



Navigating Post-Pandemic Migration

A review of migration trends
in NSW

November 2025



Sydney
Local Health District



About

Multicultural HIV and Hepatitis Service

The Multicultural HIV and Hepatitis Service (MHAHS) is a state-wide service funded by the NSW Ministry of Health. MHAHS works with culturally and linguistically diverse (CALD) communities across NSW to promote health and well-being related to HIV and viral hepatitis. Operating in more than 30 language groups, MHAHS delivers health promotion initiatives, community development programs, media campaigns tailored to CALD communities and individual support for people living with HIV and chronic hepatitis B.



MHAHS is built on the belief that fair access to health services for people from CALD backgrounds starts with an understanding of their culture and language. We recognise that community involvement and cultural insight play a vital role in improving health outcomes.

The Social Policy Group

The Social Policy Group (SPG) strives to make Australia's policies and systems better serve the diverse people and communities of Australia.

SPG delivers comprehensive, end-to-end solutions by integrating policy and programme design, economic modelling, community development, digital and multilingual communications, and by fostering impactful connections between sectors and communities.



Acknowledgements

Acknowledgement of Country

The authors acknowledge Aboriginal and Torres Strait Islander Peoples as the First Peoples and the Traditional Custodians and owners of the lands on which we live and work across Australia.

We pay our respects to their elders, past and present, and recognise their continuing connection to the land, waters, and communities.

As organisations committed to advocating for social cohesion and the well-being of disadvantaged populations nationwide, we acknowledge and celebrate the diverse cultures, histories, and contributions of Aboriginal and Torres Strait Islander peoples to our country.

We extend our respects to all Aboriginal and Torres Strait Islander peoples throughout Australia, past, present, and future. We recognise their ongoing resilience, strength, and stewardship of the land and commit ourselves to ongoing efforts of reconciliation, understanding, and collaboration.

LGBTIQA+ Acknowledgement

The authors respect everyone's right to freely identify and affirm their sexual or romantic orientation and gender identity, including terms such as lesbian, gay, transgender, non-binary, gender diverse, genderqueer, queer, aromantic, asexual, bisexual, pansexual, sistergirls and brotherboys. We support the rights of people born with intersex variations to be free from discrimination and mistreatment based on their sex characteristics.

We pay our respects to our community's lesbian, gay, bisexual, trans and gender diverse, intersex and queer pioneers and acknowledge the lives of those LGBTIQA+ persons who never made it to safety.

As organisations committed to designing and advocating for inclusive social policy, we celebrate our community's diversity and work to eliminate all forms of discrimination throughout Australia's systems.

Victim Survivor Acknowledgement

The authors acknowledge the significant impact of family and domestic violence on individuals, families and communities. We recognise the strength and resilience of the children, young people and adults who have, and are still experiencing this violence and pay our respects to those who did not survive and to their loved ones.

Executive Summary

Overseas migration is now the primary driver of Australia's population growth, accounting for over 80% of population increase in NSW in both 2023 and 2024. This demographic shift is altering the health landscape, particularly in the epidemiology and service demand for blood-borne viruses (BBVs) and sexually transmissible infections (STIs). This shift carries profound implications for health systems, particularly for public health services tasked with preventing and responding to BBVs and STIs.

This report positions migration data analysis as a critical driver of predictive epidemiology and health service planning. Understanding how population movement alters patterns of exposure, transmission, and service demand is essential for building an equitable, future-ready public health response.

Key migration-related drivers of BBV and STI service demand include:

- The rising proportion of migration as the dominant source of population growth;
- Higher incidence and prevalence of BBVs and STIs in many countries of origin compared to Australia;
- Context-specific health literacy needs, varying patterns of transmission behaviours, and different experiences in navigating care due to language and cultural diversity;
- The younger age skew of migrants, aligning closely with peak-risk cohorts for HIV, Hepatitis B (HBV), Hepatitis C (HCV), and STIs; and
- Growing cultural and linguistic diversity, expanding the complexity of community healthcare delivery, underscoring the need for inclusive, multilingual, and culturally responsive models of care.

By analysing shifts in migration flows, visa categories, and source-country profiles, planners can forecast areas of emerging risk, identify growing service needs, and inform the development of culturally competent interventions tailored to evolving community needs.

The migration program itself has evolved to become more dynamic and diverse. Permanent skilled migration has been the primary pathway in recent decades, but temporary streams - including international students, working holiday makers, and workers under the Pacific Australia Labour Mobility (PALM) scheme - now constitute a growing share of annual arrivals. Each stream brings distinct demographic, cultural, and health system considerations. For instance, PALM workers, who now number in the tens

of thousands nationally, are concentrated in essential industries such as agriculture, food processing, and aged care, often in regional or remote areas with limited access to mainstream health services. As of late 2024, 96% of PALM participants were employed in these sectors, reinforcing the need for proactive, place-based public health responses.

By analysing shifts in migration flows, visa categories, and source-country profiles, planners can forecast areas of emerging risk, identify growing service needs.

Source countries have also shifted significantly over the past decade. While in 2013–14 the dominant regions of origin were North-East Asia, by 2023–24 Southern and Central Asia became the largest contributors, with India, Nepal, Bangladesh, and Pakistan featuring prominently. Continued growth has also been seen in Southeast Asia, the Pacific, and Latin America. Meanwhile, arrivals from Sub-Saharan Africa and the Middle East have continued steadily, primarily through humanitarian pathways. This change in geographic origin carries with it different epidemiological baselines: many of these source countries have higher prevalence of HIV, HBV and HCV, and a distinct profile of STIs, necessitating tailored surveillance and culturally competent care models.

In addition to country of origin, age is a defining feature of recent migration cohorts. Over 70% of new arrivals are aged 15 to 39, the age group most at risk of acquiring STIs and least likely to engage proactively with mainstream preventive health services. In 2023–24, the median age of migrant arrivals was just 27, compared to 35 among the Australian-born population. Notably, international students and working holiday makers comprise the majority of arrivals in their early twenties. These younger cohorts also include many who are navigating the Australian health system for the first time, often without Medicare eligibility or familiarity with BBV/STI prevention resources.

Migration is also contributing to increasing cultural and linguistic complexity across NSW. The linguistic diversity of the state has expanded significantly, with many new arrivals speaking languages for which few or no health resources are currently available. Language barriers, differing health beliefs, and unfamiliarity with service systems can impede timely access to testing, treatment, and care. From a health systems perspective, this means that the effectiveness of standardised care models is diminishing. Services must now be designed with flexibility, multilingual capacity, and cultural safety embedded at their core. Multilingual health communication, bicultural workforce engagement, and community co-design are foundational elements in enabling this shift.

Epidemiological analysis reinforces these trends. Over 70% of people living with chronic hepatitis B (CHB) in Australia were born overseas. In NSW, the highest numbers of people affected by CHB trace their birth origins to China, Vietnam, the Philippines, and other high-prevalence countries. Similarly, HIV surveillance data continues to highlight elevated risk and higher undiagnosed rates among populations from South America and the Caribbean, Sub-Saharan Africa and Southeast Asia, while HCV patterns are increasingly influenced by emerging migrant groups whose risk profiles are not yet fully understood. For STIs, there remains a lack of disaggregated surveillance data by region of birth, creating a blind spot that inhibits targeted public health planning.

In response to these demographic and epidemiological developments, this report offers **four key recommendations**:

- 1. Elevate co-design and targeted service planning** – Future programs must be co-designed with CALD communities and visa-class-sensitive to ensure cultural relevance, equity, and coverage for underserved groups, including Medicare-ineligible groups, and the distinct needs of refugees, asylum seekers, and temporary migrant populations.
- 2. Integration of BBV/STI-specific touchpoints into general health promotion and service pathways** – Embedding BBV/STI prevention and care within broader consultations can reduce stigma, improve access, and better engage both community and health services.
- 3. Standardisation of data collection and strengthen utilisation practices** – Routinely disaggregated, cross-jurisdictional data, with country-of-birth and other standardised CALD data items, is essential for effective planning and monitoring.
- 4. Advancement of research initiatives focused on CALD communities** – CALD-led research must be integrated early and equitably, using both qualitative and quantitative methods to support more responsive health strategies.

Together, these strategies provide a roadmap for embedding inclusivity, proactivity, and cultural responsiveness into health system planning.

This report calls for the elevation of migration data and demographic modelling as core components of NSW Health's predictive epidemiology frameworks. It highlights the importance of tracking visa categories, country-of-origin trends, settlement patterns, and age distributions alongside traditional surveillance data. Doing so allows health planners to anticipate where new or intensified service demand will emerge and to allocate resources accordingly.

Migration is now an essential consideration in understanding and planning for health system demand in NSW.

It contributes to a growing body of work that recognises the value of applying migration analysis as a predictive tool in public health planning. With a focus on CALD health engagement, epidemiological insight, and culturally responsive service models, it offers evidence to support future-oriented strategies across BBV and STI services in NSW. The findings presented here aim to inform anticipatory, equitable, and data-driven approaches to health service design and delivery in the context of a rapidly diversifying population.

Migration is now an essential consideration in understanding and planning for health system demand in NSW. As the population continues to grow and diversify through migration, communities contribute valuable cultural perspectives, skills, and experiences that can inform and strengthen public health approaches. These shifts require that health services evolve to meet changing needs with inclusivity and cultural awareness at their core.

As part of NSW Health, the Multicultural HIV and Hepatitis Service (MHAHS) provides ongoing expertise in engaging culturally and linguistically diverse communities and supports the development of equitable, responsive BBV and STI services across the state. Integrating migration analysis into strategic health planning enables a more equitable and responsive system - one that recognises the realities of demographic change and builds upon the strengths of all communities to support better health outcomes across the state.



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Overview

Migration has become the principal driver of population growth in Australia, fundamentally reshaping the nation's demographic structure - and, with it, the epidemiology of blood-borne viruses (BBVs) and sexually transmissible infections (STIs). In New South Wales (NSW), which receives the largest annual intake of overseas migrants, the influence of migration on infectious disease trends is particularly pronounced. Understanding how population movement alters patterns of exposure, transmission, and health service demand is essential for developing a future-ready, equitable, public health response.

Over time, global migration patterns and the redistribution of populations into Australia can be used as a predictive lens to anticipate changes in BBV and STI burden. By analysing the composition of migrant arrivals and associated epidemiological profiles, health services and policy makers can gain advance insight into where service pressures are likely to emerge and which populations will require tailored interventions.

Key migration-related drivers of BBV and STI service demand include:

- The rising proportion of migration as the dominant source of population growth;
- Higher incidence and prevalence of BBVs and STIs in many countries of origin compared to Australia;
- Context-specific health literacy needs, varying patterns of transmission behaviours, and different experiences in navigating care due to language and cultural diversity;
- The younger age skew of migrants, aligning closely with peak-risk cohorts for HIV, HBV, HCV, and STIs; and
- Growing cultural and linguistic diversity, expanding the complexity of community healthcare delivery, underscoring the need for inclusive, multilingual, and culturally responsive models of care.

This report supports the strategic aims of the Multicultural HIV and Hepatitis Service (MHAHS) by analysing the evolving demographic and epidemiological landscape in NSW and highlighting key trends that will shape BBV and STI service delivery in the years ahead. It provides a foundation for predictive, data-driven planning that aligns resources, equity goals, and service delivery with the changing composition and health needs of the NSW population.

Introduction

Change in community demographic characteristics is a critical determinant of future public health service demand. In Australia, overseas migration consistently emerges as the largest contributor to population growth, with NSW receiving the highest annual intake of migrants, exceeding 142,000 in 2024 [ABS, 2024]. This significant and ongoing demographic shift introduces distinct challenges for health service planning, particularly in responding to prevention, detection and treatment of bloodborne viruses (BBVs) - including Human Immunodeficiency Virus (HIV), hepatitis B (HBV), hepatitis C (HCV) - and other sexually transmitted infections (STIs). People from migrant backgrounds present different patterns of exposure and transmission risk behaviours, influenced by infection prevalence in their countries of origin and migration-related social determinants.

In Australia, overseas migration consistently emerges as the largest contributor to population growth, with NSW receiving the highest annual intake of migrants, exceeding 142,000 in 2024.

In addition to prevalence rates of infection in the country of origin, research indicates that migration status itself is associated with unique health risks, with asylum seekers and refugee populations being at particularly elevated risk [Nkulu-Kalengayi 2021, Santoso 2022, Shiferaw 2025]. Multiple individual and structural factors influence BBV and STI diagnosis and treatment outcomes among culturally and linguistically diverse (CALD), migrant and refugee populations, including changes in social networks, distinct transmission behaviours, communication challenges, differences in access to care, and stigma [Ross 2018]. These considerations underscore the necessity for culturally responsive health service delivery to CALD communities, recognising that unmet health needs can affect community wellbeing and broader public health outcomes across NSW.

From 2020 to 2022, COVID-19 pandemic further complicated migration patterns and infectious disease reporting, causing notable disruptions, including a temporary reversal of migration flow and reduction in disease notification. While migration and infectious disease trends have since reverted to pre-pandemic trajectories, this transitional period emphasises the importance of data-driven strategic planning to anticipate and meet the evolving health service demands of a diversifying population fuelled by migration.

This report directly supports the strategic aims of the Multicultural HIV and Hepatitis Service (MHAHS), which works with CALD communities in NSW to improve health and well-being in relation HIV, HBV, and HCV. Examining migration trends enables the anticipation of demographic shifts that define the epidemiology of BBVs and STIs in NSW, providing essential insights to inform proactive, data-driven strategic planning. This approach enables effective resource allocation and ensures health interventions are culturally competent, responsive, and aligned with actual community demand, ultimately reducing disease prevalence and improving health outcomes among CALD populations.

Migration Policy Evolution

Australia's modern migration system is governed by the Migration Act 1958, which establishes the legal basis for all subsequent policy reforms. Over time, in a reflection of shifting national priorities, amendments to the Act have refined processes for visa issuance, character tests, and the balance between economic, humanitarian, and family reunion concerns.

Historically, Australia's demographic composition has significantly transformed. Before 1947, only 2% of Australia's population originated outside Australia, New Zealand, and the British Isles [McDonald 2019]. Migration initially favoured European nations under the White Australia Policy until its complete abolition in 1972. Refugees from Vietnam and Lebanon in the 1970s-1980s and increased Asian migration from the 1990s significantly diversified Australia's demographic profile [Levin et al 2022].

Since the 1990s, Australian migration policy has concentrated on skilled migration, which currently represents 72% of the permanent migration program in 2023-2024 [DOHA 2024]. The 2024-25 permanent Migration Program anticipates 185,000 visas, maintaining approximately a 70:30 split between Skill and Family streams [DOHA 2025].

Temporary visas have expanded to meet immediate labour shortages through schemes like Temporary Skill Shortage and Working Holiday visas. However, these visas present challenges to healthcare access due to language barriers, cultural differences, Medicare ineligibility and brief residency durations, complicating preventive health and chronic disease management strategies. International student policy has evolved from a revenue-driven approach in the early 2000s towards integration and pathways to permanent migration.

The Pacific Australia Labour Mobility (PALM) scheme, originating from the 2008 Pacific Seasonal Worker Pilot Scheme, addresses acute labour shortages through temporary guest workers from Pacific nations and Timor-Leste. As of December 2024, 96% of PALM participants were employed in essential sectors like agriculture, meat processing, and aged care [PALM scheme quarterly update – March 2025].

Migrants in temporary streams may face barriers in accessing services due to language, cultural differences, and brief residency durations, all of which have implications for preventive health strategies and chronic disease management. A comprehensive understanding of these patterns is crucial for public health planners to adapt services to a diverse and mobile workforce.

Australia's structured humanitarian program offers protection to refugees, with recent reforms emphasising genuine need and integration. Historically, Australia maintained mandatory detention policies for asylum seekers arriving without visas (2004-2014). Recent shifts have included more nuanced selection criteria and increased support services, with refugee origins shifting towards regions experiencing prolonged instability in Africa and the Pacific. Australia's humanitarian intake has consistently remained around 9-10% over the past decade [DOHA 2024].



Australia's Shifting Demography

Overseas migration is by far the largest contributor to population growth, at the national as well as and at state and territory level. In NSW, overseas migration contributed over 80% of total annual population growth in 2023 and 2024, and over 60% in the years 2015-2019 [Fig 1]. Due the COVID-19 pandemic, a reduction in growth in 2020 followed by negative migration flow in 2021 is observed. Trend correction followed by compensatory growth is then seen in the years 2023-2024.

NSW represents the major arrival point for overseas migration into Australia. The state experiences the largest net inflow of overseas migrants as well as largest net outflow of residents to other states and territories, further accentuating the growing proportion of the overseas born population [Fig 2]. These results include all overseas migrants, both permanent and temporary, who stay in Australia for 12 months or more.

Over the past 10 years, the countries contributing the largest proportion of Australia's net overseas migration (NOM) have been from regions of Asia.¹ Growth in migration intake is evident across Southern and Central, North-Eastern and South-East Asian regions, as well as notably Central and South America [Fig 3]. Skilled migration and international students contribute substantially to this trend.

The mix of regions where Australia's migrant arrivals are born has changed considerably over time. In 2023-24, the region that contributed the most arrivals was Southern and Central Asia, with 26%. A decade ago, in 2013-14, the largest group (20%) was from North-East Asia. In 2018-19, the year prior to the COVID-19 pandemic, this had changed with the largest group (25%) of migrant arrivals coming from Southern and Central Asia. This pattern has become reestablished post-pandemic.

In 2024, the top ten countries of birth for new migrant arrivals in NSW, excluding humanitarian intake, were China, India, Philippines, Nepal, Vietnam, Indonesia, Bangladesh, Pakistan, Brazil and South Korea [Fig 4]. Over the last 10 years, China and India have consistently remained the largest source countries for overseas migration. In the ranking of countries by number of migrant arrivals, a marked increase is seen from Bangladesh, Brazil and Indonesia, while a reduction from Iraq, Thailand and South Korea is evidenced from 2014 [Fig 5].

1. The grouping and classification of all Australian country and regional data in this report conform to major and minor groups as defined by the ABS Standard Australian Classification of Countries (SACC), 2016. Available at <https://www.abs.gov.au/statistics/classifications/standard-australian-classification-countries-sacc/latest-release>

A choropleth map visualises the relative change at a country level over the past decade [Fig 6]. Proportional increase is shown in migration from Oceania, Asia and South America. The increase across Pacific Island nations is largely attributable to the contribution of the PALM program [Fig 10-11]. Intake from Sub-Saharan Africa and the Middle East has grown slowly, with a redistribution of migration countries within the region being driven in part by alignment with changes in the humanitarian program [Fig 12-13]. European (other than Ireland) and North American migration intake has generally declined.

Growth in migration intake is evident across Southern and Central, North-Eastern and South-East Asian regions, as well as notably Central and South America.

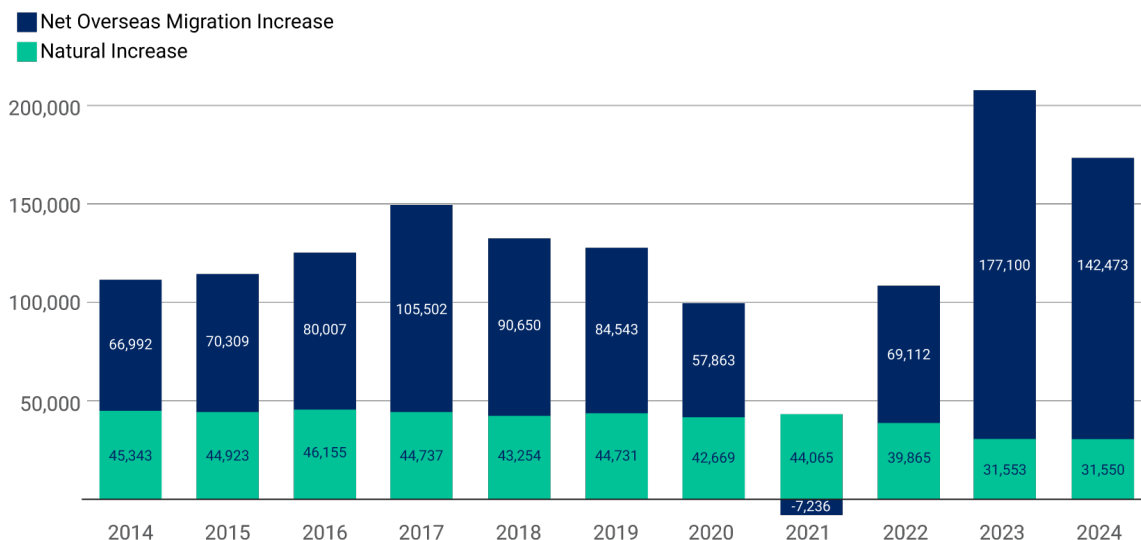
When the countries with the largest proportional increases in migration arrivals are singled out, dramatic increases across Oceania, African, Middle Eastern, and Central and South American countries are observable, in some cases up by more than 400% [Table 1]. While the raw number of arrivals from many of these countries does not draw attention with respect to being a significant proportion of Australia's overall migration intake, their relative change remains important in identifying rapid growth in minority populations. These dynamic observations require considered public health planning and prompt targeted address with the catalogue of CALD community needs and health access equity priorities.

Migrants are a younger cohort than the general Australian-born population [Fig 7]. With the Australian migration program being principally engineered toward economic development, working age adults and their families form the majority of migrant arrivals. In 2023-24, the median age of migrant arrivals was 27, compared to an Australian-born median age of 35 in June 2023 [ABS 2023, 2024]. Of the 23-year-old migrant arrivals, 57% were international students and 21% were working holiday makers [ABS 2023, 2024].

Overseas migration makes the Australian population younger. In addition to direct increase in population, due to migrants being predominantly younger and either unpartnered or with young families, over longer time periods the settlement of migrants also acts as an indirect contributor to the Australian-born (natural) population growth through influence on the birth rate.

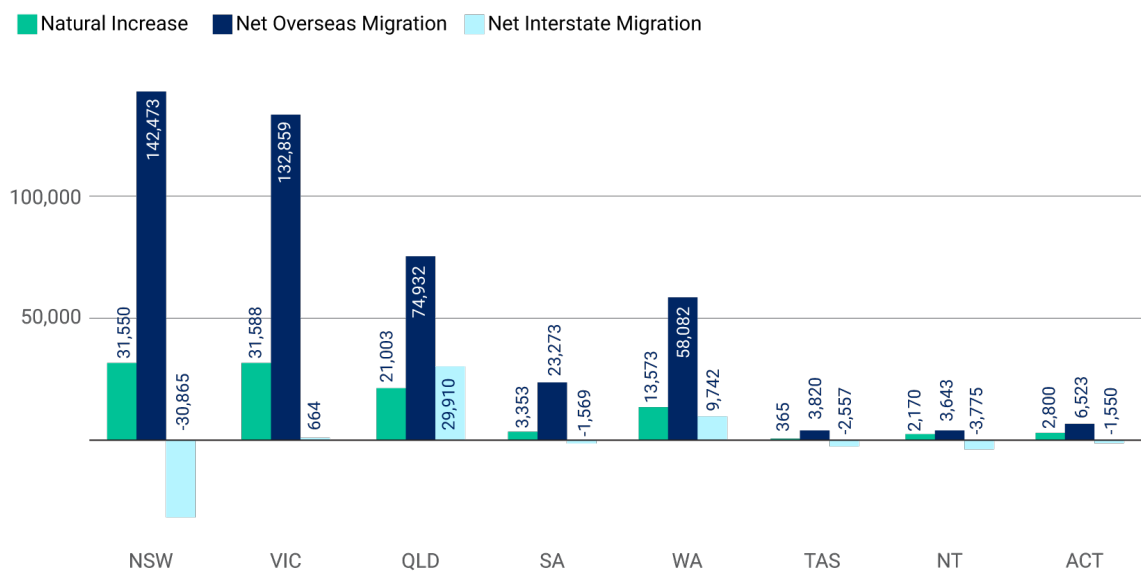
Population growth driven by overseas migration

Figure 1. Population growth from migration and natural increase – NSW (2014-2024)



Source: ABS - National, state and territory population 2024

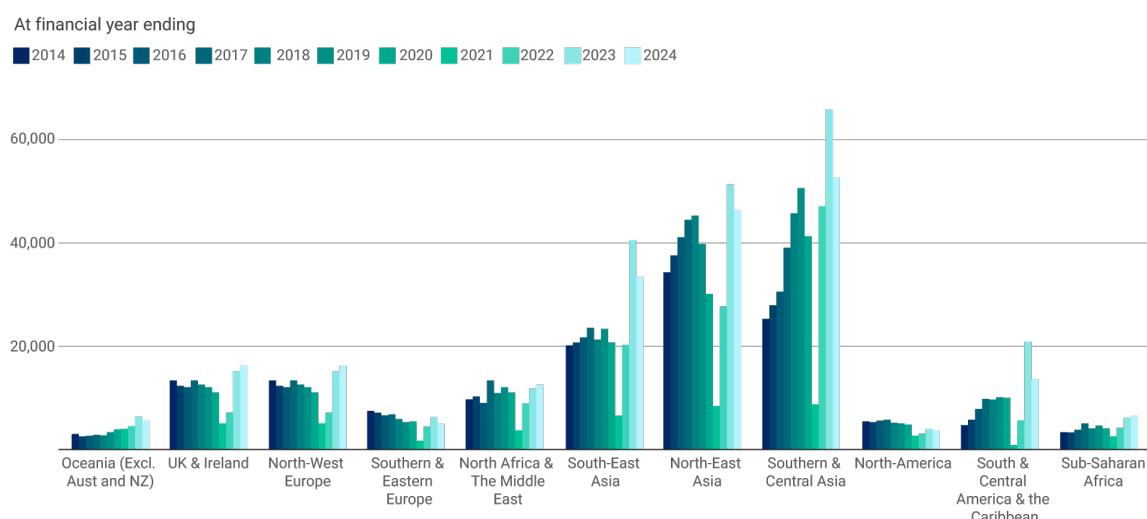
Figure 2. Distribution of overseas migration by state and territory (2024)



Source: ABS - National, state and territory population 2024

Regions and Country of Birth

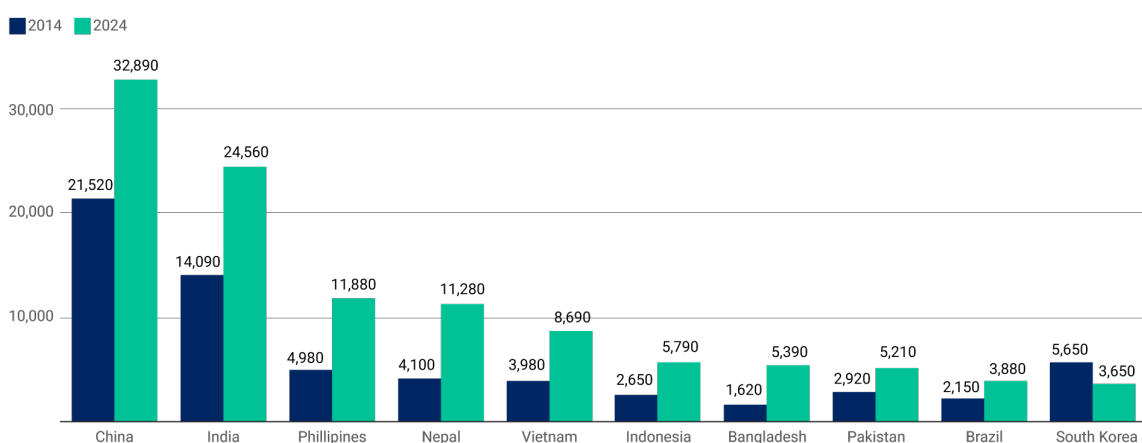
Figure 3. Migration arrivals by region of birth – NSW (2014-2024)



Source: ABS - Overseas Migration 2023-24

The grouping and classification of all Australian country and regional data in this report conform to major and minor groups as defined by the ABS Standard Australian Classification of Countries (SACC), 2016. Available at <https://www.abs.gov.au/statistics/classifications/standard-australian-classification-countries-sacc/latest-release>

Figure 4. Top 10 migration arrivals by country of birth – NSW (2014-2024)

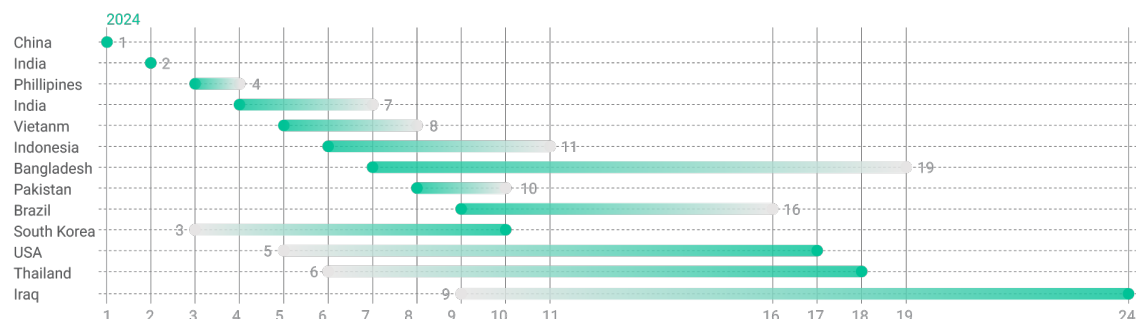


Source: ABS - Overseas Migration 2023-24

Results exclude arrivals from NZ, UK, Ireland and North America, with consideration of reporting relevance to cultural and linguistic diversity.

Changing trends in migration source countries

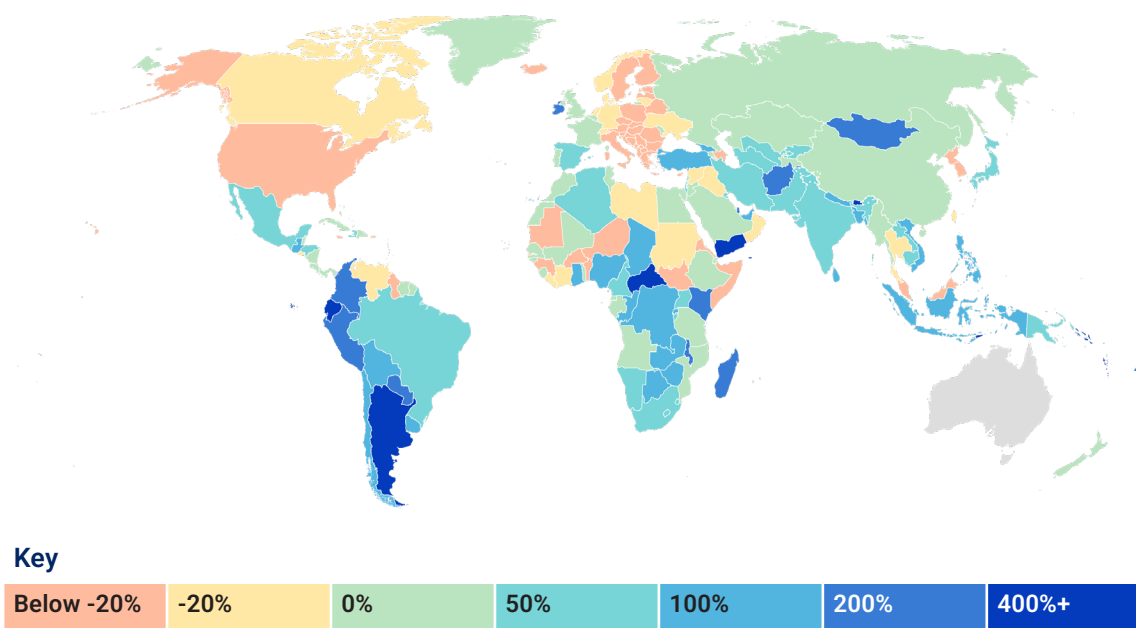
Figure 5. Change in top 10 ranking of migration arrivals by country of birth – NSW (2014-2024)



Source: ABS - Overseas Migration 2023-24

Figure 6. Change in overseas migrant arrival rate into NSW: Shifting patterns from 2014-2024

The map shows the percentage change in annual migration arrival rate into NSW by source country between 2014 and 2024



Source: ABS - Overseas Migration 2023-24

Table 1. Source countries with the largest proportional increase in migration arrivals into NSW from 2014-2024, with indication of relevance to BBV services

Countries in regions with higher migration-associated burden of HIV, HBV and HCV are indicated by labels to highlight their relevance to planning of BBV service demands.

100% increase		200% increase		400% increase and above	
Bangladesh		Afghanistan		Argentina	
Bolivia		Colombia		Bhutan	
Botswana		Fiji		Central African Republic	
Chad		Ireland		Ecuador	
Chile		Kenya		Kiribati	
Congo		Madagascar		Solomon Islands	
Democratic Republic of Congo		Malawi		Timor-Leste	
French Guiana		Mongolia		Vanuatu	
Georgia		Paraguay		Yemen	
Ghana		Peru			
Guam		Qatar			
Guatemala		Tuvalu			
Indonesia					
Marshall Islands					
Nauru					
Nepal					
Nigeria					
Philippines					
Rwanda					
Sri Lanka					
Tonga					
Turkey					
United Arab Emirates					
Uruguay					
Vietnam					
Zambia					
Zimbabwe					

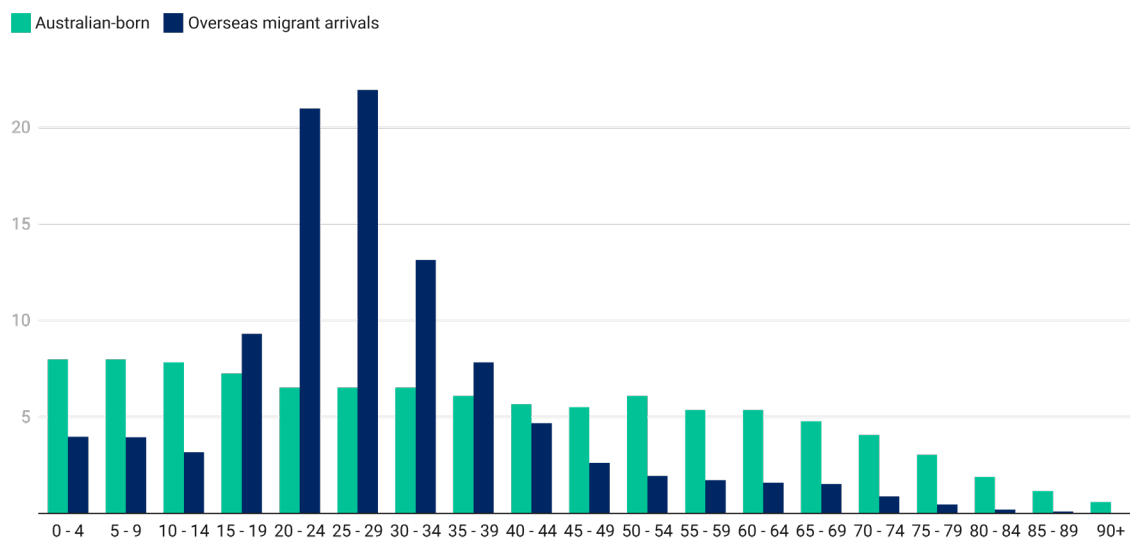
Key

HIV	HBV	HCV
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Source: Kirby Institute Annual Surveillance Report 2024; Viral Hepatitis Mapping Project 2024; WHO Global Hepatitis Report 2024

Figure 7. Age distribution of migrant arrivals compared to Australian-born residents (2023)

Shows the proportional age distribution of overseas migrant arrivals (as a percentage), compared to all Australian-born residents (as a percentage), in the year 2023. Source:



Source: ABS - Australia's Population by Country of Birth, Overseas Migration 2023

Migration Streams of Interest

In addition to general overseas migration trends, three specific areas of the migration program are identified as having characteristics of unique relevance to the landscape of BBV and STI-related health services: international student visas, the Pacific Australia Labour Mobility (PALM) scheme, and the Refugee and Humanitarian program.

From a health services perspective, the key migration source of countries of interest is reflected by the top 10 migration arrivals by stream by country of birth or country of origin (Table 2).

Student visas

International students arriving through the temporary student visa pathway gravitate toward metropolitan centres of study, with NSW educational institutions consistently receiving the largest number of student visa holders of any state or territory [Fig 8]. In 2024, 54% of student visas granted in NSW were from the following five student source countries: China (19%), India (15%), Vietnam (9%), Philippines (6%) and Nepal (5%). [Fig 9, DOHA 2024]. Consistent with the broad migration arrival trends of the COVID-19 pandemic, the number of student visas granted dipped over 2020-2022, then compensated in 2023. As of 2024, numbers have yet to reach pre-pandemic levels, with only 128,271 student visas granted in NSW, compared to 144,787 in 2019 (89% of 2019 level).

Temporary student visa holders are young, with a median age range 20 to 24 years old [DOHA Migration Trends 2023-2024]. The majority have yet to start families and have a high likelihood of future progression into permanent residency. In 2023-2024, 17.8% of permanent visas were delivered to applicants already in Australia on temporary student visas, reflecting a progressive trend toward the preferencing of grants for permanent visas to work-ready individuals who have already successfully lived in Australia for several years (an average 4.9 years to reach a permanent visa) [ABS 2023].

PALM scheme

The number of PALM scheme workers in Australia fluctuates seasonally. In December 2024 there were 27,260 workers in Australia, with 5,130 workers in NSW [Fig 10, DEWR 2025], however over the course of the year, monthly worker numbers peaked up to 26% above this figure. Due to the industries of employment (92% Agriculture and Meat Packing) geographic distribution of workers is overwhelmingly regional and rural [PALM scheme quarterly update – March 2025]. Since December 2022, NSW worker numbers have risen by 77% [Fig 11]. While Pacific Island labour force programs have existed since 2008, program changes prior to 2022 prevent direct comparison of migration numbers.

Structurally, the PALM scheme visa is arranged to suit seasonal labour hire, leading to a highly mobile Pacific Islander population with periodic residency between Australia and their country of origin, encouraging compressed return travel cycles and high migrant turnover. Short-term stream workers (27% in December 2024) are able to spend up to 9 months in any 12-month period before returning to their home countries and can apply to return to Australia in subsequent years. Workers in the long-term stream (73%) can spend up to 4 years in Australia and must then spend 6 months outside Australia before applying to return on a subsequent PALM visa. The visas permit multiple entry, meaning workers can leave Australia and return while their visas are in effect. Workers are currently not permitted to bring family members with them, leading to the formation of labour force communities of unrelated working-age adults away from overseas family for extended periods.

Refugee and Humanitarian Program

The humanitarian program responds to global resettlement needs, with source country composition changing substantially from year to year, being based on international crises rather than national strategic factors. In recent years, visa grants have predominated from regions of Asia, the Middle East, Africa and the Americas. In 2024, a total of 16,750 offshore humanitarian visas were granted, principally to nationals from Afghanistan (41.6% of offshore visas granted), Syria (16.7%), Iraq (11.0%) and Myanmar (10.6%) [Fig 12]. Women and children make up a significant proportion, with 8,674 visas granted to women (51.8% of all visas), and 6,719 to children under 18 years of age, together totalling over two-thirds of visas granted (71.5%) [DOHA 2024].

Refugees and asylum seekers experience a wide range of health vulnerabilities, including higher exposure to sexual violence and unregulated healthcare procedures, with concordantly higher rates of BBV and STI than the general migrant population [Santoso 2022, Shiferaw 2025]. While humanitarian immigrants undergo systematic pre-arrival health assessments, which provide a once-off opportunity for diagnosis and intervention, enduring cultural and socioeconomic risks for BBV and STI persist after settlement in Australia.

Migration source countries of interest

Table 2. Summary of top 10 migration source countries by stream (2024)

Summary of data correlating with figures 4, 9, 11 and 13, listing the top 10 migration arrivals by stream by country of birth or country of origin.

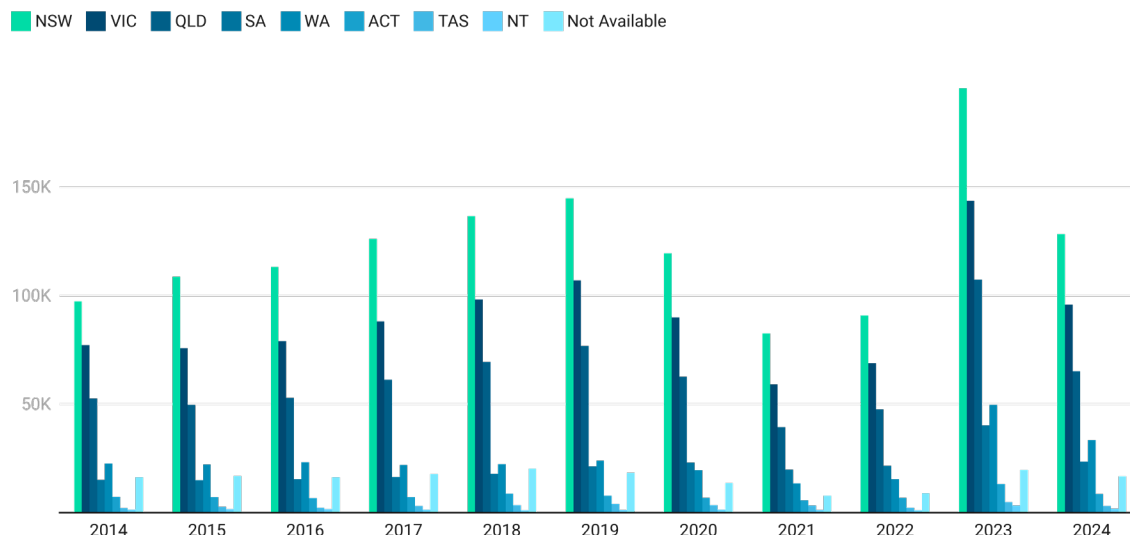
Permanent migration - NSW (Figure 4)	Student visas – Australia (Figure 9)	PALM scheme – NSW (Figure 11)	Humanitarian program – Australia (Figure 13)
China	India	Fiji	Afghanistan
India	China	Vanuatu	Syria
Philippines	Nepal	Solomon Islands	Iraq
Nepal	Philippines	Samoa	Myanmar
Vietnam	Vietnam	Tonga	Democratic Republic of Congo
Indonesia	Bhutan	Timor-Leste	Stateless
Bangladesh	Pakistan	Papua New Guinea	Eritrea
Pakistan	Colombia	Kiribati	Ethiopia
Brazil	Sri Lanka	Tuvalu	Venezuela
South Korea	Thailand	Nauru	Sudan

Source: As per Figures 4, 9, 11 and 13

International students by country of origin

Figure 8. Student visas granted by state and territory (2014-2024)

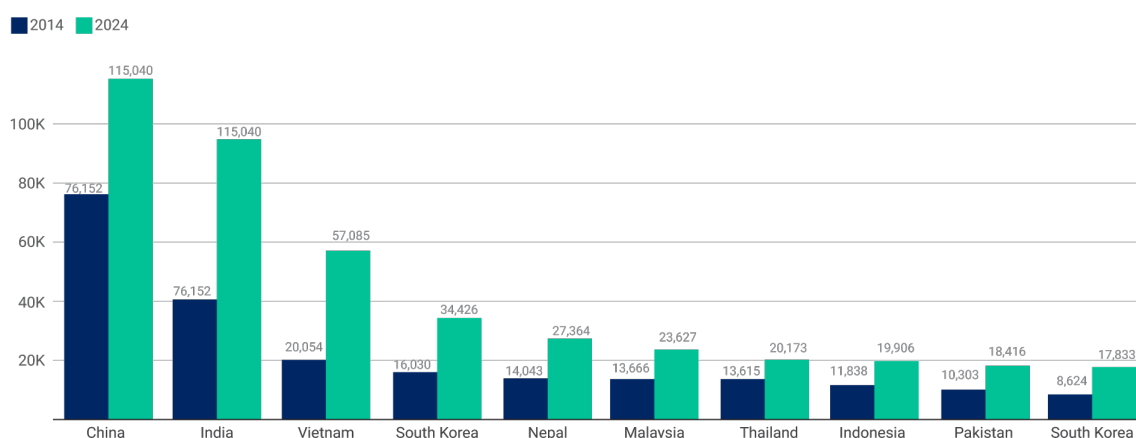
By financial year by the state and territory of the enrolled educational institution.



Source: Department of Home Affairs, Student visa program

Figure 9. Top 10 student visa holders by country of citizenship - Australia (2014-2024)

Number of student visa holders in Australia by citizenship country as of 30 June.

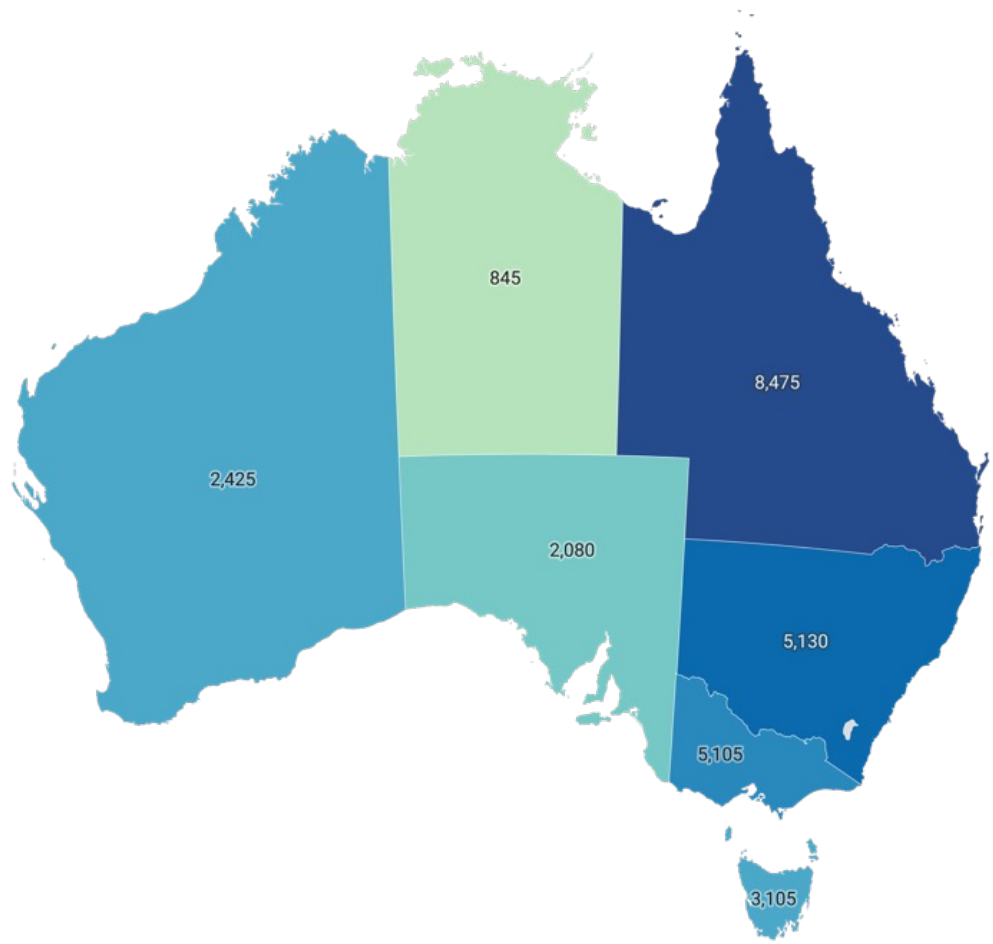


Source: Department of Home Affairs, Student visa and Temporary Graduate visa program 2024

PALM scheme migrants by country of origin

Figure 10. PALM stream workers by state and territory (2024)

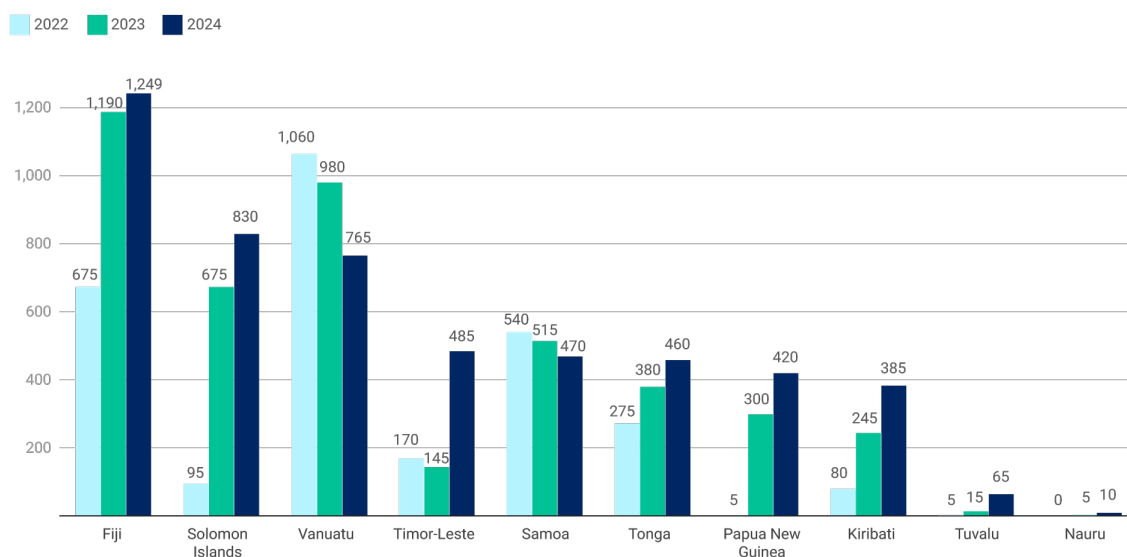
Distribution of PALM stream workers in Australia in December 2024.



Source: Department of Employment and Workplace Relations - Pacific Australia labour Mobility scheme

Figure 11. PALM stream workers by country of origin - NSW (2022-2024)

Number of PALM stream workers in NSW in December 2022, 2023 and 2024.

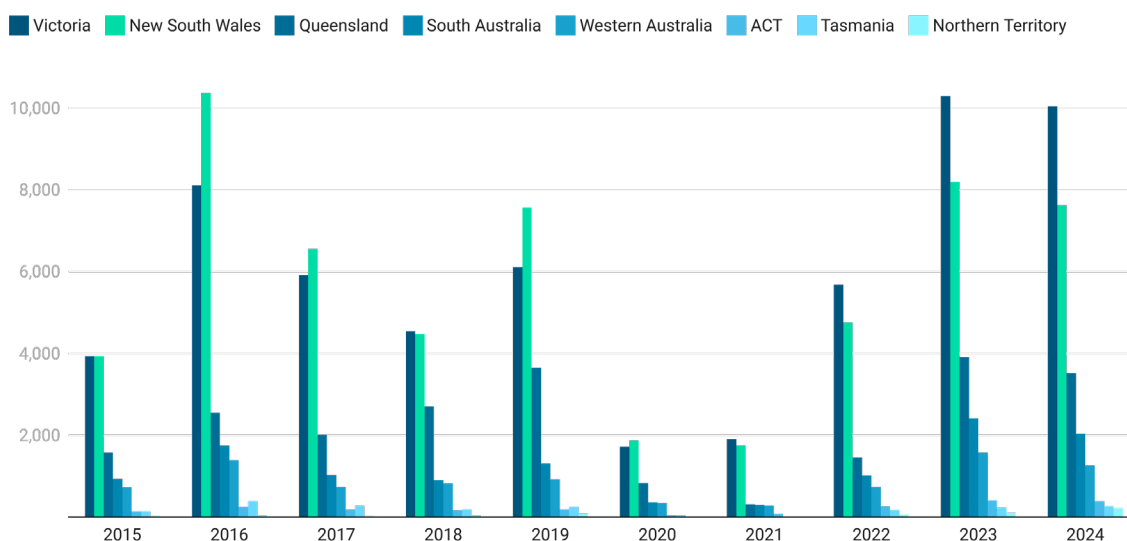


Source: Department of Employment and Workplace Relations - Pacific Australia labour Mobility scheme

The restricted date range of data is due to program changes prior to 2022.

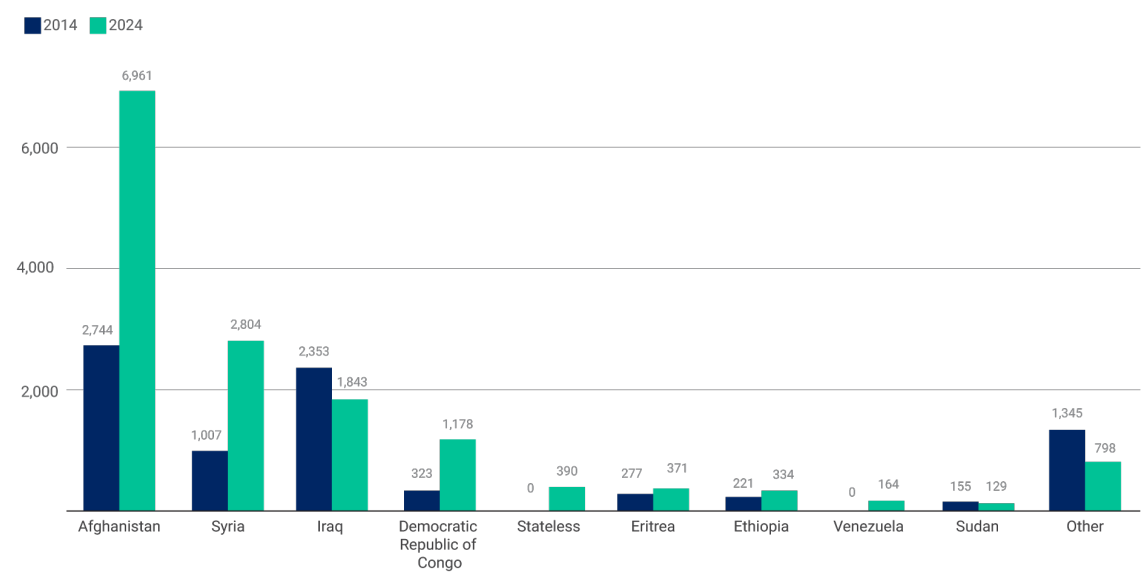
Humanitarian migrants by country of origin

Figure 12. Humanitarian stream permanent settlement by state and territory (2015-2024)



Source: Department of Home Affairs - Settlement Reports, Dec 2024

Figure 13. Humanitarian stream entrants by country of origin - Australia (2014-2024)



Source: Department of Home Affairs - Australian Migration Statistic 2023-2024

The figure shows offshore resettlement (Refugee and Special Humanitarian Program). It does not include Onshore Protection stream visas.

Migration and Patterns of BBV and Sexually Transmitted Infection Risk

Migrant populations may experience varied exposure rates and transmission risk influenced by infection prevalence and different health systems in their countries of origin and the impact of migration-related social determinants. Inflow from endemic countries elevates the exposure landscape for the Australian population. Furthermore, migrants experience an increased risk compared to the general population in their destination countries because of the circumstances surrounding the migration process, including the socioeconomic and political factors in both their countries of origin and after arrival [Nkulu-Kalengayi 2021]. These disparities impact early detection and treatment, increasing the risk of onward transmission and long-term negative sequelae, justifying strategic public health responses for priority CALD communities.

Inflow from endemic countries elevates the exposure landscape for the Australian population.

Incidence and prevalence provide composite indicators of changes in transmission and disease burden within a population. However, comparing BBV and STI rates across global data sources remains inherently challenging. Despite sustained international efforts by agencies such as the World Health Organisation (WHO) to harmonise data collection, methodologies for estimating incidence and prevalence differ markedly across countries, diseases, and health systems.

In Australia, incidence reporting for HIV, viral hepatitis and other STIs is derived from state and federal case notification datasets, providing comprehensive direct measurements across the population. In other countries, estimates reflect heterogeneous data sources - including diagnostic case reporting, surveillance of general or key populations, population-based surveys, antenatal testing, and academic studies - depending upon which method provides the most reliable data within a specific national context [UNAIDS 2024]. In addition to technical and resource limitations, cultural variation in stigma and sexual health literacy significantly influences the estimated rates of undiagnosed infections. Data gaps, methodological incompatibilities,

and wide discrepancy ranges between sources produce low-fidelity patchwork maps of global epidemiology, rather than a precise matrix of cross-country comparison.

For Australian service planning, local surveillance provides the most accurate picture. State and federal general population disease notification data stratified by region or country of birth, visa class, or other indicators of cultural background provide the best direct comparative for understanding the differential risk between Australia's migrant subpopulations. Where available, this is supported by international modelling data to contextualise risk profiles for migrant subpopulations. As with migration rates, Australian disease notification data from the COVID-19 pandemic period (2020–2022) shows a temporary dip in notifications; figures post-2022 are considered more appropriate for anticipating forward trends.

HIV

Australian HIV epidemiology shows that while fewer transmissions are occurring in Australia, the inflow of new cases through migration is rising. In addition, the proportion of the HIV burden is associated with migration and region of birth is increasing, relative to other recognised exposure categories such as male-to-male sex, injecting drug use or vertical transmission. It is also recognised that migrants are often more likely to experience worse HIV treatment outcomes compared to native-born populations [Ross 2018].

Within Australia, highest HIV notification rates in 2023 were among people born in Latin America and the Caribbean, Southeast Asia, and Sub Saharan Africa , three to five-fold higher than people born in Australia.

The Kirby Institute Annual Surveillance Report 2024 provides a current snapshot of Australian HIV burden, estimating an HIV prevalence of 0.14% for general Australian population, with higher rates in key migrant subpopulations by region of birth, notably Latin America and the Caribbean (0.47%), Sub-Saharan Africa (0.43%), and Southeast Asia (0.29%). In addition, the proportion of cases that are undiagnosed also estimated higher than the general Australian population rate of 8%, in particular for those born in Latin America and the Caribbean (19%) and Southeast Asia (23%). These disparities highlight the need for targeted, inclusive public health responses that address systemic barriers to testing and care, and help reduce ongoing transmission risks. [Kirby Institute 2024].

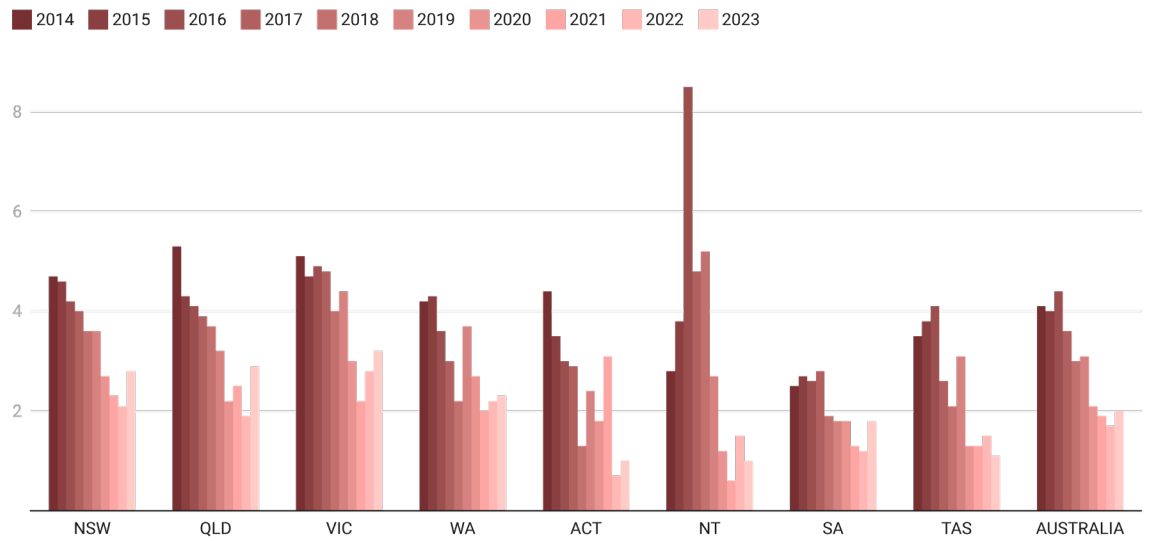
HIV incidence is the best indicator of changes in transmission in a population. Overall notification rates of HIV in Australia are in decline, with NSW reporting 4.7 cases per 100,000 in 2014, down to 2.8 cases per 100,000 in 2023 [Fig 14]. The rate of newly acquired HIV has fallen in NSW from 2.2 cases per 100,000 in 2014 to 0.8 cases per 100,000 in 2023. Similarly, the total number of NSW notifications as a first-ever diagnosis in Australia has declined, from 344 cases in 2014 to 230 cases in 2023. In contrast, the number of NSW notifications previously diagnosed overseas has increased, from 77 cases in NSW in 2014 to 116 cases in 2023. The timing of HIV acquisition in relation to migration to Australia has also shifted. For HIV notifications among migrants to Australia attributed to male-to-male sex, the proportion who acquired HIV after migration declined from 63% in 2016 to 37% in 2023, while notifications attributed to heterosexual sex fluctuated without a clear trend [Kirby Institute 2024].

Within Australia, highest HIV notification rates in 2023 were among people born in Latin America and the Caribbean (10.0 per 100 000), Southeast Asia (8.9 per 100 000), and Sub-Saharan Africa (6.9 per 100 000), three to five-fold higher than people born in Australia (1.9 per 100,000) [Fig 15]. Between 2014-2023, HIV diagnoses among Australian-born men reporting male-to-male sex have declined by 64%. However, among overseas-born men reporting male-to-male sex, this decline has been less evident, especially among men born in regions of Asia and Latin America and the Caribbean. Likewise, among HIV notifications attributed to heterosexual sex, the proportion of Australian-born persons declined from 44% in 2014, to 35% in 2023, again with rising proportions in Asia and other countries [Kirby Institute 2024].

Internationally, much of the country-level incidence data available for comparison is less precise than Australia. While HIV has strong, coordinated global data collection compared to other BBVs and STIs, data is unavailable from UNAIDS and WHO Global Health Observatory for several significant source countries for Australian migration, notably China, Korea, Pakistan (prevalence only), Iraq, and many Pacific Island nations. Acknowledging these gaps, it is generally observable that many migration source countries report incidence rates many times higher than Australia (noting that the incidence denominator of rate per 1000 population is used by UNAIDS data sources) [Fig 16]. Beyond this difference, it is further recognised in literature that the HIV prevalence ratio is generally higher among migrants than in native populations of the country of origin [Santoso 2022].

Figure 14. HIV notification rates by state and territory – Australia (2014-2023)

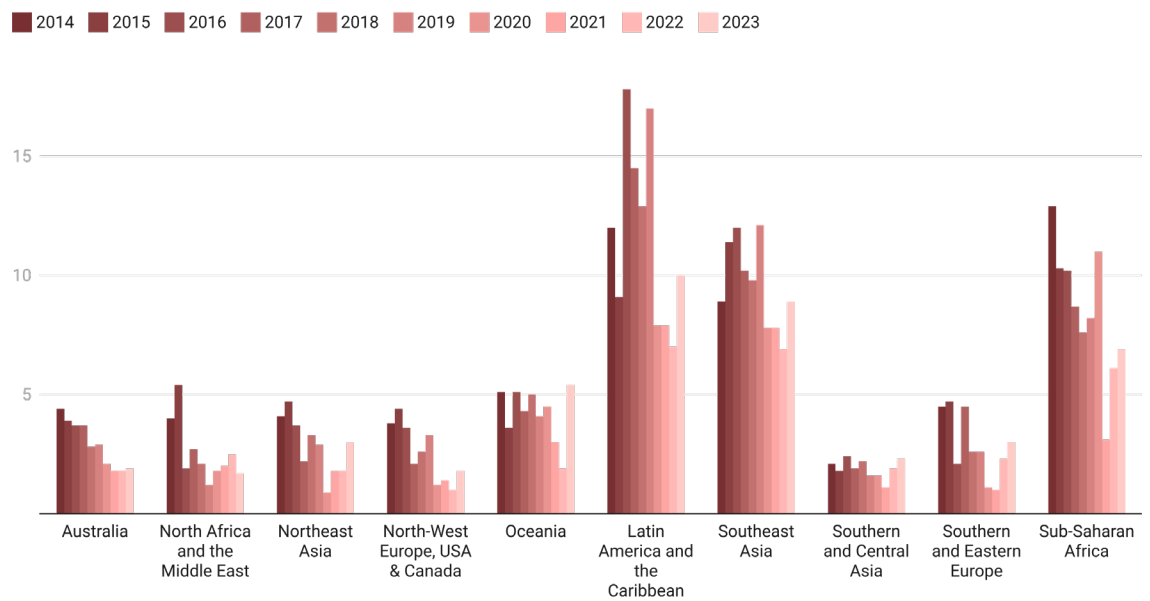
Notification rates per 100,000 population by state and territory.



Source: Kirby Institute UNSW Annual Surveillance Report 2024

Figure 15. HIV notification rates by region of birth – Australia (2014-2023)

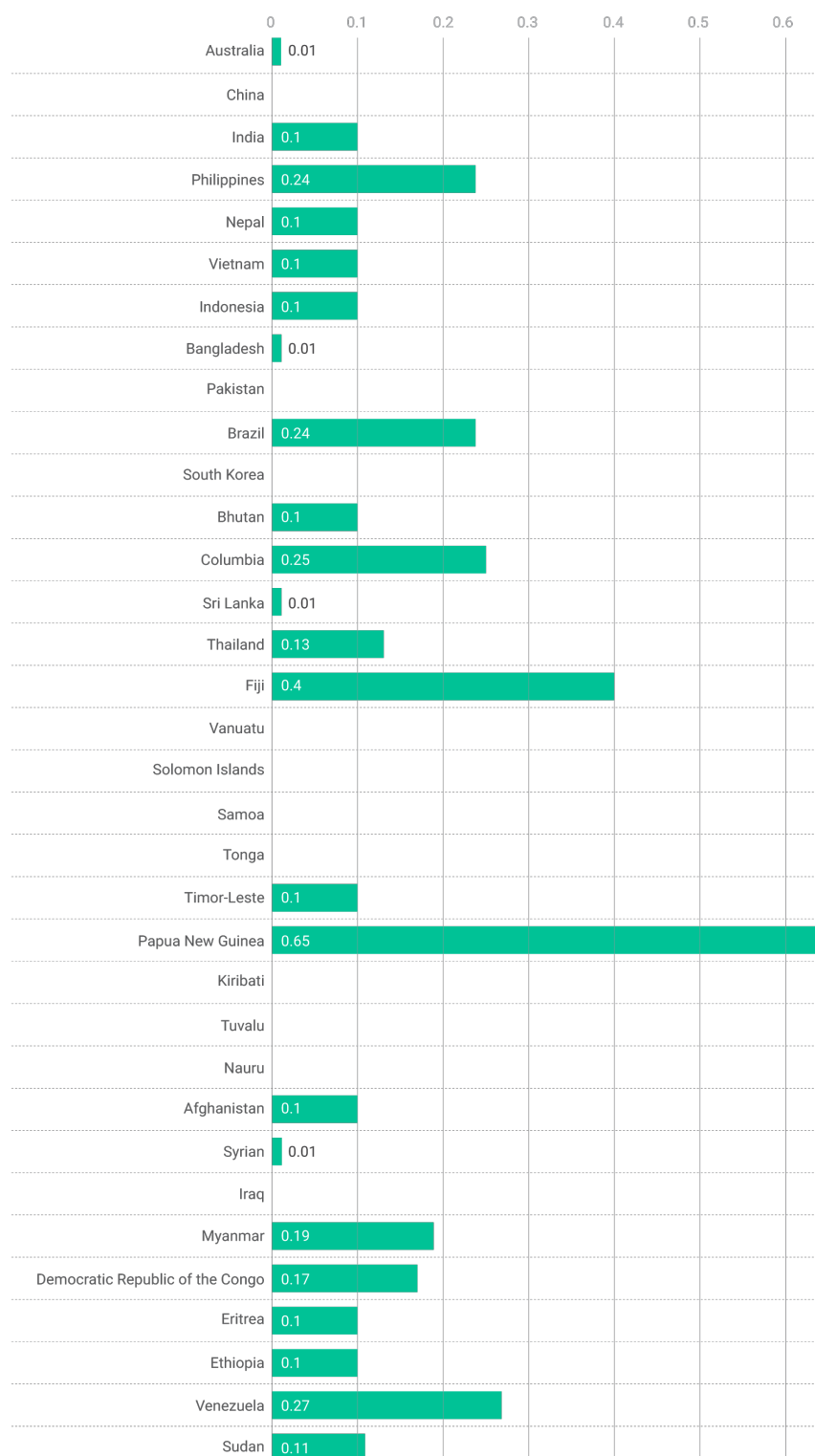
Notification rates per 100,000 population by region.



Source: Kirby Institute UNSW Annual Surveillance Report 2024

Figure 16. Comparison of HIV notification rates between Australia and migration source countries (2023)

Comparison of Australia with significant migration source countries for permanent migration, humanitarian intake and PALM program in 2023 (where data is available). Notification rates are per 1000 population.



Source: UNAIDS. HIV estimates with uncertainty bounds 1990-Present

Results are rounded to the nearest 0.01. For Australia, 2022 data has been provided as a reference due to 2023 data is not being available. Results are not displayed for countries where data is not supplied to WHO - notably China, Pakistan, South Korea, Iraq and many Pacific Island nations.

Hepatitis B

By state and territory, NSW has the highest notification rate of hepatitis B, with 24.8 cases per 100,000 in 2022 [Fig 17]. Since 2013, hepatitis B notifications have decreased across all age groups under 40 years, and especially in ages under 30 years, principally on account of universal childhood vaccinations established between in 1990s-2000s.

Despite a declining notification rate, chronic hepatitis B (CHB) infection and subsequent liver complications are rising in prevalence in Australia. As a lifelong condition once acquired, the number of people living with CHB has increased by 9.6% since 2018 [VHMP 2025]. The key driver is increased migration from endemic regions where cornerstone health interventions, including childhood vaccination, antenatal surveillance, and diagnostic access, are less established than in Australia. In particular, refugees, asylum seekers and internally displaced persons have been shown to have a high prevalence of HBV and HCV in many settings [Saseetharan 2023].

Country of birth is a key predictor of the risk of CHB for people living in Australia, and over 70% of all people living with CHB in Australia in 2023 were born overseas.

An estimated 219,800 people were living with CHB in Australia, representing 0.82% prevalence across the total population. By state and territory, NSW had the second highest overall prevalence at 0.92%, with the highest prevalences in the state located in the Sydney region in line with migration concentration: South Western Sydney (1.36%), Western Sydney (1.29%), Central and Eastern Sydney (1.28%), and Northern Sydney (1.23%) [VHMP 2025]. Of this prevalence, it is estimated that 31% of all those living with CHB in Australia are undiagnosed [VHMP 2025], leading to missed opportunities for liver cancer and cirrhosis prevention [Sievert 2018].

Country of birth is a key predictor of the risk of CHB for people living in Australia, and over 70% of all people living with CHB in Australia in 2023 were born overseas. As reported by the Viral Hepatitis Mapping Project: Hepatitis B National Report 2023, regions of birth with the highest prevalence were North East Asia (4.92% prevalence, representing 23.6% of the total Australian population with CHB), South East Asia (3.91% prevalence, 22.7% of

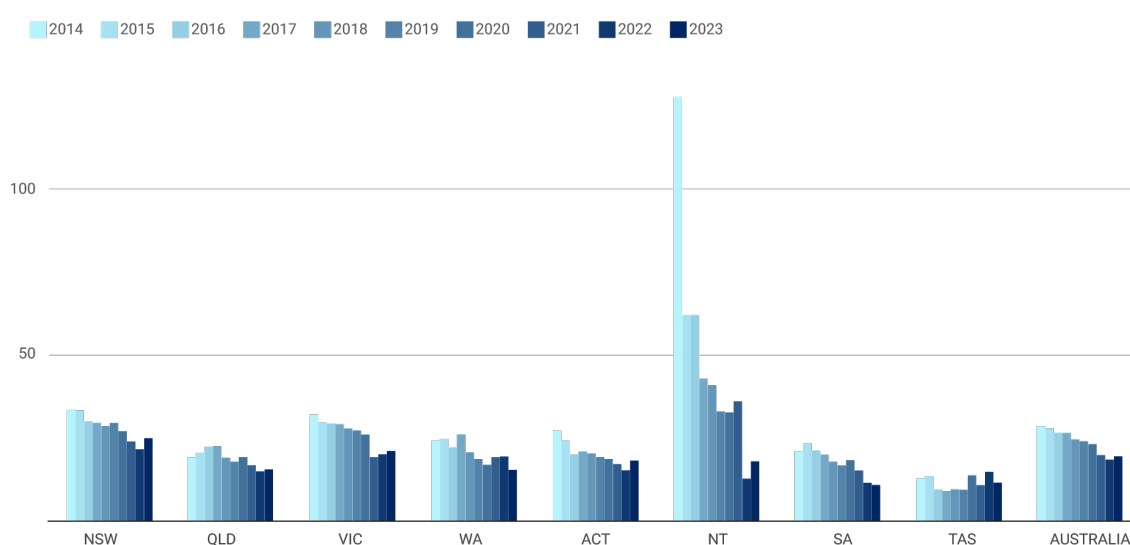
the total) and Sub-Saharan Africa (2.42%, 4.8% of the total). Overall prevalence for people born overseas was 1.91%, more than double the total Australian population average (0.82%) and six times the prevalence of people born in Australia (0.32%) [Table 2].

Among all people living with CHB in Australia who were born overseas, the majority were born in a relatively small number of countries. The 14 most common countries of birth comprised half of all people living with CHB in Australia. The highest proportion of people living with CHB in Australia by country of birth was China (18.52%), Vietnam (10.15%), Philippines (4.13%), New Zealand (2.35%) and Thailand (1.97%) [Table 3]. For evaluating migration-associated risk, this Australian subpopulation data should be considered more reliable and practical than direct international comparisons.

Internationally, the WHO Global Hepatitis Reports and the WHO Global Health Observatory offer the most comprehensive pooled global hepatitis datasets. However, to an even greater degree than HIV, methodological variation produces critical uncertainties for comparing prevalence estimates between countries. While lacking the precision of Australian data, global data does support the identification of the priority source countries for HBV associated with migration. Nine countries account for two-thirds of the global burden of HBV: China, India, Indonesia, Nigeria, Ethiopia, Bangladesh, Vietnam, Philippines and Pakistan [Table 4]. Further, it is estimated that only 13% of people living with CHB globally have been diagnosed, highlighting the significance of unaddressed infection, recognising that migrants from high hepatitis burden countries experience greater hepatitis related morbidity and mortality compared with the general population of their destination country [Sun 2025]

Figure 17. HBV notification rates by state and territory – Australia (2013-2022)

Notification rates per 100,000 population by state and territory.



Source: Kirby Institute UNSW Annual Surveillance Report 2023

Table 3. People living with CHB in Australia by region of birth or priority population - Australia (2023)

Population group	Total population	People living with CHB	Prevalence (%)	Proportion of all people living with CHB (%)
People born in Australia (total)	18,606,652	60,224	0.32%	27.40%
People who inject drugs	251,293	5,998	2.39%	2.70%
Men who have sex with men	377,818	7,952	2.10%	3.60%
Aboriginal and/or Torres Strait Islander people	1033712	14785	1.43%	6.70%
Other non-Indigenous Australian-born people^	16943829	31489	0.19%	14.30%
People born overseas (total)	8351124	159576	1.91%	72.60%
People born in North East Asia	1,053,114	51,840	4.92%	23.60%
People born in South East Asia	1,280,205	49,995	3.91%	22.70%
People born in Sub-Saharan Africa	439,770	10,658	2.42%	4.80%
People born in Southern and Eastern Europe	694,930	11,848	1.70%	5.40%
People born in North Africa and Middle East	530,425	7,582	1.43%	3.40%
People born in Oceania (excluding Australia)	825,755	11,980	1.45%	5.50%
People born in the Americas	440303	2,923	0.66%	1.30%
People born in Southern and Central Asia	1,525,542	8,234	0.54%	3.70%
People born in North West Europe	1,561,081	4,514	0.29%	2.10%
AUSTRALIA	26,957,776	219,800	0.82%	100%

Source: Viral Hepatitis Mapping Project: Hepatitis B National Report 2023

Table 4. Top ten countries by estimated burden of disease from HBV and HCV

Country	Total HBV infections	Proportion of global HBV infections (%)	Total HCV infections	Proportion of global HCV infections (%)
China	79,700,000	31.5%	4,000,000	8.1%
India	29,800,000	11.7%	5,500,000	11.2%
Indonesia	17,500,000	6.9%	1,400,000	2.8%
Nigeria	14,400,000	5.7%	1,350,000	2.7%
Pakistan	3,800,000	1.5%	8,800,000	17.8%
Ethiopia	7,700,000	3.0%	692,000	1.4%
Bangladesh	7,200,000	2.9%	1,020,000	2.1%
Vietnam	6,500,000	2.6%	900,000	1.8%
Philippines	5,700,000	2.2%	400,000	0.8%
Russia	1,700,000	0.7%	2,700,000	5.4%

Source: WHO Global Hepatitis Report 2024

Hepatitis C

The overall number of HCV notifications in Australia has declined since the introduction of subsidised interferon-free direct-acting antiviral (DAA) therapy in 2016. With their associated high cure rates, and after accounting for curative treatment, mortality and new infections, there has been an estimated 58% decrease in the number of people in Australia living with chronic hepatitis C (CHC), from 162,590 people in 2016 to 68,890 people at the end of 2023 [VHMP 2024].

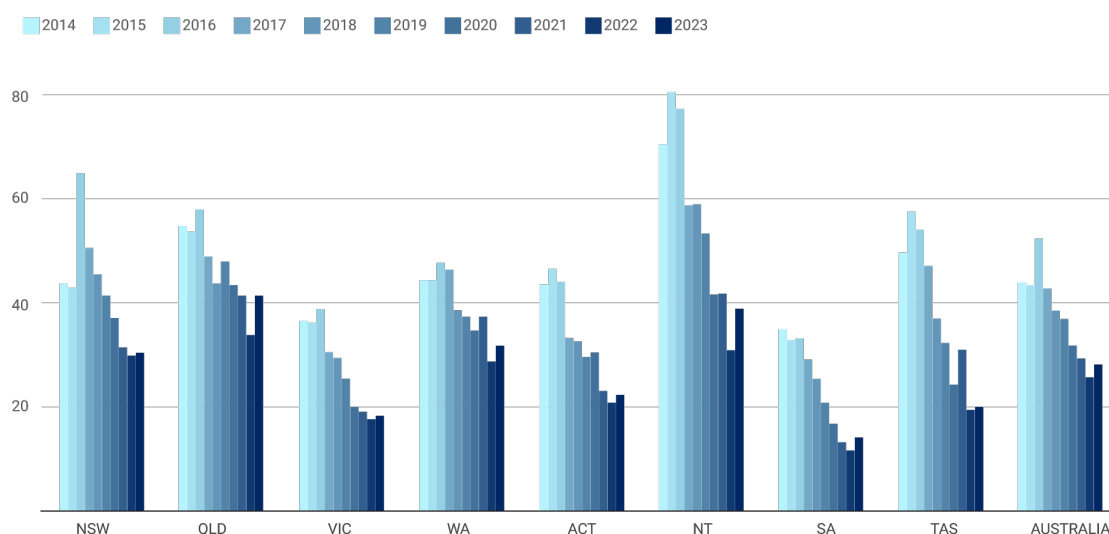
By state and territory, NSW notification rates have declined from a peak of 65.0 per 100,000 population in 2016 to 30.3 per 100,000 in 2023. This remains slightly above the 2023 Australian average rate of 28.1 per 100,000 [Fig 18]

The Viral Hepatitis Mapping Project: Hepatitis C National Report 2023-2024 indicates that priority populations for HCV risk include people with a history of injecting drugs, people with a history of incarceration, and people from high-prevalence countries. However, Australian HCV datasets are considerably less comprehensive than those maintained for HBV. Limited information on geographic distribution and no information on region and country of origin is collected, preventing further differentiation from other exposure factors.

As with HBV, international hepatitis datasets support the identification of the priority source countries associated with migration. Recognising the limitations of modelled estimations, general correlation is observable between countries with high burdens of both HBV and HCV [Table 4], pointing to broadly similar risk patterns in migrant arrivals across hepatitis B and C.

Figure 18. HCV notification rates by state and territory – Australia (2014-2023)

Notification rates per 100,000 population by state and territory.



Source: Kirby Institute UNSW Annual Surveillance Report 2024

Other STIs

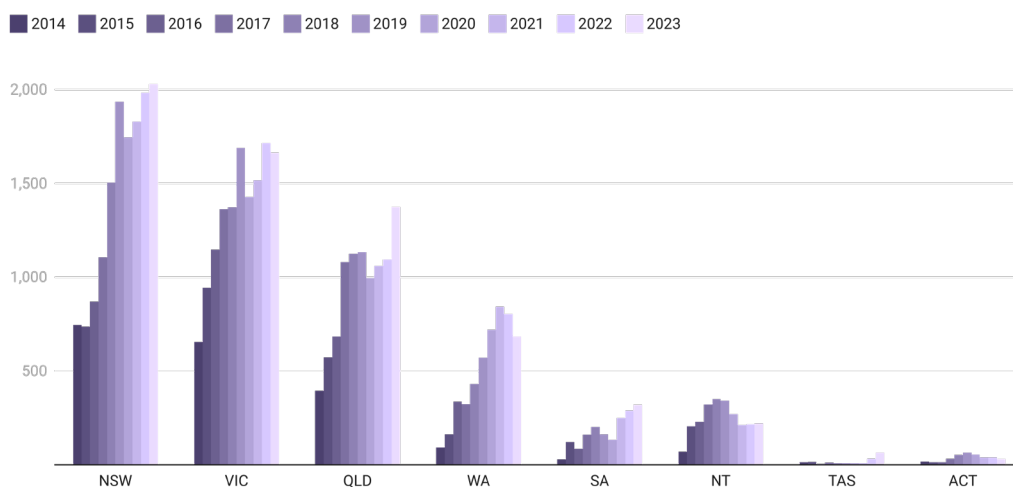
By state and territory, NSW has the highest total notifications of other STIs, with 2028 syphilis notifications, 31,237 chlamydia notifications and 12,357 gonorrhoea notifications reported in 2023 [Fig 19]. However, NT has a significantly higher notification rate per 100,000 population, associated with the larger proportion of the Aboriginal and Torres Strait Islander population. While it is well established that Aboriginal and Torres Strait Islander populations experience higher rates of STIs compared to the non-Indigenous population, national notification data collects age and location data but is not further stratified by country or region of birth.

Rising rates of syphilis notification have been reported over the last decade. Between 2014 and 2023, the infectious syphilis notification rate in NSW increased by more than 200% from 10.4 to 24.8 per 100,000 [Kirby 2024]. This trend is reflected both nationally and internationally [Fu 2019].

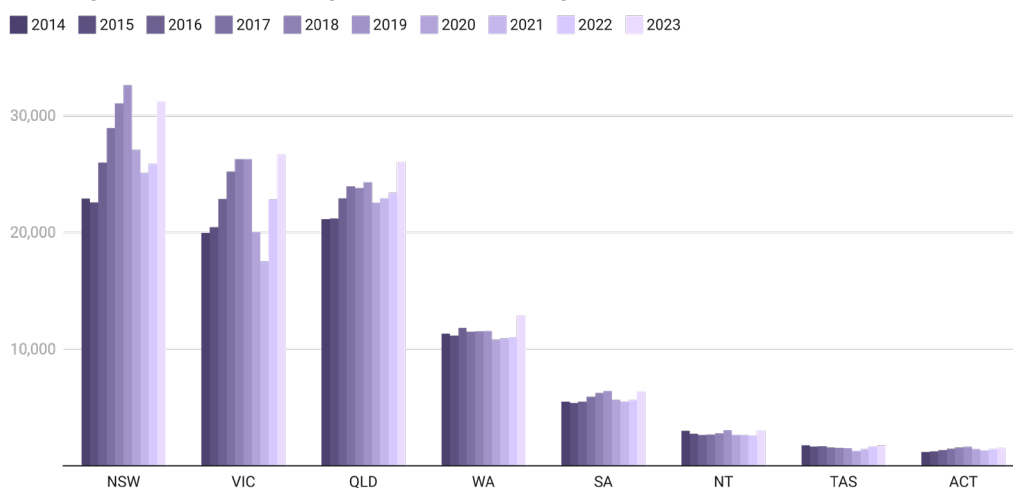
International data collection for STIs is significantly weaker and less systematic than for HIV and viral hepatitis. WHO estimates are derived from a wide range of sources and aggregated by region [WHO 2018]. These data do not allow for intercountry comparison, providing only a general overview of the global burden.

Figure19. Syphilis, Chlamydia and Gonorrhoea notifications by state and territory – Australia (2014-2023)

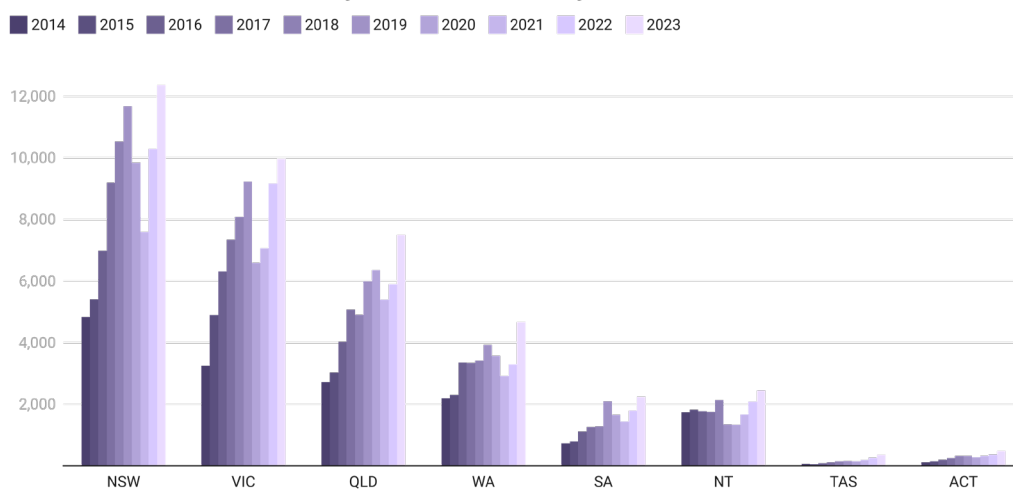
Syphilis notifications by state and territory



Chlamydia notifications by state and territory



Gonorrhoea notifications by state and territory



Source: Kirby Institute UNSW Annual Surveillance Report 2024

Future Trends and Service Implications

The transformation of NSW's population through overseas migration is directly reshaping the state's public health landscape. With overseas migration accounting for more than 80% of NSW's population growth in 2023 and 2024, the epidemiology of blood-borne viruses (BBVs) and sexually transmissible infections (STIs) is increasingly driven by migration-related factors. As shown in this report, effective future planning of BBV and STI services depends on a sophisticated understanding of how migration interacts with disease risk, access, and equity.

Migration policy can be viewed not only as a demographic input but as a strategic planning tool for anticipating future patterns of infectious disease burden and guiding investment in public health infrastructure.

This synthesis section distils the five core aspects of migration that most significantly influence BBV and STI burden in NSW: (1) the scale of migration as a demographic force, (2) higher baseline prevalence of infections in countries of origin, (3) migration-specific vulnerability factors, (4) a distinctively youthful migrant age profile, and (5) evolving service needs in response to increasing cultural and linguistic diversity.

Migration as the primary driver of population growth

NSW remains the principal receiver of overseas migration in Australia, with both temporary and permanent arrivals forming a rapidly increasing proportion of the total population. This pattern is not a short-term fluctuation but a structural shift, sustained by economic demand, education exports, and global mobility. Health systems must now assume that population growth — and therefore health demand — is predominantly migration-led. This necessitates a planning orientation that uses migration as a leading indicator for service configuration and prioritisation.

Prevalence in migrant source countries

The countries contributing the highest number of new arrivals to NSW — including China, India, Vietnam, the Philippines, Pakistan, Bangladesh, and countries in Sub-Saharan Africa and the Pacific — are also those with elevated prevalence of HBV, HIV, and other STIs. For example, migrants from North East and South East Asia experience disproportionately high rates of chronic hepatitis B, a fact reflected in Australian surveillance data showing that more than 70% of all people living with chronic HBV were born overseas.

These disparities are not simply artefacts of poor surveillance elsewhere. Many adult migrants arriving today originate from birth cohorts that missed early vaccination or treatment access. As such, they present with chronic infection that would have been preventable in a different health system context. For HIV, regional patterns of higher prevalence and lower diagnosis and viral suppression rates among migrants from Sub-Saharan Africa, Southeast Asia and Latin America highlight the need for strengthened culturally tailored engagement to support prevention and enhance participation in care.

Migration-specific vulnerabilities

Irrespective of disease prevalence in country of origin, the migration process itself introduces distinct risk factors that compound BBV and STI vulnerability. These include:

- **Language barriers and health system unfamiliarity**
- **Cultural stigma and differing health beliefs**
- **Limited access to accessible, culturally relevant information on sexual and reproductive health**
- **Visa-related restrictions on access to Medicare or public services**
- **Social isolation, transient housing, and insecure work**

Particular subgroups within the migrant population face intensified challenges. PALM scheme workers from Pacific Island nations, for instance, operate in closed, male-dominated workforces with limited community embeddedness and very low access to sexual health education. Humanitarian entrants, while medically screened prior to arrival, often face entrenched trauma and structural disadvantage post-settlement. Growth of temporary migration programs that straddle economic and international developmental objectives, and the steady post-pandemic restoration of Australia's humanitarian intake, forecasts the gradual necessary growth of multicultural BBV and STI services to meet targeted culturally responsive care needs.

Younger migrant cohort and infection risk

The younger age of migrants is highly relevant to sexual and reproductive health services. It is well established that the age group from 15 to 39 years, representing 73% of migrant arrivals compared to 33% of the Australian-born population [Fig 7], are substantially more exposed to BBV and STIs than other population segments. Australian data shows that age groups with the highest notification rates were ages 20 to 30 years for HIV (2023 data) [Kirby 2024], ages 30 to 39 years for HBV (2022 data) [Kirby 2023] and ages 15 to 24 years for HCV (2023 data) [Kirby 2024]. These peak-risk cohorts experience higher transmission rates, elevating the priority for associated health services to respond in a tailored fashion. The post-pandemic recovery of the student visa stream is particularly relevant, given the young single adult cohort and gradual uptrend in forward transition to permanent visa status.

Rising cultural and linguistic complexity in service delivery

The growing size and diversity of the CALD population in NSW increase system complexity in ways that go beyond scale. It requires a fundamental reinforcement in service design to support culturally safe, trust-building, community-based care. While it brings rich opportunities for innovation, it also presents challenges such as language diversity, heterogeneous cultural perspectives on health and healthcare, and varied trust and health-seeking behaviours. Without deliberate investment in culturally tailored models, these service access gaps risk perpetuating health inequities across migrant communities and undermining broader public health outcomes.

With migration policy settings in Australia deliberately structured around economic development and labour force growth, particularly through skilled, student, and temporary worker visa streams, there is strong certainty that these population trends will persist over the coming decades. As such, migration policy can be viewed not only as a demographic input but as a strategic planning tool for anticipating future patterns of infectious disease burden and guiding investment in public health infrastructure.

Proactive, migration-informed health service planning enables early engagement with at-risk populations and enhances the effectiveness of prevention, screening, and early treatment efforts. These strategies are particularly vital in the domain of infectious disease, where early intervention not only reduces morbidity and mortality but also delivers long-term savings to the health system and broader economic and social benefits. Key strategic recommendations to address these implications are detailed in the final section of this report.

Recommendations

1. Strengthening of co-design and targeted service planning and delivery

- Tailored service and project planning are essential to address the complexity of NSW's growing CALD population. Future activities must be co-designed with CALD communities, taking into account public health priorities, migration trends, existing services, resource gaps, and cultural relevance.
- Migration-related needs and vulnerabilities - such as Medicare ineligibility, visa-related barriers, and the distinct experiences of refugees, asylum seekers, and temporary migrants - must be explicitly reflected in health promotion and service delivery models.

2. Integration of BBV/STI-specific touchpoints into general health promotion and service pathways

- Embedding BBV/STI prevention and screening within broader health promotion and services – such as women's health, men's health, reproductive and sexual health, liver health, travel medicine - can enhance engagement from community and health providers, reduce stigma, and support alignment with wider health sector agendas, including primary health services.

3. Standardisation of data collection and strengthen utilisation practices

- Routine cross-referencing of public health datasets across state, local health district, council, and federal jurisdictions is essential for identifying priority CALD populations, understanding service demand and monitoring intervention outcomes.
- Essential minimum CALD-specific data should be consistently collected, analysed, and shared, with country-of-birth data embedded across all health data systems.

4. Advancement of research initiatives focused on CALD communities

- CALD community representation must be embedded from the outset of research design.
- Partnerships should empower CALD communities to co-lead and co-design research initiatives, combining qualitative and quantitative methods to capture nuanced and diverse health needs.

These strategies collectively provide a roadmap for embedding inclusivity, proactivity, and cultural responsiveness into health system planning, ensuring NSW's BBV and STI services remain aligned with the state's evolving demographic and epidemiological realities.



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