CHANGING HIV TRENDS, INSIGHTS FROM COMMUNITIES AND RECOMMENDATIONS
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.

CHANGING HIV TRENDS IN AUSTRALIA

HIV DIAGNOSES AMONG AUSTRALIAN-BORN AND OVERSEAS-BORN PEOPLE

In 2019, 47% of all HIV diagnoses were in people born outside Australia.[15] Of HIV notifications between 2014 and 2017 with male-to-male sex as the exposure risk, 70% of Australian-born men were likely to have acquired HIV in Australia whereas it was 48 per cent among men not born in Australia.[5]

Among Australian-born people who acquired HIV through heterosexual sex, 40% were likely to have acquired HIV in Australia whereas it was 17% among people born overseas. One significant limitation of this data is that they may not represent the actual proportion, as the place of acquisition was not available for between 17% to 28% of HIV notifications.

HIV notifications among Australian-born GBMSM declined by 33% between 2016 and 2018, but among overseas-born GBMSM there was only a 13% decline.[6] This small reduction in HIV notification among overseas born GBMSM is due to a sustained rise in late infections. Among the new HIV diagnoses in overseas born GBMSM, there was an increase in the proportion born in Asia from 2009 to 2018 (32% to 54%, respectively), and in Latin America and the Caribbean (8% to 14%, respectively). Among those born in high-income English-speaking countries there was a decline in the proportion of new HIV diagnoses from 2009 to 2018 (28% to 13%, respectively).[6]

Currently, there is no accurate way to assess cultural diversity among Australian-born GBMSM diagnosed with HIV. Understanding what proportion are in Anglo-Australian and people from CALD backgrounds, or how these trends may have changed over time, may highlight gaps and enable appropriate responses.[6]

LATE HIV DIAGNOSIS

Late diagnosis refers to a diagnosis of HIV where the illness has progressed. This can have significant impact on immediate and long-term health outcomes. The proportion of late HIV diagnoses in Australia has been relatively stable from 2008 to 2017, but as newly acquired infections decline late diagnoses are likely to make up a greater proportion of notifications.[5] In 2017, 48% of people reporting heterosexual sex as their exposure risk were diagnosed late compared with 31% reporting male-to-male sex. From 2013 to 2017, the proportion of late diagnoses was higher among people born in Central America, sub-Saharan Africa, and Southeast Asia.[5] The challenge of late HIV diagnoses among migrants is not unique to Australia. A systematic review of research concluded that migrants (particularly those from HIV endemic countries) to high-income countries are at high risk of HIV and have a higher frequency of delayed HIV diagnosis.[16]

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Among Australian-born GBMSM, late HIV notifications from 2009 to 2018 declined by 28%, however, late notifications in overseas-born GBMSM increased by 47%.[6] In 2018, for the first time there were more late diagnoses among overseas-born GBMSM (55%) than Australian-born (43%). Among overseas-born GBMSM with late diagnoses, HIV was more likely acquired prior to their arrival in Australia.

HIV DIAGNOSIS AND CARE CASCADE

The 'HIV diagnosis and care cascade' aims to have 90% of people living with HIV diagnosed, 90% of those diagnosed on treatment and 90% of those on treatment with viral suppression. In 2018 it was estimated that 90% of people living with HIV in Australia had been diagnosed, 89% of those diagnosed were receiving treatment and 95% of those on treatment had supressed viral load.[5] An analysis of the HIV care cascade among migrants in Australia found they had lower HIV diagnosis, treatment and viral suppression (85-85-93) compared to non-migrants (94-90-96).[17] The study reported a particularly low proportion of people living with HIV born in Southeast Asia who were diagnosed and that migrants from countries who were not eligible for reciprocal health care arrangements in Australia had lower HIV diagnoses and care cascades compared to those who were eligible.

Among HIV positive Australian-born and overseas-born GBMSM, the situation in 2018 was identical. A similar proportion of people with HIV were on treatments (95% for Australian-born and 94% for overseas-born) and among men on treatments there were no differences in viral suppression by region of birth.[6]

INSIGHTS INTO WORKING WITH CALD COMMUNITIES

This is a summary of insights from stakeholders on the approaches to working with people from CALD backgrounds that have proven effective.

BUILDING PARTNERSHIPS AND TRUST WITH COMMUNITIES

Engaging CALD communities and partnering with existing CALD community infrastructure was critical. While this may vary for different communities it may include religious organisations, social and sport groups, health professional associations, non-government organisations, and community leaders and activists. Developing relationships and building trust takes time, particularly with newly arrived immigrant populations, but it was considered important to ensure that appropriate solutions to HIV priorities are implemented that work for the community and to help build trust and confidence in the Australian health system. One-off funding or short timeframes for projects were considered significant barriers to building partnerships and trust.

ADOPTING A STRENGTHS-BASED APPROACH BY SUPPORTING COMMUNITIES

Focussing on a 'strengths-based' approach values the knowledge, skills and competencies of individuals and communities to improve their health. Supporting individuals, groups, and leaders can help communities to improve health outcomes. Having a cultural understanding, from customs, norms, traditions, history, role of family and religious beliefs, of the communities you are working with can inform how to best provide and deliver HIV programs and services. As HIV may not be the highest priority, it is important to listen, consult and partner with communities to identify how to best work together.

SUPPORTING DIVERSITY, REPRESENTATION AND INPUT FROM PEOPLE FROM A CALD BACKGROUND

Staff, peers, volunteers and people living with HIV who are bilingual and bicultural bring along their own cultural understanding of their communities providing a bridge between communities and HIV services. In addition to cultural and linguistic diversity, recognising that people have different migration experience depending on how and why they migrated. While there is not one approach, it is important to ensure people from CALD backgrounds are leading, collaborating, co-designing and/or inputting into programs, services and research that impact their communities and that there is a commitment to building the capacity of people from CALD backgrounds to participate in projects and research.

ADAPTABLE, FLEXIBLE AND SUSTAINABLE PROGRAMS AND SERVICES

A 'one size fits all' approach may not work given the differences between communities. There is a need for flexibility in the models used when implementing programs and service. A related theme was the need to develop interventions at the intersection between health and culture, so that communities are engaged in a manner that is effective and culturally appropriate. For example, one health intervention focussed on food and cooking in different cultures and another on ensuring education occurred at significant community cultural events. There has also been increasing use of innovative online HIV prevention programs. One-off or time limited interventions were often considered less effective at achieving change with mobile populations (for example, a high rate of turnover among international students requires sustainable interventions).

PROVIDING HEALTH INFORMATION IN PLAIN ENGLISH AND COMMUNITY LANGUAGES

Providing information in languages other than English should extend beyond just translation of existing resources, taking account of different cultures and how to effectively engage the audience. This is particularly the case with health advertisements that do not always translate effectively (campaign slogans and key messages are often plays on words). Rigorous pre-testing of translated and plain English resources is essential to ensure accurate understanding.

RECOMMENDATIONS

The development of the *Ninth National HIV Strategy* presents an opportunity to further invest in programs and services to help overcome the barriers for people from a CALD background in accessing HIV and sexual health services and therefore help contribute to achieving our ambitious national goal of ending HIV transmission in Australia.

HIV PREVENTION, TESTING AND TREATMENT

1. Invest in local solutions as the priority populations at risk will vary in each jurisdiction, build on the strengths of communities and implement HIV programs in partnership with people from CALD backgrounds.
2. Promote and increase access to HIV testing among overseas-born GBMSM, particularly from Asia and Latin America, soon after arriving in Australia.
3. Advocate for a policy mechanism that enables individuals who want to take PrEP, but who are not eligible for Medicare due to their visa status, to access subsidised PrEP as a public health measure to prevent HIV.
4. Explore and evaluate different options for HIV testing, such as dried blood spot testing and rapid HIV testing, and make them available in different settings to increase HIV testing uptake among people from CALD backgrounds.
5. Develop national and state/territory processes to ensure people from a CALD background input into the development, implementation and monitoring of responses to working with their communities.

STRUCTURAL BARRIERS TO ACCESSING HEALTH CARE

6. Review immigration health screening policies to ensure they do not deter people in Australia from HIV testing.
7. Support HIV organisations to implement systemic and organisational change, including providing professional development, to enable the provision and co-design of culturally appropriate services and programs for people from a CALD background.
8. Support GPs to identify people from a CALD background who may be at increased risk and maximise opportunistic testing and provide education on cross-cultural communication on HIV testing.
9. Funding to support organisations to develop HIV social marketing campaigns and resources that are culturally engaging and appropriate, tested with the audience, written in plain English and available in community languages for priority populations.

SOCIAL AND CULTURAL ISSUES

10. Use the Australian Human Rights Commission's Anti-Racism Framework to inform the next National HIV Strategy and its implementation.
11. Invest in research studies to demonstrate what interventions are effective at reducing stigma and discrimination for people from a CALD background living with and at risk of HIV when accessing health services.
12. Engage people from CALD backgrounds in all levels of policy, program, service, and research design.
13. Promote Australian government leadership on HIV in the Asia Pacific region to support effective local HIV policies, legislation and programs, particularly with mobile populations.

RESEARCH AND EVALUATION

14. Invest in evaluation to identify which HIV programs are effective at increasing HIV prevention, testing and treatment among people from CALD backgrounds.
15. Reach national agreement on CALD indicators that could be collected by HIV national surveillance (ethnicity and visa status were specifically identified), behavioural research and program evaluations.
16. Invest in regular behavioural research with migrants to better understand factors related to HIV and other STIs, in partnership with NGOs, state/territory health departments and CALD communities.