Pathways to engaging with sexual health services and LGBTQ+ communities among recently arrived, overseas-born gay, bisexual, and other men who have sex with men in Australia: A qualitative study

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Acknowledgement of Country

We acknowledge the traditional custodians of the unceded land on which the University of New South Wales sits and on which all participants and researchers involved in this study live, work, and reside. We pay respect our respect to all Aboriginal and Torres Strait Islander peoples whose lands, winds, and waters we have the privilege of sharing.

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Executive summary

Overseas-born gay, bisexual, and other men who have sex with men (GBM) account for an increasing proportion of new HIV diagnoses in Australia and are a priority population in the New South Wales (NSW) and Australian HIV strategies (Department of Health, 2018; NSW Ministry of Health, 2024). Despite the heightened barriers to accessing sexual health services, some overseas-born GBM do engage with sexual health services but little is known about the pathways through which these connections are made. Understanding how these connections are made is necessary to understand avenues for promoting sexual health services to overseas-born GBM. We conducted in-depth, semi-structured interviews with 27 overseas-born GBM who had arrived in Australia from 2017 onward. Eligible participants were aged 18 years or older, were born in Asia, Latin America, the Middle East, Eastern Europe, or Africa, and were GBM (inclusive of trans men and non-binary individuals).

Participants included in this analysis migrated to Australia between 2013[1] and 2023. Participants' experiences of engaging with sexual health services prior to arriving in Australia were varied: while some indicated that they had engaged with HIV/STI testing services prior to arriving in Australia, others had not. Participants described various pathways through which they learned about, and connected with, sexual health services in Australia, including:

- Large-scale HIV, sexual health, and HIV pre-exposure prophylaxis (PrEP) awareness campaigns.
- Sexual health promotion through universities and university health services
- Through peer, friendship, and/or sexual networks

Participants also described barriers to engaging with sexual health services after arriving in Australia, including:

- A sense of nervousness and/or anxiety when first accessing sexual health services, often compounded by previous negative experiences in their country of birth.
- Not being aware that publicly funded sexual health services in NSW are free.
- An assumption that PrEP was inaccessible owing to being ineligible for Medicare and subsidised medication.

For many participants, community connection also played an important role in their connecting with HIV/STI testing services. For some, these connections were made through information provided by community-based LGBTQ+ health organisations. For others, information about sexual health services was gained through more informal networks of friends and sexual partners. A very small number of participants had not engaged with LGBTQ+ communities since arriving in Australia although were engaged with other communities such as diaspora and university groups. Engaging with community groups not specifically targeted to LGBTQ+ individual may present an opportunity to promote sexual health awareness, and health information more generally, to recently arrived GBM.

[1] Further detail on participants who fell outside the eligibility require is included on page eight.

Recommendations

1. As individuals connect with sexual health services through a diverse range of pathways, continued funding is needed to promote HIV/STI testing services that include large-scale awareness campaigns, targeted promotion in LGBTQ+ venues (including sex on premises venues), and digital dating/hook-up platforms.
2. Beyond just encouraging HIV/STI testing, it is important that HIV/STI testing campaigns emphasise publicly funded sexual health clinics are *free*, *confidential*, and *respectful*.
3. There is a need for enhanced promotion of alternative pathways to accessing PrEP, such as self-importation and, when available, federally funded PrEP for those not eligible for Medicare.
4. Resources are needed, in multiple languages, that guide *both* clinicians and individuals ineligible for Medicare through alternative pathways to accessing PrEP such as self-importation and, when it becomes available, federally funded PrEP for those without access to Medicare.
5. There is a need for government and community-based LGBTQ+ organisations to continue to work with the education sector to promote sexual health awareness and the *free*, *confidential*, and *respectful* nature of publicly funded sexual health services.
6. Community-based LGBTQ+ organisations should enhance engagement with other community-based organisations, including (but not limited to) diaspora communities, university-based clubs and societies, and culturally/ethnically/linguistically/faith-based groups.
7. There is a need for further development of resources explaining sexual health norms in Australia, including information about regular HIV/STI testing, increased use of PrEP, decreased use of condoms, and the promotion of HIV/STI partner notification.
8. Further research is needed that differentiates the sexual health needs of specific population groups, including recently arrived migrant GBM, migrant GBM who have lived in Australia long-term, and Australian-born individuals from culturally, ethnically, and linguistically diverse backgrounds.

Background

Recent advances in HIV prevention technologies such as HIV pre-exposure prophylaxis (PrEP) and treatment as prevention (TasP) have been associated with a significant decline in new HIV diagnoses in Australia (Callander et al., 2023; Grulich et al., 2021). In 2023 in New South Wales (NSW), there were a total of 231 HIV diagnoses, a 20% decline when compared with a pre COVID-19 (2017-2019) average of 290. However, this decline has not been observed universally among all gay, bisexual, and other men who have sex with men (GBM). In 2023, overseas-born GBM accounted for approximately two-thirds of HIV diagnoses made in NSW (NSW Ministry of Health, 2024).

Compared with many of their Australian-born peers, overseas-born GBM often experience heightened barriers to accessing sexual healthcare. These barriers include exclusion from Medicare (Australia's universal and subsidised healthcare system), discriminatory migration policies for people living with HIV, and the need to adjust to a potentially different and unfamiliar healthcare system (Chan et al. 2021; Sudarto et al. 2022; Wong et al. 2021). Migration policies that limit how many hours international students can work, combined with Medicare ineligibility, can also increase the financial burden of accessing healthcare services for this population. Other barriers include internalised, anticipated, or directly experienced stigma within healthcare systems and among the broader community (Philpot et al., 2022, 2023). These barriers reduce the likelihood of overseas-born GBM accessing and being retained in sexual healthcare, increase the likelihood of late HIV diagnoses, and a greater length of time between HIV diagnosis and reaching viral suppression (Marukutira et al., 2020).

GBM who are more closely connected to LGBTQ+ networks and communities are more likely to have tested for HIV and have higher awareness of PrEP and HIV treatment as prevention (Chan et al., 2022; MacGibbon et al., 2023). However, some migrants experience challenges forming social connection after migrating which can also reduce their engagement with health services (Roosen et al., 2021). Challenges to connecting with LGBTQ+ communities may also affect how overseas-born GBM access and interact with sexual health services.

Despite the barriers some overseas-born GBM experience when accessing sexual health services and LGBTQ+ communities in Australia, many overseas-born GBM do make these connections (Phillips et al., 2022). However, little research exists that explores *how* and *why* these connections are made. To address this gap, we deliberately recruited overseas-born GBM who had connected with sexual health and LGBTQ+ services. This project aimed to understand the pathways through which connections to sexual health services and/or LGBTQ+ communities were made by recently arrived overseas-born GBM.

Methods

Study design

In-depth, semi-structured interviews were conducted with overseas-born GBM living in Sydney, Australia. Interviews were conducted between November 2022 and October 2023 and explored: how and why participants connected with sexual health services and/or LGBTQ+ communities; experiences of sexual health services in Australia and their country of birth; migration experience; HIV prevention strategies and treatment; degree of involvement

with LGBTQ+ communities; and experiences of discrimination in healthcare and community settings.

Eligibility

Eligible participants were:

- Born in Asia, Latin America, the Midde East, Eastern Europe, or Africa
- Living in NSW and had arrived on or after 1st January 2017
- Were GBM (inclusive of trans men and non-binary individuals)
- Aged 18 years or older
- Able to participate in an interview in English, Mandarin, Spanish, Thai, or Brazilian-Portuguese

GBM from Western Europe and Northern America were excluded as many of these countries have similar attitudes toward HIV, and similar services for HIV prevention and care, as in Australia. Additionally, the eligibility criteria of having arrived from 2017 onwards, particularly among GBM born in the Asia and Latin America regions, aligns with findings from Grulich and colleagues (2020) that the majority of HIV diagnoses in NSW in 2019 were among GBM who lived in Australia for four or less years.

Recruitment

Recruitment primarily occurred through two inner-city sexual health clinics and a sexual health clinic in the outer suburbs of Sydney. Participants were also recruited through the social media channels of Sydney-based LGBTQ+ community groups. Individuals were either directed to an online expression of interest form or provided verbal consent for their name and contact information to be forwarded to the study coordinator. The study coordinator then contacted eligible participants via email to provide more information about the study and arrange an interview time. Participants received a $30 gift card for participating.

Data collection

Depending on participants' preferences, interviews were conducted face-to-face (at a location of the participant's choosing) or via videoconferencing software. Interviews were conducted between November 2022 and September 2023. With participants' permission, all interviews were audio-recorded, transcribed verbatim, and de-identified. All interviews were conducted in English except one interview conducted in Spanish. The one interview conducted in Spanish was transcribed and translated by a professional transcription and translation service. Interviews lasted between approximately 60 and 120 minutes.

Analysis

Interview transcripts were entered into NVivo (software v.14) and analysed thematically (Braun & Clarke, 2006, 2021). An initial codebook was developed based on the interview schedule, a close reading of a small number of transcripts, and discussions with members of the research team. Using an inductive and deductive approach (Boyatzis, 1998), and drawing on existing literature, the codebook was revised as the remaining interviews were analysed. Members of the research team met regularly to discuss findings and ensure data reliability.

Findings

Sample

Sample demographics are presented in Table 1. In total, 27 participant interviews were included for analysis. The majority of participants identified as cis men (*n*=25) and gay (*n*=20). Participants were aged between 22 and 47 years of age, with a median age of 29. Just over half of participants were born in Asia (*n*=15), followed by Latin America (*n*=8), the Middle East (*n*=2), Africa (*n*=1), and Eastern Europe (*n*=1). Participants were born in China, Japan, Taiwan, India, the Philippines, Thailand, Brazil, Chile, Colombia, Mexico, Egypt, Lebanon, Russia, and South Africa. The majority of participants reported being HIV-negative (*n*=22) and five were living with HIV. The likely source and country of HIV acquisition was not specifically explored in interviews. However, based on the accounts of these participants it is likely that they acquired HIV outside of Australia. Of the participants who reported an HIV-negative status, 12 were using PrEP at the time of being interviewed. All participants living with HIV were on treatment with four reporting an undetectable viral load. The one participant reporting a detectable viral load had commenced treatment shortly after migrating to Australia, approximately three months prior to being interviewed for this study. The majority of participants (*n*=23) lived in the inner-city suburbs of Sydney, areas with higher proportions of male residents identifying as gay (Callander et al., 2020). The remaining four participants lived in the Greater Western Sydney region, an area with a lower proportion of men identifying as gay (Callander et al., 2020).

When migrating to Australia, most participants (*n*=17) held a student visa. Most participants (*n*=20) were not eligible to access Medicare (Australia's universal and subsidised healthcare system) at the time of being interviewed. The majority of participants (*n*=18) reported either having, or working toward, a tertiary qualification. Among these, seven participants reported either having, or working toward, a postgraduate qualification. While being GBM (inclusive of trans men and non-binary individuals) was an eligibility criterion for this project, the account of one participant who identified as a trans woman was included. This participant was included as when she migrated to Australia, she identified as a gay man and had begun seeking gender affirming care shortly before being interviewed. In her interview, she primarily reflected on her experiences of engaging with sexual health services and LGBTQ+ communities in Australia prior to affirming her gender. Similarly, two participants arrived in Australia outside of the eligibility criteria (one participant in 2013 and one in 2016). The participant who arrived in Australia in 2013 initially migrated to rural Australia and moved to NSW in 2017, and the participant who migrated in 2016 arrived in NSW within a few months before 2017. Given their recent arrival to NSW, the research team ultimately included their accounts in this analysis.

Participants described a variety of motivations for migrating to Australia, including for study in both public universities and private language schools, sponsored employment, and working holidays. Australia was commonly characterised as a place in which participants were able to improve their work and educational opportunities, and as a country in which they could more freely explore and express their sexual identities when compared with their country of birth. When describing how they first learnt about, and connected with, sexual health services after arriving in Australia, participants recalled a broad range of pathways, including public HIV awareness campaigns, HIV/STI outreach testing services, friends and sexual partners, and through their own proactive searching online. We outline the various pathways through which participants engaged with sexual health services. In particular, we focus on resources and initiatives that facilitated connection with sexual health services,

barriers to engaging with sexual healthcare, and the role of social and community networks in encouraging participants to connect with these services.

Table 1: Participant demographics

Demographics	Number (n=27)
Age	
20-29	14
30-39	11
40-49	2
Gender	
Male	25
Male/Non-Binary	1
Trans Female	1
Sexuality	
Gay	20
Bisexual	4
Another Identity	3
Region of Birth	
East Asia	4
South Asia	3
Southeast Asia	8
South America	6
Central America	2
The Middle East	2
Eastern Europe	1
Sub-Saharan Africa	1
HIV status	
HIV-negative	22
HIV-positive	5
Year of Arrival	
2013	1
2016	1
2017	3
2018	5
2019	7
2020	1
2021	0
2022	5
2023	3
Visa Status (on arrival)	
Student	17
Working	4
Working holiday	4
Visitor	2
Medicare Eligibility	
Ineligible	20
Eligible	5
Eligibility in-process	2

Employment Status	
Unemployed	4
Casual	5
Part-time	5
Full-time	13
Income Range	
<$20,000	5
$20,000-$34,999	3
$35,000-$49,999	3
$50,000-$74,999	2
$75,000-$99,999	7
>$100,000	5
No data	2
Education[2]	
Secondary	2
Undergraduate	18
Postgraduate	7

Sexual healthcare in country of birth

Participants reported a broad range of experiences when describing their engagement with sexual health services prior to arriving in Australia. Most participants reported that they did have a history of HIV/STI testing in their country of birth, although the frequency with which they tested varied. Joseph commented: "*[I] try to [test] twice: before Christmas and on my birthday, middle of the year, just because it gave me peace of mind*" (Joseph, gay man, 40-49, Southeast Asia). In contrast, Henrique stated: "*I did the HIV test like a few times, just for checking … Not that frequently, maybe once every year*" (Henrique, gay man, 20-29, South America). When reflecting on their experiences of sexual healthcare in their countries of birth, participants regularly described experiences that were negative. Henrique, for example, continued to reflected on his experiences of talking about sex and sexual healthcare with health services in his country of birth stating:

> *It's not comfortable: it's not about the question because I understand they [clinicians] have to do it for their job. It's their tone of the way they do it or the words they use. I feel judged. … You don't feel safe to be honest* (Henrique, gay man, 20-29, South America).

As reflected in Henrique's account, participants frequently spoke of experiencing stigma related to their LGBTQ+ identities and HIV in healthcare settings. For some, this compounded concerns and anxieties about the potential for experiencing stigma and discrimination in Australian healthcare settings.

Although it was more common for participants to describe negative experiences of engaging with sexual health services in their country of birth, a small number did describe experiences that were characterised as more positive. One participant, for example, stated:

> *If you go to the free testing clinics, there will be a lot of judgement because it's only, like, the clinic for sex workers. And when you walk into that clinic people will look at you and it's very stigmatised there. That's why I paid around 50 [dollars] because I went to a private one, which is not funded by government, so it's just privately running and they're*

[2] Participants self-reported education level and "undergraduate" and "postgraduate" include those who had already achieved this level and those studying at this level.

> *very professional, very friendly nurses, and they make you feel comfortable* (Eka, another identity, trans woman, 30-39, Southeast Asia).

While this participant did describe the care she received in more positive terms when compared with other participants, she nonetheless described the care received in free testing clinics as stigmatising. It was only by going to a private clinic in her country of birth and paying additional money that this participant received care which she felt was supportive.

When asked how sexual health information was communicated in their country of birth, it was common for participants to describe limited or, in some cases, no sexual health education programs.

> *Sexual education is almost non-existent … when you are told about it, you're not told anything. You're not told how to take care of yourself, how to remain sexually well, how to avoid contracting disease* (Ryan, bisexual man, 20-29, Middle East).

When reflecting on the limited information about sexual health in their countries of birth, participants commonly described a lack of information in general, and not just sexual health information specifically targeted to LGBTQ+ people. Some participants described proactively seeking out information about sexual health and HIV prevention, often through resources online:

> *I think I was watching a lot of YouTube and stuff. I think I got [information] through, definitely an online source like YouTubers talking about it. Reading posts on Instagram about sexual health on Facebook. Yeah, it was mainly from an online source because we don't … even at school [sexual health education] is really limited* (John, gay man, 20-29, East Asia).

Despite participants describing a general lack of information available about HIV/STIs, a small number of participants did recall grassroots and community-based initiatives to promote HIV/STI testing, prevention, and treatment, particularly by members of LGBTQ+ communities:

> *There are some movements and initiatives like in Twitter, in hospital, and in certain places. I think the community who actively engage in this kind of health promotion is the gay community* (Bayu, bisexual man, 20-29, East Asia).

Some participants themselves were involved with peer-based LGBTQ+ sexual health initiatives prior to arriving in Australia:

> *I was plugged into these peer organisations and I realised there are services. Which was why I started [a peer organisation] to pair volunteers … who could accompany [people] to the clinic, stay with them for the results, counsel them* (Ram, another identity, 30-39, South Asia).

As evident in these accounts, despite a general lack of information about sexual health in their countries of birth participants were frequently proactive in seeking out sexual health information, often through online resources. Indeed, in response to limited sexual health information, some participants also engaged with, or participated in, community-based HIV peer organisations.

HIV awareness

All participants knew about HIV and its transmission avenues prior to arriving in Australia. When explaining how HIV was characterised in their country of birth, it was common for participants to describe a strong association between HIV and sex between men: "*I think it*

was always discussed as a gay thing, or as like a prostitute, promiscuous woman disease" (Javier, gay man, 30-39, South America). Reflecting on how HIV was conceptualised in his country of birth another participant described an attitude among the general public of: "*These gays are spreading AIDS*" (Ram, another identity, 30-39, South Asia). Despite the common association between HIV and sex between men, the strength of this association was not universal among participants. One participant from East Asia, for example, commented:

> *Of course we think HIV is very common among gay people, but we don't take that seriously, honestly. … We feel like HIV is more common between sex workers, not gay people* (Yuki, gay man, 20-29, East Asia)

Another participant from sub-Saharan Africa, a region with high rates of HIV, stated: "*HIV's most concentrated in the general population, not just the gay. But mostly, mostly the straight persons*" (Ben, gay man, 20-29, sub-Saharan Africa). Despite the varying degrees to which HIV was associated with sex between men, all participants were nonetheless aware of an association between increased HIV risk and GBM.

Many participants described HIV as a highly stigmatised condition in their country of birth owing to its association with sexual activity and injecting drug use. While this stigma was most commonly said to exist in the broader population, some also described HIV-related stigma within healthcare settings:

> *I think people will judge us as naughty, sinful person … because based on the transmission, it's maybe from sexual things and drugs and the drug injections and things. It's just like something people consider as: this is something that naughty kids will do, not the normal things … Even the healthcare provider themselves, it's something they also have that judgement toward this virus* (Bayu, bisexual man, 20-29, Southeast Asia).

Learning about sexual health services in Australia

When describing how they first learnt about sexual health services in Australia, participants described a broad range of pathways. Participants commonly reported finding information about sexual health services in Australia through conducting their own searches online: "*at first I went to [sexual health clinic name] and basically it was the first thing that I found online*" (Dominik, gay man, 30-39, Eastern Europe). Others recalled seeing HIV/STI awareness campaigns developed by community-based LGBTQ+ health organisations:

> *I saw [these campaigns] in many places. … At the university and then in Oxford Street, and then some billboards in the city. … I think mostly university and billboards around the city* (Bayu, bisexual man, 20-29, Southeast Asia).

Some participants reported that it was these campaigns that prompted them to seek out further information online and from there, were directed to publicly funded sexual health clinics.

A large proportion of participants migrated to Australia to study. One participant, Bayu, described learning about publicly funded sexual health clinics through information provided to him as part of his university's orientation programs:

> *When I arrived, the scholarship and the university kind of made an additional program, an introductory program, for us and one of the topics was also about the healthcare system, how to access healthcare* (Bayu, bisexual man, 20-29, Southeast Asia).

Similarly, another participant described being referred to a publicly funded sexual health service by his university's health services, stating:

> *That's how I found [sexual health] services as well: my GP [general practitioner] on campus referred me to them when I needed testings and stuff, or any advice about sexual health … That's how I started going there* (Kabir, gay man, 20-29, Southeast Asia).

For both these participants, universities were an important pathway through which they initially found information about sexual health services, and health services more broadly, in Australia. These accounts draw attention to the potential of programs delivered to overseas-born students prior to, and soon after, moving to Australia for increasing awareness of Australian healthcare services, including services related to sexual healthcare.

For many participants, particularly those ineligible for Medicare, knowledge that they were able to access services that were free was important. One participant commented: "*it was very important to realise that these services were offered for free, because it was something that I wanted: to take care of myself*" (Matias, gay man, 30-39, South America). Similarly, another participant commented: *[I] didn't make that much money and I saw this postcard or something from the [clinic] and they provided free health services* (Ram, another identity, 30-39, Southeast Asia). Being ineligible for Medicare and subsidised healthcare meant that for these participants, accessing sexual healthcare was initially considered potentially costly and out of reach. The knowledge that these services were free, however, provided a sense that at least financially, seeking sexual healthcare was accessible.

Engagement with sexual health services in Australia

Except one participant who had not had an HIV/STI test in the two years prior to his interview, most HIV negative participants were engaged in a regular routine of HIV testing in Australia. This was unsurprising as participants were mostly recruited through publicly funded sexual health clinics. The frequency of testing varied across the group, with quarterly testing being the most common (n=11). The remaining participants indicated having at least one HIV/STI test every six to twelve months.

Publicly funded sexual health clinics were the most common means through which participants sought HIV/STI testing and most participants indicated a preference for attending these clinics over private practices:

> *I always go to [inner-city sexual health clinic] … I prefer to go to a place that specifically deals with sexual health … I really don't like to go to a [private clinic]"* (Peter, gay man, 20-29, South America).

Overwhelmingly, participants described the service they received from dedicated sexual health services as professional and free of discrimination. Experiences of negative healthcare were rarely described by participants and were instead generally associated with poor healthcare provider knowledge in non-specialist settings. One participant, for example, recalled seeking a prescription for PrEP from a university health service:

> *When I asked my GP for PrEP he had to pull up a fucking sheet … I was Googling around [and said]: "You should do this, this is the Tenofovir." And then I had to point to the meds that I needed. I was like: "This is PrEP"* (John, gay man, 20-29, East Asia).

As a student, this participant primarily accessed HIV/STI testing and PrEP through his university's health services and, while generally satisfied with the care he received, he felt that the healthcare providers lacked sufficient levels of knowledge about HIV prevention strategies such as PrEP. Importantly, this participant was also studying in a health-related field and with high levels of PrEP knowledge, felt empowered to be able to advocate for himself in a healthcare setting.

Similarly, one participant who was living with HIV described an initial concern about how he would be able to continue treatment without access to subsidised medications:

> *I looked [online at] how much was it too but, of course. $700. I was like: "That's a lot of money." So, I was trying to not worry about it. I will find the solution to call some organisation. I felt relieved when the doctor in the sexual health centre told me: "You don't have to pay anything for medication. You will get the prescription for six months"* (Miguel, gay man, 20-29, South America).

When asked about their experiences with sexual health services, participants generally reported only positive experiences. Within publicly funded sexual health clinics, participants reported no instances of being treated differently due to their sexual identities or by virtue of being born outside of Australia. When asked whether he felt he had been treated differently, for example, one participant responded:

> *Never. I think in the [inner city sexual health centre] …, I never had that inconvenient experience. Like, it's always been very friendly people and they're very diverse as well in terms of the nurses and the doctors as well* (Eka, another identity, trans woman, 30-39, Southeast Asia).

Barriers to seeking sexual healthcare

While all participants had engaged with sexual health services after arriving in Australia, the pathway to engaging was not always straightforward and participants often recounted barriers to seeking care. Some participants, particularly those who had limited or no experience of prior engagement with sexual health services prior to arriving in Australia recalled feelings of nervousness, anxiety, uncertainty about what to expect, and/or anticipated stigma and discrimination when first attending a sexual health service in Australia:

> *The bad point for me was, I would say, the fact that I wasn't sure what to expect … I wasn't sure what to expect from the [first] meeting, and I wasn't sure if the person is going to be accepting towards a gay person. And just lack of clarity. But it made sense after I met the person* (Ben, gay man, 20-29, sub-Saharan Africa).

Feelings of uncertainty, nervousness, and/or anxiety were compounded for some by previous experiences of negative healthcare prior to arriving in Australia:

> *A fear that [seeking sexual healthcare] might tarnish your reputation also plays a big part in stopping people from accessing these things. … I felt shameful when I was visiting a sexual health clinic back home because of the way that the doctors treated me. But here [in Australia] it was completely normalised and it's completely fine to seek help* (John, gay man, 20-29, East Asia).

These accounts highlight how the role of stigma and discrimination, whether from external sources, internalised, and/or anticipated, can present a barrier to accessing sexual health services.

For some participants, concerns about confidentiality and anonymity were raised as a barrier to seeking sexual health services in Australia. One participant, for example, stated:

> *I did anticipate how it would go and I felt like, 'what if there was [someone from sub-Saharan Africa] there, or my uncle or something?' Because I was worried if my parents find out, because my parents do not know I'm gay. … I was worried* (Ben, gay man, 20-29, sub-Saharan Africa)

For this participant, it was the concern about seeing someone from his country of birth and in turn, having his sexuality revealed to his family, that engendered an initial sense of worry about first attending a sexual health service.

Most participants did not experience English language as a barrier when engaging with sexual health services. However, a small number of participants did appreciate having resources available in their first language. Recalling feeling concerned prior to attending a sexual health service for the first time in Australia, one participant stated:

> *I was not familiar with Aussie English, you know? So, I was not 100% sure I can understand their English. And also, what if they found some like, you know, gonorrhoea or chlamydia or something. I need to understand what I should do. They'll say no sex for a week or some stuff. And at the same time, I was not familiar with STIs in English: I'm familiar with [them in my first language]. But in English, what's that? … I was a bit concerned if I could get proper service or I could understand properly* (Ling, gay man, 20-29, East Asia).

PrEP as a pathway to sexual health services

Some participants indicated that they were first motivated to engage with Australian sexual health services specifically to access PrEP. One participant, for example, had previously used PrEP before migrating, although was not using it at the time he arrived in Australia. Recounting his first engagement with a sexual health service after arriving in Australia he stated:

> *I did so right away because, I can remember before Mardi Gras, right before Mardi Gras I was like: "I think I need PrEP"* (John, gay man, 20-29, East Asia).

While a desire to access PrEP did motivate some participants to engage with sexual health services, perceived cost of medication, particularly for participants ineligible for Medicare, was commonly reported as the primary barrier to accessing PrEP. One participant stated:

> *I don't know why I did not do it … The main reason: it's too expensive for us … I did not have that much money to spend on PrEP and back then, they were telling you to have it every day … I had limited work hours, I could only work 20 hours a week* (Rahul, gay man, 20-29, Asia).

Without access to subsidised medication, this participant initially considered PrEP as financially out of reach. The unsubsidised cost of medication was further compounded for this participant by limitations on the number of hours he could work while on a student visa. Under Australia's migration policy, those who are living in Australia on a student visa are only able to work for 24 hours per week while they are studying.[3]

Prior to COVID-19 and the associated restrictions on social and sexual gatherings, the primary strategy for using PrEP being promoted in Australia was daily dosing. Taking medication daily was seen by some as excessive, particularly for those not engaging in sexual activities often:

> *I thought it was an everyday thing, that once you start taking it you have to take it every day. But like I said, the sexual health centre doctor, you sit down with him to talk about PrEP [and] they go into a lengthy amount of detail in terms of how it affects you, what it*

[3] Individuals in Australia who hold a student visa can legally only work a maximum of 24 hours per week during the period in which their course is running. Outside of these periods, there is no limit on the number of hours those who hold a student visa can work.

> *does, how it works, they number of ways you can take it* (Kabir, gay man, 20-29, South Asia).

The majority of participants using PrEP relied on the self-importation of cheaper, generic medications as an avenue through which they were able to access PrEP and overcome the cost of medication as a barrier. By ordering PrEP medication through online pharmacies and importing it into Australia, some participants were able to access PrEP at a cost lower than that of medications purchased through Australian-based pharmacies. One participant explained:

> *I went to the [clinic] and I got a prescription, but if I want to use PrEP in Australia I need Medicare. Otherwise I have to pay heaps of money. So, I think I was told to use [an] overseas pharmacy* (Yuki, gay man, 20-29, Asia).

While most participants found the process of self-importing relatively straightforward, some did appreciate clinicians taking some extra time to go through the ordering process in detail. Another participant explained:

> *The doctor gave me the [prescription] and he explained … "You have to buy in this page, doing this, doing that, and this is the page." And he wrote it down, everything … Really cool because even though I speak some English, with that technical language you get lost* (Alonso, gay man, 20-29, South America)

The above quotation highlights that although most participants felt comfortable in accessing PrEP through self-importation, it does add an additional and different step to the more common process of obtaining medication from a pharmacy. As noted by this participant, the use of technical and potentially unfamiliar language could make the process of self-importation more challenging.

Social and sexual networks as connection points to sexual health services

During interviews, participants were also asked about their social and sexual networks, particularly in the context of how this engagement impacted their connection to sexual health services. It was common for participants to characterise Australia as a place in which they were more able to express and explore various aspects of their sexual identity. When asked about his first time going to an LGBTQ+ venue, one participant commented:

> *Everything was just so cool and ecstatic for me because I've never seen anything like it. … It was exciting at first because I just recently, around that period, got to know that I was actually a [gay man]. So, it was cool that I could actually blend in and it's all [gay men] and you have nothing to hide, and that freedom* (Ben, gay man, 20-29, sub-Saharan Africa).

Most participants reported that they did attend venues aimed at LGBTQ+ individuals. For many, however, a specific focus on LGBTQ+ identities was not always of primary importance. After being asked if attending LGBTQ+ venues was important to him, one participant responded:

> *No, it's not important for me. If it's just a gay venue or any other even, or a festival or something else, it's just about being with the group of people that I like, or I consider my friends, or I share something with* (Dominik, gay man, 30-39, South Asia).

In the account of this participant, his priority was attending venues with people he considered friends rather than specifically attending LGBTQ+ venues.

For several participants, first connecting to sexual health services was motivated by a sexual partner, often in the context of potential exposure to an STI. One participant recalled a sexual encounter soon after arriving in Sydney and stated:

> *It was really good sex, we played both roles, but the next day I woke up and I had: you know you have gonorrhoea in your penis. I mean I never had sex in my anus and so it's kind of like, yeah, so I told him, I asked him like, "Oh, when was it?" he said, "Look, it was only two weeks ago, but I had sex with like a couple of guys around before you," and I was like, "Okay, I'm going to test," he said, "Yeah, go. I normally go," and he was the one that told me about this [sexual health clinic]* (Samuel, gay man, 30-39, South America)

This participant was using PrEP at the time of this encounter and had previously engaged with an Australian sexual health service in a different state. As evident in his account, he was also aware of the symptoms of gonorrhoea and so it is entirely possible that he would have found a sexual health service of his own volition. Nonetheless, his account highlights the potential for HIV/STI contact tracing to be a connection point for engaging individuals with sexual health services.

For many participants, social networks were an important source of information about sexual health services in Australia. Reflecting on how he initially connected with a sexual health service after arriving in Australia, one participant recalled:

> *I needed to do my testing so I asked where I could find a clinic to go ahead and do it. And I got my reply from a friend who at the time gave me the location, and so I was able to go there because it was quite close* (Peter, gay man, 20-29, South America).

Prior to migrating to Australia, Peter had a history of HIV/STI testing every three to four months and engaging with sexual health services after arriving in Australia was effectively a continuation of this routine. It was through a friend, however, that he initially found information about HIV/STI testing services.

Some participants also reported that peers, whether sexual/romantic partners or friends, also acted as a model of sexual health norms in Australia, and it was through this that they were encouraged to engage with sexual health services. One participant, who had never engaged with sexual health services prior to arriving in Australia, reflected on how he first engaged with sexual health services, stating:

> *I had hooked up with a few guys before that and [friend's name] told me that, okay, you need to get your checked because that's what we do, like he came to Sydney in 2019 and I came here in 2018, but because he already knew he was gay and then he met people easily. So, yeah, he told me that, okay, you need to get yourself checked and this is the place where they do it for free because like healthcare is expensive because I'm not a resident* (Chris, gay man, 20-29, South Asia).

The use of the phrase "*that's what we do*" in the account of this participant suggests engaging with sexual health services is almost a taken-for-granted aspect of an individual's routine healthcare and a normative aspect of GBM sexual cultures in Australia. In addition to modelling a norm around sexual healthcare, this participant also provided direct information about free, publicly funded sexual health services in Australia, which was important as this participant was excluded from Medicare because of his residency status.

Engagement with community-based LGBTQ+ and HIV health organisations

Frequently, connection to sexual health services often occurred through an initial connection to community-based LGBTQ+ health organisations. One participant commented:

> *The guy I used to work with, he was from [community-based LGBTQ+ health organisation] … Through him I actually got to know about [clinic name]. I didn't know about that place before I basically met that guy. … He explained it to me and basically: HIV testing, peer education, education and supporting people basically who don't have access to healthcare systems* (Ryan, gay man, 30-39, Eastern Europe).

As part of this study, we also examined the role of friendship and sexual networks in connecting overseas-born GBM to sexual health services. While some participants found sexual health services through their own means, friendship and sexual networks were an important pathway in connecting others to healthcare services.

While some participants had engaged with community-based HIV and LGBTQ+ health organisations, others described being more reluctant to engage. For example, one participant living with HIV described his reluctance to become involved with a community-based HIV organisation, stating:

> *There are some of the groups that I consider that I don't want to join because, like, I don't want my case to be disclosed much to the public. But I'd like to volunteer myself to be a friend with someone who has actually just [been diagnosed] HIV positive in Australia* (Noi, gay man, 30-39, Southeast Asia).

In this quote, it is important to emphasise that Noi wanted to support other people living with HIV, particularly those who shared his cultural and ethnic background. However, he was concerned that his participation in programs run by an HIV peer organisation might function as him disclosing his positive HIV status, a status he wanted to keep private.

Discussion

To identify *how* and *why* GBM who had recently arrived in Australia connected with sexual health services, we deliberately employed a strategy of recruiting participants who were already engaged with sexual health services and/or LGBTQ+ communities. Participants described a broad range of pathways through which they discovered information about, and engaged with, sexual health services after arriving in Australia. These pathways included HIV awareness campaigns, universities and university health services, community-based LGBTQ+ health organisations, and through their peers. Participants had varied experiences of sexual healthcare in their countries of birth, with some having had routine engagement with sexual health services while others had never engaged.

When describing sexual health services in their countries of birth, participants commonly recalled negative experiences. This contrasted with accounts of engaging with sexual health services in Australia where overwhelmingly, participants reported positive experiences. However, some participants experienced a heightened degree of anxiety when engaging with Australian sexual health services owing to previous negative experiences in their country of birth. Echoing previous research (Horwitz et al., 2022; Philpot et al., 2022), some participants in this study expressed initial concerns and uncertainty about what to expect from Australian sexual health services including concerns about confidentiality, as well as anticipated stigma. While all participants in this study were engaged with sexual health services, it is likely that this anxiety to attend a sexual health service for the first time in Australia may delay or completely prevent some overseas-born GBM from receiving sexual healthcare. Alongside confidentiality, participants commonly emphasised the free nature of publicly funded sexual health clinics as a strong driver for engagement. When promoting HIV/STI testing to overseas-born GBM, it is recommended that the free, confidential, and respectful nature of sexual health services is explicitly stated.

Approximately half of our participants migrated to Australia to study and over a third were on a student visa at the time they were interviewed. In 2023, student visas, particularly visas for studying at higher education institutions, made up the highest proportion of temporary migration visas to Australia (Australian Bureau of Statistics, 2024). As such, universities and university health services were found to be one pathway through which some participants learned about, and engaged with, Australia's healthcare system. However, university health services are not necessarily sexual or LGBTQ+ health specialists. It is necessary, then, that clinicians who work at university health services are equipped with the appropriate resources and training to ensure optimal sexual health outcomes for overseas-born GBM. Moreover, university student groups, clubs, and collectives (such as queer collectives) could also be further leveraged to provide resources about, and promote, publicly funded sexual health clinics.

Aligning with previous research (Chan et al., 2021), ineligibility for Medicare and subsidised medication was considered a barrier to accessing PrEP for some participants. For a small number of participants, however, a desire to access PrEP acted as the motivation for initially engaging with sexual health services. This finding suggests that promoting and creating demand for PrEP can act as a pathway to engaging overseas-born GBM with sexual health services. However, most people on temporary migration visas do not have access to Medicare and subsidised medications. While cheaper generic PrEP medications can be accessed through international pharmacies, participants generally only learnt of these pathways after attending a sexual health clinic. Given these findings, and the finding that PrEP can motivate individuals to engage with sexual healthcare, it is recommended that promotion of PrEP also explicitly include information about alternative pathways for accessing PrEP. These pathways include self-importation of cheaper, generic brands of PrEP medication and, once rolled out, the federally-funded scheme to provide subsidised PrEP to GBM who are not eligible for Medicare (Australian Government Department of Health and Aged Care, 2024) Previous research has also found that some overseas-born GBM are more likely to have fewer sexual partners than their Australian-born peers (Blackshaw et al., 2019). It is therefore also necessary to continue to promote on-demand dosing strategies of PrEP to ensure that individuals who have fewer sex partners do not automatically assume that PrEP is an unsuitable HIV prevention strategy. It is therefore necessary to advertise multiple PrEP dosing strategies *and* alternative pathways to accessing PrEP for those ineligible for Medicare to ensure PrEP is not automatically considered unsuitable nor inaccessible.

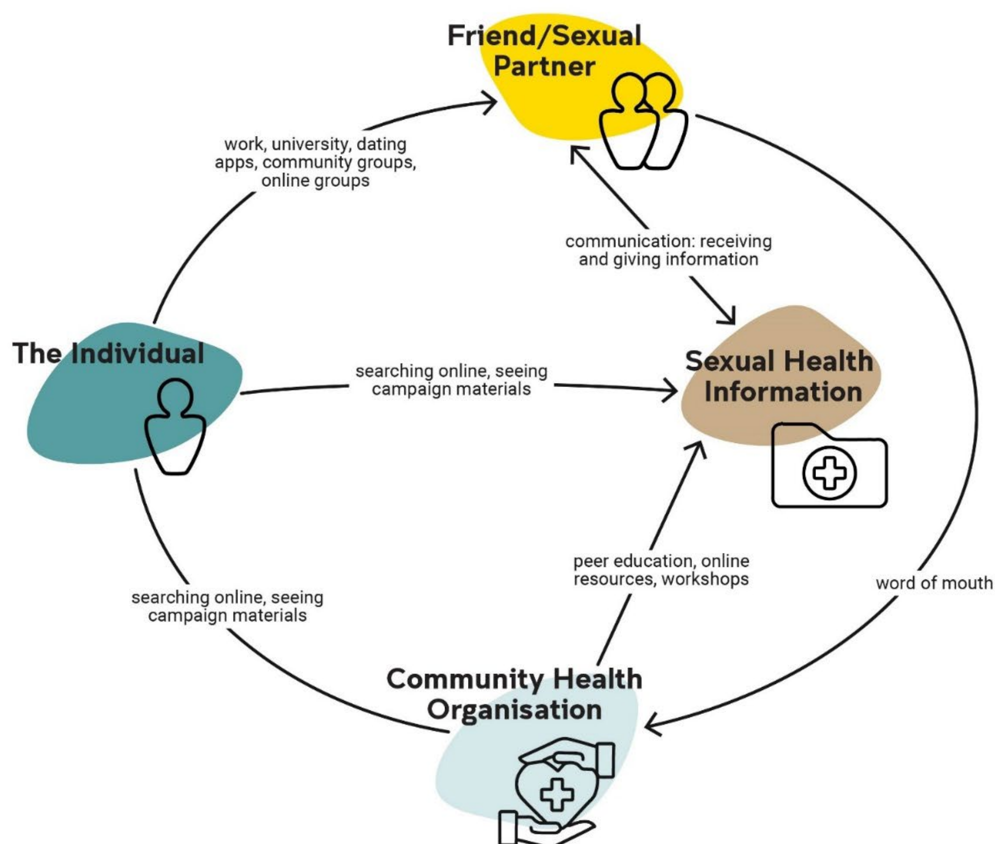
Aligning with previous research (Lee et al., 2020), peer networks and engagement with LGBTQ+ communities was found to play a role in connecting some individuals to sexual health services. Peer networks frequently acted as a pathway to sexual health services by providing information, modelling norms of HIV/STI testing, and connecting participants to LGBTQ+ health organisations, which then directed participants to HIV/STI testing services. These findings reinforce that community-based LGBTQ+ health organisations and peer networks continue to be an important pathway through which individuals learn about, and connect with, HIV/STI testing services.

While peer networks were found to play a role in connecting individuals to sexual health services, formalised community-based LGBTQ+ health organisations were not the only social networks participants engaged with. Participants often reported forming friendships through other groups, including LGBTQ+ sporting and recreational groups, as well as groups organised around cultural, ethnic, and/or faith-based identities. Government health departments and community-based LGBTQ+ health organisations could further strengthen their engagement with leaders in these groups to promote HIV/STI testing and care, including utilising their social media pages for sexual health promotion.

Most participants valued having friendships with other LGBTQ+ identifying individuals. However, a small number did not prioritise LGBTQ+ identities as necessary when establishing social connection after arriving in Australia. Some individuals, for example, established stronger social connections through university and diaspora communities rather than LGBTQ+ networks. Further work is needed to engage with these communities to promote awareness of HIV and sexual health services.

Some individuals were motivated to seek out sexual health information through a direct pathway of searching online for the location of sexual health services. Similarly, some individuals discovered community health organisations through advertising or online searching and from there where directed to sexual health services through other pathways using such as education and workshops. Another pathway involving peers included being linked to a community health organisation via word of mouth through friends and/or sexual partners which then lead to receiving information about sexual health services. As demonstrated in Figure 1, there are several pathways through which individuals could become aware of or engaged with sexual health services, and these pathways represent potential intervention points that could be promoted to further empower overseas-born GBM to engage with sexual healthcare.

Figure 1: Social/Sexual Pathways to Sexual Healthcare



Limitations

Most participants in this study were university educated, lived in inner-city Sydney, and had some form of connection to LGBTQ+ communities. As such, our findings may not be generalisable to those who are less attached to LGBTQ+ communities or living in areas with

lower concentration of people identifying as GBM. As stated earlier, however, the decision to recruit those already connected to LGBTQ+ communities and sexual health services was deliberately made to understand the pathways through which those connections were made. As interviews were only able to be conducted in one of six languages, individuals who may not have felt confident speaking those languages may have felt excluded from this study. A further limitation of this study is that during interviews, the time it took for participants to connect with sexual health services and/or LGBTQ+ community organisations was not always specifically explored. Moreover, the pathways through which participants were recruited into this study (be it through sexual health organisations and/or advertising from community-based LGBTQ+ organisations) was also not asked during interviews.

Recommendations

1. As individuals connect with sexual health services through a diverse range of pathways, continued funding is needed to promote HIV/STI testing services that include large-scale awareness campaigns, targeted promotion in LGBTQ+ venues (including sex on premises venues), and digital dating/hook-up platforms.
2. Beyond just encouraging HIV/STI testing, it is important that HIV/STI testing campaigns emphasise publicly funded sexual health clinics are *free*, *confidential*, and *respectful*.
3. There is a need for enhanced promotion of alternative pathways to accessing PrEP, such as self-importation and, when available, federally funded PrEP for those not eligible for Medicare.
4. Resources are needed, in multiple languages, that guide *both* clinicians and individuals ineligible for Medicare through alternative pathways to accessing PrEP such as self-importation and, when it becomes available, federally funded PrEP for those without access to Medicare.
5. There is a need for government and community-based LGBTQ+ organisations to continue to work with the education sector to promote sexual health awareness and the *free*, *confidential*, and *respectful* nature of publicly funded sexual health services.
6. Community-based LGBTQ+ organisations should enhance engagement with other community-based organisations, including (but not limited to) diaspora communities, university-based clubs and societies, and culturally/ethnically/linguistically/faith-based groups.
7. There is a need for further development of resources explaining sexual health norms in Australia, including information about regular HIV/STI testing, increased use of PrEP, decreased use of condoms, and the promotion of HIV/STI partner notification.
8. Further research is needed that differentiates the sexual health needs of specific population groups, including recently arrived migrant GBM, migrant GBM who have lived in Australia long-term, and Australian-born individuals from culturally, ethnically, and linguistically diverse backgrounds.

References

Australian Bureau of Statistics. (2024). Overseas Migration Statistics on Australia's international migration, by state and territory, country of birth, visa, age and sex: 2022-23 financial year. Australian Bureau of Statistics. https://www.abs.gov.au/statistics/people/population/overseas-migration/latest-release, accessed 10/09/2024

Australian Government Department of Health and Aged Care. (2024). $43.9 million to boost fight against HIV. Australian Government Department of Health and Aged Care. https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/439-million-to-boost-fight-against-hiv, accessed 10/12/2024

Blackshaw, L. C. D., Chow, E. P. F., Varma, R., Healey, L., Templeton, D. J., Basu, A., Turner, D., Medland, N. A., Rix, S., Fairley, C. K., & Chen, M. Y. (2019). Characteristics of recently arrived Asian men who have sex with men diagnosed with HIV through sexual health services in Melbourne and Sydney. Australian and New Zealand Journal of Public Health, 43(5), 424–428. https://doi.org/10.1111/1753-6405.12926

Boyatzis, R. E. (1998). Transforming qualitative information: Thematic analysis and code development. Sage Publications.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. Counselling and Psychotherapy Research, 21(1), 37–47. https://doi.org/10.1002/capr.12360

Callander, D., McManus, H., Gray, R. T., Grulich, A. E., Carr, A., Hoy, J., Donovan, B., Fairley, C. K., Holt, M., Templeton, D. J., Liaw, S.-T., McMahon, J. H., Asselin, J., Petoumenos, K., Hellard, M., Pedrana, A., Elliott, J., Keen, P., Costello, J., … Guy, R. (2023). HIV treatment-as-prevention and its effect on incidence of HIV among cisgender gay, bisexual, and other men who have sex with men in Australia: A 10-year longitudinal cohort study. The Lancet HIV, 10(6), e385–e393. https://doi.org/10.1016/S2352-3018(23)00050-4

Callander, D., Mooney-Somers, J., Keen, P., Guy, R., Duck, T., Bavinton, B., Grulich, A., Holt, M., & Prestage, G. (2020). Australian 'gayborhoods' and 'lesborhoods': A new method for estimating the number and prevalence of adult gay men and lesbian women living in each Australian postcode. International Journal of Geographical Information Science, 34(11), 1–17. https://doi.org/10.1080/13658816.2019.1709973

Chan, C., Bavinton, B. R., Prestage, G. E., Broady, T. R., Mao, L., Rule, J., Wilcock, B., & Holt, M. (2022). Changing Levels of Social Engagement with Gay Men Is Associated with HIV Related Outcomes and Behaviors: Trends in Australian Behavioral Surveillance 1998–2020. Archives of Sexual Behavior, 51(5), 2509–2521. https://doi.org/10.1007/s10508-022-02310-x

Chan, C., Fraser, D., Vaccher, S., Yeung, B., Jin, F., Amin, J., Dharan, N. J., Carr, A., Ooi, C., Vaughan, M., Holden, J., Power, C., Grulich, A. E., & Bavinton, B. R. (2021). Overcoming barriers to HIV pre-exposure prophylaxis (PrEP) coverage in Australia among Medicare-ineligible people at risk of HIV: Results from the MI-EPIC clinical trial. Sexual Health, 18(6), 453–459. https://doi.org/10.1071/SH21096

Department of Health. (2018). Eighth National HIV Strategy: 2018-2022. Australian Government. https://www.health.gov.au/sites/default/files/documents/2022/06/eighth-national-hiv-strategy-2018-2022.pdf

Grulich, A. E., Jin, F., Bavinton, B. R., Yeung, B., Hammoud, M. A., Amin, J., Cabrera, G., Clackett, S., Ogilvie, E., Vaccher, S., Vickers, T., McNulty, A., Smith, D. J., Dharan, N. J., Selvey, C., Power, C., Price, K., Zablotska, I., Baker, D. A., … Guy, R. (2021). Long-term protection from HIV infection with oral HIV pre-exposure prophylaxis in gay and bisexual men: Findings from the expanded and extended EPIC-NSW prospective implementation study. The Lancet HIV, 8(8), e486–e494. https://doi.org/10.1016/S2352-3018(21)00074-6

Grulich, A., Nigro, S., Chan, C., Patel, P., Bavinton, B., Holt, M., Prestage, G., Callander, D., Murray, C., Power, C., Pinto, A., Mao, L., Broady, T., & Keen, P. (2020). Trends in HIV and HIV prevention indicators in gay, bisexual and other men who have sex with men in NSW, 2015-2019: Implications for new interventions and for monitoring and evaluation in a new NSW HIV strategy. UNSW Sydney. https://doi.org/10.26190/5F58034FEE100

Horwitz, R., Brener, L., Marshall, A. D., Caruana, T., & Newman, C. E. (2022). Optimising community health services in Australia for populations affected by stigmatised infections: What do service users want? Health & Social Care in the Community, 30(6), e3686–e3695. https://doi.org/10.1111/hsc.14037

Lee, E., Mao, L., Bavinton, B., Prestage, G., & Holt, M. (2020). Which Gay and Bisexual Men Attend Community-Based HIV Testing Services in Australia? An Analysis of Cross-Sectional National Behavioural Surveillance Data. AIDS and Behavior, 24(2), 387–394. https://doi.org/10.1007/s10461-019-02435-6

MacGibbon, J., Bavinton, B. R., Broady, T. R., Ellard, J., Murphy, D., Calabrese, S. K., Kalwicz, D. A., Heath-Paynter, D., Molyneux, A., Power, C., Heslop, A., De Wit, J., & Holt, M. (2023). Familiarity with, perceived accuracy of, and willingness to rely on Undetectable=Untransmittable (U=U) among gay and bisexual men in Australia: Results of a national cross-sectional survey. Sexual Health, 20(3), 211–222. https://doi.org/10.1071/SH23050

Marukutira, T., Gray, R. T., Douglass, C., El-Hayek, C., Moreira, C., Asselin, J., Donovan, B., Vickers, T., Spelman, T., Crowe, S., Guy, R., Stoove, M., & Hellard, M. (2020). Gaps in the HIV diagnosis and care cascade for migrants in Australia, 2013–2017: A cross-sectional study. PLOS Medicine, 17(3), e1003044. https://doi.org/10.1371/journal.pmed.1003044

New South Wales Ministry of Health. (2024). NSW HIV Strategy 2021–2025: Annual Data Report 2023. NSW Government. https://www.health.nsw.gov.au/endinghiv/Publications/annual-2023-nsw-hiv-data-report.pdf

Phillips, T. R., Medland, N., Chow, E. P. F., Maddaford, K., Wigan, R., Fairley, C. K., Bilardi, J. E., & Ong, J. J. (2022). Newly arrived Asian-born gay men in Australia: Exploring men's HIV knowledge, attitudes, prevention strategies and facilitators toward safer sexual practices. BMC Infectious Diseases, 22(1), 209. https://doi.org/10.1186/s12879-022-07174-z

Philpot, S. P., Aung, E., Templeton, D. J., Stackpool, G., Varma, R., Power, C., Robinson, S., Stratigos, A., Mao, L., Grulich, A. E., & Bavinton, B. R. (2022). Experiences of recently HIV-diagnosed gay and bisexual migrants in Australia: Implications for sexual health programmes and health promotion. Health & Social Care in the Community, 30(6), e5801–e5810. https://doi.org/10.1111/hsc.14011

Philpot, S. P., Mao, L., Cifali, D., Power, C., Templeton, D. J., Robinson, S., Varma, R., Grulich, A. E., Aung, E., & Bavinton, B. R. (2023). Stigma Regarding HIV and Sexual Identity as Barriers to Accessing HIV Testing and Prevention Services Among Gay and Bisexual Migrants in Australia. Sexuality Research and Social Policy, 20(964–976). https://doi.org/10.1007/s13178-022-00769-w

Roosen, I., Salway, S., & Osei-Kwasi, H. A. (2021). Transnational social networks, health, and care: A systematic narrative literature review. International Journal for Equity in Health, 20(138), 1–25. https://doi.org/10.1186/s12939-021-01467-6