OVERVIEW OF HIV AND PEOPLE FROM A CALD BACKGROUND
BRIEFING PAPER

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This briefing paper draws from a discussion paper developed by the Australian Federation of AIDS Organisations (AFAO), in partnership with six culturally and linguistically diverse (CALD) and blood-borne virus (BBS) specialist organisations* and the Federation of Ethnic Communities Councils of Australia (FECCA), with input from AFAO member organisations and national organisations representing priority populations. The full discussion paper identifies specific issues and barriers to universal health care for people from a CALD background in relation to HIV and sexual health. The paper summarises key research from within Australia, as well as international research with people from CALD backgrounds in high-income countries, as well as including reference to the experiences of services providers. The final section of the discussion paper proposes recommendations that can help build on our strengths and partnerships in our response to HIV in Australia.

The full discussion paper with references for all papers can be viewed here: https://tinyurl.com/ye26awxu.

PEOPLE FROM A CALD BACKGROUND

This paper uses the term 'cultural and linguistic diversity' (CALD) as this is the terminology commonly used by the government and non-government sector. The term is often used to encompasses anyone from a non-Anglo-Celtic origin. The Australian Bureau of Statistics define CALD mainly by country of birth, language spoken at home, and English proficiency.[1] Aboriginal and Torres Strait Islander people are not included within the definition in recognition of being First Nations peoples with significantly different experiences. Prior to the adoption of the term CALD in the mid-1990s, the term Non-English Speaking Background was in common use but Commonwealth and state/territory governments dropped support for use of this term after it was seen as being oversimplified indicator of disadvantage and developed negative connotations.[1] For some commentators and academics, the term CALD has come to be seen as problematic as it can mask diversity and it can be unclear about who is included and excluded.[2,3] The Federation of Ethnic Communities' Councils of Australia (FECCA) uses the term 'cultural, ethnic and linguistic diversity' to ensure consideration of race/ethnicity and its impact on health and other inequalities.[4] One argument against use of the term 'CALD' is that the term is not used by people from a CALD background to self-describe themselves nor understood by them. However, currently there is no singular term used by different communities which captures their divergent experiences.

ENDING HIV TRANSMISSION FOR ALL

Australia has a world-leading response to HIV. It has achieved this through a strong partnership between governments, affected communities, researchers and health care providers. As a result, it has a low national HIV incidence particularly when compared to many other high-income countries.[5] The *Eighth National HIV Strategy* has an ambitious goal to achieve the virtual elimination of HIV transmission within Australia.† Advancements in biomedical prevention technologies, such as Pre-Exposure Prophylaxis (PreP), undetectable viral load (UVL), and Post-Exposure Prophylaxis (PEP) have placed this goal within reach.

Throughout the Australian HIV response, prioritisation has been accorded to the population groups most at risk. This approach recognises that some population groups have been disproportionally affected by HIV. Gay, bisexual and other men who have sex with men (GBMSM) continue to be the most affected group. But over recent years the profile of HIV in Australia has been changing, necessitating an increasing focus on people from a CALD background. Achieving an end to HIV transmission requires the inclusion of people from a CALD background in prevention, testing and treatment services, if health equity is to be achieved.

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† AFAO's Agenda 2025 identifies virtual elimination as a 90% reduction in preventable HIV diagnoses (compared to 2010 baseline).

BARRIERS TO ACCESSING HIV AND SEXUAL HEALTH CARE FOR PEOPLE FROM A CALD BACKGROUND

OVERVIEW OF HIV IN AUSTRALIA TODAY

Australia is estimated to have an HIV prevalence of 0.14%, which is very low compared to other high-income countries.[7] Over recent years, HIV epidemiology in Australia has been changing and notifications have been declining. In 2018, there was a 23% reduction in HIV notifications compared to 2014.[7] This is being driven mostly by a reduction in HIV transmission attributed to male-to-male sex, as HIV notifications among these men declined 29% between 2014 and 2018.[6] Newly acquired infections (last 12 months) declined even more rapidly among these men, at 50% between 2014-2018.

Male-to-male sex continues to be the major HIV risk exposure in Australia accounting for 59% of HIV notifications in 2019, with heterosexual notifications at 23%, male-to-male sex and injecting drug use 7% of notifications and injecting drug use 3% of notifications.[15] Male-to-male sex continues to account for the largest proportion of new HIV notifications, though this proportion has been declining.[15] By way of example, in 2015 male-to-male sex accounted for 68% of HIV notifications. From 2008 to 2018, the number of HIV notifications attributed to heterosexual sex has remained relatively stable in most states and territories, though with some fluctuations.[5]

It is estimated 28,180 people live with HIV in Australia.[7] Ninety per cent of these people are estimated to be diagnosed, leaving 10% (2,690) living with undiagnosed HIV. Among those with undiagnosed HIV, the estimated proportion was higher in people with reported risk exposures of injecting drug use and heterosexual sex, and lower among men with male-to-male sex as their HIV risk exposure. The estimated proportion with undiagnosed HIV was also higher among people born in Southeast Asia and among Aboriginal and Torres Strait Islander people.[7] Factors contributing to undiagnosed HIV, such as HIV stigma, low health literacy and lower perceptions of risk, are addressed in later sections.

HIV AND POPULATION MOBILITY

The *Eighth National HIV Strategy* identifies CALD people from high HIV prevalence countries and people who travel to high-prevalence countries and their partners as a priority population group. Particular sub-groups at risk include:[11]

- People who inject drugs from high HIV prevalence countries
- People living with HIV from high HIV prevalence countries
- Australian GBMSM acquiring HIV overseas
- Australian heterosexual people acquiring HIV overseas
- International students and backpackers
- Sex workers from CALD backgrounds

Prior to the COVID-19 pandemic, there was significant population mobility. In ten years prior to 2020, 1.9 million people in Australia were recent migrants or temporary residents, approximately half on permanent visas or having become Australian citizens.[8] In 2019, there were 500,000 international student enrolments, with a high rate of annual turnover.[9] Population mobility has been identified as a key driver of the HIV epidemic.[10] Mobility can be a risk factor for HIV acquisition, as it can result in individual behaviour change, reduced access to health services and social support.[11] People may be at risk pre-departure, during transit and at destination.[11] Mobility presents challenges to HIV prevention efforts across multiple international and domestic jurisdictions. Mobile populations can include people across a range of cultures, countries of birth, ethnicities, genders, sexualities and legal statuses.[12]

Over time migration to Australia has changed to include permanent migration, semi-migration, and people who are temporarily mobile or constantly mobile, with each experiencing their own unique challenges.[13] Understanding reasons for migration, such as whether for employment, study, escaping war and conflict, or family reunion, can help inform program design. Research has highlighted the need for programs and services to focus on migrants who experience high HIV diagnosis rates, such as Asian-born GBMSM and heterosexual men and women born in Southeast Asia and sub-Saharan Africa.[53]

CULTURAL, LINGUISTIC AND RELIGIOUS DIVERSITY IN AUSTRALIA

The Australian Census 2016 provides an overview of the cultural, linguistic and religious diversity of the Australian population.[14] Twenty-eight per cent of the Australian population were overseas born (first generation Australians) and 21% had one or both parents born overseas (second generation Australians). In total, approximately half (49%) of Australians were born overseas or had one or both parents born overseas. Among Australians who were born overseas, United Kingdom (17.7%) and New Zealand (8.4%) were still the most common countries of birth. The next most common countries of birth were China (8.3%), India (7.4%), Philippines (3.8%) and Vietnam (3.6%). Among the overseas born population, 83% live in a capital city compared with 61% of people born in Australia. Sydney has the largest overseas-born population.

One-fifth (21%) of Australians speak a language other than English at home. Of those, 82% reported speaking English very well or well and 17% reported speaking English not well or not at all. More than 300 different languages are spoken. After English, the most spoken languages were Mandarin, Arabic, Cantonese and Vietnamese. Australia is also a religiously diverse nation. Fifty-two per cent of Australians report being Christian. Islam was the second largest religion (2.6%), closely followed by Buddhism (2.4%). While the majority of Australians identify with a religion, a significant and increasing minority of Australians report 'no religion', with 30% reporting no religion in 2016 up from the 22% in 2011.