



HIV AND MOBILITY IN AUSTRALIA: PRIORITY ACTIONS



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FOR MORE INFORMATION

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FOREWORD

AFAO welcomes the release of the *HIV and Mobility in Australia: Priority Actions*. This report highlights gaps in the HIV response among Culturally and Linguistically Diverse (CaLD) people from high HIV prevalence countries, people who travel to high prevalence countries, and their partners. As the *HIV and Mobility in Australia: Road Map for Action* notes, the relationship between HIV and mobility is complex, and the links between HIV and the experiences of people travelling to settings with a high HIV prevalence have not been well articulated.

The re-inclusion of *Culturally and Linguistically Diverse (CaLD) people from high HIV prevalence countries, people who travel to high prevalence countries, and their partners* as a priority population in the *Eighth National HIV Strategy* is a critical step in addressing HIV among people from these settings. The Strategy also notes the need for tailored approaches that effectively address cultural, language and gender issues, across all aspects of the response to HIV for several sub-populations, including gay men other men who have sex with men.

While gay and bisexual men accounted for sixty three percent of HIV diagnoses in Australia in 2017, new HIV cases among overseas-born gay men remained high. Further, and as noted in the *Eighth National HIV Strategy*, new HIV diagnoses among people from high prevalence countries and their partners accounted for over one third of HIV transmission among heterosexuals in 2016. A proportion of cases occurred among people born in Australia acquiring HIV overseas. In response, the *HIV and Mobility in Australia: Priority Actions* outlines additional activities to address gaps in Australia's response to HIV and mobility to help Australia achieve its goal of ending HIV transmission.

Along with the *HIV and Mobility in Australia: Priority Actions*, AFAO's HIV Blueprint outlines the additional effort and investment in specialised programs for CALD people and for Australian travellers to end HIV transmission in Australia.

The *HIV and Mobility in Australia: Priority Actions* builds on the *HIV and Mobility in Australia: Road Map for Action* and provides approaches for working together to end HIV transmission among mobile populations. I encourage decision makers at all levels of government and those within the HIV sector to engage with *HIV and Mobility in Australia: Priority Actions* and adapt policy priorities to align with its findings and recommendations.



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PREFACE

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, with gay and other men who have sex with men being the largest.

In the last decade, HIV diagnoses in Australia have been increasing among people travelling to and from high HIV prevalence countries. Australia's HIV strategies have acknowledged people and their partners who travel to or from high HIV prevalence countries as priority populations in Australia. However, the relationship between HIV and mobility is complex and the causal links between HIV and the experiences of people travelling to and from regions of high HIV prevalence, including behaviour, access to resources and health services, are not well understood. Overlayed are issues of stigma, racism and marginalisation as well as historical contexts such as colonisation, evolving economic and migration policies, and labour mobility.

These complexities have resulted in an emphasis on short-term, small-scale projects and research studies, both in Australia and elsewhere to address HIV. Without an integrated response across government, community, health services and research there will be little progress in this emerging priority for the Australian HIV epidemic.

In 2014, the *HIV and Mobility: Road Map for Action* was the first attempt to capture what we know about HIV and mobility. It proposed 71 strategies across a range of stakeholders to operationalise national and jurisdictional policies relating to HIV. A Community of Practice for Action on HIV and Mobility (CoPAHM) was established in 2015 to keep HIV and mobility on the national agenda and to monitor momentum. While much progress has been made, some priority actions are yet to be implemented; this brief document draws attention to these gaps and outlines key activity proposed to address these.

A key goal in contemporary Australian policies was to 'virtually end' HIV transmissions by 2020, ensuring 'no one is left behind'. Despite many successes, there remain challenges we need to resolve to see this achieved. While other key documents outline approaches to addressing HIV more broadly (such as AFAO's *HIV Blueprint*¹), there is a need for strategies that specifically address culturally and linguistically diverse people from high HIV prevalence countries, people who travel to high prevalence countries, and their partners. These subgroups have different needs, and thus, require approaches that are considerate of their diversity. Addressing these two subgroups will help contribute towards the goal of zero new HIV transmissions.

Here we present six priority actions to address HIV and mobility in Australia, to further operationalise the Australian response to HIV and mobility and future iterations of national and jurisdictional policies relating to HIV.

CONTENTS

Background	2
HIV and Mobility: What are we talking about?	2
HIV and Mobility: Who are we talking about?	3
Overseas acquired HIV	3
HIV and people born overseas	3
The inception of the Road Map for Action	4
The Community of Practice for Action on HIV and Mobility	4
Building momentum for action on HIV and mobility	4
Priority actions for addressing HIV in migrant and mobile populations	7
Developing Priority Actions: Consultation process	7
Overview of Priority Actions	7
Where to next?	14
Consensus for action	14
References	16

ACRONYMS

AFAO	Australian Federation of AIDS Organisations
AIDS	Acquired Immune Deficiency Syndrome
ARCSHS	Australian Research Centre in Sex, Health and Society
ART	Antiretroviral treatment
ARTG	Australian Register of Therapeutic Goods
ASHM	Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine
CaLD	Culturally and linguistically diverse
CERIPH	Collaboration for Evidence, Research and Impact in Public Health
CoPAHM	Community of Practice for Action on HIV and Mobility
DoH	Department of Health
FIFO	Fly-in fly-out
GP	General practitioner
HIV	Human Immunodeficiency Virus
LGBTI	Lesbian, gay, bisexual, transgender and intersex
LHIV	Living with HIV
MSM	Men who have sex with men
MSAC	Medical Services Advisory Committee
NSW	New South Wales
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PEP	Post-exposure Prophylaxis
PLHIV	People living with HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People who inject drugs
SE Asia	Southeast Asia
SiREN	Sexual Health and Blood-Borne Virus Applied Research and Evaluation Network
U=U	Undetectable Equals Untransmittable
WA	Western Australia

DEFINITIONS

CD4	A type of white blood cell that protects the body from infection. CD4 cells are the primary target of HIV and CD4 cell numbers decline during HIV disease.
Combination prevention	Combination prevention is a framework used in HIV prevention, incorporating behavioural, biomedical and structural strategies.
Epidemiology	Deals with incidence, distribution and possible control of disease.
FIFO worker	People who work away from home for an extended period of time on rotational work schedules. Workers receive accommodation and food. FIFO workers spend a fixed number of days working, followed by a fixed number of days off.
Generalised HIV epidemic	The HIV prevalence rate is >1% in the general population.
Globalisation	Globalisation is a process in which the people and countries of the world are brought increasingly closer together, economically and culturally, through trade, information technology, travel, cultural exchanges, mass media and mass entertainment.
Heterosexual contact	The reported sexual intercourse between people of different sex.
High HIV prevalence country	High prevalence countries include those with $\geq 1\%$ estimated prevalence of HIV in at least one year of the last ten-year period.
HIV self-collection testing	Self-collection (or home sampling) involves taking a mouth swab or blood sample from a finger prick and mailing it to a laboratory, which makes the results available either by phone, text message, or online.
HIV self-testing	HIV self-testing (also known as home-based testing) is testing conducted in the home or similar environment by an individual who also interprets the result. It uses the same technology as HIV rapid testing.
HIV rapid testing	Rapid testing uses a pinprick of the finger (or oral fluid, depending on the test) and returns results within 10 to 20 minutes. Most rapid HIV tests detect HIV antibodies; however some can also test for the presence of the virus itself.
Late diagnosis	Measured by a CD4 cell count of fewer than 350 cells/ μl at diagnosis. CD4 cells are a type of white blood cell that fights infection. A normal CD4 count is from 500-1,500 cells per cubic millimetre (μl) of blood.
Migrant	In this document, the term 'migrant' refers to a person undergoing a semipermanent or permanent change of residence which involves a change of his/her social, economic and/or cultural environment. 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. ²
Mobile populations	People who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons. ³
Mobile workers	People who work away from their permanent residence.
Priority population	A group more vulnerable to a health condition.

BACKGROUND



BACKGROUND

The world's population is increasingly mobile. Mobility has increased dramatically in the last sixty years,⁴ contributing to the transmission of a number of infectious diseases globally, including HIV. Countries such as Australia, the United States, Canada and some European nations have noted increases in HIV notifications among people born overseas, and in some instances, among people travelling to other countries.⁵

Reasons for international movement are varied, and travel can be temporary, permanent or semi-permanent.⁵ These different types of travel are not mutually exclusive. Within each category, there are different motivations and drivers. Reasons for temporary mobility include employment, holidays and tourism. People may migrate permanently or semi-permanently for employment and economic circumstances, family reunion, escaping war and conflict, lifestyle and/or retirement, education and extended leisure and recreation. Movement can be from low or middle-income countries to high-income countries, and vice versa.

HIV AND MOBILITY: WHAT ARE WE TALKING ABOUT?

Australia has a very mobile population. In 2016, there were 37.7 million crossings of Australia's international border, including short-term departures from Australia and permanent and long-term arrivals.⁶ A large number of Australians travel internationally, for work or leisure, with 9.9 million international departures in 2016.⁶ Of those, 59% travelled for a holiday, 24% to visit family and friends, and 9% for business.⁶ In the same year, 28.5% (6.9 million persons) of Australian residents were born overseas.⁷

The relationship between HIV and mobility is complex, and the causal links between HIV and the experiences of people travelling to and from regions of high HIV prevalence are not well understood.⁸ Overlayed are international mobility issues, issues of stigma, discrimination, racism, and evolving economic and migration policies.

Mobility impacts on HIV risk and vulnerability in a number of different ways.⁸ This is influenced by motivations for mobility, travel direction and destination, and pre and post travel factors. Mobility may be a risk factor for HIV acquisition, increase vulnerability to HIV, exacerbate existing risk factors for acquisition or be a driver of HIV epidemics. These factors are summarised below but for an in-depth description, please refer to the *HIV and Mobility: Road Map for Action*.

Mobility as a risk factor for HIV acquisition. Mobility acts as a potential risk factor for HIV acquisition, in that mobility facilitates opportunities for an individual's behaviour to change. This may include changes in drug use or sexual behaviour (such as concurrent relationships, or male to male sex). Mobility may also create situations where an individual's behaviour does not change, but they are in a more risky circumstance – such as travelling to an area of high HIV prevalence.

Increase vulnerability to HIV as a result of mobility. Mobility may make people more vulnerable to HIV acquisition, as access to health services and social support changes.⁹ For example, migrants to Australia may have varying access to health care services depending on their citizenship status and visa type in Australia. Likewise, Australians travelling to other countries may encounter challenges in accessing health care services.

Exacerbation of existing risk factors for HIV acquisition. Mobility may also contribute towards greater HIV vulnerability when combined with pre-existing risk factors, such as injecting drug use or male to male sex. This group may already be at increased risk of acquisition and no longer have access to typical supports, such as condoms or sterile injection equipment.

Mobility as a driver of HIV epidemics. Mobility may increase the spread of HIV in regions, countries, communities or social groups, particularly when risk factors intersect.

HIV AND MOBILITY: WHO ARE WE TALKING ABOUT?

In this document, we use the terms migrant and mobile to refer to people from high HIV prevalence countries or people who travel to high HIV prevalence countries.

Mobile and migrant populations includes a range of people with diverse experiences. The needs of these sub-groups are unique and complex.¹⁰ Australia's response needs to reflect this complexity in order to address relevant issues.

Additionally, while people travelling to and from a high HIV prevalence country are a priority population, they may also belong to other priority groups for HIV. Particular sub-groups at risk include, but are not limited to:

- LGBTIQ people from high HIV prevalence countries
- People who inject drugs (PWID) from high HIV prevalence countries
- People living with HIV from high HIV prevalence countries
- Australian gay men and men who have sex with men acquiring HIV overseas
- Australian heterosexual people acquiring HIV overseas
- International students and backpackers
- Sex workers from CaLD backgrounds

The below section provides a brief overview of the current data regarding HIV and Mobility. While these are presented separately, it is important to note that these groups can overlap. For more detail about HIV and mobility in Australia, please see the *Road Map*.

OVERSEAS ACQUIRED HIV

With the growth in international movement to and from Australia, there has been an increase in Australian HIV diagnoses among people travelling to and from regions of high HIV prevalence. During the period 2014-2017, 17.5% of HIV notifications from male-to-male sex exposure and 49.6% of people describing heterosexual exposure were reported to have acquired HIV overseas.¹¹ Acquisition of HIV overseas was more likely among overseas born compared to Australian born, for both heterosexual and male-to-male exposure.¹¹

HIV AND PEOPLE BORN OVERSEAS

In 2017, HIV notification rates by region of birth were highest among those from Americas (13.5 per 100,000), North East Asia (4.8 per 100,000), Southeast Asia (14.0 per 100,000) and sub-Saharan Africa (13.1 per 100,000).¹¹ From 2013-2017, the proportion of late diagnoses for HIV was highest amongst people born in sub-Saharan African (53%), Southeast Asia (48%) and Central America (43%).¹¹ The proportion of new HIV diagnoses amongst men born in Asian countries (South East Asia, North East Asia and Southern and Central Asia) with male-to-male sex exposure increased from 28% in 2008 to 52% in 2017.¹¹

THE INCEPTION OF THE ROAD MAP FOR ACTION

The *HIV and Mobility in Australia: Road Map for Action (Road Map)* discussion paper, released in December 2014, explored the links between HIV and mobility in Australia. It built on a range of work conducted around Australia and internationally and is the result of partnership between the Collaboration for Evidence, Research and Impact in Public Health (CERIPH) and the Australian Research Centre in Sex, Health and Society (ARCSHS). The Road Map proposed 71 strategies across a range of stakeholders to operationalise the recommendations from the *Seventh National HIV Strategy (2014-2017)*. The paper drew on published and grey literature, and feedback from the sector through a range of consultation mechanisms prior to its release.

THE COMMUNITY OF PRACTICE FOR ACTION ON HIV AND MOBILITY

The *Road Map* intended to stimulate discussion and action amongst stakeholders with an interest in HIV and mobility issues. A Community of Practice for Action on HIV and Mobility (CoPAHM) was established in March 2015 to help keep HIV and mobility issues on the national agenda, with funding for secretariat support from the WA Department of Health Sexual Health and Blood-Borne Virus Program. The role of CoPAHM is to increase partnerships and collaboration among stakeholders to facilitate policy, research and practice efforts regarding HIV and mobility. The current CoPAHM membership includes over 80 stakeholders from government, non-government, research, community organisations and national peak bodies who are interested in working together to progress actions. Through CoPAHM, members are able to identify ways to work together to progress actions from the *Road Map* and ensure that people who travel to and from high HIV prevalence countries are considered in discussions on HIV prevention, treatment and support. This has included project alliances, advocacy and collaborative research (see examples below).

BUILDING MOMENTUM FOR ACTION ON HIV AND MOBILITY

There has been encouraging momentum on a range of actions towards addressing HIV and mobility issues in Australia in recent years. A snapshot of work in progress is outlined below:

Practice

- A HIV and Mobility forum hosted by AFAO in 2016
- The production of a HIV Pre-Exposure Prophylaxis (PrEP) Fact Sheet in plain English, Chinese, Thai, Vietnamese and Indonesian to increase the reach of PrEP awareness to individuals with limited English competency¹²

Research

- Ongoing discussions around improving HIV notification, testing and treatment data for CaLD populations
- Development of a periodic survey on HIV knowledge and use of health services among priority CaLD populations

Policy

- The inclusion of travellers and partners of people from a high HIV prevalence country (for heterosexual people) in ASHM's PrEP guidelines¹³
- Policy documents, strategies and discussion papers with an emphasis on the needs of culturally and linguistically diverse groups, migrants and mobile populations^{14, 15}

Influence

- A NSW culturally and linguistically diverse gay men's network to progress action and research
- The development of jurisdictional CoPAHMs in South Australia, Western Australia, Queensland and Victoria to progress state-specific issues
- Two interim report cards published by CoPAHM that highlight momentum across the *Road Map's* strategies (<https://siren.org.au/hiv-mobility/interim-report-card/>)

PRIORITY ACTIONS



10 GUIDING PRINCIPLES FOR DEVELOPING A STRATEGIC APPROACH TO HIV MANAGEMENT FOR MOBILE POPULATIONS AND MIGRANTS IN AUSTRALIA

Australia has a recipe for a public health approach to HIV prevention: a well-established community-led response to HIV, resourcing and support from government; sector mobilisation; access to subsidised treatment and PrEP; national needle and syringe program, and ongoing surveillance, evaluation and research. This is the legacy of Australia's original HIV response. Failing to apply what we have learned from this approach to the context of HIV and mobility risks further HIV notifications.¹⁶ Pursuing a coordinated response for migrant and mobile populations is crucial if Australia is to meet Australia's goal of **ending HIV transmission by 2020**.

The *Road Map* outlines ten guiding principles for developing a strategic approach to HIV management for mobile and migrant populations. These are provided in brief below. For more information, please refer to the *Road Map*.

1. Incorporate a human rights approach – stigma and discrimination directed at mobile populations and migrants must be reduced
2. Reduce all barriers to testing and access to treatment
3. Pay attention to the confluence between HIV and mobility – acknowledge that due to an increase in migration and mobility, HIV affects a diverse range of Australians.
4. Move beyond 'narrow protectionist policies' – recognition that migrant health screening (including for HIV) should be a voluntary, two-way process which also provides migrants with access to treatment as needed
5. Commit resources to improve migrant health
6. Continue to develop links and cooperative partnerships with affected communities locally and internationally
7. Participate in and contribute to global health governance
8. 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
9. Acknowledge that mobile populations and migrants need more than information (even if it is translated). Specialist services as well as generalised services need to be provided.
10. Know your epidemic(s) – continue surveillance and monitoring and develop evaluation strategies in conjunction with migrant and mobile populations



PRIORITY ACTIONS FOR ADDRESSING HIV IN MIGRANT AND MOBILE POPULATIONS

The first edition of the *Road Map* identified actions to be addressed within the timeframes of the *Seventh National HIV Strategy (2014-2017)*. At the conclusion of 2017, a number of strategies had not yet been addressed. New opportunities in prevention have also emerged. Urgent action is still required to address HIV in migrant and mobile populations.

DEVELOPING PRIORITY ACTIONS: CONSULTATION PROCESS

In 2015 and 2016, CoPAHM undertook two mapping exercises of momentum on the strategies proposed in the *Road Map* (<https://siren.org.au/hiv-mobility/interim-report-card/>). Results from the mapping indicated gaps in the response to HIV and mobility. Further research, desktop and policy reviews, and discussion with the CoPAHM National Governance Group refined the development of a draft list of priority actions. This list was finalised following feedback from CoPAHM members and other relevant stakeholders online and during the 2017 ASHM Australasian HIV&AIDS conference, and subsequent discussions with the National Governance Group.

OVERVIEW OF PRIORITY ACTIONS

This document outlines key activities proposed for addressing gaps in Australia's current response to HIV and Mobility. We envisage that the proposed priority actions will stimulate discussion and action amongst relevant stakeholders with an interest in HIV and mobility issues. These include: community-led non-government organisations, national peak bodies, affected communities, research centres, policymakers and jurisdictional governments. Momentum is required from all relevant stakeholders to ensure that there is appropriate support for the implementation of these actions, including the Australian Government and jurisdictional government buy-in.

These priority actions complement existing national and state strategies and policies. Taking action on these priorities will assist in creating an optimal approach to HIV and mobility that is holistic and systematic. While we have identified priority actions, further work is required across a number of areas. A number of additional strategies are outlined in the *Road Map*.

- **Local solutions:** Relevant jurisdictions to plan and implement state-specific responses to HIV in migrant and mobile populations
- **Health literacy:** Increase health literacy and know how to access combination prevention strategies available
- **Test:** Understand and reduce barriers to HIV testing and make new testing technologies widely available
- **Treatment and prevention medication:** Advocate for the inception of a policy mechanism to provide access to HIV treatment and PrEP for temporary visa holders who are ineligible for Medicare
- **Inform:** Harmonise surveillance data reporting for both migrant and mobile populations, including sexual behaviour, testing rates, notifications, treatment initiation and PrEP
- **Evaluate:** Develop core indicators to assess effectiveness of HIV programs for mobile and migrant populations

LOCAL SOLUTIONS

RELEVANT JURISDICTIONS TO PLAN AND IMPLEMENT STATE-SPECIFIC RESPONSES TO HIV IN MIGRANT AND MOBILE POPULATIONS

What's the problem?

A lack of recognition regarding the heterogeneity of mobile and migrant communities, risks a failure to meet the needs of specific communities. While there are key priorities at a national level, each jurisdiction has a unique epidemiology and patterns of migration and mobility. As such, tailored approaches are required to address and monitor the specific needs of priority populations.

The solution

- Develop a local CoPAHM in each relevant jurisdiction. Such establishment will ensure frequent communication between relevant organisations (DoHs, AIDS Councils, PLHIV organisations, multicultural organisations, members of affected communities, GPs and other health services) to avoid duplication and encourage partnership-based activity. This local CoPAHM will also support local and national work by:
 - Monitoring local momentum on HIV and mobility
 - Continuing to advocate for HIV and mobility at a local level
 - Providing updates to the national CoPAHM, and working in collaboration with national CoPAHM members to progress key activities at a multi-jurisdictional level.
- Meaningful involvement of people from migrant and mobile communities in planning and implementing responses to HIV
 - Building consensus on what meaningful involvement constitutes
 - Designing and testing strategies for improving meaningful involvement
 - Establishing inter-sectoral partnerships and other strategies as required to improve access to and engagement with migrant and mobile populations, e.g. use of online forums



HEALTH LITERACY

INCREASE HEALTH LITERACY AND KNOW HOW TO ACCESS COMBINATION PREVENTION STRATEGIES AVAILABLE

What's the problem?

Australia's HIV response includes a combination of behavioural strategies, improved access to the means of prevention (i.e. sterile injecting equipment, condoms) and biomedical prevention. Prevention strategies including PrEP (Pre-Exposure Prophylaxis)ⁱ, PEP (Post-exposure Prophylaxis)ⁱⁱ and Treatment as Prevention (TasP)ⁱⁱⁱ present an opportunity to reduce new HIV infections among priority groups. Condoms and sterile injecting equipment remain critically important in the prevention of HIV¹⁷ and promotion of these tools should continue.

The difficulties experienced in PrEP trials in recruiting people from priority migrant communities (particularly gay Asian men) suggest barriers experienced by certain groups in accessing PrEP.¹⁴ A further understanding of these barriers is necessary to ensure equitable access.

Previous research with PLHIV and LGBTIQ has highlighted that PEP is largely under-utilised and not well-understood.¹⁸⁻²⁰ It is likely that knowledge of PEP amongst mobile and migrant groups is also limited.

The solution

- Research to better understand the barriers experienced by individuals from priority migrant groups in accessing and initiating PrEP and PEP, particularly among gay Asian men.
- Determine appropriate mechanisms for improving health literacy amongst community groups, such as peer education, fact sheets and resources, knowledge dissemination through paper-based and digital media, involvement of bilingual workers and opportunistic education through health professionals.
- HIV community-led organisations and other non-government organisations to expand targeted promotion of PrEP, PEP and TasP to priority migrant groups, particularly gay Asian men.
- Increase PrEP awareness²⁰ and expand the number of sites where PrEP is available.
- Continued work with GPs and emergency department staff by HIV national peak organisations and non-government organisations to increase knowledge of PrEP and PEP, and how to discuss the use of PrEP and PEP in a non-judgmental manner.

ⁱ For more information about the PrEP Guidelines, visit <http://arv.ashm.org.au/arv-guidelines/prep-resources-for-clinicians>

ⁱⁱ For more information about the PEP Guidelines, visit <https://www.ashm.org.au/HIV/PEP/>

ⁱⁱⁱ For more information about TasP, visit <https://www.afao.org.au/about-hiv/hiv-prevention/treatment-as-prevention/>

TEST

UNDERSTAND AND REDUCE BARRIERS TO HIV TESTING AND MAKE NEW TESTING TECHNOLOGIES WIDELY AVAILABLE

What's the problem?

People born overseas and men and women who identify as heterosexual are often overrepresented in late HIV diagnoses.^{11, 21} The barriers to accessing HIV testing for migrant populations are complex and include both sociocultural and structural factors.²²⁻²⁶ These include: low visibility of HIV; an assumption that Australia is 'free' from HIV; the perception that HIV is a 'death sentence'; low risk perception of HIV; experiences of stigma and discrimination; HIV-related stigma; barriers to health services; and limited opportunities to test, particularly for those not regularly engaged with health services.

General practitioners and other health care providers are missing opportunities to test and diagnose HIV. While doctors are aware of the main context for testing (male patients who have sex with other men), testing rates are suboptimal among other priority populations.²⁷ For some individuals, HIV is not diagnosed despite multiple presentations with the presence of indicators.

New testing methods (including rapid testing, HIV self-collection kits and HIV self-testing kits^{iv}) present an opportunity to diversify opportunities to test. However, these methods are not widely available and self-testing kits have not yet been approved for use in Australia by the *Therapeutic Goods Administration*. In addition, there are opportunities to expand the number of rapid testing centres, particularly outside metropolitan areas.¹⁸

The solution

Diagnosing people living with HIV will reduce onwards transmission of HIV within Australia. We need a better understanding of what stops and motivates particular groups from testing for HIV and find ways to address these barriers. This includes reorienting health services and making testing technologies widely available. This will require:

- Continued joint advocacy for approval of HIV self-testing kits by the *Therapeutic Goods Administration*, with support available to link people promptly to care after a positive test.
- Interventions delivered in partnership between researchers, government and non-government organisations that explore the effectiveness of making rapid testing and/or self-collection kits available in community-based settings, such as at multicultural organisations.
- Continued implementation of interventions to address stigma and discrimination, delivered in partnership with government and non-government organisations.
- Continued work with GPs by peak bodies, government and community-led non-government organisations to increase health care provider knowledge of at-risk populations for HIV testing and HIV indicators^v; and provision of necessary training for cross-cultural communication on HIV testing.

^{iv} For more information on HIV self-testing, visit <https://www.afao.org.au/wp-content/uploads/2018/06/AFAO-HIV-Self-Testing-Update-June-2018.pdf>

^v http://testingportal.ashm.org.au/images/HIV_Testing_Policy_Feb_2017.pdf

TREAT

ADVOCATE FOR THE INCEPTION OF A POLICY MECHANISM TO PROVIDE ACCESS TO HIV TREATMENT AND PREP FOR TEMPORARY VISA HOLDERS WHO ARE INELIGIBLE FOR MEDICARE

What's the problem?

The Australian Government provides subsidised antiretroviral treatment (ART) to PLHIV eligible for Medicare through the Pharmaceutical Benefits Scheme. Temporary residents who are ineligible for Medicare must therefore pay the full treatment cost, source treatment from their home country or import generic drugs from overseas suppliers.²⁸ In some cases, individuals may be offered compassionate access to treatment via pharmaceutical companies or access treatment via jurisdiction-level arrangements. This current process is not ideal, as the goodwill of companies is subject to change. Without access to effective HIV treatment, health outcomes for these individuals are further complicated and present the risk of onward HIV transmission to their partners.²⁹

This is at odds with the efforts of all governments and community partners to virtually eliminate HIV transmission in Australia by 2020.^{29, 30}

The Australian HIV Observational Database Temporary Residents Access Study estimated that there were 450 temporary residents living with HIV who were ineligible for Medicare. Modelling demonstrated that providing treatment to 450 PLHIV for 5 years could avert 80 new infections and is unlikely to place a significant cost burden on the Australian Government.²⁹ This provides convincing justification to provide ART to all temporary residents living with HIV, based on patient health outcomes and public health objectives.

PrEP is also unavailable for people who are Medicare ineligible.³¹ For those wishing to access PrEP, they may access PrEP through personal importation. In some cases, this medication has not been approved by the TGA, and there is no guarantees about the safety or quality of the purchased drug.³¹

The solution

Providing universal access to HIV treatment and PrEP for temporary residents without Medicare access is critical to meet Australia's target of virtual elimination of transmission by 2020. The Australian Government must reform policies to ensure access to treatment for all.

Universal access to HIV treatment has long been a priority for community organisations, and much work has been done to draw attention to this need. To continue with this work, we need:

- Continued collaborative pressure from all HIV community organisations and relevant multicultural organisations, peak bodies, state departments and public health organisations.
- Continued research to further demonstrate the financial and public health benefit of universal access.
- Commitment from both political parties leading into the 2019 Federal election to provide access to HIV treatment for Medicare ineligibles.

HARMONISE SURVEILLANCE DATA REPORTING FOR BOTH MIGRANT AND MOBILE POPULATIONS, INCLUDING SEXUAL BEHAVIOUR, TESTING RATES, NOTIFICATIONS, TREATMENT INITIATION AND PREP

What's the problem?

Surveillance data allow us to track trends as they emerge, to evaluate current strategies and to provide better understanding of at-risk sub-groups. However, gaps remain in the data at a national and jurisdictional level. Differences exist in how data are represented by jurisdiction, with mobile and migrant populations not always reported on. Where it does exist data are at times not reported on in a timely manner or data are not available online.

Currently, there are no routine data on testing uptake of mobile or migrant populations at a jurisdictional or national level. Likewise, there is no current 'cascade of care' (undiagnosed, diagnosed, retained in care, receiving antiretroviral therapy and suppressed virus load) for priority migrant groups living with HIV.¹¹

The solution

Up to date and relevant data by jurisdiction will enable identification of new trends in acquisition and at-risk populations.

- Relevant jurisdictional governments to release surveillance data publicly in a timely manner (annually); and report on priority migrant and mobile populations (and overseas vs. Australian acquired HIV).
- Investment from the Australian Government in a community-based periodic survey of HIV knowledge and use of health services for priority migrant communities, to be delivered in partnership with research, government, non-government organisations and communities.
- Convene a national roundtable on the epidemiological, behavioural and social data routinely required to inform and monitor progress toward the goals of Australia's HIV strategies, with an emphasis on mobile and migrant populations, and implement national reforms^{vi}
- Anticipate and advance reforms including⁶:
 - creating a national online data portal for access to jurisdictional quarterly HIV data on demand; or including HIV in an existing data portal, such as the National Notifiable Diseases Surveillance System
 - developing HIV data reports periodically for mobile and migrant populations.

^{vi} Strategy sourced from AFAO *HIV Blueprint* - <https://www.afao.org.au/our-work/hiv-blueprint/>

MONITOR AND EVALUATE

DEVELOP CORE INDICATORS TO ASSESS EFFECTIVENESS OF HIV PROGRAMS FOR MOBILE AND MIGRANT POPULATIONS

What's the problem?

Evaluation of programs and policies contributes to our understanding of what is most effective in HIV prevention and with whom. Current investment in health and support services for mobile populations is often ad-hoc with limited time and funding. As such, the evaluation of projects is often not reported on or not undertaken.

The risks and vulnerability for HIV acquisition are complex and extend beyond individual factors. While it is well-demonstrated that HIV knowledge alone has very little impact on HIV prevention behaviour and willingness to test for HIV, some programs still use awareness or knowledge as the sole measures of success.

The solution

While programs are often diverse and employ a range of strategies, a core set of indicators are required to assist in determining successes of programs. Such indicators could address HIV-related stigma, attitudes towards condom usage and testing, and behaviour change. This would require:

- Research organisations, peak bodies, government and non-government organisations to work in partnership with affected communities to develop a set of culturally acceptable indicators and tools to evaluate programs that extend beyond measuring knowledge gains. Proxy indicators may be required in the short term.
- Jurisdictional governments to encourage and promote the reporting of evaluation by government and non-government organisations in online reports, peer reviewed journals or through online case studies.



WHERE TO NEXT?

We envision this document to be a tool for continued discussion and action among stakeholders in the area of HIV and mobility. It presents clear areas of concern regarding Australia's response to HIV and mobility. We now require momentum and uptake from relevant stakeholders to achieve Australia's goal of zero new transmission by 2020, with particular reference to mobile and migrant populations.

This is a shared challenge. It is essential that there is a commitment from the Australian Government and state and territory governments, community-led organisations, peak bodies, clinical services, research groups, and affected communities to work together to provide informed leadership, policy and coordinated support.

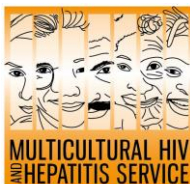
Progress towards these priority actions requires coordination and collaboration across jurisdictions. We need a national collective to drive action, supported by local champions in each jurisdiction. A whole of government approach is critical.¹⁶

You can get involved in the conversation in a variety of ways. Share this document with others, talk about it, read the *Road Map*. The report is available online at <https://siren.org.au/hiv-mobility/>. Get involved in social media discussions via twitter #HIVMobile. Join the **Community of Practice for Action on HIV and Mobility** to progress action on advocacy, research, policy and practice. Look for opportunities to partner with others to explore the issues and keep HIV and mobility on the agenda.



CONSENSUS FOR ACTION

The below organisations support the need for momentum on the six priority actions areas described in this document.



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Follow us on Twitter at @CoPAHM or get involved using the hashtag #HIVMobile