Qualitative Interviews

with Overseas-Born Gay and Bisexual Men Recently Diagnosed with HIV from Non-English Speaking Countries: **Report of Results**

Qualitative Interviews with Overseas-Born Gay and Bisexual Men Recently Diagnosed with HIV from Non-English Speaking Countries: Report of Results

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EXECUTIVE SUMMARY

Over recent years, the epidemiology of HIV among gay, bisexual, and other men who have sex with men (GBM) in Australia has changed. Overseas-born GBM accounted for 28% of HIV notifications in 2009, rising to 46% in 2018. In Australian-born GBM, there was a 45% decline in HIV notifications between 2014 and 2018, but in overseas-born GBM, there was a 3% increase in HIV notifications. Responding to the changing epidemiology of HIV requires focused attention on the sub-populations of GBM who are now disproportionately affected by HIV.

We conducted a qualitative study utilising semi-structured interviews with 24 overseas-born GBM from non-English speaking countries living in Sydney, Australia, who had recently been diagnosed with HIV. Interviews were conducted between October 2018 and December 2019. Most were completed in English, three in Spanish, one in Thai, one in Mandarin, and one in Brazilian-Portuguese. The study explored the sexual health practices and social and sexual networks of these men prior to HIV diagnosis, and their experiences at and after their diagnosis. The study aimed to characterise the key factors and barriers contributing to new HIV diagnoses among this group, providing an opportunity to explore issues around HIV prevention practices, HIV testing, use of pre-exposure prophylaxis (PrEP), initiation of antiretroviral therapy, identity, community, culture, the impact of stigma, and engagement with healthcare services and community organisations.

Summary of key findings:

- Participants recounted the immense stigma of HIV and homosexuality in their country of birth.
- This manifested in low HIV testing (the majority having only tested once or never tested in their country of birth) and anxieties about testing in both their country of birth and Australia, as well as poor knowledge of HIV, PrEP, and negotiating HIV prevention with sexual partners.
- Some held a belief that they did not engage in high-risk behaviours and therefore did not need to get tested for HIV or take PrEP.
- There was a range of understandings and practices related to sexual identity. Some participants were engaged with gay and bisexual communities, but others lacked an affiliation with a gay or bisexual sexual identity, lacked gay or bisexual social networks, or rarely attended gay or bisexual venues and events. This diversity produces a challenge for disseminating health promotion messages through traditional 'gay community' avenues to some of these men.
- Knowledge of PrEP was low, with several participants only finding out about PrEP after they had been diagnosed.
- Some lacked knowledge of the Australian healthcare system and had an assumption that HIV testing and PrEP would be inaccessible to them because of their visa status, so they never pursued these options in Australia.
- A few participants found it difficult to adapt to the sexual norms in Australia in which PrEP was

more common than condoms to prevent HIV, and felt pressured to forego condoms even though this was their preferred option to prevent HIV acquisition.

- Data on geographical location of HIV acquisition were limited. Most likely acquired HIV in their country of birth, highlighting the importance of linking GBM into HIV testing and treatment soon after arrival in Australia. However, others likely acquired HIV in Australia, indicating a need to engage recently arrived GBM with prevention information and access to sexual health services earlier to encourage PrEP uptake and regular HIV testing.
- All participants praised the way the sexual health clinics handled their diagnosis.
- However, several participants had concerns about how their diagnosis might impact the status of their residency visa, including that they may be forced to return to a country with limited access to HIV medication and stigma towards people living with HIV and homosexuality.
- Living with HIV remained a secret for many, with some disclosing that their HIV clinician and the interviewer were the only people who knew about their status.
- Most had a low desire to use community-based HIV support services post-diagnosis, but the few who did use them valued the support and information received.
- These formal and informal support services, including sexual health clinics and community organisations, may be particularly beneficial to overseas-born men who are diagnosed after very recently arriving in Australia because they may have had little time to develop other forms of social support.

Summary of key implications for policy and practice

There are several recommendations for policy and practice to better engage recently arrived overseas-born GBM from non-English speaking countries in Australia:

- Produce culturally appropriate health promotion resources and sexual health services that encourage access to regular HIV and STI testing soon after arrival in Australia. Information should explain how to access services and describe biomedical HIV prevention options in Australia.
- Tailor health promotion messages to address language barriers, ensuring they are simple and easy to understand. HIV information should be culturally and linguistically appropriate.
- Increase availability of affordable options for PrEP to non-residents and people ineligible for Medicare, particularly for those who cannot afford it.
- Deliver and scale up culturally appropriate communication campaigns using micro-targeting for overseas-born GBM. It is important to extend campaigns beyond historical settings and channels that have predominantly targeted gay-identifying and gay-community attached GBM. Messages should be delivered within and outside of gay communities. This may include international schools, private colleges and universities, and GBM hook-up and dating apps.
- Acknowledge the concerns overseas-born GBM have about the status of their visa at their diagnosis and provide referrals to organisations and information sources that can provide support, such as the Multicultural HIV and Hepatitis Service and the HIV/AIDS Legal Centre in NSW.
- Advocate in migration policies for people living with HIV in Australia to have no barriers to permanently migrate to Australia.

- Ensure newly diagnosed overseas-born men feel supported through referrals to psychosocial and peer support, with a particular focus on men who have been in Australia for six months or less.
- Continue to ensure the rapid initiation of antiretroviral therapy for newly diagnosed overseas-born men.
- Connect GBM international students to relevant health websites such as the International Student Health Hub in NSW.

INTRODUCTION

In the last decade, since the advent of highly effective methods of biomedical HIV prevention, Australia has made significant gains in reducing HIV notifications. In particular, rapid implementation of pre-exposure prophylaxis (PrEP), which involves HIV-negative people taking HIV medications to protect them from HIV, has helped to reduce HIV incidence (Grulich et al. 2018). Australia-wide data show that from 2014 to 2018, there was a reduction of 29% in HIV notifications among gay and bisexual men (GBM) (Aung et al. 2020).

However, these reductions have not been uniformly observed across sub-populations of GBM. Data from a national report identifying HIV prevention gaps in Australia (Aung et al. 2020) found that among Australian-born GBM, there was a 45% decline in HIV notifications between 2014 and 2018. By contrast, there was a 3% increase among overseas-born GBM. Of overseas-born GBM in Australia, the majority of HIV notifications in 2018 were from men born in Asia (54%, up from 32% in 2009), followed by Latin American (14%, up from 8% in 2009). Similarly, while there was an overall 50% decline in newly-acquired HIV notifications and a 58% decline in these notifications among Australian-born GBM, there was a smaller 31% decline among overseas-born GBM. In 2018 for the first time, late-stage HIV diagnoses were observed more frequently in overseas-born (55%) compared with Australian-born GBM (Aung et al. 2021). Late-stage HIV infection means a person living with HIV has had HIV for quite some time and has developed AIDS-defining illnesses (such as cancer, tuberculosis, and pneumonia). This suggests overseas-born men more likely acquire HIV in their country of birth before migrating to Australia. Together, these data indicate that the epidemiology of HIV in Australia has changed. This overseas-born GBM sub-population is thus at risk of being left behind in the fight to end HIV transmission.

Studies have found that overseas-born GBM who migrate to Australia and other developed Western countries face multiple barriers to accessing healthcare, including a lack of understanding of how to navigate the healthcare system, cost, eligibility to access healthcare, HIV-related stigma, embarrassment, feeling ashamed, and fear of being judged healthcare providers (Agu et al. 2016; Medland et al. 2018). One study found that 75% of Asian-born GBM in Australia spoke a language other than English at home (Blackshaw et al. 2019). This suggests some men have difficulty understanding HIV information that is not culturally or linguistically appropriate. Also in this study, 88% did not have access to Medicare (Australia's universal healthcare system), impacting the accessibility of subsidised or free healthcare. Given these barriers, studies have argued that relocating to a new country can be a risk factor for HIV acquisition (Agu et al. 2016; Gray et al. 2018).

Moreover, studies have reported that several cultural issues influence the ways overseas-born GBM engage with sexual health and understand sexuality. A gay sexuality, though comprehensible by many in the New Zealand sample researched by Adam and Neville (2020), was not a critical marker of identity. Some were not well connected to large social networks of other GBM and kept their gay sexuality secret. They reported concerns with confidentiality and discomfort talking about sex to healthcare workers. Other Australian research has similarly found that recently arrived gay men

from Asia often hide their sexual identity and have low HIV knowledge due to the stigma common in their country of birth (Phillips et al. 2020). When they arrive in Australia they may carry internalised stigma, which manifests as continued hesitancy to share their sexual identity, fear of HIV testing, and low knowledge of HIV prevention, including PrEP (Adam and Neville 2020; Phillips et al. 2020).

These available data provide some insight into why disparities between Australian-born and overseas-born GBM may have emerged. However, to continue to see declines in HIV notifications, further research is needed to understand the practices and needs of overseas-born GBM living in Australia (Blackshaw et al. 2019). Some men may struggle to understand information related to HIV prevention and transmission due to their English language skills. As such, it is important that research studies are conducted in ways that appropriately and inclusively engage this population, including providing study material and collecting research data in languages other than English.

STUDY OBJECTIVE

There is a need to better understand the issues affecting the divergence in outcomes for overseas-born GBM to improve HIV prevention outcomes. The purpose of this study was to characterise the key factors and barriers contributing to new HIV diagnoses among overseas-born GBM living in NSW, Australia. We explored issues around prevention practices (such as access and adherence to PrEP, testing frequency, use of PEP, and condoms), initiation of ART, engagement with primary healthcare services, and engagement with broader HIV organisations and community-based HIV prevention education.

METHODS

Study design

Qualitative semi-structured interviews were conducted to explore the experiences of overseas-born GBM newly diagnosed with HIV in Sydney, Australia. Interviews were conducted between October 2018 and December 2019. Ethical approval was received from the Human Research Ethics Committee of the Prince of Wales Hospital and the community-based Research Ethics Review Committee at ACON Health. Governance approval was received from Sydney Local Health District (LHD), South Western Sydney LHD, South Eastern Sydney LHD, and ACON.

Eligibility

To be eligible for the study, participants must have been:

- Born in a non-English speaking country in Asia, Latin America, Africa, the Middle East, or Eastern Europe[1]
- Diagnosed with HIV in Australia after 1 January 2017
- Diagnosed at or had visited one of the following clinics or community organisations: Sydney Sexual Health Centre (including a[TEST]), RPA Sexual Health, Liverpool Sexual Health Centre, Short Street Centre, Multicultural HIV & Hepatitis Services (MHAHS), ACON,
- Able to participate in the interview in English, Mandarin, Thai, Vietnamese, Spanish, or Brazilian-Portuguese.

Recruitment

Recruitment occurred at sexual health clinics and community organisations based in Sydney that saw a high volume of overseas-born HIV-positive patients. Eligible participants were contacted directly by staff members (doctor, nurse or counsellor) of the participating clinics or community organisations, briefly told about the study, and asked if they would be interested in participating. Those interested were asked to give verbal consent to have their first name, mobile phone number and email address forwarded to the study coordinator at the Kirby Institute; this consenting information was documented at the clinic or organisation. The study coordinator then contacted participants to provide more details about the study and to arrange an interview (for those who agreed to participate), including organising an interview in a non-English language if required. Participants were guided through the Participant Information Sheet (including translated versions if required) by the interviewer and gave verbal consent to participate in the interview. Participants were given a $30 gift card for their participation.

[1]Men born in Western Europe were excluded because despite most of the countries not having English as a first language, many have similar cultural attitudes towards HIV and available services for HIV prevention and care.

Data Collection

Semi-structured interviews were conducted with 24 men in a private room at a community organisation or a sexual health clinic. Interviews in English were conducted by two members of the study team from the Kirby Institute, UNSW. Interviews in languages other than English were conducted by four cultural support workers from the Multicultural HIV and Hepatitis Service (MHAHS) who were provided with training in qualitative interviewing techniques and who fluently spoke the native language of the participant. Most interviews were completed in English, three in Spanish, one in Thai, one in Mandarin, and one in Brazilian-Portuguese. Interviews were generally between 60 and 90 minutes in length, were audio-recorded, transcribed verbatim, and de-identified. The six interviews conducted in languages other than English were transcribed in language by the MHAHS staff member who conducted the interview and then translated by a professional service or the staff member who conducted the interview.

The interview schedule covered men's reasons for coming to Australia and social networks within Australia, sexual behaviour pre- and post-diagnosis, the event they believed led to their HIV infection, use and knowledge of PEP and PrEP, testing frequency and barriers to testing, issues around late diagnosis, initiation of antiretroviral therapy, engagement with health services, HIV and sexual health literacy pre- and post-diagnosis, engagement with gay/HIV community organisations and sources of information about HIV/sexual health, and comparisons between their country of birth and Australia in terms of culture, gay community, and HIV knowledge.

Analysis

Interviews were analysed using thematic analysis (Braun and Clarke 2006). The process began with a close reading of each transcript to ensure familiarity with the data. Short summaries were written for each interview. Transcripts were then imported into NVivo version 12 for coding. As each transcript was re-read, recurring patterns from the data were categorised into a set of codes. At this point, codes that connected to each other were grouped thematically. Most interviews were conducted by Author 2 and all analyses were conducted by Author 1. Authors 1 and 2 met regularly to exchange reflections and ideas and check that interpretations were accurate. Where interpretations did not match, the issue was raised in meetings with all members of the research team to explore possible solutions. Upon receiving advice and opinions, Author 1 ultimately decided which interpretation to take. All members of the research team work as clinicians, epidemiological and social researchers, or at HIV and gay community organisations. Together, the research team has decades of expertise in HIV prevention and transmission, and working with people living with HIV, GBM, and overseas-born men.

RESULTS

SAMPLE

The demographics of the sample are presented in Table 1. Of the 24 men who participated, 21 identified as gay and three as bisexual. Ages ranged from 19 to 64 with a median of 33 (IQR 25-37). Nine were born in South-East Asia (three in the Philippines, two in Thailand, two in Vietnam, one in Malaysia, and one in Cambodia), eight in Latin America (three in Mexico, two in Colombia, one in Ecuador, one in Peru, and one in Brazil) five in North-East Asia (two in Taiwan, two in China, and one in South Korea), and one each in South Asia (India) and Eastern Europe (Russia). Data on time in Australia at diagnosis are incomplete because this was not explored in six interviews, but of those whose length of residency was known, six had been in Australia for less than one year, five for between one and three years, seven for three years or more. Just over half (13) lived in a postcode in which the proportion of gay residents was lower than 5%, eight lived in a postcode in which the proportion was between 5% and 19%, and three lived in a postcode in which the proportion was 20% or greater (Callander et al. 2020). Half came to Australia on a student visa. At the time of interviewing 14 were not studying and 10 were at a private college or university. Half had a green Medicare card (for people living permanently in Australia), one had a light blue (for people who have applied to live permanently in Australia), and 11 had no Medicare card. The majority had tertiary education. Employment status was mixed, with six employed full time, five part time, nine casual, and four unemployed. All participants had undetectable viral load (UVL) at the time of their interview.

Table 1. Sample demographics

Demographic	Number (n=24)
Age	
18-25	8
26-35	8
36-45	6
46-55	1
56+	1
Country of birth	
South Asia	1
South-East Asia	9
North-East Asia	5
Latin America	8
Eastern Europe	1
Sexual identity	
Gay	21
Bisexual	3
Postcode category	
<5% gay residents	13
5-19% gay residents	8
>20% gay residents	3

Demographic	Number (n=24)
Year of HIV diagnosis	
2017	5
2018	7
2019	6
Unknown	6
Time in Australia at diagnosis	
<1 year	6
1-2 years	2
2-3 years	3
3-4 years	2
4-5 years	2
>5	3
Unknown	6
Visa on arrival	
Student	12
Working holiday	3
Partner/family	2
Skilled	1
Permanent Resident	3
Tourist	2
Unknown	1
Current visa	
Student visa	12
Working holiday	1
Partner/family	1
Temporary graduate	3
Permanent resident	6
Citizen	1
Medicare status	
None	11
Light blue (having applied for permanent residency)	1
Green (permanent residents)	12
Education	
Secondary	2
Diploma	3
Tertiary	19
Employment	
Full time	6
Part time	5
Casual	9
Unemployed	4
Current study arrangements	
Private college	7
University	3
Not studying	14

LIFE IN COUNTRY OF BIRTH

In their interviews, participants were asked about the cultural norms in their country of birth. Many called attention to the immense stigma and discrimination related to both HIV and homosexuality that existed. Their use of language was particularly telling. Participants said, for example, that it was taboo to talk about HIV in their country of birth, that people living with HIV were considered dirty and outcasts, and that they were marginalised. Regarding homosexuality, participants said that it was considered wrong to be gay/bisexual, that bullying and homophobia were common, that it was considered a sin, and that people identifying as gay/bisexual sometimes had rocks thrown at them. In the below dialogue, it is clear that cultural norms related to homosexuality in the participant's country of birth had a direct influence on his choice to remain secretive about his sexual orientation, even after leaving his country of birth.

> **Interviewer:** *And are you out to your friends or other family?*
>
> **Participant:** *No. I keep it close to myself.*
>
> **Interviewer:** *Why is that?*
>
> **Participant:** *Well, Asian society doesn't accept it at the moment. I've been here [Australia] for 30 years. I was living in a straight community. So I was never out of the closet. My society, my community background wouldn't tolerate this. So just has got to be some sort of a secret movement. I wouldn't go to parade. I wouldn't participate* (64, South-East Asia)

Participants also frequently explained that there was a lack of public awareness or discussion of HIV and homosexuality in their countries of birth, that the sexual health services and health promotion were inadequate, and that there was limited acceptance or visibility of gay community. For example, the below participant explained that there were limited campaigns for HIV testing in his country of birth and very discreet gay communities that rarely received attention in public health.

> *Not as much as it is here [Australia] I would say because there's no governmental campaigns, especially for gay men, to be going for regular tests or getting diagnosed. There is no particular movement. But it's mostly pocketed within very small, like, the LGBT community is very discreet not very conspicuous in the social health structure* (39, South-East Asia)

Participants were also asked about their personal understandings of HIV and sexual identity, their HIV prevention and testing practices, and their relationship to the gay community when they lived in their country of birth. It was clear through the way participants described their lives in their country of birth that the existing cultural norms had a direct influence on their practices and understandings related to HIV and homosexuality. For example, many explained that they were fearful of testing for HIV, that they rarely considered it, or that they did not bother with it due to the inadequacy of the

available services (for example, waiting up to half a day to get a test, having to pay for it, or lack of confidentiality).

> *When I lived in [country of birth], I don't necessarily see need to see doctor. And also the cultural difference as well. You fear having that kind of fear to go access that sort of place. You feel like people will discrimination. You walk in the building, people will judge you. Like you are gay or you are like carry some STI things* (25, North-East Asia)

Similarly, most men reported that they had low HIV literacy in their country of birth, with some holding the belief that HIV remained a 'death sentence' and many not knowing of any other preventative options aside from condoms.

> ***Interviewer:*** *So where did you normally get your information about HIV or sexual health?*
>
> ***Participant:*** *Before, never. I never find out all that information. I know what is HIV. Actually, I will say I just well understand what HIV is just last year. Before, [country of birth], all the media or what they're warning people is so strong. You know what I mean? Like it seem like HIV or AIDS people very yucky and to say must be avoid. No talk to them. Don't touch them. That the information I got from my country* (44, South-East Asia)

Only eight men said they regularly tested for HIV in their country of birth; the majority had never tested or only tested once before arrival in Australia. In terms of sexual practices and HIV prevention before arrival in Australia, four men had never had sex, and six were in a monogamous relationship and one in a non-monogamous relationship in which condoms were not used. The remaining men said they mostly used condoms, but most had nonetheless participated in anal sex without condoms at least once. Given the taboo nature of HIV and sexual health in their country of birth, participants also rarely discussed condoms and HIV status with sexual partners.

Although not explored in all interviews, most men were not openly gay in their country of birth or had very limited and discreet gay friendships. Only a minority of men felt attached to their respective gay communities in their country of birth. Men often recalled that there was either no gay community they knew about or they were concerned about being identified as gay and consequently stigmatised. Conversely, migrating to Australia provided an opportunity for a few to explore their sexuality. When asked why he hadn't been sexually active in his country of birth, one man from South-East Asia said:

> *'Cause I was studying, living with family. I just didn't want dating and stuff, and I'm really, really careful, and very conservative in terms of my sexual desires. And, considering the history of my life and family background, [country of birth] culture, it depends on the family. We're really like conservative and, in terms of being gay, it's an embarrassment for the family to have a gay, especially if you have a business. And it might affect reputation and stuff like that. So I live a life of secret so, when I move here, I started discovering stuff about myself and what I want to be… Because there's no family issues that I need to worry about. It's a new life, new culture, everything* (28, South-East Asia)

The above quotation exemplifies how conservative norms in most participants' countries of birth proved to be a significant barrier to participating in gay life. It points to a general regional commonality among some of the Asian men. Familial pressures and expectations played a role in their own sense of identity, their motivations for acting on their sexual desires, and their participation in gay life. Some Asian participants said that the expectation to follow the life trajectory their family valued was immense. Expectations commonly noted by participants included: keeping close ties with family, focusing on work and/or study, and forming a steady (heterosexual) relationship. It was not uncommon for participants to explain that the family was the first order priority and that the desires of the individual were a second order priority. As a result of these expectations, participants believed that coming out as gay publicly would expose the family to shame and coming out as gay to the family might expose the participant to being shunned. Consequently, sexual orientation was rarely discussed, and participants were apprehensive about participating in gay life socially and sexually.

> ***Participant:*** *When a discussion emerge about sexual orientation, I don't deny that I like guys. But that's just for my social relations. For family one, I try to avoid the topic.*
>
> ***Interviewer:*** *Why is that?*
>
> ***Participant:*** *Because it has been like that and [country of birth] culture, family, they don't discuss the sexual orientation. They take it for granted that son has to, you know, you have to have a daughter-in-law from sons and you have sons-in-law for daughters. We don't discuss that. And it's taboo in a family when they talk about it, so that's the reason why I don't discuss* (27, South-East Asia)

As evidenced in the quotations provided in this section, participants commented on the stigma and discrimination prominent in their countries of birth and the inadequacy of the services available to them. This had direct effects on their understandings of HIV and homosexuality, their practices related to HIV testing and prevention, and their participation in gay and bisexual life. Some participants brought the understandings and practices they had learned in their countries of birth to Australia. So, they remained hesitant to share their sexual identity, feared HIV testing or assumed it

would be difficult to do, and had low knowledge of HIV prevention, including PrEP, when in Australia. But this was not the case for all; there were a few men who found that coming to Australia had indeed opened opportunities to engage more with their gay identity.

SOCIAL AND SEXUAL NETWORKS, IDENTITY, AND COMMUNITY BELONGING IN AUSTRALIA

Participants' social and sexual networks in Australia were mixed. Most had no family in Australia, but a few lived with family or had family living elsewhere in Sydney. Very few regularly attended specific events intended for their cultural community; most who did feel they had maintained a cultural connection with their country of birth did so through friendships rather than community events. The social networks of about half of the participants included their work and/or study friends only.

In relation to sexual networks, about one-third said they rarely had sex in Australia. Six participants were in relationships before their diagnosis that still existed at the time of interviewing, one of which was non-monogamous and one that was non-sexual. Two had previously been in relationships in Australia that had ended. Most men met their sexual partners using dating apps, and most of these partners were casual, but a few participants had regular (non-boyfriend) sexual partners.

Gay identity and gay community belonging

Some men had considered their migration to Australia an opportunity to participate in gay or bisexual life and explore their sexuality.

> *"At home I was focusing on studying, getting to uni, finish my first degree, get to work, try to help my sister, my parents. So that was my priority. Having a boyfriend, a relationship, or try to explain to my family that I'm gay was something that I'm not gonna worry about at that time. So, when I came to Australia, I met this guy. He was already very comfortable with his sexuality. And I learn a little bit from him. Like, how to go and talk to guys, how to kiss a guy, how to approach to them, how to have sex. And, also I remember it took him two years to convince me to go to the sauna, like a place where you can go and have sex and meet guys"* (37, Latin America)

However, this was not an opportunity taken up by most, and, as the man quoted indicated, was a slow and gradual process and not an immediate priority for those that did. Of those that did participate in some way in gay or bisexual life (including Mardi Gras, clubs/bars, workshops at ACON, and socialising with gay friends), a few considered themselves well connected and a few stated that they connected infrequently and only through friendship networks rather than community events/ venues.

About three quarters of participants generally did not affiliate with a gay or bisexual identity and

did not feel they belonged to the 'gay community'. Among these men, connection to gay or bisexual life came only through using dating apps such as Grindr, through only a few gay or bisexual friends, or it did not exist at all. Very few of this group of men knew about or had participated in events run by gay community organisations. The most frequent reason participants within this group did not affiliate with a gay or bisexual identity was because they were reluctant to have others know of their sexual orientation, often explaining that they lived 'normal' lives. About one-third of this group of men remained entirely secretive about their sexual orientation.

> *Sometimes I say, "Why I have to tell people that I'm gay?" because I just want normal life. It doesn't mean that I want to dress like a girl or ladies, you know. I don't hang out. I don't go out at all. I just stay at home and working, cooking. I'd be at home like, like normal people… I don't have many gay friend here. That doesn't mean that I don't like them though. It means like … just normal people, you know. I'm not party boy and I don't like hang out with many people* (44, South-East Asia)

> *I don't have really much gay friends in Australia. I've met gay people but I don't have a connection with them. I just feel like do I have a time to connect with them; I'm more focused on studying and obligations in the house. Like that's the culture: I need to be home and help do housework chores and stuff, and do assessments, and go with family, rather than go off* (28, South-East Asia)

As these participants described, part of the assertion of normality was associated with a focus on what they believed most other 'normal' people did – focus on work, study, and family. Evidencing the cultural values he had brought with him from his country of birth, the second participant quoted said he could not engage in 'community' because he was expected to meet his family obligations. Similarly, potentially pointing to the stigma regarding homosexuality he had internalised in his country of birth, the first participant quoted seemed to hold a belief that being seen as gay might cast him as feminine and not 'normal'. Another 36 year old participant from Latin America held a similar belief, explaining that he saw no need to advertise his sexual orientation: "Nobody shakes my hand and says 'Pleased to meet you, my name is [name] and I'm a heterosexual'. And I have absolutely no need to shake anyone's hand and say 'My name is [name] and I'm gay.'" Part of the reason he did not strongly identify as a gay man was because he did not want to be seen as more "fragile" than others in his blue-collar workplace.

Another issue that affected a sense of community belonging included living distant to suburbs with a high proportion of gay or bisexual residents, often because participants lived with family or lived close to their place of work. Just over half of the participants lived in suburbs that had less than 5% gay residents (Callander et al. 2020). However, this often occurred in concert with a lack of desire to live near suburbs with a high prevalence of gay or bisexual residents because they did not have

a strong gay or bisexual identity. Finally, two participants mentioned language barriers as a reason they did not feel they belonged to community. These participants did have a desire to participate but had found it difficult because of their English skills. The participant quoted below had tried to volunteer at Mardi Gras but could not understand the people around him.

> *In general about gay social networks, I have made a little effort to meet people from Australia, but due to the language barrier, it has been a bit difficult. I can say that at the level of sexual encounters it is much more feasible, it has happened, but I have sought friendships, but it has not been an easy task, it takes time because of the language. Because gay people here in Australia have a very special way of being that allows them to have good friendships but you have to have a minimum of English for good communication* (23, Latin America)

Gay community norms and values

Many participants, whether attached to gay communities or not, cited ambivalence about the norms and values they believed circulated in those communities, and for some, these presented barriers to participation. Some participants, who self-identified as sexually conservative, were surprised at the sexual adventurism of other gay/bisexual people they had met, and believed a life closely affiliated with a gay/bisexual identity was one directed too closely towards a life of partying and sex: *"When you say gay community, the images that come to me are like drugs, the party, a lot of sex, and I think it's not too far from that idea"* (25, Latin America). When asked about their understanding of community, there was often a direct assumption that 'the gay community' correlated only to 'the gay scene' of bars/clubs. This perceived lifestyle directly contrasted the focus on living a 'normal' life of work and study that some participants desired, or indeed felt they needed to live for their career, as the below participant identified.

> *The image of my professional career got attached too severely into the cultural image of how a teacher should be, and since sexual orientation is not something that a teacher who…just as long as you're a teacher, you're the statue. You're the virtue of representation of the whole culture, of everything good, everything that is disciplined. So that is a reason why I don't expose myself much to the gay community* (27, South-East Asia)

Some also felt that gay and bisexual men judged men born in overseas countries as having less sexual worth, which presented a barrier to them feeling welcome to participate. The majority of these judgments were seen to relate to attractiveness, including a belief that Asian men were viewed as less sexually attractive: *"If you are Asian you will be like the lowest level beside than if you're Latino or American, or you're white, or you're European. So that's why I feel I don't belong in this society"* (25, North-East Asia).

One participant also described an intersection between migration and economy, how it affected his confidence in his appearance, and the impact this had on his participation in community. For him, participating had proved difficult because of the expenses associated with socialising. Because he could not afford the same lifestyle as others, he felt he was not presenting himself well, which diminished his confidence in his appearance.

> ***Interviewer:*** *Is there any other reason why you're not participating more in the gay community here?*
>
> ***Participant:*** *One that is body positivity. I don't feel confident with my appearance. There's a lot of things that entails. I was not born here. I live in a cheap accommodation. Everything's practically is as cheap as possible. It's not a good picture to present to anyone that is actually want to develop a social image that is presentable to whoever it is potentially your friends. I don't get governmental support so I don't have the confidence to actually participate in any social events. Entertainment in Sydney, as Google put it two-dollar signs, which is considerably cheap, it's actually costing me two, three hours of working already. So that's a financial problem. And that's built up to my lack of confidence in participating in gay community activities* (27, South-East Asia)

However, previous research has found that some GBM, regardless of cultural background, struggle with the sexual norms they see operating in gay/bisexual communities (Holt 2011), so these findings may not be unique to this population.

HIV TESTING

HIV testing in Australia was generally low – only seven participants said they tested regularly before their diagnosis. For 16 of the 24 participants (67%), their first HIV test in Australia was their diagnosis. However, there was an interesting mix between testing patterns in participants' country of birth when compared to their testing patterns in Australia.

- Only one participant said he tested regularly in both his country of birth and Australia.
- Six participants said they tested regularly after moving to Australia but did not do so in their country of birth. Their reasons for not testing in their country of birth included: very rarely having sex or having low risk sex, not knowing they were gay or bisexual and therefore not perceiving themselves as at risk, and being in a relationship, which they assumed meant there was no need to test. Also, often implied through participants' descriptions of the norms in their country of birth, a lack of availability and accessibility of health services proved a more general reason participants had not tested.
- Eight participants said they tested regularly in their country of birth but not in Australia. The

most common reason for not testing in Australia was because they had not had an opportunity to commence regular testing because they only very recently arrived and sexual health was not an immediate priority ahead of settling in. Other reasons included a general fear of HIV testing, a reluctance to test due to fear of losing a visa, and not perceiving oneself as having high-risk sex.

- Two participants tested very infrequently or only once in their country of birth and never in Australia and the remaining seven had never tested in their country of birth or Australia.

Barriers to HIV testing among infrequent or never tested

Among the participants who had never tested or tested infrequently in their country of birth, and never tested in Australia, several barriers were discussed. The most common barrier was that participants were anxious they had already acquired HIV and preferred not to find out. When asked why he had not tested more frequently in Australia, one man said:

> *I think it's mostly because of the consciousness about how and also I think there's a niggling fear that, "What if …" You probably want to just be an ostrich and bury your head in the sand, and not think about it because … 'cause it's not gonna go away and what if it happens? What if worst fears come true? So you don't want to put yourself in that position* (39, North-East Asia)

This was particularly the case for a few participants who were concerned their visa status may be threatened if their result returned positive. The participants who cited this kind of anxiety as a barrier had brought with them the stigma they had internalised in their country of birth, often explaining that when they moved to Australia they were still fearful of HIV or did not want to think about it.

Another barrier commonly reported was a low perception of risk. Often in the belief that they were sexually conservative, some participants reported that they rarely had sex or rarely participated in high-risk sex (because they frequently used condoms, were in a monogamous relationship, or did not enjoy anal sex). For others, because they felt that they had little engagement with gay networks and identity, they did not see themselves as part of an 'at-risk' population.

> *I hadn't looked into where to test. And in my circle of friends no one had said "this so far." I feel like this in the gay community is something that is talked about a lot, but in the heterosexual community still a myth there that HIV is only for gay people. Then there's not much talk… and until my friend said to me, "hey you should go", "hey, yes, he already has a lot that I don't take the test"… yes, thanks to him I came* (28, Latin America)

Along similar lines, two participants believed that because they did not feel unwell, there was no need to test: *"There's a popular saying, only people who are sick take tests, so if you don't do the test, it's because you are not sick"* (38, Latin America). Given their low perception of risk, these

participants saw little need to test for HIV and instead prioritised other aspects of life, such as study, work, and settling into Australia.

A third barrier to HIV testing was a lack of knowledge of the available services in Australia. Participants who cited this barrier were often ineligible for Medicare. They were unaware of the free sexual health services available in Australia, instead believing that HIV testing would be expensive or that they would be required to attend a General Practitioner (GP) clinic.

> *You join a different country and you really don't know about the services. And you know like a student here you don't have too much money. So it's like, "Oh my God. Well, if I want to get a test, I need to go to a laboratory." And here, services in Australia are quite expensive. So you don't know that there is a free service. It's like you just postpone and postpone again. "Maybe next month, when I have more money". So that is one of the main reasons: the money. And the not knowing there is free services* (25, Latin America)

Unlike the men who did not see themselves as high-risk, these participants and the participants who had anxieties about their HIV status believed they should have tested but delayed doing so.

HIV PREVENTION

When first asked about their use of condoms, most participants said they mostly used condoms with their sexual partners prior to their diagnosis, and a few initially stated that they always used condoms. However, the complexity of participants' HIV prevention practices was revealed when the interviewer asked further questions about specific events. Some of those who initially said they always used condoms later identified specific events where they did not. In particular, common to this group was a lack of discussion around HIV status, condoms, and sexual health with sexual partners. While condoms were discussed more than HIV status, this was nonetheless infrequent.

> *So this is the thing: I've hooked up with many guys but we've never really talked about HIV. Like seriously I never met a guy that actually talked about HIV or any STI. If we use condom, we just pull it out. If he doesn't, he just don't. So, yeah, we don't talk about STIs at all* (21, South-East Asia)

Participants described several general patterns of discussion about condoms with their sexual partners: Deliberately discussing and requiring condoms, not discussing but automatically using condoms, discussing condom use but acquiescing to the choice of a sexual partner, or not discussing and not using condoms. A key reason discussion of HIV/STI prevention was not common was because it was not normalised in participants' country of birth. There was very little health promotion about how to negotiate HIV/STI prevention with partners, so it was not something

they had learned nor something they regularly practiced. Similarly, given many participants had low knowledge of HIV before their diagnosis, discussing sexual health with partners was unfamiliar and it often exacerbated their anxieties about the issue. While participants did not always directly state these as specific reasons for not discussing sexual health, they were often implied through their descriptions of the norms about HIV and sexuality in their country of birth.

When directly asked about their HIV prevention practices, participants did provide some behavioural reasons for engaging in condomless sex or not discussing HIV/STI prevention, including a perception that a partner posed little risk, heat of the moment, and trust and relationships. These are issues that have for a long time been commonly reported by GBM in Australia, regardless of their country of birth (Gianacas et al. 2015; Marcus and Gillis 2017; Philpot et al. 2020a). As such, they are unlikely to exclusively apply to overseas-born GBM, but they were nonetheless mentioned as reasons for engaging in condomless sex and may be experienced in specific ways by overseas-born GBM. A fourth reason, adapting to unfamiliar sexual norms, may be more specific to be overseas-born GBM. Each of these reasons is explored in greater detail below.

Limited perception of risk of partner

Several participants cited a belief that a partner was well informed or looked healthy as a reason they believed sex with that partner would pose little risk. Some said they made assumptions that a sexual partner posed little risk to them: "I only knew he was working in medicine, so I'm assuming he was taking care of himself pretty well" (25, North-East Asia). Others described instances where they felt that their sexual partner was trying to convince them that they were not a risk.

> *He told me, "See that I take care of myself a lot, that I don't have sex with anyone". So with him my behaviour was like more careless. That is why we were having unprotected relationships, reaching the end [ejaculating inside the anus] both ways. Because if before I played in my casual encounters, I always tried to use protection. But he told me that he took care of himself a lot, he told me that he was a doctor and that he knows about this and above all he knows how to take care of himself* (37, Latin America)

Heat of the moment

Some participants reported that the pleasure they enjoyed from sexual encounters overshadowed the need to discuss sexual health and use condoms, and that condoms would otherwise interfere with the spontaneities of sex.

> *Once you've had the feeling of not using condoms, it's completely different to using condoms. And there are times where it's always in my head that, "Use condoms! Use condoms! Use condoms!" But then I'm always a bottom so I feel that sensation. And then, once it's [the condom] in there it feels different. I get that temptation. It's just ask them to remove condom. And they just do. I feel, after, feel bad. Like, "Oh, fuck. What did I do? I shouldn't do this again." And then it comes to that time again and then you're like, "Oh… Fuck it!"* (19, South-East Asia)

While for some of these men, getting lost in the 'heat of the moment' was described as a one-time 'slip up', for others like this participant from South-East Asia, it led to more regular condomless sex, despite knowledge that this may present risk.

Trust and relationships

Some participants held a belief that sex within relationships should naturally involve no condoms. This was coupled with an assumption that because a relationship had formed, a partner should be implicitly trusted and considered trustworthy. When asked why he did not use condoms with his partner, one participant said:

> *I thought we were lovers, so we didn't use condoms. But I didn't know what his background was. But we have been dating for 3 years. He didn't want to put on a condom, so we just didn't because we are already lovers. It's normal for every couple. What I have noticed is that people rarely use condoms when they have been together for a long time or are already in a relationship…. Because we are lovers, I didn't think that he would be infected.* (34, South-East Asia)

Although not explicitly explored in interviews, very few participants said they specifically discussed HIV status or had HIV testing before choosing to forego condoms within a relationship. Similarly, for some other participants, a link between familiarity, intimacy, and feelings of trust produced a perception that a partner posed little risk. This mostly applied to men with whom a romantic potential was felt, as the participant in the below interaction identified.

> ***Participant:*** *I'm interested about the amount of trust you have in a person because once you get to know them enough and you've found so much in common, I found there's a lot of common in-between the two. So, he seemed okay. And I'm afraid that, as popping the question, "Are you positive? Are you tested?" would ruin the kind of atmosphere and the kind of intimacy that was in place at that time. So I didn't pop the question. Rather, we kind of*

trust each other. He didn't ask me. I didn't ask him. And yeah that was a time that I recall. For everyone else I always use protection.

Interviewer: *Can you tell me a little bit about the dynamics of that relationship you had with this person?*

Participant: *We had a really good talking and really good conversations. Really good, intimate time: not just sexual intercourse. We hang out and we did a lot of things together, watched movies, just lazy, on a couch together.*

Interviewer: *Over the course of it, did you guys discuss things like being exclusive or safe sex?*

Participant: *We didn't. Because there's this kind of unofficial announcement, we do not talk about it because we both understood. The problem is once you say it, you make it so. And maybe, by saying that and by proposing that, I might risk losing it. And I didn't want to lose it that time… I am aware that this [becoming HIV positive] could happen but maybe I was so blinded by the things that I was seeking, that it didn't seem to matter at the time* (27, South-East Asia)

The familiarity this participant had developed with his sexual partner increased his sense of trust in him, reducing a perceived need to use condoms. However, a conversation about exclusivity and condoms, and confirmation of HIV status through testing never occurred between the pair. According to the participant, such discussions were not appropriate because to have them could imply more than could be said of the connection they shared, consequently putting the future of the relationship at risk. Instead, he believed there was a mutual unspoken assumption that each partner posed no risk.

Adapting to unfamiliar sexual norms

Some participants identified how moving to a new country with different norms made them feel the need to adopt those norms. They believed condomless sex was highly normative in Australia and found themselves engaging in it on occasion or more frequently. Some felt pressured to adapt to these norms, struggling to reconcile the prevalence of condomless sex against their own understandings of sex, risk, and condoms.

> *I would say that 85% of 100% of the people who reside here in Australia when I moved do not use a condom, that is the truth. The person does not take the time to ask either, because it is something that people do not use, there is no custom, they do not really use it. Then of course, if there is more than one person who does not use it, no one will come and say well I use the condom, it just doesn't happen, well then, you see that and that leads you to practice the same as others do. It shouldn't be like that, but that's the way it is* (23, Latin America)

Given their status as migrants who come from countries with different sexual norms, this issue may have been experienced more acutely among these overseas-born men than what Australian-born men might experience.

POST-EXPOSURE PROPHYLAXIS (PEP) AND PRE-EXPOSURE PROPHYLAXIS (PREP)

PEP involves HIV-negative people taking a 30-day course of HIV medication very soon after a possible exposure to HIV to prevent HIV acquisition. PEP use and knowledge was not explored evenly across interviews, and in those that it was it was not explored in detail. Eleven participants had never heard of PEP before their diagnosis and nine said they knew about PEP, but most of these men did not believe it was relevant given their sexual practices, even those who had engaged in condomless sex. Detail of exactly what kinds of knowledge these men had about PEP was limited. Only one participant had used PEP in the past, after an encounter in which a condom broke. He accessed PEP from the emergency department of a hospital but it was not explored whether this was in Australia or in his country of birth.

Most participants said they knew about PrEP prior to their diagnosis. However, the extent of their knowledge was very limited, with many explaining that they knew a medication existed but not much beyond that. Just over half (14) learned about PrEP only after arriving in Australia, often citing public advertisements or discussions with gay friends or sexual partners as information sources. Four said they knew about PrEP in their country of birth but did not see it as relevant or found accessibility too difficult (it was too costly and too difficult to find), and six found out about PrEP only after they were diagnosed. Although not explored in all interviews, many participants did not know of ways outside of Medicare to access PrEP. Two participants had used PrEP in the past (detailed below), three participants had intended to commence PrEP but were subsequently diagnosed with HIV when they tested to get on it, and one participant had picked up a prescription for PrEP but went overseas and lost the prescription. Upon returning to Australia he had lost motivation to commence PrEP. Some participants only properly learned about PrEP after they were diagnosed, and said if they had known more about it would have used it.

Commencing and discontinuing PrEP

Two participants had commenced PrEP in the past and then discontinued. One 33 year old man from South-East Asia found out about PrEP through conversations with sexual partners, and then sought it out from a sexual health clinic. He discontinued because he entered a series of two relationships. He had only known the first partner for less than a month and decided that because he was seeing only this partner and had asked him of his HIV status, he could discontinue PrEP. However, he and the first partner never discussed PrEP or condoms. He met the second partner within two weeks of the first relationship ending and decided not to recommence PrEP because he was having sex with only the second partner, and trusted the partner when he told him he was HIV negative. Another man

commenced PrEP because he felt that not being on it would make sexual partners think he wanted to use condoms, which could made them less willing to have sex with him.

> *I'm living in [gay suburb] and every time that I go into a gay app and try to meet someone the first thing that comes up is, "Are you on PrEP?" I mean I'm more comfortable using condoms. And I've been turned down so many times so I was feeling like I was left behind because everyone in the gay community in [gay suburb] is on PrEP. And I was feeling like, "Oh, yeah, should I take this tablet? I mean I don't really want to take a tablet." But I kind of felt a little bit of pressure on that. And, to be honest, it was much easier to go on one of those gay apps and hook up with someone, go on a date or whatever, just simple for the fact that you are on PrEP.* (37, Latin America)

As explored in the previous section, other participants also felt pressured to adapt to the norms in Australia by using PrEP and/or foregoing condoms. However, this man believed his continued use of PrEP was encouraging him to become overly sexually active and impeding opportunities to develop genuine intimate connections, so he discontinued two months after commencing it.

> *But then I realised that it was more sex rather than other things. When you just try to have a conversation with people, like you say, "Oh, you wanna go to the movies? Do you wanna go this?" Not dating but try to have more a meaningful friendship or whatever you want to call it. And people are like, "No I wanna have sex. I wanna have sex, sex, sex, and sex." And I think, "This is really not me." I like having control of my body and for me taking a pill I realise it was more like the pill is controlling me in some kind of way and controlling how I'm having sex, who I'm having sex with, how much sex I'm having. And I said no.*

Barriers to PrEP uptake

Several, often intersecting, belief-based barriers to PrEP uptake were discussed by participants. Most commonly, a lack of relevance was noted; several participants believed their practices were low risk.

> *I guess it's very hard to know when you will need it. This is the major reason because I have been careful with having sex with someone. I only have sex without condom with those people that I do think who are fine. If I feel I was in danger, I probably will think. And, secondly, I still got that strong impression that the process of having PrEP was quite physically hard or difficult, or uncomfortable. And also there might be some side effect. So, unless it is very necessary, otherwise do not have it* (50, North-East Asia)

This participant saw no need to take PrEP not just because he believed his practices were low-risk, but because they were too low-risk to consider taking a medication that he thought could be harmful to his body. Here, a low perception of risk intersected with a concern for side effects. Similarly, other participants did not see themselves as part of an 'at-risk' population because they felt disconnected from a gay identity and community: *"When someone who is not really thinking they need to be in LGBTQI society, so you just doesn't really want to know what's PrEP"* (25, South-East Asia).

Another barrier to PrEP uptake was perceived inaccessibility through cost or lack of knowledge of where to get it.

> *I wanted to know if I covered it… for example when I started researching PrEP was like, "But how am I going to pay for it? Because I don't think student insurance covers those expenses." So also for the AIDS test (HIV) because it surely has a cost… why the cost of living in Sydney is high, so I said surely has some cost* (28, Latin America)

Although this participant said he did research PrEP, this was not the case for others, who never pursued researching it because they assumed it would be inaccessible to them. Some participants also mentioned that in their country of birth PrEP was expensive to access, and they thought that would be the same in Australia, especially given they were not citizens of Australia.

Finally, some participants had chosen not to commence PrEP because they were concerned about potential short or long term side effects. Often, this was attached to a belief that healthy people do not need medication especially if it was not essential to live, and they preferred condoms anyway.

> *It wouldn't be the collateral effects that you have in the beginning, but the collateral effects that you have over a lifetime. The medicine is not good, the medicine that I take today, for example, almost all the medicine for those under treatment produces some type of problem in the future, for example, I have major chances of getting osteoporosis. These are collateral effects, so if you take the medicine, it will fix this and this, but it could attack something else. So, medicine is not good. I think that I have other ways of protecting myself, which is a condom.* (25, Latin America)

The behavioural reasons men provided for having not accessed PrEP are similar to those expressed in samples of broader populations of GBM (Holt et al. 2019; Philpot et al. 2020b), and as such may not be specific to overseas-born GBM.

SEXUAL EVENT LEADING TO HIV ACQUISITION

Following on from previous iterations of the Seroconversion Study (Gianacas et al. 2015), which explored the experiences of people diagnosed with HIV in Australia, the participants were asked if they could identify an event that might have led to HIV acquisition. Data on the event that led to HIV acquisition should be read with caution because many participants struggled to accurately identify one specific risk event. Even if they could largely estimate the time and country of HIV acquisition based on a combination of CD4 count at diagnosis and how recently they had arrived in Australia, as well as past sexual experiences and/or recollecting an illness, specific events were often difficult to recall. This section provides estimates of the contexts of the risk event and whether acquisition occurred overseas or in Australia.

Six (25%) participants believed they acquired HIV in Australia, nine (38%) in their country of birth, and nine (38%) were unsure. Most of those who believed they acquired HIV in Australia had lived in Australia for over one year at the time of infection. Eight (33%) believed they acquired HIV in the context of sex with a casual or anonymous partner, five (21%) with a 'regular' (more familiar) or boyfriend partner, and 11 (46%) were unsure. Those that felt they could accurately recall a risk event often called attention to their state of mind at the time, stating they were drunk, depressed, or prioritising pleasure over risk, or said they trusted their sexual partner or believed they posed little risk.

EXPERIENCE OF HIV DIAGNOSIS

Seven participants said they were diagnosed with late-stage HIV infection, three were unsure, and 14 said they had recently acquired HIV. However, these data should be read with caution as many participants were unable to determine how they became infected and some could not recall their CD4 counts at diagnosis. For several participants, HIV did not come to mind when experiencing seroconversion symptoms because it was not an important consideration in their lives, and as such their knowledge of when they became infected was low.

Four participants recalled presenting to a GP with an illness, but neither they nor the doctor recognised their illness as seroconversion. One of these men explicitly chose not to disclose his gay sexual identity and his previous sexual history to his doctor because he did not believe it had anything to do with his illness. About one-third attended a rapid HIV testing clinic and were then referred to a sexual health clinic; the majority were diagnosed at a sexual health clinic directly. The overwhelming majority of participants appreciated the support of the sexual health clinics that diagnosed them and believed their diagnosis was conducted smoothly, professionally, and sensitively. Many felt that the diagnosing doctor 'normalised' life with HIV, explaining that their health prospects would be much the same as when they were HIV-negative if they took their medication.

> *It's not something that you want to hear, "You are HIV positive." But the treatment from the staff, my God, really excellent. They are really human. They are, "Don't worry. Nothing to be worried. We are in 2018. There are medications. You will have a normal life, like any other. You just need to take your pill every day." When talk with the nurses, they're, "Oh no, no. No worries. You will be right." And they explain you all little things. And now I'm completely okay with it* (25, Latin America)

Despite excellent support from the clinics, participants nonetheless described a range of responses and concerns upon diagnosis that depended on their level of HIV knowledge. Based on their descriptions of the diagnosis appointment, those who had limited knowledge required extra support and longer appointments to increase their understanding of what it would mean to live with HIV. They were also more appreciative of the ways their diagnosing doctors framed the 'normality' of living with HIV. However, many participants felt a lost sense of hope or uncertainty about the future upon diagnosis, and this was felt more acutely among those with limited HIV knowledge.

> *At first it was pretty hard. I lost hope I guess. There was no motivation at all. When I found out, it felt like my world was falling apart. Like I've ruined my life and there was a time where I just wanted to end it all. Like I was ashamed of myself I guess. I just kept it to myself and for days I was just in bed not knowing what to do. It's like completely blank. I just wanted to lock myself and not do anything. I didn't even want to go out like to go downstairs to have something to eat* (19, South-East Asia)

Despite what his doctor had told him about the effectiveness of the medications available, this young man felt ashamed and without hope in the period immediately after his diagnosis. Several other participants also felt weighed down by their diagnosis even though they came to understand that they could live long and healthy lives. As such, once they understood the medical advantages of commencing HIV treatments for their health, an important consideration for many participants that impacted how they understood their diagnosis was that living with HIV could reduce their sexual and romantic opportunities and expose them to stigma and discrimination.

There were two concerns at the time of diagnosis that were specific to the visa status of participants. First, several were concerned they may have limited access to treatment because they were not eligible to access HIV treatments via Medicare. This largely dissipated when their doctors explained the compassionate access system and assured them that while in Australia they could access medication at a significantly reduced cost or for free. Second, many participants believed that their HIV diagnosis potentially affected their visa status and reduced their long-term opportunities to stay in Australia. This put them in an uncertain space; potentially less eligible to stay in Australia but reluctant to return to their country of birth.

> *The original plan was to get here, get residency, stay and become a citizen. But now, since it's almost impossible for me to get any permanent residency I'm freaking out right now because what if they fail me and I had to explain everything [to my family]? Because I want to just bury this one. No-one needs to know because it's just hurtful. A certain thing might happen if you're not careful and then that might hurt your loved ones, it kills me… It's just I'm still having this kind of fear of maybe I will get another two years here in Australia and continue receiving compassionate delivery. But what if I get to [country of birth] and there is no such thing as discreet treatment? Because the people [in country of birth] are not good in keeping things confidential. That's the kind of fear I have to deal with right now, the medication and treatment* (27, South-East Asia)

As exemplified above, apart from wanting to remain in Australia because they generally enjoyed their life, being forced to relocate to their country of birth for some meant they may have to explain their diagnosis to their family, bringing with it a feeling of shame, and could make it more difficult to access treatments due to cost and stigma.

Reasons for testing at the time of diagnosis

Participants recalled several reasons for taking the test that led to their diagnosis. In order of how frequently they were mentioned, these included: in response to an illness or symptoms, as part of regular testing, a feeling of intuition after risk exposure, to go on PrEP, to commence regular testing after exposure to health promotion, and entering a monogamous relationship and wanting to forego condoms. In the quotation below, a 23 year old man from Latin America described how the way in which HIV was framed in Australia was a catalyst for him to connect to health services.

> *Initially what led me to take HIV tests was advertising that they do for the disease itself because there is ample information about it. So I went to the doctor, well initially it was on Oxford Street where I saw that they did free tests, but because of my language they told me that I should go to the medical [sexual health] centre directly. What led me to make the decision was to see that in Australia the issue of HIV is something that is normal, it is like another disease, not you will be discriminated against for being HIV positive. Many guys talk about them being HIV positive and that they could live with it, so that led me to make the decision that I could do it and give a solution to it* (23, Latin America)

This man had previously not tested because he was anxious he may have already acquired HIV. Once living in Australia, increased exposure to health promotion and reframed notions of what it might mean to live with HIV (that it would not lead to discrimination and that it was not an exceptional health condition) encouraged him to seek an HIV test.

LIVING WITH HIV

Participants' feelings about living with HIV were mixed, and not unlike experiences reported in other studies of people recently diagnosed with HIV in Australia (Gianacas et al. 2015). Common descriptions included not wanting to have a condition that was a marker of difference, weakness, or ill-health, feeling ashamed, particularly in relation to disappointing family, expecting reduced sexual and romantic opportunities, and feeling infectious. The feelings of infectiousness a few felt when recently diagnosed were quite profound, as the man below indicated.

> *I initially felt that I had HIV written on my forehead, that people detected that I had the virus. I felt that if they came across me I was going to infect them, I felt that if I sneezed or used my spoon I would infect, because when I found out if I shared the apartment as I live here, that I was a student, I felt bad because I took my personal things and tried to put them away because I didn't know what could happen* (37, Latin America)

Nonetheless, there was also an overall sense among participants that being diagnosed with HIV had made them more health conscious and that given time life would 'normalise', with HIV having less impact on day-to-day life. Despite this, most participants chose to keep their HIV status hidden. They only told those on a need-to-know basis, which included a relationship partner, structural supports such as their doctor, or the interviewer. Also, a few participants were very reluctant to disclose to family members for fear of upsetting or bringing shame to the family, especially when considering the HIV stigma they knew persisted in their country of birth.

> *And I understand people who got HIV now they're just people. I know now. Don't call them AIDS. But I don't know how to make this happen in [country of birth] because they call everyone AIDS and they look down. So that's why I'm worried if I want to go back to [country of birth]. One day, I might get sick and get a blood test, and my family finds out about this or I have to tell them. How are they going to look at me? So at the moment it's only me. No one knows except my doctor and you… I'm not really sure that I can handle that [telling family]. I worry about this because I don't want to hurt them. Asian family, when they know that something happen to you, even I'm sick they worry about me. So I try not to tell anyone and keep it with me forever. And that's why I chose to live here because, when I go to see doctor, I feel comfortable. Not like in [country of birth]* (44, South-East Asia)

Part of the reason this man remained in Australia was because he imagined it was much easier to live with HIV than in his country of birth, a place in which disclosure may trigger concern from his family, negative clinical experiences, and stigma.

Finally, many participants chose not to access structural supports (such as workshops or peer

support programs) because they wanted to remain discreet about their HIV status or saw these supports as being for people closely connected to gay or bisexual networks. This topic was also not explored in some interviews. However, those that did utilise and comment on these supports were thankful for the opportunity to attend them.

> *I always say that if there had not been this place [HIV community organisation], I don't know what would have happened to me when they told me that I had HIV. They went 24 hours a day and they helped me a lot, they called me, they said "excuse me that I called you. I just wanted to know that you are doing well, that if you want you can come at any time of the day that we are here to help you". If that happens in [country of birth], my family would not have known and nobody would have helped me because nobody would know, and the way to proceed there is very different. They would tell you that you have HIV and you have to take care of yourself and nothing else. Here they tell you if you have it and then they take you by the hand and do not leave you* (37, Latin America)

These support programs provided a sense of belonging, renewed hope, and acted as a resource for receiving relevant information about living with HIV.

DISCUSSION

Many participants recounted the immense stigma against HIV and homosexuality in their country of birth. This directly influenced their HIV prevention and testing practices, resulting in low HIV testing and reluctance to test, poor knowledge of HIV, PrEP, and negotiating prevention, and limited perception of risk both in their country of birth and in Australia. These experiences indicate that there are several key challenges for engaging overseas-born GBM from non-English speaking countries with sexual health services in Australia.

GAY AND BISEXUAL IDENTITY AND DIVERSIFYING AVENUES FOR DELIVERING HEALTH PROMOTION

Among all participants, there were mixed connections to a gay or bisexual identity. Some were well connected to gay/bisexual community but about three quarters did not want to live a life in which their gay or bisexual identity was a central feature. They rarely attended gay/bisexual events, had few gay or bisexual social or sexual connections, and rarely engaged with community organisations. Some also lived distally to, and had little desire to live in, suburbs with a high prevalence of gay/bisexual residents. This resonates with previous research that has similarly found that a gay/bisexual sexual orientation is not a critical marker of identity for many GBM born in overseas, non-English speaking countries (Adam and Neville 2020; Phillips et al. 2020). However, it is in contrast to other research, which has found that there are many overseas-born GBM who do participate in and feel part of the gay/bisexual community, regardless of cultural background (Broady et al. 2019; Hammoud et al. 2019). The differences in these findings may be explained, in part, by recruitment methods. Studies recruiting via gay community organisations and social media advertisements targeting gay men may tend to recruit more gay community attached men. By contrast, our study recruited through sexual health clinics; this may be one reason our sample appeared to be less gay community attached.

There is a need to continue health promotion initiatives through traditional gay community avenues, but extend beyond this to appeal to overseas-born men who are not community attached. Historically, HIV education in Australia has been done through peer-based community organisations using a community-centric approach. This approach relies on GBM having closer ties to gay/bisexual community, regular attendance at gay/bisexual community events and venues, and gay/bisexual social networks through which information can disseminate. Some of the men who participated in this study had closer connections to gay/bisexual community, and for these men traditional avenues for health promotion are likely to continue to be effective. For the men for whom gay/bisexual life was not a central feature, this kind of HIV education may not resonate with or reach them to the same extent.In recognition of this, some community organisations such as ACON have already made efforts to diversify their health promotion efforts beyond gay community-centric avenues. Such efforts include outdoor advertising in metropolitan areas and advertising on dating/

hook-up apps such as Grindr. These are spaces that do not necessarily require that people have close ties to a gay/bisexual identity. Also, given that half of the participants arrived on a student visa, international schools/colleges and universities may be productive avenues through which to deliver these initiatives. Indicating progress in this area, an online International Student Health Hub has recently been created for students in NSW (internationalstudents.health.nsw.gov.au). In the future, more health promotion that expands beyond traditional gay community avenues to target non-gay community attached overseas-born men and international students is needed, with more even efforts across all jurisdictions in Australia.

INCREASING ENGAGEMENT WITH THE HEALTHCARE SYSTEM

Several participants believed they acquired HIV while still in their country of birth, and most who believed they acquired HIV in Australia had been in Australia for one year or more. This indicates a need to engage this population in earlier HIV testing soon after arrival in Australia. This will allow opportunities for those who have already acquired HIV to be offered treatment. For those who are HIV-negative, earlier testing will encourage increased HIV knowledge, and uptake of PrEP and a regular testing regime earlier. Yet, for many of our participants, their first clinical interaction in Australia was their HIV diagnosis. There were several challenges that affected their lack of engagement with sexual health services. Some participants did not understand the Australian healthcare system after they arrived and assumed that because of their visa status HIV testing would be difficult to access and costly. They sometimes also translated their knowledge of the costly and less efficient services common in their country of birth to the Australian context, not understanding that they could access free testing from a sexual health clinic or community-based service. Their limited knowledge of the services available to them may be exacerbated by the difficulty of finding information online. Previous research has found that information about available services can be difficult to find online or out of date (Gray et al. 2020). Similarly, for those who have not tested before, HIV testing in general was not something they had done because they did not see themselves as having engaged in risk or as part of an 'at-risk' population. For some others, sexual health was not a priority ahead of settling in and they did not consider testing until well after arriving in Australia. There were also some men who believed they should be testing, but continued to delay it because they were anxious they may have already acquired HIV and preferred not to find out. This is likely due to stigma they had internalised in their country of birth. Together, these challenges indicate a need for continued delivery of educational initiatives in the form of, for example, health promotion or peer-based workshops. The aims of these initiatives should be to inform overseas-born GBM from non-English speaking countries of the sexual health services available in Australia, and de-stigmatise HIV so that HIV testing becomes normalised.

INCREASING PREP KNOWLEDGE AND ACCESS

Knowledge of PrEP among our participants was generally low, although three had attempted to start using it but were diagnosed before they could commence taking it and two had used it in the past. Those that did have any knowledge of what PrEP was and how it worked did not pursue it because they assumed it would be inaccessible to them through lack of Medicare. While it is true that those without Medicare cannot access PrEP via the Pharmaceutical Benefits Scheme, there are other options available such as personal importation and coupons for those experiencing financial hardship (using the PrEP Access Now website: www.pan.org.au). However, lack of knowledge of these options is an issue – very few participants within this study knew of them. Similarly, ordering PrEP online can be a complex process requiring knowledge of the terminology pharmaceutical companies use to describe PrEP and trust in the payment system used by websites, which is not similar or as simple as general online ordering. These complexities may deter some people from utilising online ordering. After data collection for this study was completed, the Australian government committed to enabling non-Medicare eligible PLHIV access to subsidised HIV treatment (NAPWHA and AFAO 2020). Given that some men saw cost and accessibility as barriers to PrEP uptake, the findings presented in this report provide evidence that non-Medicare eligible HIV-negative GBM should have access to subsidised PrEP.

However, a few men also cited some belief-based reasons for not accessing PrEP, including its potential side effects, a preference for condoms, a belief that healthy people do not need to take medication, and a perception that they did not engage in high-risk sex. As such, increasing knowledge of its benefits including but beyond preventing HIV (such as decreasing HIV anxiety; see Keen et al. 2020 for example), how it can be accessed, its minimal side effects, and its suitability for particular candidates depending on the type of sex they have may concomitantly increase its uptake by this population. At the same time, the beliefs some men had about PrEP indicate that, even with education, PrEP in pill form may not be a suitable strategy for all, so promotion of the benefits of PrEP should be done in a way that does not favour it above other prevention strategies, including condoms. In the future, education about and ease of access to new methods of PrEP delivery, such as long-acting injectables, which are also effective methods of preventing HIV, may also prove beneficial (Landowitz et al. 2020).

SUPPORTING NEWLY DIAGNOSED MEN AS THEY LEARN TO LIVE WITH HIV

The findings of this study also present challenges for assisting and providing support for overseas-born GBM recently diagnosed with HIV. At their diagnosis, some participants had low knowledge that HIV treatments were effective, could keep them healthy, and make them non-infectious to sexual partners. Some also held a belief that HIV remained a death sentence. These men required longer appointments and extra education at their diagnosis appointment, which the clinics provided. Their low HIV knowledge before their diagnosis highlights the importance of updating the knowledge of newly arrived overseas-born GBM in Australia to reduce the HIV fear and stigma some within this

population still carry. Doing so may in turn have positive impacts on their HIV testing and initiation of PrEP when HIV-negative, and their motivation to initiate antiretroviral therapy if diagnosed with HIV.

Some recently arrived men had few social support networks at their diagnosis, having had limited opportunities to develop meaningful and trusting friendships and other connections. At the same time, many, including the very recently arrived men, were reluctant to disclose their diagnosis to family in their country of birth or in Australia due to persistent stigma and the cultural expectation not to bring shame onto the family. This means structural supports from clinics, health providers, and community organisations are vital for some newly diagnosed GBM, who may need to turn to them if they have few other supports. Finally, the consequences of an HIV diagnosis on the visas of some participants were felt acutely and should continue be discussed and supported at diagnosis.

IMPLICATIONS FOR POLICY AND PRACTICE

Building on the findings and conclusions detailed in this report, there are several implications for policy and practice as stakeholders seek to better engage with overseas-born GBM from non-English speaking countries who have recently arrived in Australia:

1. **Produce health promotion resources and new services that seek to:**
   - Encourage and facilitate immediate HIV and STI testing soon after arrival in Australia, and ongoing HIV and STI testing thereafter.
   - Educate about the accessibility of sexual health testing services available to them, including the availability of free sexual health testing at publicly funded sexual health centres and community-based testing sites.
   - Educate that confidentiality is a key feature of the Australian health system.
   - Educate about the biomedical HIV prevention options available in Australia, including PrEP and Treatment as Prevention.
   - Provide clarity and appropriate guidance to these men on the ways they can access PrEP.
2. **Tailor culturally and linguistically appropriate health promotion messages directed towards these men and do so according to their level of HIV knowledge. In recognising that many of these men will have had limited HIV education in their country of birth, this should include:**
   - Basic HIV education that advances their understandings of the transmission routes of HIV, how it can be prevented, what HIV treatments mean for the health of people living with HIV, and that having undetectable viral load means that HIV is untransmittable.
   - Simple and easily understood messaging about contemporary combination and biomedical HIV prevention while simultaneously retaining the complexity that more HIV-literate GBM require.
3. **Provide information and supports about HIV prevention and transmission, HIV testing, and living with HIV in languages other than English and also in simple English, such as through the Multicultural HIV and Hepatitis Service in NSW.**
4. **Provide interpreter services in clinical consultations where required and resources in languages other than English.**
5. **Increase availability of affordable PrEP options to non-residents and people ineligible for Medicare, particularly for those who cannot afford it.**
6. **Scale up culturally appropriate communication campaigns using micro-targeting for overseas-born GBM, and scale up dissemination of campaigns that include but extend beyond settings that have traditionally targeted gay community attached GBM. This may include international schools, private colleges and universities, and with GBM hook-up/dating apps.**

7. **Acknowledge the concerns overseas-born GBM have about the status of their visa at their diagnosis and provide referrals to organisations and information sources that can provide support, including the Multicultural HIV and Hepatitis Service and the HIV/AIDS Legal Centre.**

8. **Advocate in migration policies for people living with HIV in Australia to have no barriers to permanently migrate to Australia.**

9. **Ensure newly diagnosed overseas-born men feel supported through referrals to the HIV Support Program and linkage to psychosocial and peer support, with a particular focus on men who have been in Australia for six months or less.**

10. **Continue to ensure the rapid initiation of antiretroviral therapy for newly diagnosed overseas-born men.**

11. **Promote the Australian government's commitments to providing subsidised access to antiretroviral therapy for all people living with HIV, including migrants.**

12. **Connect GBM international students to relevant health websites such as the International Student Health Hub in NSW.**

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