Curtin University

HIV AND POPULATION MOBILITY IN AUSTRALIA: REPORT CARD 2026

CoPAHM Community of Practice for Action on HIV & Mobility

CERIPH HEALTH PROMOTION | HEALTHIER POPULATIONS

ODYSSEY migration & mobility/ public health research hub

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FOR MORE INFORMATION

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You can find out more about CoPAHM at https://www.odysseyresearch.org/copahm

Curtin University would like to pay respect to the Aboriginal and Torres Strait Islander members of our community by acknowledging the traditional owners of the land on which the Perth campus is located, the Whadjuk people of the Nyungar Nation.

ACRONYMS

ARCSHS	Australian Research Centre in Sex, Health and Society
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
FFA	Federation Funding Agreement
GBMSM	Gay, bisexual and men who have sex with men
HEM	Health Equity Matters
HIV	Human Immunodeficiency Virus
PALM	Pacific Australia Labour Mobility
PLHIV	People living with HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People who inject drugs
MiBSS	Migrant Blood-borne Virus and Sexual Health Survey
SiREN	Sexual Health and Blood-Borne Virus Applied Research and Evaluation Network
U=U	Undetectable Equals Untransmittable

OVERVIEW

Australia has long been recognised as a global leader in its HIV response. Yet success has not been shared equitably. Declines in HIV notifications were primarily driven by reductions among Australian-born men who have sex with men. Over the last two decades, HIV notifications have remained steady or increased among people born overseas and those travelling to and from high-prevalence countries.

Reaching Australia's target of zero new HIV transmissions by 2030 will require a more coordinated approach to HIV and population mobility. The 2014 *HIV and Mobility in Australia: Road Map for Action* (the *2014 Road Map*) laid the groundwork for a collective response, setting out 71 recommendations to address HIV in the context of population mobility. More than a decade on, progress has been made against a number of these recommendations; however, others remain outstanding, and new challenges and opportunities have emerged.

The 2026 Report Card provides an update on the progress made, contextualised with epidemiology of the last decade. It has been informed by a review of the 71 strategies and broader consultation with experts from Australia's HIV and multicultural health workforces.

A statement on language

'Population mobility' in this document refers to the movement of people across international borders. Two main priority groups are addressed: people born overseas who travel to Australia (referred to as 'migrants', regardless of visa status), and people who travel from Australia (referred to as 'travellers'). While these groups differ significantly, they share a common experience of global mobility. These groups may also overlap with other priority groups set out in the 9th National HIV strategy, for example, gay and bisexual men who have sex with men (GBMSM), sex workers, Aboriginal and Torres Strait Islander peoples, people who inject drugs, and trans and gender diverse people.

The relationship between HIV and population mobility is complex, and the causal links between HIV acquisition and the experiences of international travel are not fully understood. Stigma, discrimination, racism, and evolving economic and migration policies compound this complexity, shaping access to HIV prevention, testing and treatment services. The *2014 Road Map* set out a national response while recognising the need for localised approaches tailored to specific communities within 'migrant' and 'traveller' populations.

The 2014 Road Map

In 2014, the Collaboration for Evidence, Research and Impact in Public Health (CERIPH) at Curtin University in partnership with the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University, released *HIV and Mobility in Australia: Road Map for Action*, funded by the Commonwealth. The report, built on the range of work conducted across Australia and internationally, presents 71 strategies organised across five action areas as summarised below.

International Leadership and Global Health Governance
8 strategies

Commonwealth and State Leadership
13 strategies

Community Mobilisation
11 strategies

Development of Services for Mobile or Migrant People and Groups
19 strategies

Research, Surveillance and Evaluation
20 strategies

A national response: The Community of Practice for Action on HIV and Mobility

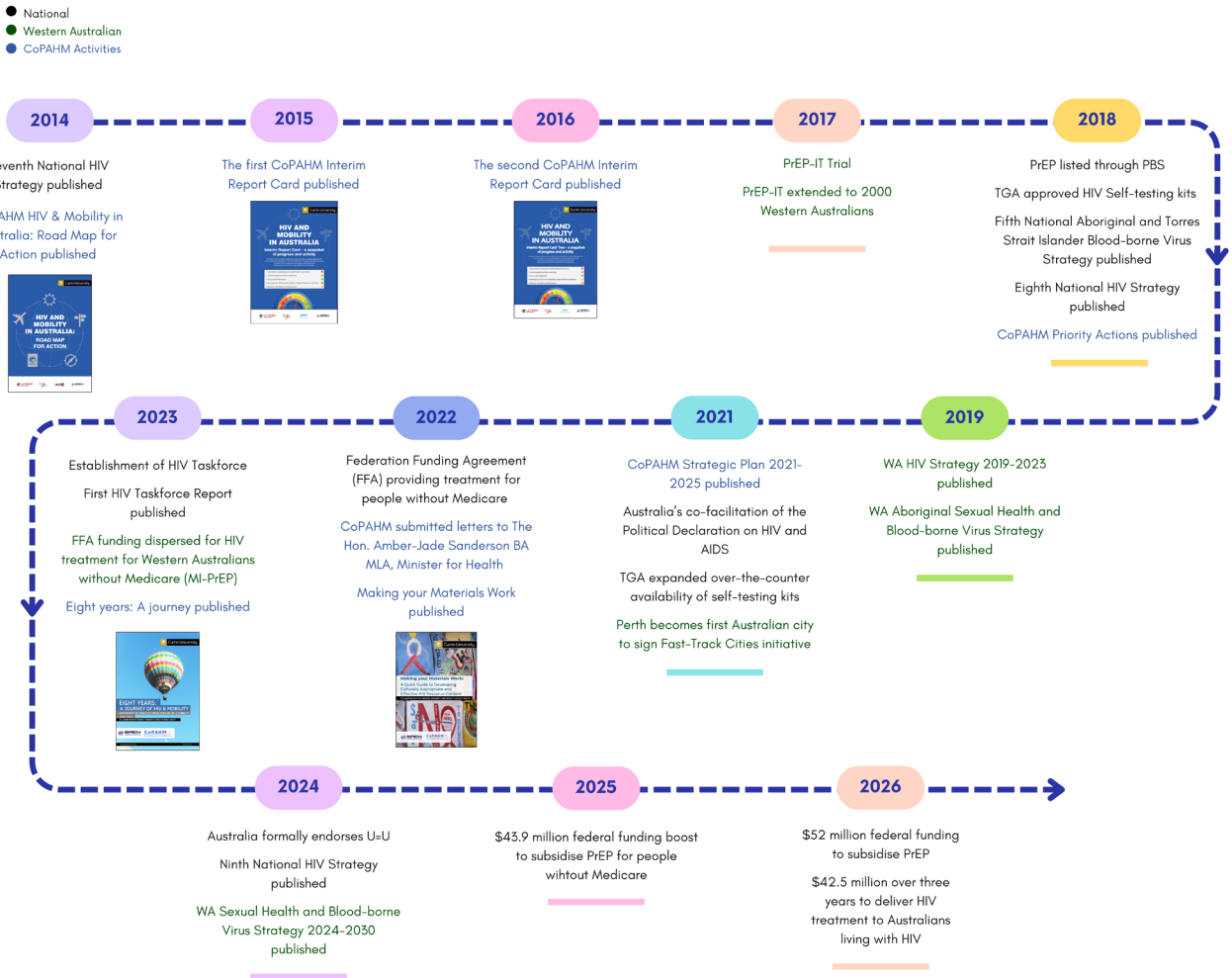
The *2014 Road Map* aimed to operationalise the recommendations of the 7th National HIV Strategy and sought to do this collaboratively. To sustain HIV and population mobility on the national agenda, funding was provided by the Western Australian Department of Health Sexual Health and Blood-Borne Virus Program to establish the Community of Practice for Action on HIV and Mobility (CoPAHM). More than 250 CoPAHM members across government and non-government organisations, research institutions, community groups, and national peak bodies have worked together to advance HIV and mobility policy, research and practice since its establishment.

CoPAHM has continued to monitor and support Australia's response to HIV and population mobility. This has included the publication of three report cards in 2015, 2016 and 2023, a stocktaking activity in relation to the 71 strategies, and the publication of the Priority Actions document, which identified key areas for action. These collaborative efforts ensure that population mobility remains part of the ongoing dialogue on HIV prevention, treatment, and support.

A decade on

Significant progress has been made in Australia's HIV response. Key developments include the listing of PrEP through Pharmaceutical Benefits Scheme (2018) and subsequent federal funding boost to subsidise PrEP for people without Medicare (2024); TGA approval of HIV self-testing kits (2018); Australia's co-facilitation of the Political Declaration on HIV and AIDS (2021); expanded over-the-counter availability of self-testing kits (2021); Federation Funding Agreement (FFA) providing treatment for people without Medicare (2022); formal endorsement of Undetectable = Untransmissible (U=U) (2024); and the establishment of the HIV Taskforce (2023).

Within WA, local initiatives have included the PrEP-IT trial (2017) and PrEP demonstration for 2000 Western Australians (2017); asymptomatic outreach testing at Perth Steam Works; Perth becoming the first designated Australian Fast-Track city on World AIDS Day, 1 December 2021; FFA funding dispersed for HIV treatment for Medicare ineligible Western Australians (2023); and the establishment of Medicare ineligible PrEP (MI-PrEP) (2026).



Know your epidemic

Australia has continued to celebrate marked success in responding to HIV. New HIV cases have fallen by 27%, from 1030 notifications in 2015 to 757 in 2024. In the same period, HIV incidence among gay and bisexual men attending sexual health clinics in ACCESS reduced from 0.33 to 0.07 new infections per 100-person years. Australia continues to maintain a low HIV prevalence in comparison to other high-income countries, with a prevalence of 0.14% in 2024 (King et al., 2025).

However, Australia's success has not been equitable. Declines in the past decade were primarily driven by a decrease in notifications among Australian-born GBMSM. New diagnoses in other populations, including people born overseas and people who acquired HIV through heterosexual sex, have not shown comparable declines.

People born overseas: a growing share of notifications

Notification rates by region of birth fluctuated between 2015 and 2024 (King et al., 2025). Among Australian-born people, the notification rate declined by 53% (2.1 per 100,000 in 2024), while it increased among people born in Latin America and the Caribbean by 50% (13.6 in 2024) and among people born in Oceania (excluding Australia) by 77% (6.4 in 2024). In 2024, the rates for people born in Southeast Asia (7.7 per 100,000) and sub-Saharan Africa (7.4 per 100,000) remained substantially higher than the Australian-born rate, though both have shown some decline in recent years (King et al., 2025). Total HIV cases among people born overseas are not available in national surveillance reports. However, data from King et al. (2023) reported that 44% of diagnoses between 2016 and 2020 were among people born overseas. Of those, 49% were estimated to have acquired HIV after arrival in Australia, and 13% close to arrival.

While there have been decreases among GBMSM, this decline has mostly been among Australian-born men, with a 54% decline between 2015 and 2024 (from 444 to 205 notifications) (King et al., 2025). By contrast, among men born in Asia, the decline was 15% (from 168 to 143), and among men born in other regions, the decline was 9% (from 137 to 124). In 2024, 43% of notifications among GBMSM were among Australian-born men; 30% were among Asian born men and the remaining 26% born in countries other than Australia or in the Asian region (King et al., 2025).

In the context of heterosexual exposure, the proportion born in Australia declined from 44% in 2015 to 35% in 2024 (60% among men and 40% among women). In the same period, the proportion of those born in Asia increased from 18% to 26%, while the proportion born in sub-Saharan Africa and other regions fluctuated (King et al., 2025).

Overseas acquired HIV: a missing piece

Likely place of acquisition for HIV was last reported in the 2022 Annual Surveillance Report. Additionally, data relating to overseas acquired HIV captured by jurisdictional surveillance is ad hoc, as outlined by the CoPAHM desktop review. Among HIV notifications attributed to GBMSM exposure in 2021, 15% were likely to have acquired HIV overseas, although this was less than the 26% estimated in 2018 and may be attributed to COVID-19 travel restrictions. Among notifications attributed to heterosexual exposure, 47% were estimated to have acquired HIV overseas; less than the 55% estimated in 2018 (King et al., 2022).

Late diagnosis and undiagnosed HIV

The proportion of cases with late diagnosis (a CD4+ cell count below 350 cells/μL at diagnosis, indicative of infection acquired at least four years prior) increased from 27.3% in 2015 to 38.4% in 2024 (King et al., 2025). The proportions were highest among people born in Southeast Asia (58%), Oceania outside Australia (53%), and sub-Saharan Africa (47%).

In 2024, the estimated proportion of people living with HIV who were undiagnosed was highest among people born in Southeast Asia (23%) and among those born overseas with a reported exposure of heterosexual sex (45%), compared with 2% among Australian-born men with male-to-male sex as their reported exposure risk (King et al., 2025).

HIV diagnosis and care cascades: Towards 95-95-95

Care cascades are available online (https://www.data.kirby.unsw.edu.au/hiv), estimating the number of people living with HIV in Australia, the number and proportion who are diagnosed, receiving antiretroviral treatment, and who have a suppressed viral load (<200 HIV\ RNA copies/mL). In line with the UNAIDS Fast-Track Targets, Australia supports the global 95-95-95 targets.

In 2023, overall national estimates were 92-97-98, which reflects an ongoing gap in testing, but high engagement with care and treatment once diagnosed. These percentages were lower for people born in Latin America and the Caribbean (81-69-97), people born in Southeast Asia (77-89-97), and people born in sub-Saharan Africa (93-92-97). Cascades for other regions of birth are not currently available.

SCOPE OF PROGRESS

A review of progress against the 71 strategies from the *2014 Road Map* was undertaken. Each strategy was reviewed through a desktop review of published literature, government documents and sector reports, with outcomes assessed and compiled into a research framework. Each recommendation was assigned a status: substantial progress, limited progress, and no progress. Findings were refined through iterative feedback.

Fewer than half of the 71 strategies had been fully achieved. Twenty-three (32%) were assessed as substantial progress, though many of these require ongoing support to be sustained. A further 31 (44%) had limited progress, where outcomes had been constrained by limited resources or incomplete implementation. The remaining 17 (24%) had no progress, most commonly where responsibility for action was unclear, mechanisms for operationalisation had not been established, or evidence was not able to be located online.

For a full overview of the *2014 Road Map* strategies, status assigned, and desktop review findings, see Appendix 1.

INTERNATIONAL LEADERSHIP AND GLOBAL HEALTH GOVERNANCE

Australia has consistently positioned itself as a regional leader in HIV prevention and treatment. This is evidenced by the establishment of the HIV Taskforce in 2023 and Australia's ongoing contributions to UNAIDS and the Global Fund, including co-facilitation of the 2021 Political Declaration on HIV and AIDS, in which migrants were named a priority population. However, the goal of embedding HIV and population mobility as a cross-cutting priority in international policy has only been partially achieved, with limited consideration of health demonstrated in trade or immigration policies.

Consultation with the sector indicates substantial agreement with the need for ongoing participation in international monitoring, including standardisation of tools and measurement tools (85%). Internationally, gaps in surveillance infrastructure continue to limit a coherent regional response. The UNAIDS Global AIDS Monitoring framework lacks migration-specific indicators (UNAIDS, 2023), and a lack of harmonised surveillance systems and data-sharing protocols across organisations and borders continues to hinder a fully integrated regional response (King et al., 2024). There was strong agreement on the ratification of international agreements (88%), and the opportunity to leverage Australia's presence at international forums more deliberately by advocating for equitable access to biomedical innovations across the region. Limited agreement was seen in the need for international relationships (75%), though this may reflect current uncertainty surrounding the President's Emergency Plan for AIDS Relief (PEPFAR), suggesting a need to direct bilateral and multilateral investment toward building long-term self-sufficiency in partner health systems across the Asia-Pacific.

Sector feedback highlighted ongoing problems alongside new challenges. Climate-driven displacement is increasingly reshaping population mobility across the Asia-Pacific, with implications for HIV exposure and service access not yet adequately reflected in either regional surveillance or advocacy frameworks. Additionally, there is an ongoing need for the routine inclusion of health impact assessments in trade and bilateral agreements, evidenced by health inequities experienced by Pacific Australia Labour Mobility (PALM) workers. Progress on removing HIV-related travel and migration restrictions has continued through the advocacy of UNAIDS and the International Organisation for Migration, but this has not been translated into Australia's own policies. Finally, a culturally competent, globally connected health workforce, and supported participation in key global forums, are essential to translating policy commitments into sustained programmatic impact.

Table 1. Strategies for International Leadership and Global Health Governance, 2014

Strategy	Status
1.1 Parliamentary liaison group to have greater awareness of the relationship between HIV and mobility.	Substantial progress
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.	Substantial progress
1.3 Participation in international monitoring and surveillance activities including the development of standardised definitions and measurement tools.	Limited progress
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.	Substantial progress
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.	Limited progress

Strategy	Status
1.6 Continue to build relationships with new players in the 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.	Limited progress
1.7 Advocacy regarding need for greater attention on mobility and cross-border issues as well as in-country responses at UNAIDS and other AIDS organisations.	Substantial progress
1.8 Advocacy regarding international health governance and impact across border HIV policies and programs at G20, APEC and CHOGM.	Substantial progress

COMMONWEALTH AND STATE LEADERSHIP

While there have been meaningful reforms in some areas (including treatment for those who are Medicare-ineligible), structural gaps remain in others (including the criminalisation of sex work and restrictions on the entry, stay and residence of people living with HIV). Concerningly, new immigration laws expanding government powers to search, detain and repatriate certain migrant groups have been introduced, strongly criticised as a step backward for migrant rights and safety. Consequently, progress is uneven.

Consultation with the sector indicates high agreement in the need for a whole-of-government approach to migrant social and health needs (90%), as well as reviewing laws relating to migration that are inconsistent with health needs (92%). Most critically, consultation indicated a need for prioritised resourcing and services for at-risk sub-groups (95%). Governments have relied heavily on non-government organisations to advance the HIV response, with inconsistent funding and resources to sustain this. While some non-government organisations have integrated responses to population mobility within their organisations, funding and service delivery is for the most part ad hoc, with little joined-up strategy to determine how to best serve multiple, disparate priority populations. Despite ongoing calls to address racism and its health consequences (Australian Human Rights Commission, 2024), nationally funded diversity campaigns remain absent and are an agreed need (83%). Sector consultation also indicated agreement (83%) for cultural and migrant sensitivity training for health professionals, police, immigration and embassy staff, previously not seen to be delivered at a national level.

Sector feedback highlighted ongoing structural barriers in Australia's response. Migration health requirements continue to deter testing and restrict permanent residence for people living with HIV. Migrant sex workers face compounding barriers, including police harassment, visa vulnerability, and limited access to culturally competent services; these have been clearly documented and remain inadequately addressed at a systemic level. At a strategy level, mobility has not been acknowledged as a risk factor or driver. Though the 9th National HIV Strategy acknowledges "CaLD communities" as a priority, and the HIV Taskforce noted HIV diagnoses among overseas-born GBMSM, neither document acknowledges structural factors relating to population mobility, and neither document identifies travel as a factor or as a priority population. There is an ongoing need for a more strategic approach to a culturally competent workforce, employing staff from priority groups, as well as strengthening mechanisms for a national peak body that can hold government accountable and co-produce strategic direction with priority groups.

Table 2. Strategies for Commonwealth and State Leadership, 2014

Strategy	Status
2.1 Reform policies on universal access to HIV treatment and related health care for temporary visa holders currently without Medicare access.	Substantial progress
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.	Limited progress
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.	No progress
2.4 Provide financing and funding for a comprehensive and integrated response to at-risk mobile populations and migrants.	Substantial progress
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 mainstream services as well as specific community based programs.	Limited progress

Strategy	Status
2.1 Reform policies on universal access to HIV treatment and related health care for temporary visa holders currently without Medicare access.	Substantial progress
2.6 Review and reform any Commonwealth 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.	Limited progress
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.	Limited progress
2.8 Prioritise resources and services for at-risk subgroups according to risk and vulnerability as follows: • PLHIV migrants/visa holders who do not have access to treatments • Partners of PLHIV from migrant/mobile backgrounds • Migrants generally from high prevalence countries • GMSM, particularly from Asian backgrounds and other high-prevalence countries, especially GMSM African men • Migrant sex workers from CaLD backgrounds • PWID from CaLD backgrounds • Some priority groups travelling to high prevalence countries.	Limited progress
2.9 Sensitivity and skills training for police, immigration, health and embassy staff to include accurate content and contexts regarding above risk subgroups.	No progress
2.10 Continue to protect migrants' human rights and legal protection against discrimination.	Limited progress
2.11 Continue efforts at state and Commonwealth 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.	Limited progress
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.	No progress
2.13 Provide funding and resources to support networks of migration organisations.	Substantial progress

COMMUNITY MOBILISATION

Progress under this domain remains limited. Funding for the CoPAHM has supported the development of advocacy networks connecting migrant community groups, HIV and health sector organisations, and people living with HIV. Health Equity Matters (HEM) has furthered this work through the establishment of Australian Multicultural HIV and Community Health Alliance group. However, community mobilisation requires long-term investment to develop capacity and opportunity for power shifts. Involvement of affected communities remains the cornerstone of Australia's successful response to HIV; this principle has not been consistently extended to those from migrant backgrounds, driven in part by unsustained funding.

Sector agreement was seen in the need for supporting capacity for communities in advocacy and peer involvement (97%), as well as the delivery of culturally sensitive material for new arrivals (96%) and the development of referral pathways for migration services (93%). Initiatives to address the aforementioned strategies are often ad hoc. Programs that promote access to HIV testing and treatment had strong support from the sector (98%), consistent with evidence of late diagnosis and lower treatment cascade outcomes among overseas-born people and Australian-born travellers. While such programs exist, these are often localised and tailored to specific groups, with limited evidence seen for the promotion of HIV testing to travellers. Stigma reduction programs centred on the lived experiences of migrant or travellers (82% sector agreement) have not been systematically developed or funded, nor have programs addressing the intersections of HIV with gender equity, domestic and sexual violence, and social exclusion (84%). Less clear from sector consultation was the role of engagement with transnational corporations employing people across high-prevalence countries (64%), a strategy that recognises the role of the private sector in shaping mobility-related HIV risk.

Sector feedback reiterated the continuation of structural and social barriers. Criminalisation of HIV non-disclosure, mandatory testing, and HIV-related discrimination embedded in migration policy actively deter testing, disclosure, and engagement with care. Stigma remains one of the most significant and underaddressed drivers of delayed testing and disengagement from care, compounded for sexuality and gender diverse migrants by experiences of homophobia, transphobia, and cultural marginalisation. Standard testing pathways similarly fail to reach many in these communities, where cost, language barriers, cultural unfamiliarity, and fear of immigration consequences all operate as deterrents (Gray et al., 2019; Marukutira et al., 2020). Addressing these challenges requires targeted structural reform and a shift toward migrant community control over HIV prevention, testing and treatment responses.

Table 3. Strategies for Community Mobilisation, 2014

Strategy	Status
3.1 Develop an advocacy network of migrant community groups, mobile populations, HIV sector organisations, PLHIV, and professional organisations.	Substantial progress
3.2 Develop HIV knowledge and capacity amongst migrant community, cultural and spiritual leaders.	Limited progress
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 peer involvement.	No progress
3.4 Further develop partnerships with transnational non-government organisations and aid organisations working in HIV/AIDS across borders.	Substantial progress
3.5 Further develop partnerships with transnational companies who employ people in Australia and high prevalence countries and have a high level of cross-border travel of employees.	No progress

Strategy	Status
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.	No progress
3.7 Further develop and deliver programs which promote access to HIV testing and treatment services for migrant and mobile populations.	Limited progress
3.8 Further develop programs (personal perspectives etc.) which aim to reduce stigma and discrimination related to migrant and mobile populations.	Limited progress
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.	Limited progress
3.10 Develop mutual sensitivity training regarding issues around sexuality, cultural sensitivity, alcohol and drug use, sex work and any other related issues.	Limited progress
3.11 Develop multilingual and culturally sensitive materials focusing on prevention information for new arrivals and for specific sub-populations.	Limited progress

DEVELOPMENT OF SERVICES FOR MOBILE OR MIGRANT PEOPLE AND GROUPS

Action in this domain remains limited by resourcing. The development and delivery of appropriate services continues to fall predominantly on peer-based, volunteer and community organisations operating with limited, unsustained funding. Investment in peer-led programs specifically targeting migrant populations remains fragmented. Programs addressing GBMSM from migrant backgrounds are more developed, though challenges persist in engaging recently arrived GBMSM in prevention services. For migrant sex workers, the advocacy and peer support work carried out by Scarlet Alliance and state-based organisations such as Sex Workers Outreach Project and Respect Inc continues to represent the primary, and largely self-funded, infrastructure for this population.

Sector feedback indicates the need for the expansion of culturally sensitive and accessible treatment, care and support for migrants living with HIV (97%). The enhancement of services for migrant GBMSM (95%), sexworkers (95%), and migrant PWID (89%) reached agreement, alongside the delivery of peer programs for migrants (88%). Though these exist, services often remain siloed, vulnerable to funding changes, and without systematic reach or monitoring. While the delivery of HIV information to travellers had agreement (87%), less clear was the need for social media marketing and in-situ information for travellers (70%), peer-based information for backpackers (54%) and responses to partners of travellers (37%). The limited agreement related to strategies for travellers may reflect differences in jurisdictional epidemiology, and the removal of travellers from national data and subsequently, strategy. Finally, support for agencies to implement programs for international students engaging in sex work was also low (79%).

Sector feedback highlighted several service gaps. Overseas-born women represent one of the most underserved populations in Australia's HIV response, with sexual and reproductive health services rarely integrating HIV awareness in culturally appropriate ways. More broadly, significant service gaps persist for migrants and travellers across the prevention-to-care continuum. PrEP remains poorly understood and difficult to access for many migrants and travellers who fall outside the networks through which PrEP literacy and uptake have been built. Opt-out testing models and hub-based clinic services that are bulk-billed, bilingual, and culturally safe may be more practical in addressing service gaps. For people living with HIV, quality of life, psychosocial support, and culturally appropriate care remain chronically under-resourced. Closing these gaps requires deliberate investment in designing models and services to meet the needs of migrant and mobile populations from the outset.

Table 4. Strategies for Development of Services for Mobile or Migrant People and Groups, 2014

Strategy	Status
4.1 Ensure travel medicine clinics continue to deliver HIV information to travellers.	No progress
4.2 Encourage sexual health testing for travellers upon return to Australia.	Limited progress
4.3 Further develop programs and services to be delivered by peers in migrant and multicultural organisations and HIV sector organisations.	Limited progress
4.4 Enhance specific strategies aimed at GMSM from migrant backgrounds through sexual health clinics and AIDS Councils and other relevant community-based organisations.	Limited progress
4.5 Expand strategies to inform and engage GMSM who have at-risk sex in high prevalence countries.	No progress
4.6 Enhance specific strategies aimed at migrant sex workers at peer-based sex worker programs, sexual health clinics and advocacy organisations.	Limited progress
4.7 Enhance specific strategies aimed at PWID from migrant backgrounds through needle and syringe programs or alcohol and other drug programs.	No progress

Strategy	Status
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.	No progress
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: expatriate employees (resource sector, military/peace keeping and aid workers) working in high prevalence countries for extended periods; migrants returning to high prevalence countries for holidays; males, travelling to or through high prevalence countries.	No progress
4.10 Assess viability of delivering peer-based information for incoming and outgoing backpackers.	No progress
4.11 Expand culturally sensitive and accessible treatment, care and support for migrants living with HIV.	Limited progress
4.12 Deliver sensitive HIV screening for migrants and mobile populations including antenatal screening and sexual health screening.	Substantial progress
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.	No progress
4.14 Consider responses for partners of travellers.	No progress
4.15 Consider interstate migration as people may access services in other states if there are shortages of services in their own state.	Limited progress
4.16 Identify what services are needed on arrival in Australia, by whom, and who is responsible for providing services.	No progress
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.	Limited progress
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.	Limited progress
4.19 Better availability of accessible health hardware (condoms, sterile injecting equipment) where migrants and travellers can access it.	Substantial progress

RESEARCH, SURVEILLANCE AND EVALUATION

Australia's research and surveillance infrastructure in HIV is strong, with a large proportion of strategies having been met. Risk factor analysis, phylogenetic mapping, treatment effectiveness studies, cost-benefit modelling, and transmission analysis are active areas of work, anchored by institutions like the Kirby Institute, the Burnet Institute, the Centre for Social Research in Health, Australian Research Centre in Sex, Health and Society and the Collaboration for Evidence, Research and Impact in Public Health (Curtin University). The evidence base on HIV in migrant and mobile populations has expanded considerably, with studies documenting gaps in the care cascade (Marukutira et al., 2020), barriers to testing and treatment (Gray et al., 2019; Li et al., 2024), PrEP uptake among migrant GBMSM (Yu et al., 2024), and challenges in late diagnosis among overseas-born people (Kirby Institute, 2024). However, research has not consistently translated into structural changes or funded activities, and there is a noteworthy gap in intervention and evaluative research and national, harmonised research projects such as the Migrant Blood-borne Virus and Sexual Health Survey (MiBBS) delivered in the same periodic manner as other key surveillance projects (such as the GBQ+ Community Periodic Surveys).

Surveillance still differs state by state, data collection is inconsistent across jurisdictions, and standardised approaches for sub-populations, including sex workers, people who inject drugs, and migrants, have not been achieved and remain a need identified by the sector (80%). Other strategies agreed include identifying pathways and experiences of travellers and migrants (86%), and consolidation of studies in relation to services and health-seeking behaviours of migrants (85%). There was less agreement within the sector on the need for core evaluation frameworks (79%), and cost-benefit analysis of interventions (61%). Additionally, the quality of life for migrants living with HIV (79%) and community-level HIV migration pathways (79%) also had less agreement.

Feedback from the sector noted that the evidence base for HIV prevention for migrants remains heavily dependent on academic and institutional research, with grassroots organisations rarely resourced to generate or own the evidence that shapes responses to their communities. Targeted and universal service models continue to operate in parallel without rigorous evaluation of what works, for whom, and under what conditions. Prioritising and funding action-based research, alongside community organisations and communities, is necessary to address the research-practice gap. Presently, there is no national research strategy to ensure more even progress, reduce duplication and scale up intervention research. There is ongoing need for a clearinghouse and a mechanism to ensure that national and international research findings are being shared to enhance impact and knowledge mobilisation.

Table 5. Strategies for Research, Surveillance and Evaluation, 2014

Strategy	Status
5.1 Standardise surveillance for sub-populations such as GMSM, sex workers, PWIDs.	Limited progress
5.2 Design studies/ monitoring to better understand acquisition risks for different people.	Limited progress
5.3 Analysis of the costs and benefits of universal access to treatments.	Substantial progress
5.4 Effectiveness of health screening of asylum seekers.	Substantial progress
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	Substantial progress

Strategy	Status
related knowledge, attitudes and behaviours and the role and impact of religion, gender and culture.	
5.6 Phylogenetic analysis to understand spread of HIV in migrant and mobile populations.	Substantial progress
5.7 Analysis of uptake and maintenance of treatment by migrants.	Substantial progress
5.8 Analysis of effectiveness of treatments on health of migrants.	Substantial progress
5.9 Identify where HIV infections are occurring to target and tailor interventions.	Substantial progress
5.10 Review the impacts of legal regulations on migrant health and access to HIV treatments.	Substantial progress
5.11 Analysis of factors that hinder provision of HIV treatment to migrants.	Substantial progress
5.12 Develop core evaluation indicators for programs aimed at migrant groups or mobile populations to better contribute to evidence of what works.	No progress
5.13 Explore the feasibility of the role of treatment in preventing HIV transmission in migrant communities.	Substantial progress
5.14 Quality of life, coping strategies and support needs unique or specific to migrants living with HIV.	Limited progress
5.15 Analysis of media contribution to discrimination and stigma of migrants.	Limited progress
5.16 Conduct cost-benefit analysis on different interventions aimed at different mobile populations.	No progress
5.17 Look at pathways and experiences of mobile populations and migrants to identify opportunities for policy and program intervention.	Limited progress
5.18 Risk factor analysis for HIV infection in HIV positive and/or the general migrant population.	Substantial progress
5.19 Analyse impact of increased migration on HIV prevalence.	Limited progress
5.20 Report on community-level HIV migration patterns to Australia (i.e. state-based surveillance based on migration patterns).	Limited progress

WHERE TO NEXT?

The *2014 HIV and Mobility: Road Map for Action* paved the way for a strategic national response to HIV and population mobility. However, a decade on, many strategies have no or limited progress, and new challenges have emerged. The HIV epidemiology reflects ongoing health inequities for both migrant and mobile populations – groups that remain both unacknowledged in national strategies and under-resourced.

Broad findings from consultation with the sector point to the need for a contemporary, nationally supported framework for addressing HIV and population mobility, to better address persistent gaps in prevention, testing and treatment. A national peak advocacy body to ensure accountability and co-produce policy with affected communities, alongside adequate resourcing, is critical in ensuring Australia meets virtual elimination targets among migrant and mobile populations.

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APPENDIX 1: REPORT CARD

This table presents the findings of a desktop review of progress against each strategy from the *2014 HIV and Mobility Road Map for Action*. Status ratings are indicative and based on available evidence identified through desktop search in June 2026 and may not be exhaustive.

No.	Strategy	Desktop Review Findings	Status
International Leadership and Global Health Governance			
1.1	Parliamentary liaison group (PLG) to have greater awareness of the relationship between HIV and mobility.	The HIV Taskforce, established in May 2023, produced a comprehensive report providing advice to the Australian Government on HIV prevention, testing, treatment, decriminalisation, destigmatisation and partnership. The Ninth National HIV Strategy sets a target of virtual elimination of HIV transmission by 2030. The Parliamentary Friends for ending HIV, STIs and other BBVs (formerly the Parliamentary Liaison Group) was operated by Senator Dean Smith and former Senator Louise Pratt serving as co-chairs. The 2024-25 Federal Budget committed $43.9M to boost the HIV response, including PrEP access for Medicare-ineligible people, pilot health education program for people from CaLD backgrounds, and HIV self-testing vending machines.	Substantial Progress
1.2	Develop whole-of-government approach including PM, Foreign Affairs, Trade and Immigration, with particular attention to the impact of trade and commerce on health in Australia and the Pacific.	The 2024-25 Federal Budget committed $43.9M to the domestic HIV response, with targeted investments in prevention, testing and multicultural outreach. The DFAT-UNAIDS Strategic Partnership Framework (2022-27) provides $5M annually in core funding plus $9M to UNAIDS to support HIV responses in Cambodia, Fiji, Indonesia, Papua New Guinea and the Philippines (2024–2028). The 2025–26 Official Development Assistance Budget includes an $81M regional health resilience package maintaining HIV and tuberculosis services across the Pacific and South East Asia in the context of PEPFAR disruptions.	Substantial Progress
1.3	Participation in international monitoring and surveillance activities including development of standardised definitions and measurement tools.	The Kirby Institute Annual Surveillance Report 2025 (reporting on 2024 data) includes HIV notifications by region of birth. UNAIDS Global AIDS Monitoring does not include migration-specific indicators. Australia supported the UNAIDS Asia-Pacific HIV estimates workshop at the Regional Workshop on HIV Estimates and Projections for Asia and the Pacific, held in Bangkok in February 2025.	Limited Progress
1.4	Consider programs, responses and policies outside Australia that may have downstream effects relating to the behaviour and attitudes of travellers to and from Australia.	UNAIDS continues to advocate globally for the removal of HIV-related travel restrictions. HALC, NAPWHA, Health Equity Matters and ASHM jointly submitted to the Department of Home Affairs Review of the Significant Cost Threshold (SCT), recommending removal of HIV from visa assessment and reform of the cost calculation methodology. Following that review, the SCT was increased from $51,000 to $86,000 effective 1 July 2024; however, HIV has not been removed from the SCT assessment. The January 2025 US executive order freezing PEPFAR has disrupted HIV programs in source countries relevant to Australian migration, including Indonesia, the Philippines, Papua New Guinea and Cambodia, with consequences for migration-related HIV risk (UNAIDS Asia-Pacific, 2025). Health Equity Matters and UNAIDS partnership, funded by the Department of Foreign Affairs and Trade, have delivered the Indo-Pacific HIV Partnership program since 2024.	Substantial Progress
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.	Australia is a signatory to the UNAIDS Political Declaration on HIV and AIDS, committing to 95-95-95 targets and the enabling environment agenda, and co-facilitated the 2021 UN High-Level Meeting on AIDS. In 2024, Australia became the fourth signatory country to the Multinational Undetectable=Untransmittable (U=U) Call-To-Action. Australia endorsed the 2026 UN High-Level Meeting on AIDS outcome document. Australia is not a signatory to the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Australia is a signatory country to the Sustainable Development Goals. In line with International Labour Organization workplace non-discrimination conventions, it remains illegal to discriminate against PLHIV in Australia.	Limited Progress
1.6	Continue to build relationships with new players in the 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	Australia and UNAIDS signed a new $12M partnership agreement in May 2024 at the 77th World Health Assembly, funding HIV responses in Papua New Guinea, Fiji, the Philippines, Indonesia and Cambodia (2024–2028). This expands the existing AU$25M DFAT-UNAIDS Strategic Partnership Framework (2022–27). Australia maintains a long-standing partnership with the Global Fund, including Debt2Health initiatives. The January 2025 US executive order freezing PEPFAR has created disruption to HIV programs across Asia-Pacific; UNAIDS has called for national, regional and international solidarity to restore community-led services.	Limited Progress

No.	Strategy	Desktop Review Findings	Status
	(International Council of AIDS Service Organizations), UNHCR (United Nations Refugee Agency) and Immigration Department.		
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.	IOM remains the leading multilateral actor on cross-border HIV responses. The UNAIDS 2018 Global Compact on Safe, Orderly and Regular Migration provides a framework for reducing migration-related HIV risks. Australia supported a UNAIDS Asia-Pacific HIV Estimates Workshop in Bangkok (February 2025) to update national HIV estimates, particularly critical following the PEPFAR funding disruption.	Substantial Progress
1.8	Advocacy regarding international health governance and HIV policies and programs at G20, APEC and CHOGM.	G20 Brazil 2024 established a Global Coalition for equitable access to health technology, with implications for HIV treatment access in low- and middle-income countries. The 2025 APEC Health Working Group, under Korea's presidency, focused on pandemic preparedness and universal health; however, it did not explicitly list HIV as a priority. The 2024 CHOGM in Samoa included health equity discussions, but HIV was not highlighted in communiqué outcomes. The Australian Government responded to the HIV crisis in Fiji and PNG through UNAIDS and DFAT partnerships (DFAT, 2025 (Oct); DFAT, 2025 (Nov)).	Substantial Progress
Commonwealth and State Leadership			
2.1	Reform policies on universal access to HIV treatment and related health care for temporary visa holders currently without Medicare access.	The HIV treatment access scheme for Medicare-ineligible people was implemented from July 2023 across all Australian states and territories, providing free ART through public hospital pharmacies and sexual health clinics. The 2024-25 Budget extended this program and allocated $26M over two years (2025-26) for subsidised PrEP for Medicare-ineligible people, a significant expansion of access beyond treatment to prevention. NHMRC-funded research by UNSW mathematically modelled that providing ART to temporary residents was cost-neutral and would prevent onward transmission, providing the direct evidence base for this policy reform.	Substantial Progress
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.	No Australian state or territory has dedicated and advisory migrant health units in State Health Departments. However, most state and territory health departments fund primary healthcare services for migrant and refugee groups. The Victorian Department of Health implemented the Refugee Health Program and has published a Multicultural Health Action Plan 2023-27. Western Australia offers the Humanitarian Entrant Health Service, New South Wales Ministry of Health funds the statewide NSW Refugee Health Service, Northern Territory Primary Health Network funds the Refugee Health Program and South Australia delivers the Refugee Health Service.	Limited Progress
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.	The Department of Immigration is now the Department of Home Affairs (DHA). Health and wellbeing of migrants is a function of Settlement Services, though not determinable if policy advice regarding cross-border health issues is included. HIV is referenced only in relation to health and Significant Cost Threshold assessments for visa applicants.	No Progress
2.4	Provide financing and funding for a comprehensive and integrated response to at-risk mobile populations and migrants.	Australian Government has committed $5M per year to UNAIDS via DFAT, in addition to $43.9M, including $26M for PrEP access, for people who are Medicare-ineligible. The Partnerships for a Healthy Region initiative provides $620M over five years (2022-2027) to support public healthcare systems in Pacific and Southeast Asian countries.	Substantial Progress
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 mainstream services as well as specific community-based programs.	The Multicultural Framework Review, released July 2024, recommended that culturally responsive service delivery be embedded across health, disability, education, aged care and housing. The Humanitarian Settlement Program, soon succeeded by the Humanitarian Integration and Settlement Program, remains the main delivery vehicle, with the 2026–27 Federal Budget allocating $910.9 million to Refugee, Humanitarian, Settlement and Migrant Services, including $10.8 million over 2026–2028 for community-led health literacy initiatives for refugee and migrant women. Housing and national health mainstreaming remain the weakest links, with no standalone Migrant and Refugee Housing Strategy yet committed and only patchy uptake of dedicated multicultural health programming across Primary Health Networks.	Limited Progress
2.6	Review and reform any Commonwealth 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.	The 2023 HIV treatment access scheme for Medicare-ineligible people is the most significant positive law reform since 2014. The Migration Strategy, released 2023 with eight key actions and over 25 policy commitments, is the main cross-portfolio reform vehicle, but does not reconcile migration law with tax, health and social security settings such as Medicare ineligibility for temporary visa holders. No dedicated review has yet targeted these specific cross-legislative inconsistencies as a discrete reform package.	Limited Progress

No.	Strategy	Desktop Review Findings	Status
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.	Diversity Council Australia monitors diversity-related media coverage. DFAT has a Diversity, Equity and Inclusion Strategy 2024-27 but no specific public relations campaign. The Australian Government committed $11M over three years to multicultural independent media in 2025. No explicit government-led public communications campaign targeting general population attitudes toward migrants has been identified.	Limited Progress
2.8	Prioritise resources and services for at-risk subgroups according to risk and vulnerability.	The Ninth National HIV Strategy 2024-2030 identifies priority populations including people from CaLD backgrounds, The strategy does not disaggregate GMSM from CaLD backgrounds by region of origin (e.g. Asian and African backgrounds) and does not address migrant-specific risk factors for sex workers and PWID.	Limited Progress
2.9	Sensitivity and skills training for police, immigration, health and embassy staff to include accurate content and context regarding above risk subgroups.	HIV Taskforce names additional training for health staff but not for immigration, police, or embassy staff. No national standards for police training identified.	No Progress
2.10	Continue to protect migrants' human rights and legal protections against discrimination.	The Migration Amendment (Strengthening Employer Compliance) Act 2024 improves workplace protections for migrant workers. The Racial Discrimination Act 1975 and state anti-discrimination legislation remain in force. The DHA Review of the SCT (2024) acknowledged disability discrimination concerns but retained HIV in visa health assessment. The 2024 migration enforcement reforms, including expanded detention and removal powers, have raised concerns from the Refugee Council regarding protection of asylum seekers and undocumented migrants.	Limited Progress
2.11	Continue efforts at state and Commonwealth 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 states and territories.	No Commonwealth framework for decriminalisation exists. Queensland's sex work decriminalisation framework commenced 2 August 2024, following Victoria's full decriminalisation, 2023. NSW, NT and ACT have long-standing decriminalisation frameworks. SA and WA retain partial to full criminalisation. Scarlet Alliance continues to advocate for nationally consistent decriminalisation.	Limited progress
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.	HOLA, NAPWHA, and ASHM provide HIV clinical training resources, though these are largely oriented toward S100 prescribers and peer navigators rather than migrant-specific care. No government-funded, migrant-specific HIV clinical training program was identified.	No Progress
2.13	Provide funding and resources to support networks of migration organisations.	The Multicultural Peak Body Project Funding program provides dedicated Commonwealth funding to multicultural peak bodies and their networks. FECCA received $2.5 million in seed funding to establish the Australian Multicultural Health Collaborative. Current funding remains peak-body- or program-specific rather than a dedicated investment in network infrastructure across migration organisations.	Substantial Progress
Community Mobilisation			
3.1	Develop an advocacy network of migrant community groups, mobile populations, HIV sector organisations, PLHIV and professional organisations.	The Community of Practice for Action on HIV and Mobility was established in 2015 and includes jurisdictional-based networks. Long-term resourcing would improve functionality.	Substantial Progress
3.2	Develop HIV knowledge and capacity amongst migrant community, cultural and spiritual leaders.	Localised initiatives exist, including those reported in Report Card 1 and 2. No dedicated national program was identified that builds HIV knowledge and capacity among migrant community, cultural and spiritual leaders.	Limited Progress
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 peer involvement.	NAPWHA's Positive Leadership Development Institute supports PLHIV in leadership and advocacy skills but is not specific to migrant groups and mobile populations. Australian Government allocated $1 million in 2024-25 to establish a national HIV multicultural peer navigation program, though online information about the program cannot be found.	No Progress

No.	Strategy	Desktop Review Findings	Status
3.4	Further develop partnerships with transnational NGOs and aid organisations working in HIV/AIDS across borders.	Investment includes DFAT's Australian Support for Pacific HIV Action (ASPHA), a $48 million six-year initiative (2025-26 to 2030-31) supporting Pacific countries to implement national HIV responses, and the Indo-Pacific HIV Partnership with UNAIDS and Health Equity Matters, which strengthens HIV programs and community-led advocacy capacity. Kirby Institute also awarded $5million for the ACTUP-PNG program. The Kirby Institute's CHART Program trains HIV researchers from partner Asia-Pacific countries. Partnerships for a Healthy Region has partially filled the gap left by the 2025 PEPFAR freeze.	Substantial Progress
3.5	Further develop partnerships with transnational companies who employ people in Australia and high prevalence countries and have a high level of cross-border travel of employees.	No HIV programs in industries with high rates of cross-border worker mobility (such as mining, defence, agriculture, hospitality, maritime) were identified.	No Progress
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.	Limited evidence. Structural inequities named in Ninth National Strategy.	No Progress
3.7	Further develop and deliver programs which promote access to HIV testing and treatment services for migrant and mobile populations.	Several national self-testing initiatives funded, including the CONNECT vending machine network dispensing free HIV self-test kits and NAPWHA's home delivery self-testing program. On treatment, the $26 million PrEP subsidy for Medicare-ineligible people and free HIV treatment guaranteed regardless of visa status provide genuine access mechanisms once diagnosed. However, no dedicated national testing program specifically targets migrant and mobile populations — access currently relies on general self-testing infrastructure and community models like Queensland's RAPID program, and migrants continue to be diagnosed later and less consistently than non-migrants across the HIV care cascade.	Limited progress
3.8	Further develop programs (personal perspectives etc.) which aim to reduce stigma and discrimination related to migrant and mobile populations.	Examples include AIDS 2024, NAPWHA and Living Positive Victoria hosted a Global Village session on the lived experience of migration. LPV features ongoing migrant PLHIV narratives such as Mani's story of growing up in silence around HIV in India. SBS has documented the visa struggles of migrants living with HIV, including Tito's account as a student visa holder and Carlos Araya's experience navigating a health waiver. ViiV Healthcare's Positive Action Community Grant program is funding Positive Life NSW's "Kitchen Table Stories" for Latin American, Asian and African communities. No programs identified that include mobile populations.	Limited Progress
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.	The HALC Positive Migration Guide and ASHM's HIV and Immigration guidance equip clinicians and migration agents to support PLHIV through visa processes, while Living Positive Victoria's peer navigators actively refer clients to migration lawyers. NAPWHA hosts webinars on migration and HIV. Services Australia provides materials in multiple languages, and TIS National's Free Translating Service allows permanent residents and eligible temporary visa holders — including student visa (subclass 500) holders — to translate up to 10 documents free within two years of their visa grant.	Limited Progress
3.10	Develop mutual sensitivity training regarding issues around sexuality, cultural sensitivity, alcohol and drug use, sex work and any other related issues.	Available training programs address these topics individually: ASHM's professional training covers HIV, STI and BBV management for the health workforce; HOLA (HIV Online Learning Australia) provides free workforce development for the HIV community sector; and state-level programs — such as the Mental Health Commission's AOD training, Magenta (WA) for sex worker health education, WAAC Community Education workshops — provide single-topic training in cultural sensitivity, AOD, or sex work. No training program addressing the intersection of migration status with sexuality, cultural sensitivity, alcohol and drug use, and sex work as a combined, mutual competency model was identified.	Limited Progress
3.11	Develop multilingual and culturally sensitive materials focusing on prevention information for new arrivals and for specific sub-populations.	MHAHS provides HIV, hepatitis B, hepatitis C and STI materials across 20+ languages. Multicultural resources are available via HEM. Not identified are materials for new arrivals.	Limited Progress
Development of Services for Mobile or Migrant People and Groups			
4.1	Ensure travel medicine clinics continue to deliver HIV information to travellers.	Limited evidence of sexual health information on visible travel medicine clinics' website. Smartraveller references HIV only briefly within general infectious disease advice. Beforeplay campaign (aimed at young people travelling) provides information on PEP and PrEP.	No Progress

No.	Strategy	Desktop Review Findings	Status
4.2	Encourage sexual health testing for travellers upon return to Australia.	Evidence of national HIV testing guidance for returning travellers is embedded in clinical practice. STI Guidelines Australia lists travel to areas of higher prevalence as an indication for STI/HIV testing. ASHM's HIV testing guidance recommends testing for people who have travelled to high-prevalence countries and engaged in risk exposures. Beforeplay campaign (aimed at young people travelling) focuses on testing before travel. Pozhet provides travel tips.	Limited Progress
4.3	Further develop programs and services to be delivered by peers in migrant and multicultural organisations and HIV sector organisations.	Peer programs exist (such as NAPWHA's Positive Asian Network Australia and Positive Latinx Australian Network); however, they are generally volunteer-run and/or focused on PLHIV. ACON runs ConversAsian aimed at gay, bisexual and queer men.	Limited Progress
4.4	Enhance specific strategies aimed at GMSM from migrant backgrounds through sexual health clinics, AIDS Councils and other relevant community-based organisations.	ACON delivers the Emen8 project. Services available that provide testing and/or PrEP without Medicare, such as PrEPAccessNow.	Limited Progress
4.5	Expand strategies to inform and engage GMSM who have at-risk sex in high prevalence countries.	No explicit evidence identified.	No Progress
4.6	Enhance specific strategies aimed at migrant sex workers at peer-based sex worker programs, sexual health clinics and advocacy organisations.	Scarlet Alliance provides advice for migrant sex workers. SWOP (NSW) lists a Thai and Chinese peer project. SIN (SA) has a CaLD project. Respect Inc (QLD) lists drop-in support and has material in-language. Magenta (WA) provides STI testing without Medicare and limited translations.	Limited Progress
4.7	Enhance specific strategies aimed at people who inject drugs (PWID) from migrant backgrounds through needle and syringe programs or alcohol and other drug programs.	Some alcohol and other drug services for migrants exist, but not specific to BBVs. No evidence of specific strategies for migrants.	No Progress
4.8	Assess viability of in-situ HIV information in high-tourist areas and/or high-prevalence areas such as Phuket, Bangkok and Bali, in partnership with, or supportive of, local organisations.	No evidence of Australian-initiated programs identified.	No Progress
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: expatriate employees (resource sector, military/peace keeping and aid workers) working in high prevalence countries for extended periods; migrants returning to high-prevalence countries for holidays; males, travelling to or through high-prevalence countries.	The WAAC Safe Travels campaign provides general HIV health promotion for travellers. "Going Somewhere? Don't Bring HIV Home" 2019 WA campaign targeted males travelling to Southeast Asia (online link not found).	No Progress
4.10	Assess viability of delivering peer-based HIV information for incoming and outgoing backpackers.	No backpacker-targeted peer education identified.	No Progress
4.11	Expand culturally sensitive and accessible treatment, care and support for migrants living with HIV.	NAPWHA's #NoMedicareNoProblem campaign, with links to peer support. Evidence of culturally sensitive clinical care limited, with no training for s100 prescribers identified. ASHM provides information on accessing treatment for people without Medicare.	Limited progress

No.	Strategy	Desktop Review Findings	Status
4.12	Deliver sensitive HIV screening for migrants and mobile populations including antenatal and sexual health screening.	The Australian Government Department of Health and Aged Care Pregnancy Care Guidelines recommend routinely offering and recommending HIV testing at the first antenatal visit. The National HIV Testing Policy recommends offering testing to migrants from high-prevalence countries. No mention of travel. No evidence of considerations for ensuring cultural sensitivity.	Substantial Progress
4.13	Support current agencies to implement programs for Australian students overseas and international students doing sex work in Australia. Link with universities.	No evidence identified.	No Progress
4.14	Consider responses for partners of travellers.	No evidence identified.	No Progress
4.15	Consider interstate migration as people may access services in other states if there are shortages of services in their own state.	Medicare-eligible patients able to dispense medication nationally. S100 prescriber nationally consistent. Linkage between jurisdictions for Medicare-ineligible patients is not clear as each jurisdiction manages its Medicare-ineligible program independently.	Limited Progress
4.16	Identify what services are needed on arrival in Australia, by whom, and who is responsible for providing them.	Humanitarians managed through Humanitarian Settlement Program. No evidence of similar framework for migrants. No evidence of a program that connects migrants living with HIV to services pre- or post-arrival.	No Progress
4.17	Consider needs of travellers before arriving in Australia, while in Australia, and after leaving Australia. Consider differences depending on visa type, including bridging visas.	Mandatory testing for permanent and humanitarian visas (though critiqued) and some temporary visas. Gaps in Medicare accessibility while in Australia depending on visa type, often ad-hoc support provided by jurisdictions. No evidence of consideration of needs after leaving Australia.	Limited Progress
4.18	Advocate for increased availability of multilingual and culturally sensitive HIV prevention materials for new arrivals and specific sub-populations including asylum seekers.	Multilingual HIV prevention materials developed by MHAHS, MHSS and ECCQ, as well as some Health Departments. No evidence of materials specific to new arrivals or asylum seekers.	Limited Progress
4.19	Better availability of accessible health hardware (condoms, sterile injecting equipment) where migrants and travellers can access it.	Free health hardware available, though limited evidence of specific strategies to increase accessibility for migrants or travellers.	Substantial Progress
Research, Surveillance and Evaluation			
5.1	Standardise surveillance for sub-populations such as GMSM, sex workers and PWID.	The Kirby Institute Annual Surveillance Report 2025 reports on HIV notification rates and includes GBMSM, sex workers, PWID and trans and gender diverse individuals, but does not distinguish people born overseas. A nationally consistent minimum data set for sub-population HIV surveillance, including migration-related variables, has been supported by HEM. Overseas-acquired HIV is no longer reported in the Annual Surveillance Report, with inconsistent data variables reported by CoPAHM. The GBQ+ Community Periodic Survey and Australian Needle Syringe Program Survey provide sub-population surveillance, but data on migrants is limited though increasingly a focus. Some behavioural data available through MiBSS, GLAAAM+ and NEXUS.	Limited Progress
5.2	Design studies and monitoring to better understand acquisition risks for different people.	Yu et al. (2024) explored social and behavioural characteristics of migrant GBMSM and HIV risk, Medland et al. (2024) analysed characteristics of HIV incidence among PrEP users, Herbert et al. (2022) analysed characteristics of heterosexually-acquired and homosexually-acquired HIV among HIV Observational Database, King et al. (2023) established a population-level method for estimating timing of HIV acquisition for migrants and Sacks-Davis et al. (2020) identified phylogenetic clusters among heterosexual migrants. Studies appear ad-hoc and specific risks for different people are not always explicit.	Limited Progress
5.3	Analysis of the costs and benefits of universal access to HIV treatments.	Gray et al. (2019) conducted a mathematical model to estimate the number of HIV infections avoided and associated lifetime costs over 5 years if HIV-positive temporary Australian residents had access to antiretroviral treatment (ART) and subsidised medical care. Results suggest that access to ART would significantly reduce HIV transmission and avert $22 million in new infection costs. See also Gray (2023). Lim et al. (2022) demonstrated significant lifetime cost of HIV management in Australia using an economic model.	Substantial Progress

No.	Strategy	Desktop Review Findings	Status
5.4	Effectiveness of health screening of asylum seekers.	The Medicare Benefits Schedule funds the Refugee Health Assessment which provides comprehensive health assessments to those from refugee backgrounds and is funded up to 1 year post-arrival. The DHA require visa applicants to undertake specific health examinations. Position statements of the AMA (see also Sexual and Reproductive Health Position Statement) and RACGP, support equitable and culturally sensitive screening and services. Specific research and evaluation on the effectiveness was not identified.	Substantial Progress
5.5	Investigate and consolidate studies of available services and health-seeking behaviours of migrants relating to HIV.	Gray et al. (2019) identified barriers and enablers to HIV testing among people born in sub-Saharan Africa (SSA) and South-East (SEA) or Northeast Asia (NEA) living in Australia. Lakin and Kane (2023) conducted a systematic review to examine how the literature conceptualises migrants' interactions with and their experiences of the Australian health system. The 2026 WHO World report examines how countries are integrating refugee and migrant health into broader public health, migration governance, development, and universal health coverage initiatives. Saito et al. (2021) reported on findings from the OPTIMISE study to improve the primary care management of people from refugee backgrounds. Vujcich et al. (2023) aimed to identify the knowledge, attitudes and practices, and the barriers and enablers to HIV prevention and testing among SEA, NEA and SSA migrants living in Australia. Gray et al. (2023) explored transnational experiences of Indonesian women living in Perth. Philpot et al. (2022) explored the impact of stigma on HIV service access among migrant GBMSM.	Substantial Progress
5.6	Phylogenetic analysis to understand spread of HIV in migrant and mobile populations.	Sacks-Davis et al. (2020) investigated the characteristics of phylogenetic clusters in notified cases of HIV among heterosexual migrants in Victoria, Australia. Taiaroa et al. (2024) applied molecular epidemiology and related mathematical models to a collection of HIV-1 *pol* sequences to reveal patterns of HIV transmission in Victoria, Australia. Health Equity Matters published a paper providing an overview of molecular epidemiology and its role in the virtual elimination of HIV in Australia.	Substantial Progress
5.7	Analysis of uptake and maintenance of HIV treatment by migrants.	Marukutira et al. (2020) compared cascades between migrant and non-migrant populations in Australia and identified gaps in care. Gunaratnam et al. (2018) identified that migrants were less likely to start HIV treatment early. However, current cascades published by the Kirby Institute suggest once diagnosed, engagement in care is maintained.	Substantial Progress
5.8	Analysis of effectiveness of HIV treatments on the health of migrants.	Tran et al. (2024) documented that the significant cost threshold incentivises migrants to use suboptimal ART due to visa challenges. Petoumenos et al. (2015), Tilley et al. (2015), Yu et al. (2025) demonstrate that when equitable access to ART is achieved, treatment effectiveness does not differ by migration status.	Substantial Progress
5.9	Identify where HIV infections are occurring to target and tailor interventions.	Holt et al. (2023) and Keen et al. (2025) provide examples of postcode analysis, though specific to GBM.	Substantial Progress
5.10	Review the impacts of legal regulations on migrant health and access to HIV treatments.	The Significant Cost Threshold was increased from $51,000 to $86,000 effective 1 July 2024. However, HIV remain part of the assessment over a 10-year period (compared with 5 years for other conditions). Ghimire (2025) suggests that the SCT risks violating rights to non-discrimination, family unity and health; and supports raising the threshold, as recommended by Health Equity Matters, NAPWHA, HALC and ASHM's joint statement.	Substantial Progress
5.11	Analysis of factors that hinder the provision of HIV treatment to migrants.	Barriers to HIV treatment for migrants identified by Ryan et al. (2019), Ziersch et al. (2021)., Norman et al. (2025), Tran et al. (2024) and Power et al. (2019) include: the Significant Cost Threshold, Medicare ineligibility (now partially addressed), racism, stigma, fear of visa consequences, lack of culturally appropriate services, and limited awareness of rights and entitlements.	Substantial Progress
5.12	Develop core evaluation indicators for programs aimed at migrant groups or mobile populations to better contribute to evidence of what works.	No evidence of standardised or suggested evaluation indicators for programs aimed at migrant groups or mobile populations.	No Progress
5.13	Explore the feasibility of the role of treatment in preventing HIV transmission in migrant communities.	Callander et al. (2024) conducted a 10-year longitudinal cohort study on Australian GMSM demonstrating that treatment-as-prevention is effective. ASHM's National PrEP Guidelines support treatment-as-prevention. Extending subsidised treatment medication for those who are Medicare-ineligible helps to meet this strategy.	Substantial Progress
5.14	Quality of life, coping strategies and support needs unique or specific to migrants living with HIV.	The HIV Futures 9 published by ARCSHS, La Trobe University studies the quality of life among PLHIV. Norman et al. (2025) conducted a qualitative study to understand migration experiences and quality of life among Asian-born men living with HIV in Australia. HALC, QPP and NNAPWHA's joint submission presents case studies relating to visa-related quality of life impacts.	Limited Progress

No.	Strategy	Desktop Review Findings	Status
5.15	Analysis of media contribution to discrimination and stigma of migrants.	All Together Now and University of Technology Sydney collaborated to analyse how 724 media pieces from Australian mainstream media portrayed race. Research by the Australian Government Department of Immigration and Border Protection, conducted a comparative analysis of media reporting on migrants.	Limited Progress
5.16	Conduct cost-benefit analysis on different interventions aimed at different mobile populations.	No evidence identified.	No Progress
5.17	Look at pathways and experiences of mobile populations and migrants to identify opportunities for policy and program intervention.	HALC has identified migration pathway barriers for migrants living with HIV and provide recommendations for migration policy reform. Chan et al. (2025) identified social networks as a source of HIV information for newly arrived GBM.	Limited Progress
5.18	Risk factor analysis for HIV infection in HIV-positive and/or the general migrant population.	Kirby Institute Annual Surveillance Reports disaggregate HIV notifications by country of birth, sex, and transmission route. Yu et al. (2024) explored social and behavioural characteristics of migrant GBM and HIV risk. Vujcich et al. (2023) examined HIV knowledge and risk practices among Asian and African migrants in Australia.	Substantial Progress
5.19	Analyse impact of increased migration on HIV prevalence.	The Kirby Institute 2025 surveillance report provides epidemiological data relating region of birth. Gunaratnam et al. (2019) conducted a trend analysis of new HIV diagnoses in Australia by country of birth.	Limited Progress
5.20	Report on community-level HIV migration patterns to Australia (state-based surveillance based on migration patterns).	HIV surveillance and reporting vary between states. The Kirby Institute primarily maintains and synthesises national data however, notifications are incomplete for several key variables used in the cascade calculations.	Limited Progress