Curtin University

Hard critique of 5 years since the *HIV & Mobility in Australia: Roadmap for Action.* What has changed?

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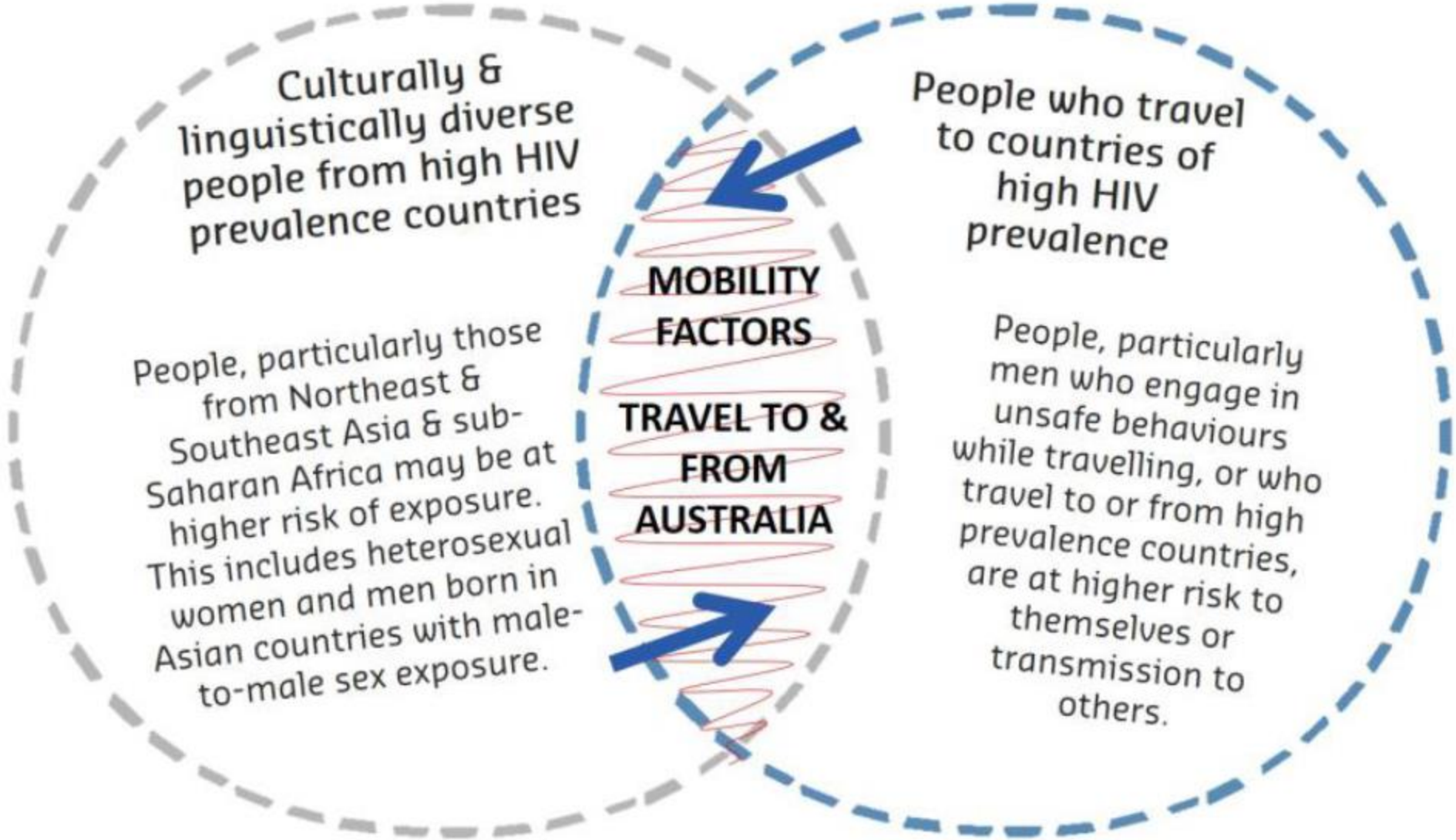
HIV & MOBILITY: WHAT ARE WE TALKING ABOUT?



Adapted from Crawford, G (2014). Australian travellers, relationships & risk: exploring the nexus.

HIV AUSTRALIA

People on the move: implications for meeting Australia's 95:95:95 targets by 2022

By Dr Roanna Lobo, Corie Gray, and Gemma Crawford

With over one billion people moving across the world in 2018 [1], mobility is an increasingly important driver of infectious diseases including HIV. The way we conceptualise and respond to HIV in migrant and mobile populations is a global challenge. This is in part because mobility is continuous and complex, and does not by itself, or always, increase HIV risk. Gaps remain in the available data for migrant and mobile populations related to behavioural, social, political, economic and environmental risk factors. To enable effective, tailored responses for populatio
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responses needed to address HIV and mobility. All have consistent messages about targeting mobile groups in local responses and ensuring programs are responsive to the unique needs of mobile populations.

The UNAIDS report 'Fast-Track: Ending AIDS by 2030' in 2014 set an ambitious goal of achieving the 95:95:95 targets[5]. This means: 95% of people living with HIV knowing their HIV status; 95% of people who know their status on treatment; and 95% of people on treatment with suppressed viral loads.

66.7%

culturally and linguistically diverse

prevention and treatment and abolish stigmatising and detrimental laws and policies which may facilitate HIV acquisition or punish those who acquire HIV. This has mutual benefits for all countries in the region since mobility drives transmission of infectious diseases across borders.

Recognising complexity

'Mobile populations' is a broad term gaining currency which includes people across a range of genders, cultures, countries of birth, ethnicities, and legal

ons

highly variable, often making it difficult

WHAT ARE THE ISSUES?

Who do we target for health promotion? How do we reach them?
Travellers, migrants and MSM who are not connected to the gay community are not getting the education around HIV prevention, early testing, and medications available

Migrants may have reasonable knowledge of HIV transmission but readiness to test is influenced by:

- **previous experiences** in their country of birth – stigma, cost, exclusion
- **low visibility of HIV** and perceptions of **'safety'** in Australia
- **low awareness of HIV risk** – people don't see themselves at risk and therefore don't seek testing or medications to prevent HIV
- **language and cultural barriers** – many local dialects, low accuracy of translation, fear of confidentiality, low literacy
- **other priorities** – employment, housing, trauma

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WHAT ARE THE ISSUES?

Diversity and complexity – huge cultural diversity, refugees, international students, migrants, expats, travellers, GMSM, PWHIV, heterosexual women

Intersectionality – e.g. Asian gay men, migrant PWHIV or migrant sex workers …

Stigma and discrimination - fear of a positive diagnosis, *"double stigma"* (migrant AND living with HIV), migrants not welcomed, concerned about contact with 'authorities', fear of *"being seen as using too many resources"*

Service-level barriers – navigating the health system, AIDS Councils (?), Medicare-ineligible temporary residents, lack resources to offer holistic services, uncertainty about what they can offer to whom

Workforce cultural competency – individual focus, lack knowledge of traditional gender roles, health beliefs and role of religion

These issues are increasingly acknowledged across all jurisdictions and contribute to later diagnoses, poor health outcomes, and a public health risk if people remain undiagnosed or untreated

Five Areas for Action

Five areas for action are proposed. The overall goals and strategies related to each of these action areas are outlined in the tables below. They include the proposed primary responsibilities and suggested timeframes.

More activity is needed in some areas than others, however there should be a commitment to activity in all areas.

1. International Leadership and Global Health Governance
2. Commonwealth and State Leadership
3. Community Mobilisation
4. Development of Services for Mobile or Migrant People and Groups
5. Surveillance, Research and Evaluation.

There are likely to be associated resource implications for the groups suggested for primary responsibility for particular strategies. In addition, given the changing epidemiology of HIV infection in some locations in Australia (WA, north QLD, SA) some consideration of equity in resourcing responses (including national research) is required. CW government buy-in and support for these strategies will be necessary in some cases, and the associated lead-in times for advocacy and budgeting would need to be considered. It should be noted that specific recommendations for action concerning particular priority populations have been detailed elsewhere.[K] The five areas for action presented here should be considered in conjunction with other recommendations for mobile and migrant communities.

https://siren.org.au/hiv-mobility/

Road map to address HIV and mobility issues

Published in 2014

71 strategies in 5 action areas

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On reflection, maybe this was a bit overwhelming . . .

COMMUNITY OF PRACTICE FOR ACTION ON HIV AND MOBILITY (COPAHM)

The national CoPAHM aims to progress the Road Map action areas and ensure that migrant and mobile populations are part of the ongoing dialogue on HIV prevention, treatment and support.

1. Established by Curtin University in 2015 with funding support from WA Department of Health Sexual Health & Blood-borne Virus Program
2. More than 80 members across all jurisdictions from government and non-government organisations, research institutions, community groups, and national peak bodies who are interested in HIV & Mobility issues
3. Virtual community for knowledge sharing and collaboration
4. Facilitates policy, research and practice efforts regarding HIV and mobility
5. Local CoPAHMs (or similar) in SA, VIC, QLD and WA.

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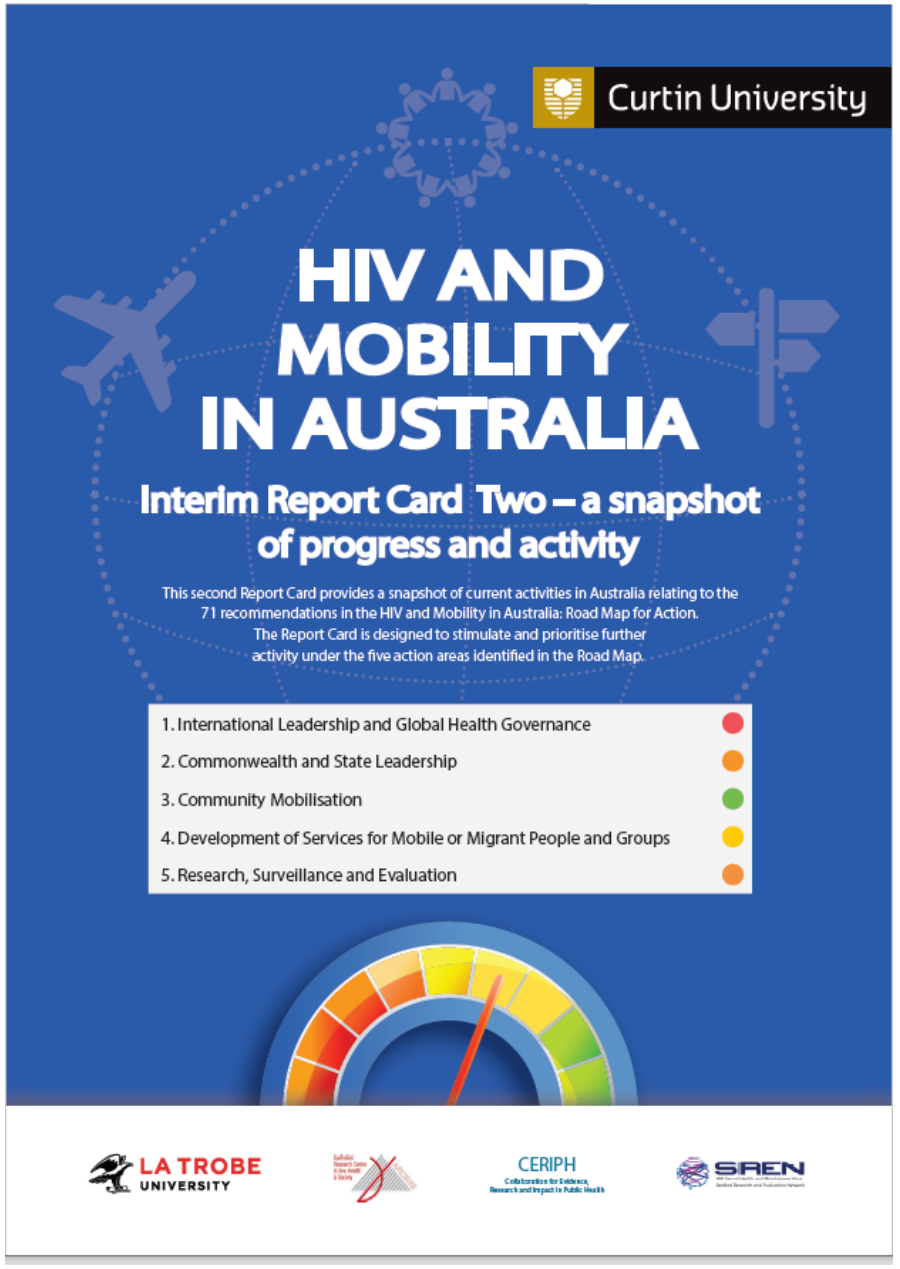

Report Card One 2015

Report Card Two 2016

We are observing many small scale, targeted responses in isolation, but no coordinated efforts, and a risk that short term programs will discontinue when funding stops

WHAT HAS CHANGED SINCE 2015?

2015: ATRAS[1] 2 year follow up study, NAPWHA and Kirby Institute found it was cost neutral to provide treatment to 180 Medicare-ineligible temporary residents and this averted 81 new HIV infections

2016: U=U[2] Consensus statement endorsed by 910 organisations in nearly 100 countries

2016-ongoing: Stigma Indicators Monitoring Project, global commitments to reduce HIV-related stigma and discrimination

2016-2018: EPIC-NSW/ACT, QPrEP, PrEPX (VIC, TAS, SA), WA PrEPIT

2017: 937 new HIV diagnoses, down from 1,013 in 2016

2018: Availability of PrEP on the PBS

2018: HIV self testing kit approved by TGA

2018: *"Culturally and linguistically diverse people from high HIV prevalence countries, people who travel to these countries, and their partners"* prioritised in 8th national HIV strategy

2019: MI-EPIC – Medicare Ineligible Expanded PrEP trial NSW

[1]Australian HIV Observational Database Temporary Residents Access Study
[2]Undetectable viral load = Untransmittable virus

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Our success in treating and containing the spread of the virus has highlighted inequalities and disparities for key populations

More than 24 Australian studies including 6 scoping or systematic reviews, and many media articles and conference papers

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WHAT HAVE WE LEARNED?

- Increasing overseas acquired HIV in heterosexual Australian expatriates, long term and frequent travellers to regions of high HIV prevalence
- The epidemiology of HIV amongst overseas-born populations in Australia is complex and changing
- High HIV diagnosis rates in migrant populations - Asian-born MSM, South-East Asian and Sub-Saharan African born heterosexual men and women
- Medicare ineligible people are four times more likely to become HIV positive in the four years after arriving in Australia compared to their local peers and have delayed HIV diagnosis.
- Very low uptake of HIV testing among people born in sub-Saharan Africa and South-East Asia

WHAT HAVE WE LEARNED?

- Most interventions focused on individual migrant behaviour, consisting of a single strategy, with few addressing wider sociocultural factors, including the role of family and religion
- More targeted, culturally appropriate interventions that address the known barriers to HIV testing need to be implemented to increase early diagnosis and prevent onward transmission of infection
- Critical need for more comprehensive interventions that consider both individual and broader socioeconomic and sociocultural factors associated with HIV testing and utilisation of sexual health care services
- Challenges collecting reliable data and gaining adequate participation of migrant and mobile populations in research

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Many sociocultural and structural barriers to testing and treatment, responses and intervention efforts are not community-led or peer-led

RESEARCH HIGHLIGHTS

- Analysis of data to identify populations with late diagnoses, low uptake of testing, treatment and prevention technologies and changing epidemiology
- Exploratory and intervention research with specific communities including co-design intervention research
- Innovation in research methodologies to increase cultural appropriateness and participation of communities in research and improve quality of data (e.g. peer researchers, ACASI[4], walking interviews)
- Consideration of extending the GCPS[5] to overseas-born gay and bisexual men, and bisexual and heterosexual men who have sex with men
- ARC Linkage project (MiBSS[3]), Curtin University – migrant blood borne virus and sexual health behavioural surveillance survey (2018-2022)

[3]Migrant Blood-borne virus and Sexual health Survey
[4]Audio Computer-Assisted Self Interview
[5]Gay Community Periodic Survey

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Migrant Blood-borne Virus and Sexual Health Survey

MiBSS

- 4 year study led by Curtin University, Perth WA
- Collaboration of 10 NGOs and multicultural services, peak bodies, 3 Health Departments (WA, VIC and SA), Kirby Institute, ARCSHS, and CSRH
- Study extended to Qld in 2019 with ASHM funding
- Mixed methods design to increase participation of diverse groups

Research questions

1. Feasibility of implementing a periodic STI/BBV behavioural surveillance survey in CALD populations from SEA and SSA (~1800 sample)
2. Qualitative inquiry to inform development and testing of survey tool
3. Effectiveness of recruitment and survey methods – peer researchers, online, social media, F2F, ACASI

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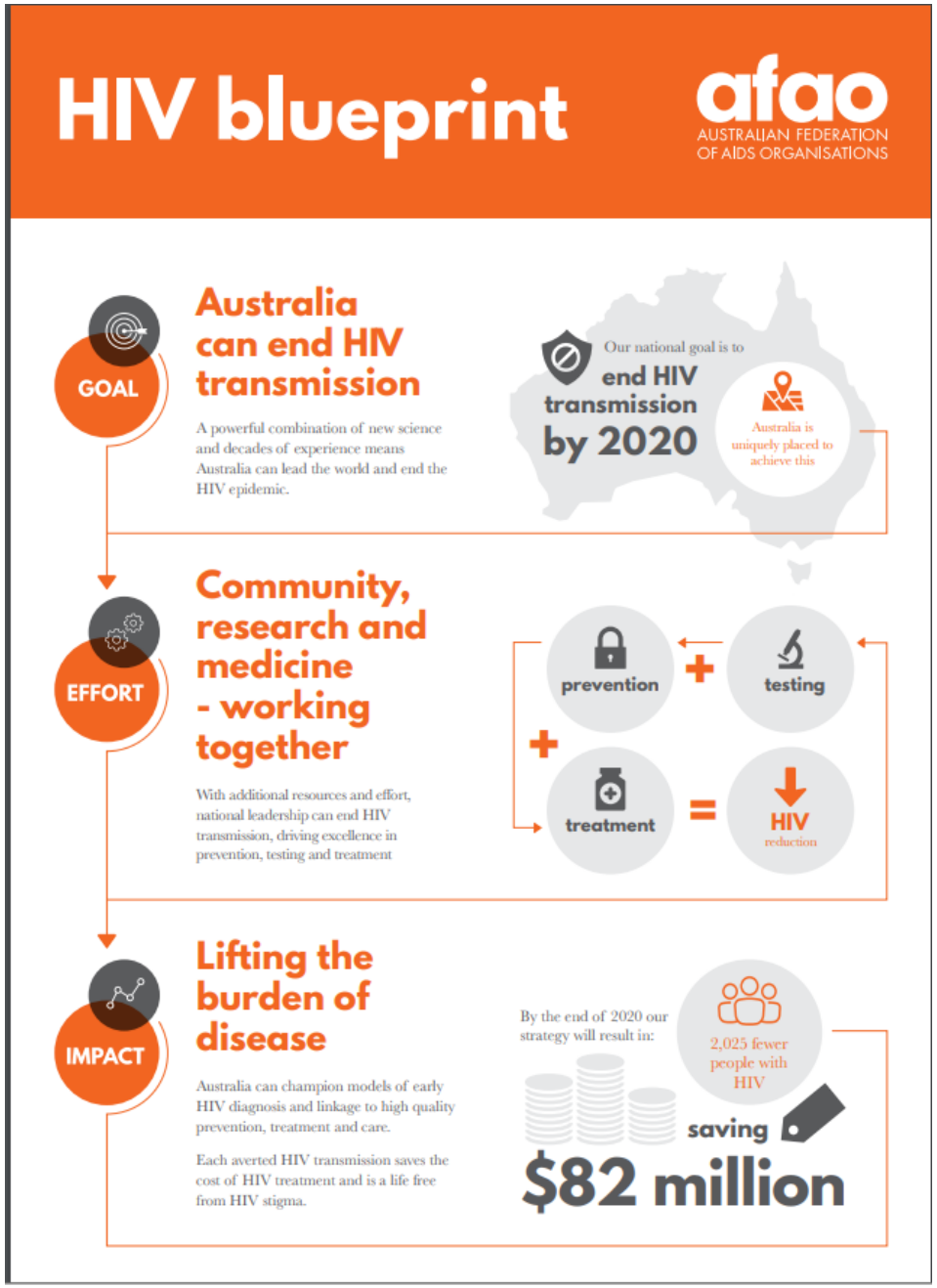
Australia has the tools and the know-how to *"virtually end new HIV transmissions by 2022"* if inequalities are addressed



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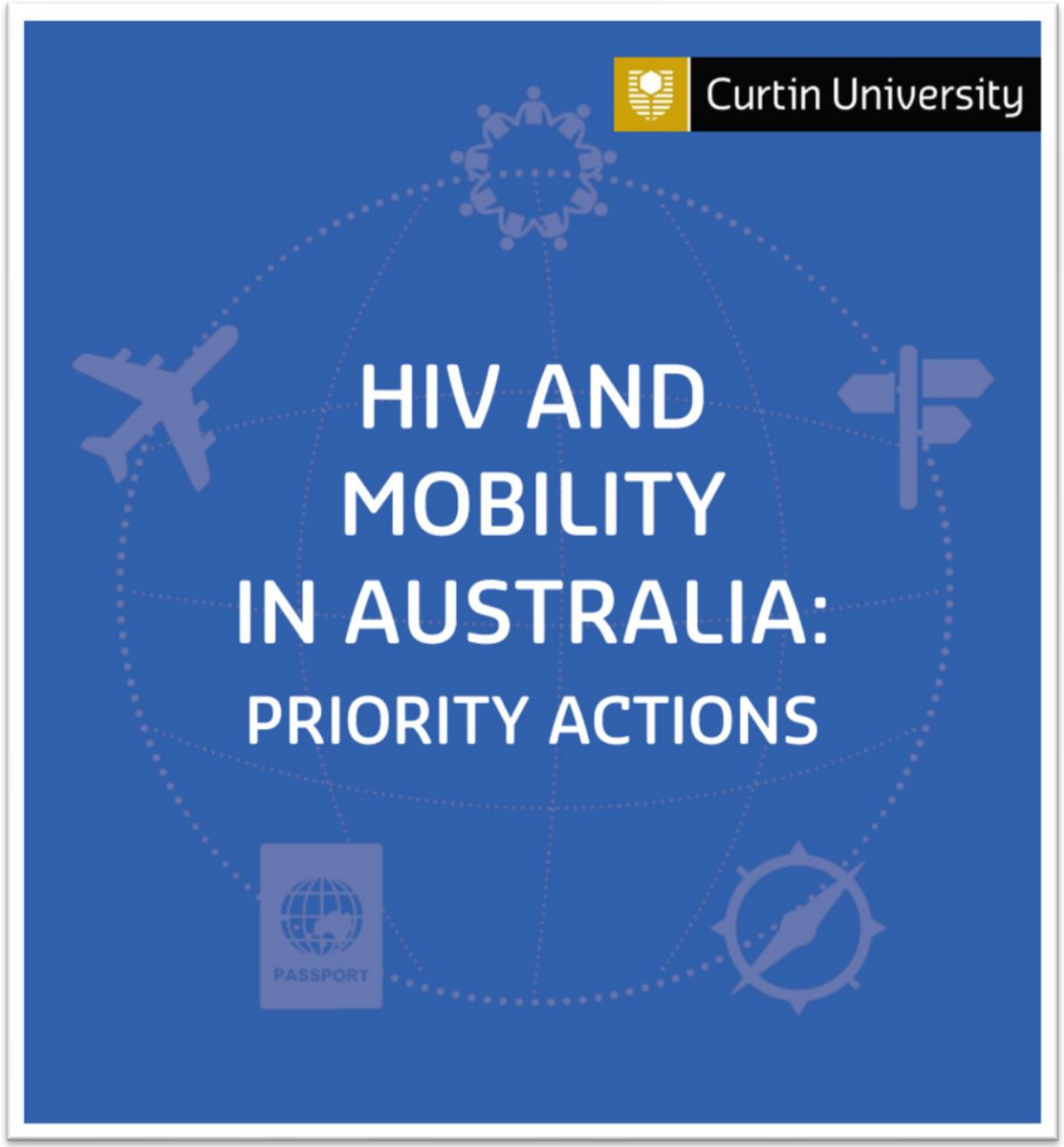

https://siren.org.au/hiv-mobility/community-of-practice-for-action-on-hiv-and-mobility/priority-actions/

SIX PRIORITY ACTIONS

- **Local solutions**: Relevant jurisdictions to plan and implement state-specific responses to HIV in migrant and mobile populations
- **Health literacy**: Increase health literacy and ‘know-how’ to access combination prevention strategies available
- **Test**: Understand and reduce barriers to HIV testing and make new testing technologies widely available
- **Treatment and prevention medication**: Advocate for the inception of a policy mechanism to provide access to HIV treatment and PrEP for temporary visa holders who are ineligible for Medicare
- **Inform**: Harmonise surveillance data reporting for both migrant and mobile populations, including sexual behaviour, testing rates, notifications, treatment initiation and PrEP
- **Evaluate**: Develop core indicators to assess effectiveness of HIV programs for mobile and migrant populations

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There is definitely momentum to understand the issues better and respond but leadership and accountability is lacking

“Nobody’s business or everybody’s business”?

There is no peak body to advocate for migrant and mobile populations, many of our multicultural services do not have a specific health remit.

HOW DO WE BUILD A REGIONAL RESPONSE TO END HIV?

- **Coordinated response** grounded in human rights – equitable and equal access to testing, treatment and prevention medications for all
- **Systematic** – *"no one left behind"*, biomedical HIV prevention less effective if parts of the community are not covered *"herd immunity effect"*
- **Meaningful engagement with affected communities** – avoid 'tokenism', build capacity within communities to problem solve, *they know what will work*, enable and support community-led and peer-led approaches.
- **Representation** – Multicultural services have good engagement with migrant communities, but need adequate resourcing for health-related issues. *Who will be seen by communities as a legitimate advocate?*
- **Surveillance and evaluation** – improve data available, monitor and see what is working
- **Scale up** – investment in effective strategies

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A coordinated response, community mobilisation and cross-border collaboration are needed if we are to meet our 95:95:95 goals. Roles and responsibilities need to be clearly articulated

ROLES AND RESPONSIBILITIES

- Who is accountable, for what actions by when?
- What is the role of Commonwealth and State government?
- What is the role of NGOs and peak bodies?
- What is the role of research institutes?
- How will mobile and migrant populations be involved?
- Who will champion and advocate for policy change?
- What partnerships are needed in Australia? Both within the sexual health sector and in other sectors
- What partnerships are needed with countries in high HIV prevalence regions to maximise the effectiveness of our response?

We now need leadership and political will to take action and ensure no-one is left behind. Everyone matters.

ACKNOWLEDGEMENTS

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Lisa Bastian
Sian Churcher

CoPAHM Network members and everyone who is doing great work in this area trying to highlight and reduce inequalities and advocate for action on HIV and mobility issues

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