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

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HIV PREVENTION, TESTING AND TREATMENT
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.

HIV AWARENESS AND KNOWLEDGE

Research conducted with several CALD communities (Thai, Cambodian, Ethiopian, Sudanese) in Australia found that knowledge and HIV awareness was very high, though this was not surprising given the high levels of education among survey respondents (85% had attended high school, technical college or University).[18] A significant association between levels of education and HIV knowledge has been reported in studies with migrants in high-income countries.[19]

The Kirby Institute research with six CALD communities (Thailand, Cambodia, Zimbabwe, Ethiopia, Sudan, South Africa) found that 84% correctly identified that HIV can be transmitted by sexual intercourse, but that almost four-fifths were not able to correctly identify all five modes of HIV transmission.[20] The researchers concluded that respondents had both lower levels of knowledge and condom use when compared to general population surveys. Gray and colleagues' research with people from Southeast Asia and sub-Saharan Africa living in Western Australia found a similar proportion (85%) correctly identified that HIV can be transmitted by sexual intercourse but by contrast 37% of respondents incorrectly believed HIV could be acquired by mosquitos.[21] They reported that increased length of time in Australia did not appear to increase HIV knowledge. Overall, they concluded that respondents' HIV knowledge was on par with knowledge among Australian high school students.

A consultation to develop an understanding of the health needs of culturally diverse GBMSM in Melbourne identified that it should not be assumed that all migrants to Australia did not receive sex education in their country of origin.[22]

Research with migrants living in Perth found the experiences of sex education in countries of origin were varied with most sub-Saharan African participants not having been exposed to sexual health education, and for those that had received information the content was diluted and delivered mostly from a religious perspective.[23] This contrasted to Asian participants who were taught about sexual health in high schools, including some focus on HIV and sexually transmissible infections (STIs). Even when sex education occurs it may be minimal, as was reported by international students from Asian countries in Melbourne[24] or it may focus on body parts and physical development as, for example, research with young people in Vietnam reported.[25]

PERCEPTIONS OF PERSONAL HIV RISK

In summarising findings of their research with people from CALD backgrounds in Sydney, Asante and Körner found that while their mostly heterosexual participants may have knowledge about HIV risk and prevention and access to health services, they rarely applied this knowledge to themselves as they perceived their HIV risk as low.[26] The Kirby Institute survey with people from a CALD background in NSW found low levels of HIV testing, just over half of respondents reported having ever being tested, with the main reason for not testing related to a perception of not being at risk.[20] Research with migrants in Canada found similar results that people's perception about their HIV risk may be inconsistent with their actual risk.[27]

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

There are multiple factors that may influence how people from a CALD background perceive their own HIV risk. HIV transmission in Australia has mostly occurred through male-to-male sex and therefore much of the response has focussed on HIV prevention among this group. An unintended consequence is that has reinforced a perception that heterosexual people are not at risk in Australia.[28] Furthermore, the mandatory requirement for HIV testing when migrating permanently to Australia, the assumption that any applicant who tests positive will be rejected, low HIV prevalence in Australia, and low visibility of HIV in mainstream media may reinforce this perception that they are at low risk of HIV in Australia.[29] The experience of GBMSM may be different, as community surveys with Asian men in Sydney and Melbourne found that those who engaged in high levels of sexual activity were more likely to frequently seek out HIV/STI testing.[30]

HIV PREVENTION AND TESTING

Behavioural research has monitored shifts in unprotected condomless anal intercourse (CLAIC) and protected CLAIC (either via PrEP or an HIV positive person on treatment with UVL). While there has been a small decline in the proportion of Australian-born GBMSM reporting unprotected CLAIC from 2014-2018, there was no change for overseas-born GBMSM during the same period.[6] Importantly given there were concerns about uptake of PrEP among Asian GBMSM in some initial PrEP trials[31], the proportion of overseas-born men reporting protected CLAIC increased from 6% in 2014 to 27% in 2018. This was identical to the 28% Australian-born men using protected CLAIC in 2018.

Between 2010 and 2018, one data set showed that the proportion of men having had an HIV test in the previous twelve months has been consistently higher among overseas-born GBMSM compared to Australian-born GBMSM.[6] According to another data set, there was no difference. Among heterosexual people from a CALD background, a Kirby Institute study in 2016 found that just over half (54%) had ever had an HIV test.[20] This is higher than around 40% of men and women in the general community who had never been tested for HIV.[32]

HIV SHAME, STIGMA AND DISCRIMINATION

The Kirby Institute found positive attitudes towards people with HIV more prevalent than negative attitudes among people from a CALD background.[20] For example, 57% of respondents when thinking about people with HIV felt 'It was not their fault, anybody can be infected'. Similarly, Gray found that most participants had accepting views of people living with HIV, with 88% of people willing to care for a family member if they had HIV.[21] Yet despite these findings, shame, stigma and fear of discrimination have also been recurring themes in HIV research with people from CALD backgrounds.

Some Australian migrants believe people living with HIV were at fault due to 'bad behaviour', particularly given HIV transmission risk for those with multiple sex partners, homosexual people and people who use drugs.[33,35] A systematic review of the barriers to HIV testing among migrants in high-income countries found that stigma was a significant issue.[34] The review identified that HIV stigma related to association of HIV with social exclusion and rejection and death. Migrant perceptions of HIV shame and stigma have often been shaped by their experiences in their country of origin.[35,23] Migrants who knew people living with HIV in their country of origin saw how they were stigmatised in their community, being considered to have breached strong and persistent cultural norms and values around morality, sexuality and gender roles.