health departments and the AIDS Councils have also implemented programs and projects for migrants and mobile populations. Services, programs and projects for specific priority populations, including refugees, gay men and MSM, travellers and sub-Saharan African and CaLD communities are also evident. There is currently no consistent provision of health services, treatment and care for migrants and mobile populations.

## Summary of Australian Research Related to HIV and Mobile Populations

Australian research since 1993 has investigated the diversity of the HIV epidemic in Australia associated with migrant and mobile populations and the implications for health promotion, service provision, access to health care and policy.

The research has focused on a range of issues related to HIV prevention and transmission including: understanding delayed or late diagnoses;<sup>137-140</sup> HIV risks associated with injecting drug use;<sup>141-144</sup> HIV knowledge, information access and health literacy in migrant populations;<sup>83, 145-149</sup> stigma, social risk/inclusion and human rights issues;<sup>150-153</sup> health promotion and service provision;<sup>154, 155</sup> HIV interventions for migrants including peer education, risk reduction and media campaigns;<sup>88, 156</sup> the impact of visa status and Medicare eligibility on access to health care;<sup>134, 157, 158</sup> overseas-acquired HIV;<sup>96, 100, 159, 160</sup> the role of social networks;<sup>96, 161</sup> surveillance;<sup>162</sup> HIV diversity and cultural

competence;<sup>14, 89, 163-165</sup> AIDS-defining illnesses related to country of birth;<sup>166</sup> and exploration of HIV subtypes.<sup>21, 167, 168</sup>

Migrant and mobile populations of particular interest were:

- CaLD communities including Salvadorean and Chilean,<sup>169, 170</sup> Indo-Chinese,<sup>171-174</sup> Iranian,<sup>151</sup> Turkish and Greek,<sup>175</sup> and Vietnamese people<sup>176</sup>
- LGBTI people from CaLD backgrounds<sup>177-179</sup>
- People who inject drugs from CaLD backgrounds<sup>141, 172-174, 180, 181</sup>
- People living with HIV from CaLD backgrounds<sup>182</sup>
- African Australians including those from refugee or migrant backgrounds<sup>21, 150, 183-188</sup>
- Australian gay men and men who have sex with men acquiring HIV overseas<sup>96, 100, 160</sup>
- Australian heterosexual people acquiring HIV overseas<sup>159</sup>
- Australian travellers (males and females) and Australians migrating overseas<sup>24, 25, 92, 97, 99, 161, 189-191</sup>
- Local and international sex workers<sup>133, 192-194</sup>
- International students and backpackers.<sup>195, 196</sup>

See Appendix for the full list of references.

# Part 2.

## HIV and Mobility in Australia: An Agenda for Action



# Australia's Response

Australia has used a combination of strategies to respond to HIV with a focus on prevention. These include:

- mobilising communities most impacted by HIV
- encouraging individuals in priority groups to reduce risk behaviour, undergo regular HIV testing and start and maintain treatment
- changing government laws and modifying policies to ensure that a human rights approach underpinned the Australian HIV response and that other strategies could be implemented
- undertaking appropriate surveillance, research and evaluation to guide and inform responses.<sup>13, 88</sup>



**The Australian response has been comparatively successful to date and has resulted in Australia having one of the lowest HIV prevalence rates among high income countries<sup>197</sup>**



However, HIV epidemics are changing as a result of globalisation, rapid urbanisation and mass mobility.

Australia is one of many high income countries experiencing a disproportionate number of new HIV diagnoses among people from high prevalence regions, particularly from sub Saharan Africa and South East Asia. The context of mobility may increase the vulnerability of HIV acquisition to a greater or lesser extent in all migrant and mobile populations. People move for a variety of reasons including for work, education, improved life opportunities, family reunion, recreation and adventure or to escape conflict and natural disasters.

Despite the fact that HIV has always been, and still is, a condition related to population movement and mobility, many governments and regions have been slow to understand the impact of mobility on local HIV epidemics. This has been exacerbated by global health governance structures unable to influence sovereign countries' responses to HIV, and increasingly porous borders. However, some governments and regions have developed strategies and approaches in response to the increase in HIV infections related to mobile populations that are starting to pay dividends.

Australia must respond to these emerging challenges with courage, creativity and commitment.

**Australia is one of many high income countries experiencing a disproportionate number of new HIV diagnoses among people from high prevalence regions, particularly from sub Saharan Africa and South East Asia**

# The Seventh National HIV Strategy and Mobility

## Guiding Principles

The Seventh National HIV Strategy<sup>197</sup> identifies seven guiding principles which underpin Australia's response to the '*challenges, threats and impacts of HIV, STIs and viral hepatitis*'. These are: a human rights approach, access and equity, health promotion, prevention, harm reduction, shared responsibility, and partnership. In relation to mobile populations and migrants, these principles have the following implications.

**A human rights approach:** Mobile populations and migrants who have HIV participate fully in society, without experience of stigma or discrimination, and have the same rights to comprehensive and appropriate health care as other members of the community (including the right to the confidential and sensitive handling of personal and medical information).

**Access and equity:** Health and community care in Australia should be accessible to all based on need. The multiple dimensions of inequality should be addressed, whether related to geographic location, gender, sexuality, drug use, occupation, socioeconomic status, migration status, language or culture.

**Health promotion:** The Ottawa Charter for Health Promotion provides the framework for effective HIV, STI and viral hepatitis health promotion action. It facilitates the:

- active participation of affected migrant communities and mobile populations to increase their influence over the determinants of their health
- formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights.

**Prevention:** The transmission of HIV can be prevented by adopting and maintaining protective behaviours. Tailored education and prevention programs developed with and for migrants and mobile populations nuanced to their needs, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures.

**Harm reduction:** Strategies relating to migrants and mobile populations must take into account unintended consequences and must not result in physical, psychological or social harm.

**Shared responsibility:** Mobile individuals and migrant communities share responsibility to prevent themselves and others from becoming infected, and to inform efforts that address education and support

needs. Governments and civil society organisations have a responsibility to provide the necessary information, resources and supportive environments for prevention.

**Partnership:** An effective partnership of governments, affected communities, researchers and health professionals is characterised by consultation, cooperative effort, respectful dialogue and joint action to achieve this strategy's goal. This includes:

- recognition that those living with, and at-risk of infection are experts in their own experience and are therefore best placed to inform efforts that address their own education and support needs
- timely and quality research and surveillance to provide the necessary evidence base for action
- a skilled and supported workforce
- leadership from the Australian government and the full cooperative efforts of all members of the partnership to implement the strategy's agreed priority actions.

## Priority Populations

Priority populations of particular interest in relation to HIV and mobility, as identified in the Seventh National HIV Strategy,<sup>197</sup> are described below.

### PLHIV from a migrant background

Epidemiological data<sup>23</sup> and psychosocial research conducted in Australia<sup>89, 184</sup> and other parts of the world (France, Switzerland, UK) show that people from migrant populations are diagnosed late because of perceived stigma related to their migrant status, fear of deportation and discrimination. This results in overall poor health outcomes. There is also evidence that migrants are fearful of confidentiality breaches in their ethnic communities so they do not seek the mutual support of other people with HIV.<sup>83, 152</sup>

... people from migrant populations are diagnosed late because of perceived stigma related to their migrant status, fear of deportation and discrimination. This results in overall poor health outcomes

Partnerships must be forged between migrant communities and the HIV sector so that migrants with HIV have access to the full range of services and supports offered to PLHIV in Australia and to ensure affected communities (including PLHIV) and services work in partnership to develop services that are relevant and appropriate for their needs.

### People from high HIV prevalence countries and their partners

In Australia, HIV diagnoses have been increasing among people from high HIV prevalence countries, including South East Asia and sub Saharan Africa with more women than men being diagnosed.<sup>23</sup> Among cases of HIV infection newly diagnosed in Australia over the past five years, 10% were in people who reported speaking a language other than English at home.<sup>23</sup>

Targeted prevention and treatment approaches must address the context of mobility and consider the

### Among cases of HIV infection newly diagnosed in Australia over the past five years, 10% were in people who reported speaking a language other than English at home

additional vulnerability conferred on mobile populations which are exacerbated by differences in socio-economic circumstances, language, cultural background, religious and spiritual beliefs, sexuality and gender issues. Other issues are: low health literacy and perception of risk, limited health-seeking behaviour, lack of familiarity with health system and services,

previous negative experiences of healthcare in Australia or in their home country, and issues relating to privacy and confidentiality (e.g. use of interpreters).

There is additional vulnerability for already at-risk groups in Australia:

- GMSM from migrant backgrounds or holding temporary visas may not be attached to GMSM communities thereby without prevailing education and may feel isolated. They may be coerced into having unsafe sex due to economic circumstances or to feel a sense of belonging.
- PWID from migrant backgrounds or on temporary visas may be marginalised within their own community and yet not feel accepted within the broader Australian community. They may also travel back and forth (and inject drugs) in their home countries without access to sterile equipment, and with exposure to higher HIV and other BBV prevalence.

- While safe sexual practices of migrant sex workers in Australia have been found to be similar to non-migrant workers<sup>106</sup>, criminalisation and licensing and the fear of arrest and deportation create barriers to migrant sex workers accessing health, legal and support services and can exacerbate marginalisation from their own ethnic communities.

### Travellers and mobile workers

People may engage in behaviour putting them at risk of HIV acquisition while travelling for work, leisure and education. People from high HIV prevalence countries who are employed temporarily in Australia (some of whom may also be FIFO/DIDO

workers and other mobile workers) are emerging as a factor in the epidemiology of HIV in some areas such as WA. It should be noted that 'temporary' could mean up to eight years, which in the context of HIV means very poor health outcomes and the added risk of onward transmission without access to HIV treatment and care.

### People in custodial settings or detention centres

Refugees and asylum seekers are a mobile population and are very likely to have experienced significant trauma or violence during the course of mobility. Some, like other migrants and mobile populations in custodial settings, may be at risk of HIV transmission through unsafe injecting drug use, unsafe tattooing and unprotected sex (including through sexual assault).<sup>198</sup> If HIV is acquired in a custodial or detention setting there is also an increased risk of transmission to others within the centre or in the community when they are discharged. Barriers to HIV prevention in custodial and detention settings include lack of access to the means of prevention. There is a legal liability of authorities for preventable infections occurring in custodial settings due to absence or failure of evidence-based prevention strategies.

### People may engage in behaviour putting them at risk of HIV acquisition while travelling for work, leisure and education

## Priority Actions

The Seventh National HIV Strategy identifies priority action areas.<sup>197</sup> These are: prevention, testing, management care and support, workforce, removing barriers, and surveillance, research and evaluation. The priority actions needed in the context of mobility are discussed below.

### Prevention

Prevention strategies include a range of actions for migrants entering Australia which are different to those for mobile populations from Australia travelling in high prevalence countries.

#### *Migrants entering Australia*

These strategies require a long-term, comprehensive approach as well as strong advocacy and building relationships with other migrant organisations.

- Health promotion initiatives need to be tailored to meet the needs of migrant populations, particularly those from high HIV prevalence countries. Patterns of infection, including infections that may occur on visits to the country of origin, from overseas partners who travel to Australia temporarily or from other people in Australia—require more research.
- Barriers such as inadequate health services for mobile and migrant populations generally, a lack of appropriate resources, underlying stigma and discrimination, legal barriers and punitive responses, and the lack of culturally appropriate initiatives and services with communities need to be explored.
- Specific HIV education, information and skill building programs need to be formulated in partnership with migrant communities, community and spiritual leaders. The purpose of these programs is to prepare individuals for visits to their country of birth or other high prevalence areas, to assist when sexual relations are formed with people from high prevalence countries in Australia, and to educate people about the laws related to sex in Australia so that they do not experience legal difficulties.
- In the context of mobility—assess the emerging evidence on the uptake, experience and impact of the use of ‘treatment as prevention’ to determine whether these approaches are feasible, acceptable and cost effective. There are significant barriers in getting migrant populations tested, and significant barriers for people who are ineligible for Medicare having access to HIV treatments.<sup>157</sup>
- Attention must be directed towards potential risks for migrants with undiagnosed HIV, and the consequences of later testing and treatment.
- Increased cultural sensitivity of organisations working with sub populations such as GSM, PWID and sex workers from migrant backgrounds. This is because

migrants who are also members of these sub groups are less likely to seek services from specialist migrant services than ‘mainstream services’ due to migrant community stigma and discrimination.

- The success of HIV prevention among sex workers in Australia can be attributed to effective implementation of safe sex practices by sex workers, supported by effective peer education and a culture of high levels of condom use and testing. The very low rates of HIV among sex workers, including migrant sex workers, provides evidence of the effectiveness of condoms as a prevention tool, and of peer education and outreach strategies for informing hard-to-reach groups about HIV risk and establishing peer norms.
- Prevention policies which aim to ‘contain and control’ HIV at the border are not adequate or appropriate in the era of mass mobility by air. Policies relating to migrants with HIV or at risk of HIV must transition to aiming at the social protection of health.<sup>77</sup>
- Strengthen mechanisms to monitor and benefit from innovations and advances in biomedical, social and behavioural prevention sciences.
- There is a particular need to develop harmonised, cross-portfolio/cross-jurisdictional health components of settlement programs that incorporate BBV and STI sexual health promotion and education.

#### *Mobile populations from Australia travelling in high prevalence countries*

It is a difficult and complex proposition to influence risk behaviour when people travel outside of Australia, particularly to areas where structural measures are poorly developed or non-existent. It needs to be recognised that Australians are used to structural approaches where ‘risks’ are reduced for them in a number of different health related issues. They are used to not having to make decisions about risk. Closer cooperation with destination countries to harmonise HIV prevention initiatives relevant to populations travelling between these countries and Australia could be considered. It should also be noted that many travellers and tourists seek risk as part of the travel/tourist experience. Risk reduction strategies need to incorporate compensation for the pleasure derived from the ‘freedom to take risks’ while away from Australia.<sup>161</sup>

**Closer cooperation with destination countries to harmonise HIV prevention initiatives relevant to populations travelling between these countries and Australia could be considered**



## Many travellers and tourists seek risk as part of the travel/tourist experience. Risk reduction strategies need to incorporate compensation for the pleasure derived from the ‘freedom to take risks’ while away from Australia

There are patterns related to individuals, groups, behaviours and contexts that are associated with greater risk of HIV acquisition in high prevalence countries that require more research. In terms of planned interventions, even in circumstances where there is a good understanding of these patterns, it is difficult to plan viable, cost-effective and practical programs that will influence at-risk behaviour or the context in which it occurs. This is because specific information, education and skill building would need to

be delivered in Australia prior to travel, which may not be possible if there is no existing systematic pathway of engagement with individuals or groups.

In circumstances however where engagement pathways with key affected populations exist, the following is proposed:

- identify at-risk sub groups using epidemiological and behavioural evidence:
  - GMSM who may increase sexual experiences while travelling
  - People working in high prevalence countries such as for resource companies
  - Military personnel and aid organisations
  - Heterosexual men who travel frequently and may be over confident with their familiarity with new environments and their risk behaviour
  - Middle-aged heterosexual men travelling to South East Asia to find a partner
- design and provide specific information and education about understanding the context of unsafe sexual behaviour in high prevalence countries to be delivered in pre-existing institutions such as sexual health clinics or through employers.
- increase social capital and resilience of disaffected risk takers who travel.
- develop skills in people to recognise and deal with different risk situations and scenarios (i.e. determining what risk looks like).

## Testing

In keeping with the success of structural approaches in Australia it is envisaged that actions targeting migrants and mobile populations need to focus on voluntary early testing. For people who are tested and found to be HIV negative, information, education and skill development to avoid HIV infection is necessary.

In order for ethical HIV testing to take place among newly arrived migrants, particularly from high prevalence countries, the following issues must be resolved and are the basis for further advocacy:

- a whole of government approach to enhance the health and well-being of migrants (access to health services, housing, education, community services)
- social capital must be built in migrant communities with long-term community development processes particularly with leaders and spiritual leaders to gain trust of older generation
- societal stigma and discrimination related to migrants must be addressed including protecting the human rights of migrants to receive equitable access to health services
- the threat of penalties including deportation regarding HIV and visa status must be addressed via advocacy around policy changes
- access to voluntary testing (and treatment) facilities must be culturally sensitive and accessible
- structural barriers to voluntary testing such as cost, location, and access to interpreter services must be addressed.

## Management, Care and Support

For those diagnosed with HIV, early and sufficient access to treatment, treatment uptake, and care and support services are crucial. The following must be considered:

- promote treatment uptake by mobile and migrant populations by addressing barriers such as lack of access to Medicare or culturally appropriate health care to commencing or continuing antiretroviral medications and retention in care.
- ensure that current care and support providers are sensitive to the needs of migrant and mobile populations with HIV.
- systemic and structural barriers to treatment uptake, such as access to Medicare, and dispensing arrangements need to be explored by Commonwealth, state and territory governments.

## Workforce

A highly skilled and knowledgeable workforce is paramount to progress towards Australia's vision of no new infections by 2020. Actions required include to:

### A highly skilled and knowledgeable workforce is paramount to progress towards Australia's vision of no new infections by 2020

- ensure that HIV testing and treatment providers have adequate training and support to deliver appropriate services to mobile and migrant groups
- work together with relevant organisations to ensure delivery of cultural sensitivity training, continued

education and professional support programs, including in regional and remote areas, and for new workforce entrants

- improve collaboration between migrant services, mental health, drug and alcohol, disability, clinical and community services to address the care and support needs of people with HIV
- support the capacity and role of migrants and HIV community organisations to provide education, prevention, support and advocacy services to migrant and mobile populations
- HIV education should address stigma and discrimination related to people from culturally and linguistically diverse backgrounds. Migrants and mobile groups should be included in training programs for staff of all specialist, primary care and community service providers
- peer support programs offering HIV education within mobile and migrant populations should be used to enhance education and improve engagement in HIV assessment and treatment. The role of peer educators in migrant communities and counsellors trained to undertake HIV tests in helping to increase testing rates should be further explored. Such a service could be linked into community-based migrant health services.

## Removing Barriers

Enabling social and legal environments are important in ensuring access to HIV prevention, treatment, care and support. HIV continues to attract stigma that can have negative consequences for psychological well-being and on health outcomes for people with HIV. Discriminatory or unfair treatment increases the

negative impact on the health status of people with BBVs and can reduce access to care. Stigma and discrimination have been correlated with poor access to health care and risk behaviour. Essential actions include:

- reducing stigma and discrimination directed at mobile and migrant populations in community and health care settings, and empower mobile and migrant populations to increase individual and community resilience
- removing institutional, regulatory and systems barriers to equality of care for migrant and mobile populations infected and affected by HIV in the health sector, including ensuring informed and voluntary HIV testing and access to treatment
- establishing a dialogue between health and other sectors aimed at reducing stigma and discrimination against HIV infected, and affected individuals and migrant and mobile communities.

People from affected communities require protection from multiple forms of discrimination, not only because they may be thought to be living with a BBV, but also because of the primary stigma they may suffer because of their vulnerable status, such as GSM, PWID, prisoners and sex workers or people from high prevalence countries.

All partners in Australia's HIV response have a responsibility to work toward ensuring the response to HIV is human rights based. Discrimination, unfair treatment and social burdens increase the negative impact of health status and can reduce access to care.

There is an ongoing need for Australian governments to continue to review and work towards removing barriers to access HIV prevention, treatment, care and support; to promote and protect the human rights of people with HIV and people among affected communities; ensure that all HIV testing is informed and voluntary; and to break down the stigma and discrimination associated with HIV.

### All partners in Australia's HIV response have a responsibility to work toward ensuring the response to HIV is human rights based





**Support must be provided to health care professionals, such as clinicians at the front line of HIV diagnosis and treatment to ensure they are well informed about legal issues, including their own legal obligations, and can provide optimal information and support to patients**

Programs that address advocacy and empowerment of mobile and migrant populations to access HIV prevention, treatment, care and support in community, education, workplace, health care and legal settings should be promoted. Approaches include awareness raising initiatives, education and training programs, supporting advocacy and empowerment, improving access to effective complaint systems, and promoting research.

Support must be provided to health care professionals, such as clinicians at the front line of HIV diagnosis and treatment to ensure they are

well informed about legal issues, including their own legal obligations, and can provide optimal information and support to patients.

Implementation of this strategy rests within the health system; however, many of the barriers to access and equal treatment of affected individuals and communities fall outside the responsibility of the health system. For example, it could be argued that criminalisation perpetuates the isolation and marginalisation of priority populations and limits their ability to seek information, support and health care. It is important the health sector enters into a respectful dialogue with other sectors to discuss impacts of wider decisions on the health of priority groups.

#### **Surveillance, Research and Evaluation**

An effective HIV response is underpinned by excellent data and robust evaluation of what works and why. The following actions are required:

- address critical data gaps for migrant and mobile populations, including incident measures and information on risk behaviours
- explore improved and innovative approaches to measuring testing rates among migrant and mobile populations, antiretroviral treatment rates and quality of life indicators among people with HIV
- enhance evaluation and implementation research to support evidence-based and evidence building policy and program development

- undertake research across the relevant disciplines, including social, behavioural, epidemiological, clinical and basic research to inform the delivery of the strategy
- evaluate health promotion, testing, treatment, care, support and education and awareness programs
- explore opportunities to strengthen surveillance and patterns of HIV testing in migrant and mobile populations. Surveillance measures of the uptake and patterns of treatment use, the adequacy of HIV treatment, and antiretroviral drug resistance across populations will be considered and strengthened
- consider international surveillance tools and the further development of the most appropriate indicators to report against quality of life for PLHIV (building on the indicator in The Seventh National HIV Strategy)
- develop an indicator related to removing barriers to equal care that informs activities and strategies in a meaningful way. This would assist to address the ability to monitor the health impact of stigma, discrimination, legal and human rights on priority populations.



**An effective HIV response is underpinned by excellent data and robust evaluation of what works and why**



# A Proposed Road Map for Action

This section proposes a suggested way forward for the Australian HIV partnership. It is informed by:

- the Seventh National HIV Strategy (2014-2017)
- frameworks and approaches successfully used in Australia
- frameworks and approaches used with mobile populations and migrants in similar countries
- relevant research from Australia and overseas
- discussions with key stakeholders.

## Principles for a strategic approach

This project has identified ten principles for developing a strategic approach to HIV management for mobile populations and migrants in Australia.

### Ten principles for developing a strategic approach to HIV management for mobile populations and migrants in Australia

- Incorporate a human rights approach—stigma and discrimination directed at mobile populations and migrants must be reduced
- Reduce all barriers to testing and access to treatment
- Pay attention to the confluence between HIV and mobility
- Move beyond ‘narrow protectionist policies’
- Commit resources to improve migrant health
- Continue to develop links and cooperative partnerships with affected communities locally and internationally
- Participate in and contribute to global health governance
- Create closer cooperation between Australia and the HIV policy, public health, treatment and support sectors in countries of origin and destination for Australian mobile populations and migrants
- Acknowledge that mobile population and migrants need more than information (even if it is translated). Specialist services as well as generalised services need to be provided
- Know your epidemic(s)—continue surveillance and monitoring and develop evaluation strategies in conjunction with migrant populations.

These ten principles are discussed below.

### **Incorporate a human rights approach—stigma and discrimination directed at mobile populations and migrants must be reduced**

Migrants may have particular vulnerabilities to many adverse health outcomes, including HIV, which are exacerbated by social exclusion and discrimination. Access to culturally competent health care is vital. However as clinicians grapple with treating more diverse migrant groups including those with HIV, policy makers are attempting to implement restrictive or exclusive immigration related health policies that contradict public health needs and undermine medical ethics that operate on the ground.<sup>82</sup> Australian governments must assess existing policies, legislation and laws that disproportionately affect migrant populations such as in citizenship, access to government health programs, employment and education, and approaches to anti-trafficking.

Prevention and health promotion programs will not be effective if people do not feel accepted or if people feel stigmatised. This is the single most important barrier for people accessing HIV testing and as a result, late diagnoses are more likely to be made amongst migrants than others. Migrants who come forward for any health care, including HIV testing and treatment, must be treated with respect and not judgement or blame.<sup>199, 200</sup>

Policies that discriminate against migrants, in terms of Medicare access, institutionalise stigma. Temporary visa holders contribute to Australian society, economically and socially but must have insurance coverage as a condition of entry.<sup>157</sup> In the context of HIV, this can be counterproductive to migrants’ own health and population health if they do not test in fear that their insurance will not cover treatment or fears that they may be deported. Political leaders need to make conscious bipartisan decisions to avoid creating and exploiting differences between social groups for short-term political gain. Issues around the Migration Health Policy<sup>117</sup> must be addressed.

**Migrants may have particular vulnerabilities to many adverse health outcomes, including HIV, which are exacerbated by social exclusion and discrimination. Access to culturally competent health care is vital**

While migrants may be vulnerable to HIV it is not helpful for service organisations to treat them as vulnerable. By developing links with organisations working with migrants a more respectful and sustainable response will occur.

### **Reduce all barriers to testing and access to treatment**

Mobile populations and migrants already have significant barriers to accessing health care. Hours of opening, location, transport, child care availability, and appropriately trained staff are essential to ensuring that people access health care. Providers and clinicians need to be trained and supported in both cultural sensitivity and linguistic capacity.<sup>201, 202</sup> Innovative models of testing such as peer delivered rapid HIV testing for African communities has worked in Leicestershire in the UK and could be examined for use in Australia.<sup>46</sup>

In the US, for example, many states, but particularly New York State, provide HIV-related medical services for free. This program, called the AIDS Drug Assistance Program (ADAP), is accessible to migrants residing in New York State regardless of their immigration status. ADAP is seen as a public health driven response around disease control that supersedes immigration policy (see <http://www.cdph.ca.gov/programs/aids/Pages/TOAADAPindiv.aspx>).

### **Pay attention to the confluence between HIV and mobility**

**There are different HIV epidemics around the world; however Australia's epidemic will become increasingly diverse due to the mobility of people**

CW and state governments must understand the importance and complexity of global population mobility in relation to HIV. This is not a one-off endeavour but rather long-term and ongoing as the speed, volume, disparity and diversity of mass mobility and migration is here to stay. There are different HIV epidemics around the world; however Australia's epidemic will become increasingly diverse due to the mobility of people.

### **Move beyond 'narrow protectionist policies'**

Relying on migrant health screening, including for HIV, to protect the general population from either disease or health care costs is simplistic in the context of global mobility. While there are some infectious conditions which should be screened for, the policy assumes that health outcomes are a 'one way street' where migrants are concerned and that the general population is somehow unsafe from migrants.

This blunt policy does not acknowledge that the general population confers negative health outcomes on migrants, and migrants make social and economic contributions to Australian society.<sup>117</sup> HIV screening of migrants should be voluntary and only done in the context of ensuring that migrants have access to treatment and care rather than as a condition of entry.<sup>117, 203</sup> The unintended consequence of the current policy is that migrants and others who have been screened are 'lulled into a false sense of security' that they cannot have HIV even though they may have been exposed to it in Australia or another setting. This can lead to late diagnosis or having engaged in activities that could lead to onward HIV transmission.<sup>117</sup>

### **Commit resources to improve migrant health**

All population health and public health planning must incorporate specific management plans for the health of migrants and mobile populations including emerging and re-emerging infectious diseases and communicable diseases such as HIV and non-communicable diseases.<sup>204</sup> This should include having migrant health units within Ministers' offices. Strategies should be holistic, equity driven and focus on the overall health and wellbeing of migrants rather than take a specific disease focus.

### **Continue to develop links and cooperative partnerships with affected communities locally and internationally**

Australia has a strong foundation of the active and central role of affected communities and PLHIV in the response to HIV. This can be enhanced through broader community partnerships locally and internationally. The global Review

**Australia has a strong foundation of the active and central role of affected communities and PLHIV in the response to HIV**

of Policy and Programmatic Responses to HIV/AIDS commissioned by the AB-DGN44 has suggested evidence-based resources should be shared between countries with African diaspora. The AB-DGN has formed networks around the world including with AFAO. There are also existing global networks of GMSM, sex worker, injecting drug user groups and PLHIV with whom partnerships can be formed for the same purpose as well as international advocacy.

### **Participate in and contribute to global health governance**

The International Organisation for Migration has noted that 'it is futile for countries to have a purely national approach to migration and health'.<sup>205</sup> The Australian government is adept at negotiating economic agreements and other cooperative activities with other countries. Global health governance arrangements, which are more than dealing with outbreaks of infectious diseases, will become increasingly important. Issues such as having globally accepted minimum standards of migrant health, portable health benefits for labour migrants, equitable pharmaceutical arrangements, and continuity of care for mobile populations are aspects likely to be discussed in the future.

### **Create closer cooperation between Australia and the HIV policy, public health, treatment and support sectors in countries of origin and destination for Australian mobile populations and migrants**

The issues associated with HIV and mobile populations and migrants in Australia cannot be comprehensively addressed by Australia alone. With increasing awareness of mobility patterns, the sectors involved in HIV policy, public health, treatment and support in Australia need to forge and establish links with their counterparts in the countries of origin and destination of mobile populations and migrants to implement a coordinated and stronger response.

### **Acknowledge that mobile population and migrants need more than information**

Many public health interventions, including some HIV interventions, assume that people will immediately stop doing something if they know it is risky, dangerous or bad for health.<sup>38</sup> This somewhat naive proposition does not take into account the context in which risk behaviour occurs. Individual notions of risk are variable and sustained behaviour change is highly complex, requiring more than information to make it happen.<sup>38</sup>

There is overwhelming evidence that structural factors, such as social, political, economic and physical contexts either regulate risk behaviours from occurring or encourage less risk behaviour. Ensuring that the context in which mobile populations and migrants live, work and socialise are safe/ less risky is essential. For migrants and mobile populations this means also taking into consideration past contexts which have an impact and effect on their current behaviour and risk profile.

Mobile population and migrants have complex needs that require specialist services and they also have ordinary needs that can be delivered within the broader health system. There needs to be a balance between these service models. Incorporating a historical perspective and recognising its impact on the HIV response will be important.

Integrating HIV prevention and treatment within broader health and social support services (such as housing, transport, education) can address issues of stigma, racism and discrimination, and in some circumstances may be preferred, particularly if there is stigma and marginalisation of sub groups within migrant populations. However nuanced services are also required. Prevention services targeting people from migrant backgrounds need to be more than translating pamphlets or using images of people from different cultures. Vulnerable sub-groups of migrants will also need special attention.



**Individual notions of risk are variable and sustained behaviour change is highly complex, requiring more than information to make it happen**



**Know your epidemic(s)—continue surveillance and monitoring and develop evaluation strategies in conjunction with migrant populations**

An understanding of local epidemics is paramount. This includes: local epidemiological circumstances, epidemics in sub groups such as GSM and PWID, where epidemics are occurring, what behaviours are resulting in new infections, and whether there are significant social and cultural determinants, barriers or drivers.<sup>34</sup>

**Evaluation that examines the synergy and relationship between components should be seen as a valued aim of interventions.<sup>207</sup> Systems models may be useful in this regard, also training in evaluation for practitioners and communities involved in the prevention initiative**

For mobile populations and migrants a further layer of knowledge is necessary. This includes who moves, how and why they move and related aspects of departure, transit and the community in which they live, including sexual networking patterns and location specific HIV epidemiology.<sup>39, 49, 65</sup>

If interventions are broad in scope, they may not be easily assessed by experimental methods, widely regarded as the gold standard for effectiveness.<sup>206</sup> However a range of interventions is required to address HIV and mobility. Evaluation that examines the synergy and relationship between components should be seen as a valued aim of interventions.<sup>207</sup> Systems models may be useful in

this regard, also training in evaluation for practitioners and communities involved in the prevention initiative. Evaluation of processes should be undertaken—examining which approaches work and why, how, and in what social context.<sup>207, 208</sup>

Policy makers and program designers need to abandon their potential preoccupation with seeing progress towards biomedical endpoints as a measure of success. Where the goals of intervention are predominantly social a reappraisal of the key performance indicators and choice of endpoints is essential.<sup>64</sup>



# Five Areas for Action

Five areas for action are proposed. The overall goals and strategies related to each of these action areas are outlined in the tables below. They include the proposed primary responsibilities and suggested timeframes.

More activity is needed in some areas than others, however there should be a commitment to activity in all areas.

- 1. International Leadership and Global Health Governance**
- 2. Commonwealth and State Leadership**
- 3. Community Mobilisation**
- 4. Development of Services for Mobile or Migrant People and Groups**
- 5. Surveillance, Research and Evaluation.**

There are likely to be associated resource implications for the groups suggested for primary responsibility for particular strategies. In addition, given the changing epidemiology of HIV infection in some locations in Australia (WA, north QLD, SA) some consideration of equity in resourcing responses (including national research) is required. CW government buy-in and support for these strategies will be necessary in some cases, and the associated lead-in times for advocacy and budgeting would need to be considered. It should be noted that specific recommendations for action concerning particular priority populations have been detailed elsewhere.<sup>K</sup> The five areas for action presented here should be considered in conjunction with other recommendations for mobile and migrant communities.

<sup>K</sup> For example, AFAO made specific recommendations in *Discussion Paper: HIV and sub-Saharan African communities in Australia*.



# 1. International Leadership and Global Health Governance

## Overall Goals:

- Ensure that Australia's population health response to HIV and mobile populations is contemporary and appropriate through participating in and contributing to international dialogue on cross border HIV responses

- For the CW Government to provide policy leadership to minimise rates of HIV as a result of mobility in the Pacific region, and to ensure that Australian policies are consistent with this outcome
- For the CW Government to ensure that HIV and other health impacts are taken into consideration in non-health related international policy deliberations.

Table 5 summarises the proposed international leadership and global health governance strategies.

**Table 5: International leadership and global health governance strategies**

Proposed Strategies	Proposed Responsibility	Proposed Time Frame
1.1 Parliamentary liaison group (PLG) to have greater awareness of relationship between HIV and mobility	HIV/AIDS peak organisations	As soon as possible (ASAP)
1.2 Develop whole of government approach including the Prime Minister, Foreign Affairs, Trade and Immigration paying particular attention to the impact of trade and commerce on health in Australia and the Pacific region	CW Government MACBBVS	2015
1.3 Participation in international monitoring and surveillance activities including the development of standardised definitions and measurement tools	Research Institutions	Ongoing
1.4 Consider programs, responses, policies outside Australia that may have downstream effects in Australia relating to the behaviour/attitudes of travellers to and from Australia	CW Government HIV/AIDS peak organisations	Ongoing
1.5 Continue to ratify International agreements such as the Millennium Development Goals, the International Labour Organization(ILO) World of Work provision of PLHIV, UNGASS 2006, Political declaration to HIV/AIDS 2011, and Migrant Workers Convention	CW Government	Ongoing
1.6 Continue to build relationships with new players in global HIV and health governance arena such as the Global Fund, Gates, Lowy, PEPFAR (President's Emergency Plan for AIDS relief), Oxfam, Red Cross, IOM (International Organization for Migration), ICASO (International Council of AIDS Service Organizations), UNHCR (United Nations Refugee Agency) and Immigration Department	CW Government	Ongoing
1.7 Advocacy regarding need for greater attention on mobility and cross border issues as well as in-country responses to HIV at UNAIDS and other AIDS organisations	CW Government HIV/AIDS peak organisations	AIDS2014 Legacy
1.8 Advocacy regarding international health governance and impact across border HIV policies and programs at G20, APEC and CHOGM	CW Government	As required



## 2. Commonwealth and State Leadership

### Overall Goals:

- Within a human rights framework, ensure that the Australian HIV response enables an effective response to migrants and mobile populations which experience increased vulnerability to HIV acquisition or transmission

- That the CW and state governments show strong leadership in relation to building overall community support and consensus to prioritisation of health services related to mobile populations and migrants
- CW and state governments provide appropriate funding levels and resources
- Ensure there are coherent legal and policy responses to mobile populations and migration.

Table 6 summarises the proposed CW and state leadership and global health governance strategies needed.

**Table 6: Commonwealth and state leadership strategies**

Proposed Strategies	Proposed Responsibility	Proposed Time Frame
2.1 Reform policies on universal access to HIV treatment and related health care for temporary visa holders currently without Medicare access	CW Government	Urgently
2.2 Create migrant health units in State Health Departments (if they are not in existence) to provide policy advice in matters regarding impacts of mobility, cross border health issues and migrant health	State governments	ASAP
2.3 Create (or enhance) a health unit within the Department of Immigration to provide policy advice on matters regarding cross border health issues and migrant health	CW Government	ASAP
2.4 Provide financing and funding for a comprehensive and integrated response to at-risk mobile populations migrants	CW Government State governments	2015
2.5 Develop a whole of government approach to meeting migrant social and health needs including access to housing, education, employment, health and recreation services both integrated into main stream services as well as specific community based programs	CW Government State governments	2015
2.6 Review and reform any CW laws (and policies) which relate to migration and temporary migration which are inconsistent with other laws and policies or otherwise counterproductive such as tax, health, social security and immigration.	CW Government	In the time frame of the Seventh National HIV Strategy
2.7 Develop public relations plan aimed at delivering positive stories on migrants' contribution to society dispelling myths, correcting misinformation with overall aim of changing perception of migrants in general community	CW Government State governments	In the time frame of the Seventh National HIV Strategy
2.8 Prioritise resources and services for at-risk subgroups according to risk and vulnerability as follows: <ul style="list-style-type: none"> <li>• PLHIV migrants/visa holders who do not have access to treatments</li> <li>• Partners of PLHIV from migrant/mobile backgrounds</li> <li>• Migrants generally from high prevalence countries</li> <li>• GSM particularly from Asian backgrounds and other high prevalence countries especially GSM African men</li> <li>• Migrants sex workers from CaLD backgrounds</li> <li>• PWID from CaLD backgrounds</li> <li>• Some priority groups travelling to high prevalence countries</li> </ul>	CW Government State governments State HIV organisations	In the time frame of the Seventh National HIV Strategy
2.9 Sensitivity and skills training for police, immigration, health and embassy staff to include accurate content and contexts regarding above risk subgroups	CW Government State governments	Ongoing
2.10 Continue to protect migrants' human rights and legal protection against discrimination	CW Government State governments	Ongoing
2.11 Continue efforts at state and CW government based law reform which takes into account needs of migrant sex workers as part of efforts to incorporate an evidence-based decriminalisation of sex work across all states and territories	State governments	Ongoing
2.12 Provide resources for training to ensure a competent and sensitive health workforce which has the capacity to meet the needs of diverse mobile and migrant populations	CW Government State governments	Ongoing
2.13 Provide funding and resources to support networks of migration organisations		Ongoing

### 3. Community Mobilisation

#### Overall Goals:

- Improve mobile population and migrant community awareness, health literacy, knowledge, attitudes and risk reduction behaviours around HIV in the context of living in Australia
- Develop partnerships between migrant groups, other community groups and the HIV sector to advocate

for change and improvements in health and other service delivery

- Encourage leadership and peer advocacy within migrant and mobile populations (including PLHIV) and increase participation in the HIV response
- Encourage community consultation and empowerment through creative, flexible and ongoing engagement
- Develop social capital and resilience in migrant communities and mobile populations.

Table 7 summarises the proposed community mobilisation strategies needed.

**Table 7: Community mobilisation strategies**

Proposed Strategies	Proposed Responsibility	Proposed Time Frame
3.1 Develop an advocacy network of migrant community groups, mobile populations, HIV sector organisations, PLHIV, and professional organisations	HIV/AIDS peak organisations Migrant peak organisations State HIV organisations State migrants organisations	2015
3.2 Develop HIV knowledge and capacity amongst migrant community, cultural and spiritual leaders	HIV/AIDS peak organisations Migrant peak organisations State HIV organisations State migrants organisations	In the time frame of the Seventh National HIV Strategy
3.3 Support and build capacity of migrant groups and mobile populations (including PLHIV) to develop skills in advocacy, the development of advocacy networks and peers involvement.	Migrant peak organisations State migrant organisations	In the time frame of the Seventh National HIV Strategy
3.4 Further develop partnerships with transnational NGOs and aid organisations working in HIV/AIDS across borders	HIV/AIDS peak organisations International Aid organisation Migrant peak organisations State HIV organisations State migrants organisations	In the time frame of the Seventh National HIV Strategy
3.5 Further develop partnerships with transnational companies who employ people in Australia and high prevalence countries and have high level of cross border travel of employees	HIV/AIDS peak organisations State HIV organisations	In the time frame of the Seventh National HIV Strategy
3.6 Further develop and deliver sensitive and comprehensive HIV programs which address wider issues such as gender equity, domestic and sexual violence and social exclusion	HIV/AIDS organisation and Migrant organisations	In the time frame of the Seventh National HIV Strategy
3.7 Further develop and deliver programs which promote access to HIV testing and treatment services for migrant and mobile populations	Migrant peak organisations Migrant organisations	In the time frame of the Seventh National HIV Strategy
3.8 Further develop programs (personal perspectives etc.) which aim to reduce stigma and discrimination related to migrant and mobile populations	Migrant peak organisations Migrant organisations	In the time frame of the Seventh National HIV Strategy
3.9 Develop referral pathways, translated documents and migration rights and responsibilities for migration agents and migration health services which have contact with migrants and other temporary visa holders	Migration agents	In the time frame of the Seventh National HIV Strategy
3.10 Develop mutual sensitivity training regard issues around sexuality, cultural sensitivity, alcohol and drug use, sex work and any other related issues	HIV/AIDS, Sex Work and Drug User peak organisations Migrant peak organisations State HIV, migrant and sex worker organisations	Ongoing
3.11 Develop multilingual and culturally sensitive materials focussing on prevention information for new arrivals and for specific sub populations	HIV/AIDS, Sex Work and Drug User peaks Migrant peak organisations State HIV, migrant, sex worker and drug user organisations	Ongoing

## 4. Development of Services for Mobile or Migrant People and Groups

### Overall Goals:

- To maximise the physical, psychological, sexual and social health and well-being of migrants and other mobile PLHIV through the provision of high quality, tailored, clinical services
- Increase the uptake of sexual health testing, treatment, sexual health education and referral amongst migrants and mobile populations with an emphasis on early detection and treatment

- Increase the health literacy of migrants and mobile populations
- Improve the capacity for migrants and other mobile populations in maintaining risk reduction strategies
- Decrease discriminative attitudes to migrants and other mobile people with HIV
- To provide high quality information to inform the strategic response to mobile populations and migrants
- To understand cultural, structural impacts of services on mobile populations and migrants.

Table 8 summarises the proposed strategies needed for development of services for mobile or migrant people and groups.

**Table 8: Development of services for mobile or migrant people and groups strategies**

Proposed Strategies	Proposed Responsibility	Proposed Time Frame
4.1 Ensure travel medicine clinics continue to deliver HIV information to travellers	Travel medicine clinics	ASAP
4.2 Encourage sexual health testing for travellers upon return to Australia	Travel medicine clinics GPs	ASAP
4.3 Further develop programs and services to be delivered by peers in migrant and multicultural organisations and HIV sector organisations	Multicultural groups HIV sector organisations	2015
4.4 Enhance specific strategies aimed at GMSM from migrant backgrounds through sexual health clinics and AIDS Councils and other relevant community based organisations	HIV organisations Gay community Sexual health clinics	2015
4.5 Expand strategies to inform and engage GMSM who have at-risk sex in high prevalence countries	Community HIV organisations Sexual health clinics	2015
4.6 Enhance specific strategies aimed at migrant sex workers at peer-based sex worker programs, sexual health clinics and advocacy organisations	Community HIV organisations Sexual health clinics	2015
4.7 Enhance specific strategies aimed at PWID from migrant backgrounds through needle and syringe programs or alcohol and other drug programs	Service user groups Community HIV organisations	2015
4.8 Assess viability of in-situ information in high tourist areas and or high prevalence areas such as Phuket, Bangkok and Bali in partnership with, or supportive of, local organisations	Research institutions Community HIV organisations	2015
4.9 Deliver information to travellers via social marketing or other appropriate means to specific mobile populations and travellers who are at higher risk of acquisition of HIV for example: <ul style="list-style-type: none"> <li>• expatriate employees (resource sector, military/peace keeping and aid workers) working in high prevalence countries for extended periods</li> <li>• migrants returning to high prevalence countries for holidays</li> <li>• males, travelling to or through high prevalence countries.</li> </ul>	Transnational companies Travel medicine providers Community HIV organisations	2015
4.10 Assess viability of delivering peer based information for incoming and outgoing backpackers	Backpacker associations	2015
4.11 Expand culturally sensitive and accessible treatment, care and support for migrants living with HIV	Health providers and clinicians Community HIV organisations	Ongoing

**Table 8: Development of services for mobile or migrant people and groups strategies (continued)**

Proposed Strategies	Proposed Responsibility	Proposed Time Frame
4.12 Deliver sensitive HIV screening for migrants and mobile populations including antenatal screening and sexual health screening	Primary care Migrant health clinics Antenatal clinics Sexual health clinics	After barriers are removed
4.13 Support current agencies to implement programs for Australian students overseas and international students doing sex work in Australia. Link in with universities to work better with students	University student health services Sex worker organisations Community HIV organisations State Health departments Migrant organisations	In the time frame of the Seventh National HIV Strategy
4.14 Consider responses for partners of travellers	Community HIV organisations State Health departments Migrant organisations	In the time frame of the Seventh National HIV Strategy
4.15 Consider inter-state migration—people may access services in other states if there are shortages of services in their own state		In the time frame of the Seventh National HIV Strategy
4.16 Identify what services are needed on arrival in Australia, by whom, and who is responsible for providing services.	Community HIV organisations Sex Worker organisations State Health departments Migrant organisations	In the time frame of the Seventh National HIV Strategy
4.17 Consider needs of travellers before arriving in Australia, while in Australia, and after leaving Australia. Consider differences depending on visa type. Bridging visas may be most vulnerable.		In the time frame of the Seventh National HIV Strategy
4.18 Advocate for increased availability of multilingual and culturally sensitive materials in particular prevention information for new arrivals and for specific sub populations including asylum seekers.	Multicultural groups	Ongoing
4.19 Better availability of accessible health hardware (condoms, sterile injecting equipment) where migrants and travellers can access it	Sex Worker organisations Service user groups Sex worker organisations State migrant organisations	Ongoing

## 5. Research, Surveillance and Evaluation

### Overall Goal:

- To provide high quality information to inform the strategic response to mobile populations and migrants.

Table 9 summarises the proposed research, surveillance and evaluation strategies needed.

**Table 9: Research, surveillance and evaluation strategies**

Proposed Strategies	Proposed Responsibility	Proposed Time Frame
5.1 Standardise surveillance for sub populations such as GSM, sex workers, PWIDs	Research centres State Epidemiology and Surveillance	ASAP
5.2 Design studies/ monitoring to better understand acquisition risks for different people		ASAP
5.3 Analysis of the costs and benefits of universal access to treatments		ASAP
5.4 Effectiveness of health screening of asylum seekers		2015
5.5 Investigate and consolidate studies of available services and health seeking behaviours of migrants relating to HIV. Establish the barriers and enablers to HIV management at primary and tertiary health care levels; audit and feedback research—who is doing what and how, what needs to be improved (quality improvement research); social research on sexual attitudes, mores, networking and mixing in different migrant communities; social research in migrant communities on HIV related knowledge, attitudes and behaviours and the role and impact of religion, gender and culture	Research centres in collaboration with key stakeholders including government and community organisations	2015
5.6 Phylogenetic analysis to understand spread of HIV in migrant and mobile populations		
5.7 Analysis of uptake and maintenance of treatment by migrants	Research centres State Epidemiology and Surveillance	In the time frame of the Seventh National HIV Strategy
5.8 Analysis of effectiveness of treatments on health of migrants		
5.9 Identify where HIV infections are occurring to target and tailor interventions (replicate work from UK)		
5.10 Review the impacts of legal regulations on migrant health and access to HIV treatments	Research centres in collaboration with key stakeholders including government and community organisations	In the time frame of the Seventh National HIV Strategy
5.11 Analysis of factors that hinder provision of HIV treatment to migrants		
5.12 Develop core evaluation indicators for programs aimed at migrant groups or mobile populations to better contribute to evidence of what works		
5.13 Explore the feasibility of the role of treatment in preventing HIV transmission in migrant communities		
5.14 Quality of life, coping strategies and support needs unique or specific to migrants living with HIV		
5.15 Analysis of media contribution to discrimination and stigma of migrants		
5.16 Conduct cost benefit analysis on different interventions aimed at different mobile populations		
5.17 Look at pathways and experiences of mobile populations and migrants to identify opportunities for policy and program intervention		
5.18 Risk factor analysis for HIV infection in HIV positive and/or the general migrant population		
5.19 Analyse impact of increased migration on HIV prevalence		Ongoing
5.20 Report on community level HIV migration patterns to Australia (i.e. state based surveillance based on migration patterns)	Research centres State Epidemiology and Surveillance	Ongoing

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# Appendix

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