ART and PrEP in migrant key affected populations (newly arrived Asian-born MSM)

Nick Medland | 19th September 2019
HIV in migrant populations

44% decline over five years

Number of HIV notifications by characteristic

Year

Characteristic • MSM* Australian born • MSM* born overseas

Number of Notifications

0 100 200 300 400 500


2014

MSM* Australian born 535
MSM* born overseas 256

297
264
Declining incident HIV in 12,000 MSM attending MSHC

- aOR 4.40 (2.38-4.93)
- Consistent condom use: 52% vs 38%
- >10 sexual partners 3 months: 10% vs 14%
Late Diagnosis

111 newly-diagnosed, newly-arrived Asian-born MSM at MSHC, SSHC, RPASH

- Compared to 209 newly-diagnosed Australian-born and long-term resident MSM
- 61% International students
- 29% never testing vs 11%
- CD4 cell count at Dx:
  - < 350/uL 55% vs 22%
  - > 500/uL 15% vs 55%
Southeast Asian-born people living in Australia

HIV in migrant populations

The HIV diagnosis and care cascade, 2014-2018

27% undiagnosed in 2018

Source: State and territory health departments
Undiagnosed GBM by place of birth

- Australian-born GBM
- Overseas-born GBM

Population trends from 2010 to 2018.
HIV in migrant populations

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- 264 in 2018

Characteristic: 
- MSM* Australian born
- MSM* born overseas

Legend:
- MSM* Australian born: 535
- MSM* born overseas: 256
Why have notifications declined in Australia

1. Viral suppression:
   - Early diagnosis
   - Low undiagnosed fraction
   - High rates of treatment uptake

2. PrEP uptake:
   - Has been so successful because UVL was already interrupting transmission chains.
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HIV in newly-arrived Asian-born MSM

- Higher rates of prevalent/long term infection: acquired in home country
- Higher rates of incident/recent infection: acquired after arrival in Australia
HIV in migrant populations

**Figure**: New HIV diagnoses by subtype and the proportion of new HIV diagnoses with non-B subtype. Diagnoses among long-term resident gay and bisexual men testing at Melbourne Sexual Health Centre.
Obstacles to successful biomedical HIV prevention

• Sophistication required to navigate complexity of HIV prevention
• Language, culture
• Perception and understanding of risk
• HIV health literacy
• Discrimination in immigration
Late diagnosis:

- Limited free testing sites
- Fear of losing visa
- Discrimination in country of origin
- Avoiding testing in home country and arrive already HIV positive
Treatment access

- UK, NZ pay for treatment
- Uniformity needed in Australia: WA, SA pay for treatment
- Cost effective public health intervention
- Mechanism in place for tuberculosis
Compassionate access programs

- How sustainable are they?
- Problematic relationships with companies
- MSHC 260 patients ~ $2.8M/year
- Have they prevented state health departments from responding?
Free ART for all

- Politically acceptable?
- Fear of attracting HIV positive migrants
PrEP access

High coverage will not be achieved through:

- Small intensive demonstration projects
- International importation

Locally subsidised PrEP will need to be provided
Conclusion

Failing to provide adequate HIV prevention and treatment to people living in Australia is intolerable, unethical and irresponsible.

Elimination of HIV transmission through biomedical prevention will fail while there are unequal coverage of ART and PrEP.