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

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SOCIAL AND CULTURAL ISSUES
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.

COMMUNITY AND INDIVIDUAL NORMS AND BELIEFS

Social, cultural and religious beliefs can restrict discussion of sexuality and impact upon sexual health seeking behaviour.[23,58] Sexual health has a taboo connotation in many migrants' countries of origin.[23] Gender norms has been found to be an obstacle to accessing sexual health services, particularly if migrant identities are shaped by the norms of their country of origin.[59] Women from a CALD background have said that when accessing sexual and reproductive health that providers do not have knowledge about their cultural norms, traditions and religious beliefs.[60] If people feel afraid of being judged and feel embarrassed to discuss sexual health this can act as a barrier to seeking sexual health services.[54] Southeast Asian participants in one research study described their culture as conservative, making sexual health a topic rarely discussed.[23] Even though constructions and understandings of sexual health may change, others may experience difficulty integrating new cultural values after migration.[61] However, it should be noted that not all migrants' constructions are different from those held in Australia. Dune observed that it may not be ethnic culture which drove understanding of sexual health but instead their religious beliefs.[61]

Research with heterosexual men and women from CALD backgrounds living with HIV in Australia has identified that the stigma of HIV was experienced differently by women, due to perceptions about HIV impacting women who did not behave according to the gender norms of their culture. This has led to fears of how they may be labelled and how this would reflect on their family.[65] The research has highlighted that disclosing HIV status can be influenced by gender, sexual orientation and cultural background.[65,61]

Another issue impacting on health-seeking behaviour is the cultural norm in many non-Western countries whereby the individual's needs and wishes are overridden by family and community ties and interest.

ATTITUDES AND ACCEPTANCE OF HOMOSEXUALITY

Homosexuality is still illegal in 69 countries throughout the world, including some in the Asia and Pacific region.[62] The Global Commission on HIV and Law reported that such laws have significant impact as they discourage at risk populations from getting tested and treated. Recently, there have been cultural shifts in attitudes towards homosexuality and sexuality in Asia that has impacted upon the knowledge and experience of GBMSM who migrate to Australia. Even with such progress, GBMSM must negotiate family and cultural expectations. *Writing Themselves in 3* highlighted that there is a tension for young people between their religious and CALD-specific beliefs and their same sex attraction.[63] Reeders commented that GBMSM may go through an experience of crisis in relation to their ethnic identity and sexual identity, negotiating homophobia and heterosexist beliefs in their community, as well experiencing social exclusion and discrimination from the gay community.[22] A disconnection from social support may result in sexual risk taking, as well as impacting upon mental health.

* Victorian African Health Action Network (VAHAN), Centre for Culture, Ethnicity and Health (CEH) Multicultural HIV and Hepatitis Service (MHAHS), Relationships Australia South Australia (RASA), Ethnic Communities Council of Queensland (ECCQ), Community of Practice for Action on HIV and Mobility (CoPAHM)/Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN), Curtin University.

STIGMA, DISCRIMINATION AND RACISM

Stigma, discrimination and racism can reduce access to health services and impact an individual's health and wellbeing. This may include systemic discrimination where institutions are biased in their dealing with minorities. Interestingly, the systematic review of cultural competency training referenced earlier noted that few of the studies they included within the review addressed racism and bias.[43]

'Layered' stigma associated with multiple stigmatised identities require specific attention.[64] This has been identified as a particular issue for people from culturally and linguistically diverse backgrounds (especially men who have recently arrived from countries where HIV and homosexuality stigma is higher than in Australia), and also stigma for people who are multiply labelled because of their HIV status and other practices and identities which attract stigma (such as sexual orientation, injecting drug use, sex work or co-occurring health conditions). When accessing health services, research with women from CALD backgrounds found that they often experienced racism and/or discrimination.[60] This occurs when health care workers held stereotypical assumptions about them and they were treated in negative ways because of their ethnic background. Women from CALD backgrounds living with HIV may find disclosing their HIV status problematic because of the stigma attached to HIV, and concerns about discrimination.[65] This can act as a major constraint on seeking out social and support services.[52]

Experiences of stigma and discrimination extend beyond just accessing health services, and can impact employment, accommodation, education and social exclusion. Participants in one Australian sexual health study reported that systemic discrimination was particularly present when seeking employment and accommodation.[23] These experiences have been found to deter help seeking behaviour.[23]

REGIONAL RESPONSES TO HIV

Globally, there has been recognition of the increases in HIV risk associated with mobility.[12] People from high HIV prevalence countries and people who travel to high prevalence countries and their partners are a priority population group in the *Eighth National HIV Strategy*. Targeted interventions are required to support and educate highly mobile populations who may be at increased risk, both before, during and after travel or migration.[13] Researchers have called for greater leadership to effectively implement and evaluate responses to address overseas acquired HIV within migrant and mobile populations (particularly as there is often little evidence that single strategy interventions have been effective[66]), as well as to better understand the drivers of migrations.[66] The HIV and mobility in Australia Road Map for Action[13] called for a variety of strategies including: a) better research, surveillance and evaluation, b) public health policies reflecting a human rights approach, c) a nationally coordinated, sustained response with commitment to ongoing investment and evidence-informed prevention strategies, and d) cross-jurisdictional responses.[66] Australia can play an important role in supporting HIV responses in countries in its region to ensure effective HIV testing, prevention and treatment and abolishing laws and policies that stigmatise and act as barriers.[12] This has mutual benefits for all countries in the region.