

The AFAO research briefs highlight selected research about a topic or issue relevant to the HIV response in Australia. The research briefs are intended to inform people working in HIV and sexual health policy and health promotion.

Late HIV Diagnoses in Australia

While the proportion of late HIV diagnoses¹ in Australia has been relatively stable over the ten years 2008-2017, the proportion was at its highest in 2017 (36%). Late HIV diagnosis can result in poor health outcomes for individuals, including opportunistic infections associated with AIDS.ⁱⁱ Additionally, undiagnosed HIV increases the risk of onward HIV transmissionⁱⁱⁱ.

A significant proportion of Australia's late HIV diagnoses occur through heterosexual sex. In 2017, of the 238 people reporting heterosexual sex as their exposure risk 48% were late diagnoses, this compares with 31% among men reporting male-to-male sex as their exposure risk^{iv}. Late diagnoses are higher in people born overseas and highest in those born in Sub-Saharan Africa, South East Asia, and Central America^v.

Persson, A. Brown, G., McDonald, A. & Korner, H. (2014). Transmission and Prevention of HIV Among Heterosexual Populations in Australia. AIDS Education and Prevention, 26(3), 245-255

The article by Persson and colleagues is a review of existing surveillance data and findings from research studies conducted in New South Wales and Western Australia, to highlight some of the gender, culture and mobility factors that influence HIV transmission and prevention among heterosexuals in Australia. The authors note that while HIV transmission through heterosexual sex is low in Australia there has been a gradual increase in the number of HIV cases attributed to heterosexual sex overtime (245). This upward trend has predominantly occurred among people born in countries with a high HIV prevalence, and people who have acquired HIV while travelling to countries with a high HIV prevalence (245-246). The authors also note that people from minority ethnic groups are 'overrepresented among people with a late HIV diagnosis' (248).

HIV in ethnic minority populations in New South Wales key findings

The article highlights several factors that contribute to the increasing rates of HIV among people born in Asia and Sub-Saharan African including high rates of undiagnosed and therefore untreated HIV, low levels of HIV literacy, misconceptions that Australia is HIV free, and HIV stigma that prevents people getting tested, treated or seeking information (248). While some research studies found low levels of HIV knowledge among minority ethnic populations other studies found relatively high levels of knowledge about how HIV is transmitted, good awareness of where to get a HIV test, and beliefs that health checks and HIV testing were important. However, despite relatively good HIV literacy HIV testing, engagement with prevention and use of health services were low. The authors note that the available research shows a disconnect between knowledge and individual perceptions of risk.

¹ A newly diagnosed HIV infection is defined as a late diagnosis when the CD4+cell count is less than 350 cells/uL. A CD4 of less than 350 indicating the infection may have occurred 4-5 years prior to diagnosis except if there is evidence of a negative or indeterminate HIV test in the previous 12 months or a seroconversion illness in the past 12 months.

Issues of migration, culture and gender feature in the research conducted in New South Wales in relation to low levels of use of health services, including regular HIV testing. Among minority ethnic populations these included 'Interpreting new experiences in the host country through the lens of their country of origin' where HIV meant death and ostracisation and health care had to be paid for, used only for serious illness and not for screening or preventive health. There were also gender norms in countries of origin where men controlled women's access to health services. The authors make the important observation that models or approaches to health-care in Australia may be incompatible with models of health in countries of origin: 'Neo-liberal models of health assume a rational, autonomous and informed actor who weighs cost and benefits to maximise individual gain. But for migrants from diverse and more collectivist cultural backgrounds, health care decisions are often located in broader social and cultural contexts that encompass families and ethnic communities' (249).

Overseas acquired HIV Among Men in Western Australia key findings

In Western Australia, between 2006-2010 there was a significant increase in the number of men reporting heterosexually acquired HIV. Most of these men reported being infected while overseas, commonly in Thailand and Indonesia. The authors note that people from Western Australia travel more frequently to these two countries than other Australians, because of their proximity to Western Australia. The article reports on the findings from a qualitative study of men who had acquired HIV while travelling in a high prevalence country. Key findings of the study were that the men perceived themselves to be experienced travellers or expatriates, had limited familiarity with HIV prevention campaigns, and did not test regularly for HIV and, therefore, tended to be diagnosed later. Their sexual practices changed as a result of being in a different cultural context and in a different emotional space.

Conclusion

The authors argue that while the HIV response in Australia has rightly been directed at gay men this has had the unintended consequence of making HIV largely invisible in the broader society and of marking heterosexuality 'as safe and as exempt from risk' (252). The authors propose that the relatively distinct populations of heterosexuals affected by HIV creates opportunities for targeted health promotion, for example targeting heterosexual men who travel to high prevalence countries with messaging that taps into their desire for connection with the local culture and their desire for adventure and new experiences, including new sexual experiences. In relation to minority ethnic communities the authors identify the need for greater cultural competency across the health system and initiatives to support immigrants, in particular strategies that assist women from ethnic minorities to transition to full citizenship and research to better understand the complex nature of HIV stigma and the implications of stigma for peer-based programs in ethnic communities.

Gray, C., Crawford, G., Reid, A. & Lobo, R. (2018). HIV Knowledge and use of health services among people from South-East Asia and Sub-Saharan Africa Living in Western Australia. Health Promotion Journal of Australia, doi: 10.1002/hpja.168

The article reports on findings from a cross sectional survey investigating HIV knowledge and use of health services among adults eighteen years and older born in sub-Saharan Africa and South-East Asia who arrived in Australia in the past 10 years, living in Perth, Western Australia. Of the 209 people who completed the survey, there were 163 from South-East Asia and 46 from Sub-Saharan Africa, 132 women and 77 men. Half of the participants had been in Australia for less than two years, only 28% of the participants were citizens or permanent residents and 139 participants were on temporary student visas.

Key findings

HIV knowledge was generally good, but incorrect beliefs were also common. 69.9% of participants correctly identified that condoms can protect against transmission, 85.2% knew that HIV could be acquired through sexual contact, however, 36.8% incorrectly believed that HIV could be acquired through mosquitos and 23% through sharing food. Men were more likely than women to know that condoms protect against HIV transmission (86.4% compared to 65.9%) but there were no other significant differences between men and women. While the majority (92.3%) thought testing was important only 34.4% had ever tested. The reasons for not testing included not engaging in risk behaviours (55.9%), not liking needles or blood tests (10.5%), not knowing where to go (8.6%), difficulty finding time (8.1%) and cost (8.1%). The most common reasons for being tested were for getting a visa (50%) and as part of a regular check-up (31%), of those who had previously tested for HIV most had occurred overseas (65.3%). Of the 50% of participants who had had sex in the previous 12 months 62.8% had not used a condom during their last sexual encounter. However, only 2 participants reported not being in a relationship with the person they had sex with. Barriers to accessing health services included the cost (32.1%), getting an appointment (19.6%) and difficulty finding the time (17.2%). The authors note that it is unsurprising that cost was reported as a barrier to accessing health services given almost half the participants did not have access to Medicare.

The study found inconsistencies between knowledge and behaviour, for example, while 23% of participants thought HIV could be transmitted by food sharing, 41% said they would not buy fruit and vegetables from a shop keeper they believed to have HIV. Nonetheless, most participants had accepting attitudes to people living with HIV. Participants who had arrived more recently i.e. less than 2 years, were more likely to report having concerns about being treated differently if they received a positive result from a HIV test. It was unclear whether they were concerned about stigma from among their social groups or whether it related to broader level fears about deportation or being reported to authorities. People who had lived in Australia for more than two years were more likely to have travelled overseas (91.5% compared to 43%) than those who had been in Australia for less than two years. Just over a third (35%) of participants had travelled to another country while living in Australia with 30 participants travelling to a high prevalence country. Five participants reported having sex in a high prevalence country and two reported not using a condom.

Conclusion

The authors observe that despite relatively good knowledge of HIV transmission, uptake of HIV testing is very low among people born in Sub-Saharan Africa and South-East Asia. They argue that this finding highlights the need for interventions that 'extend beyond knowledge'. To address the low rates of testing, the authors call for more culturally appropriate ways for people from these regions to test for HIV, including the use of self-collection samples delivered by bilingual community workers, or rapid HIV testing. They also recommend interventions targeting people who frequently return to their country of origin to promote safe sex while away and testing upon return. They also advocate the development of strategies to address HIV related stigma in these communities.

Implications for policy and practice

Together these two articles suggest that addressing late HIV diagnosis will involve attending to the disconnect between knowledge and self-perceptions of HIV risk among people who travel from or to countries with high HIV prevalence, particularly heterosexuals. Migration and mobility are key factors in late HIV diagnosis and both articles show that increasing HIV testing among minority ethnic populations will involve understanding and addressing the specific culture and gender norms that shaped their health seeking practices in their countries of origin.

Suggestions for further reading

Botfield, J., Newman, C., & Zwi, A. (2017). Drawing them in: professional perspectives on the complexities of engaging 'culturally diverse' young people with sexual and reproductive health promotion and care in Sydney, Australia. *Culture, Health and Sexuality*, 19(4), 438-452. Doi.org/10.1080/13691058.20161233354

Crawford, G., Maycock, B., Tobin, R., Brown, G., & Lobo, R. (2018). Prevention of HIV and other sexually transmissible infections in expatriates and traveller networks: Qualitative study of peer interaction in an online forum. *Journal of Medical Internet Research*, 20(9). Doi: 10.2196/10787

Collaboration for Evidence, Research and Impact in Public Health. (2018). "I want to test but I'm afraid": Barriers to HIV testing among people born in South East Asia and sub-Saharan Africa: Final report. Perth, WA: Curtin University

Gullón, A., Verdejo, J., de Miguel, Gómez, A., & Sanz., J. (2016). Factors associated with late diagnosis of HIV infection and missed opportunities for earlier testing, *AIDS Care*, 28(10), 1296-1300. Doi: 10.1080/09540121.2016.1178700

Medland, N., Chow, E., Read, T., Ong, J., Chen, M., Denham, I., Gunaratnum, P., & Fairley (2018). Incident HIV infection has fallen rapidly in men who have sex with men in Melbourne, Australia (2013–2017) but not in the newly arrived Asian-born. *BMC Infectious Diseases*, 18, 410, doi.org/10.1186/s12879-018-3325-0

Peach, E., Lemoh, C., Stooze, M. Aguis, P., El Hayek, C., Higgins, N. & Hellard, M. (2018) Aiming for 90-90-90 – the importance of understanding the risk factors of HIV exposure and advanced HIV infection in migrant populations and other groups who do not report male-to-male sex, *Sexual Health*, online first 15 October 2018 doi.org/10.1071/SH17192

Rade, D., Crawford, G., Lobo, R., Gray, C. & Brown, G. (2018). Sexual Health Help-Seeking Behaviour among migrants from Sub-Saharan Africa and South East Asia Living in high income countries: A systematic review, *International Journal of Environmental Research and Public Health*, 15, 1311, doi:10.3390/ijerh15071311

ⁱ Kirby Institute, 2018. *HIV in Australia: Annual surveillance short report*. Sydney, Kirby Institute, UNSW Sydney.

ⁱⁱ <http://hivmanagement.ashm.org.au/index.php/hiv-management-for-nurses-and-midwives/late-presentation-of-new-diagnosis>

ⁱⁱⁱ Ibid

^{iv} Kirby Institute, 2018. *HIV in Australia: Annual surveillance short report*. Sydney, Kirby Institute, UNSW Sydney.

^v Ibid