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“This is How We Live”:

Perceptions of HIV Risk amongst

Heterosexually Identifying Migrants in Australia

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Collaboration for Evidence, Research & Impact in Public Health, Curtin School of Population Health



SIREN

WA Sexual Health and Blood-borne Virus
Applied Research and Evaluation Network

CoPAHM
Community of Practice
for Action on HIV & Mobility

Acknowledgement of Country

We would like to acknowledge the Whadjuk Noongar people, the traditional custodians of the land we meet today, and pay our respects to the Elders, past, present, and emerging.

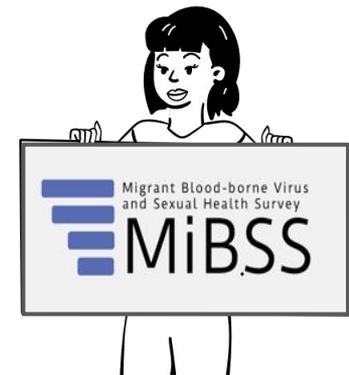


Background

- Increase in **HIV notifications** over the last decade in Australia
 - Specifically among migrants from **CaLD backgrounds** from sub-Saharan Africa (**SSA**), Southeast Asia (**SEA**), and Northeast Asia (**NEA**)
- Research shows *some* data about risk and knowledge → **no national picture**

Migrant Blood-borne Virus and Sexual Health Survey (MiBSS)

- First national survey of migrants from CaLD backgrounds around sexual health and blood-borne viruses
- Most recent survey identified there were still gaps in knowledge and awareness



Research Overview

Ethics Approval: HRE2019-0395-32



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Perceptions of HIV risk amongst heterosexually identifying migrants from Culturally and Linguistically Diverse (CaLD) backgrounds in Australia

→ Participants completed **~45 minute** semi-structured **interview** via WebEx or phone

February 2022:

Research design commenced

May 2022:

Ethics approval granted

August - October 2022:

Recruitment and interviewing

November 2022:

Reflexive thematic analysis and compilation of findings

Recruitment

- Study developed in consultation with:
 - *Office of Multicultural Interests (OMI)*
 - *Sexual Health Information Networking and Education South Australia (SHINE SA)*
 - *Relationships Australia (RASA)*
 - *Ethnic Communities Council of Queensland (ECCQ)*
 - *Ethnic Communities Council of Western Australia (ECCWA)*
 - *Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN)*
 - *ODYSSEY Migration & Mobility in Public Health Research Hub*

→ Assisted with promotion and recruitment
- Location: open **Australia-wide**
- Sampling type: purposive and snowball sampling



Participants

Requirements

- All aged **18 years** or older
- Min. **6 months** living in Australia
- All identified as **heterosexual/straight**

Our Sample = 16 participants

- **13 female, 3 male** (sex/gender entered manually, no other options entered)
- **4 from SSA, 7 from SEA, 5 from NEA**
- Located in **QLD, SA, and WA** → **WA participants (n=6)**
- More than **50% aged 35 years or older**
- Most employed or volunteered within **health or community** roles



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PERCEPTIONS OF HEALTH RISKS AMONGST PEOPLE BORN OVERSEAS

INTERVIEW PARTICIPANTS WANTED

WHO ARE WE LOOKING FOR?

We are looking for participants to take part in an online interview exploring beliefs, attitudes and perceptions surrounding HIV risk.

This interview will take up to an hour of your time and your responses will be kept confidential.

REQUIREMENTS

- Must be at least 18 years old
- Born in Sub-Saharan Africa, Southeast Asia or Northeast Asia
- Lived in Australia for at least six months
- Identify as heterosexual
- Able to participate in an online interview conducted in English

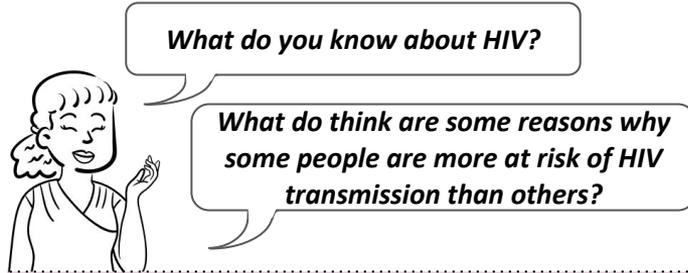
REIMBURSEMENT

Participants will be offered an **e-gift card** for their participation and time.

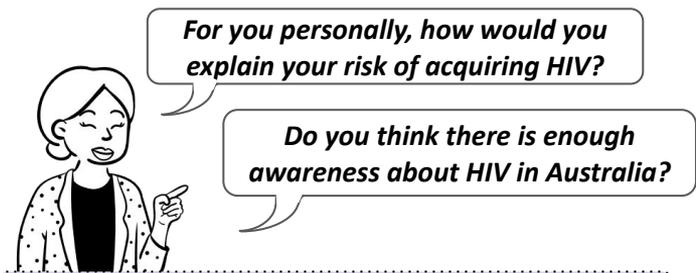
Scan the QR code or email migranthealthstudy@gmail.com for further information and/or to take part in this study

Curtin University Human Research Ethics Committee has approved this study (HRE2019-0395-32)

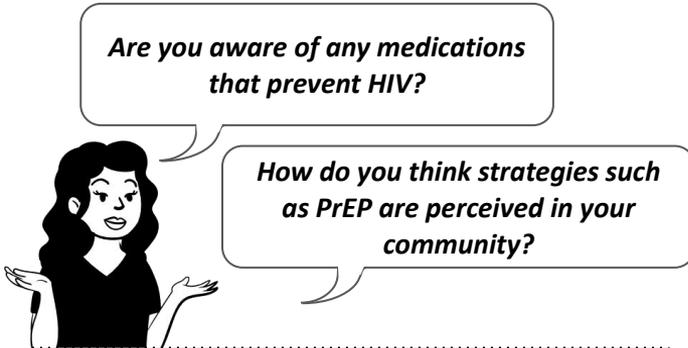
What We Asked



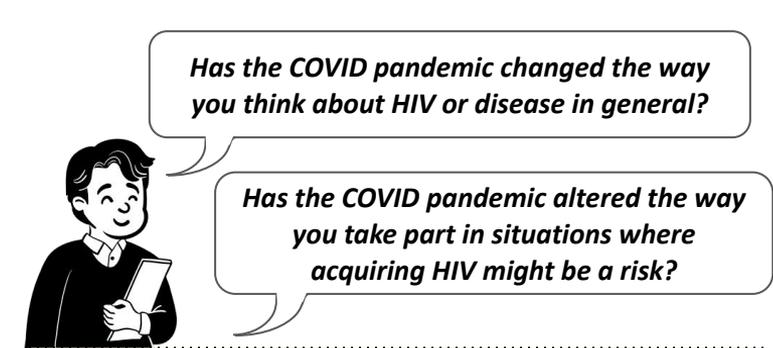
Understanding of and Susceptibility to Risk



Risk Assessment and Management

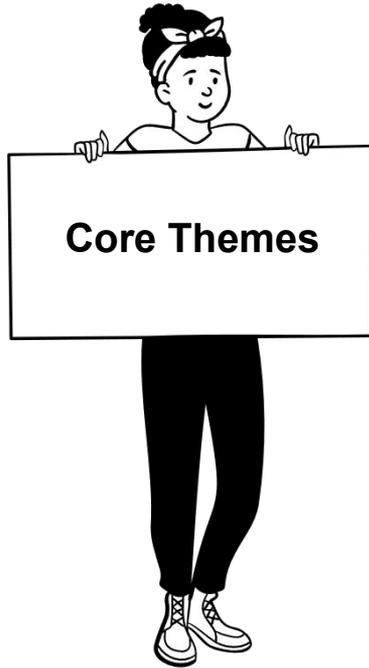


Risk Influencing Uptake of PrEP



COVID's Influence on Risk Engagement

What Else?



Stigma and Personal Responsibility



Awareness, Access, and Low Perceived Risk



Differing Socio-Cultural Attitudes



Proximity vs Distance



Stigma and Personal Responsibility

Findings:

- Data from **every interview** noted **stigma**
 - Associated with acquiring HIV and preventing HIV
- Links to “*immoral*” or “*indecent*” behaviour
 - Victim blaming
 - Locus of control in HIV prevention (**internal vs external**)
 - Less judgement of non-sexual transmission
- Stigma surrounding **PrEP**
 - PrEP is for “*those people*”
 - Judgement of PrEP use despite low awareness of it
 - Shame attached to PrEP use despite prevention of HIV

“If someone is HIV positive it means they have not behaved properly”

“It’s kind of shame if you go to the doctor and ask for the HIV test, they kind of look at you like what have you done?”

“PrEP should not be needed in very healthy relationships”

“Maybe PrEP is okay for people who don’t really want to be careful and are still happy to go with unsafe activities...I mean, PrEP is for who? I’m not going into those activities therefore I don’t need PrEP”

Awareness, Access, and Low Perceived Risk

Findings:

- More knowledge about HIV and broad risk than expected
→ “**Death sentence**” turned **liveable disease**
- Limited awareness of **PrEP**
→ Reluctance to use and limited awareness of access
- Lack of **visibility** in Aus → more **trust** in Aus healthcare
→ Contrast of treatment **availability** in countries of origin
→ Language as a barrier to access
- Majority stated they didn’t think they were at risk “**at all**”
→ Lack of engagement in “**risky behaviours**”
→ Risk assessment becomes more considered as one ages

“It’s quite different from Australia, people don’t promote testing and we don’t have to ask for a test. I don’t think they are free either, we need to go straight to the hospital where there are hundreds of people around”

“It’s not my case but if other people in my community cannot understand English very well it’s very difficult for them to access HIV related services”

“[My risk] is not high, but it doesn’t mean that I do not have risk for it. Because we don’t know what is happening behind our back”

Differing Socio-Cultural Attitudes

Findings:

- **Discriminatory disease**
 - HIV associated with behaviours **stigmatised** in some cultures (ie. non-monogamy, drug use)
 - Judgement directed at **behaviour** rather than HIV
- Sexual health **education** and **awareness** in countries of origin
 - Most stated limited exposure
- **Transnational beliefs**
 - **Conservative attitudes** towards discussion of sexual health
 - Testing is not normalised
 - Barrier to help-seeking and prevention

“Especially CaLD people like me, we don’t speak about sex. For people who are at really high risk for HIV they will never go to these places [sexual health clinics] to learn more about HIV in Australia”

“HIV is not really frowned upon it’s maybe being gay or having so many partners and being sexually active before getting married”

“Polygamous families is quite rampant in Africa... so it becomes tragic web. If one of the people in that web becomes infected, subsequently everyone is at risk”

Proximity vs Distance

Findings:

- **Personal experience** (direct or indirect) altered participant perceptions of risk
→ Lack of exposure = **indifference**
- Influence of **migration**
→ **Higher standards** of health expected in Aus
→ COVID impact = behavioural measures **reduced** HIV-risk by proxy
- Contrast with visibility and impact of **COVID**
→ **Fear** associated with visibility of death
→ Lack of HIV visibility = “**it doesn’t seem to be a big deal here**”

“Because I can see the risk I understand them more. Maybe to other people the availability of services can affect their perception of risk. Because if we’re not talking about it we’re not thinking about it and if we’re not thinking about it we’re not preparing for it”

“People know about HIV but they don’t know enough people in their lives with HIV. So they might just be very indifferent to it”

“When I was in my country of birth I was like oh it’s so dangerous and so scary if somebody has HIV it’s like the end of the world. After I moved to Australia I got another perspective because I know as long as you take your medications or you have treatment you can live as normal”

Strengths

&

Limitations

- Building on MiBSS study enabled purposeful recruitment and sampling
- Online and telephone interviews enabled anonymity of participants and allowed national participation
- Capacity building of participants through providing information that was not previously known to them
- Community referrals aided in recruitment through snowball sampling

- De-identification of participants potentially represented participants and migrants as homogenous
- Digital literacy as a barrier to conducting online and telephone interviews
- Sampling method → overrepresentation of participants in health/community roles with high health literacy
- Data is a snapshot and does not represent the experiences of all migrants from CaLD backgrounds

Take Away Points

- Greater need for visible and widely understandable public health messaging outside of dedicated sexual health spaces (particularly re: PrEP)
- Migrants from CaLD backgrounds are diverse → they cannot be homogenised nor would a universal approach to HIV prevention be appropriate
- More visibility and information about HIV is needed for communities of migrants from CaLD backgrounds
- Reliance on healthcare professionals should be utilised to decrease stigma and increase community reception
- Interventions/recommendations from peers/community-led services were considered to be highly effective by our cohort



That's a Wrap!

Thank you again to the organisations and participants who contributed to this research, we appreciate your time and dedication.

Questions?

For more information about HIV in migrant and mobile populations:

Visit: www.odysseyresearch.org

Email: COPAHM@curtin.edu.au

