

"I WANT TO TEST BUT I'M AFRAID"
BARRIERS TO HIV TESTING FOR
PEOPLE BORN IN SOUTH EAST ASIA
& SUB-SAHARAN AFRICA

COLLABORATION FOR EVIDENCE, RESEARCH & IMPACT IN PUBLIC HEALTH

FINAL REPORT

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ACKNOWLEDGEMENTS

Many individuals contributed to this research. We are extremely grateful for their time and insight.

Western Australia Project Advisory Group: Tony Bober, Sian Churcher, Professor Donna Mak, Bernadette Masbayi, Dr Indi Pattni, Sue Laing and Sue Lee

Facilitators: Matthew Bacon, Adrian Banks, Tony Bober, Mabor Chadhoul, Dr Praveena Gunaratnam, Amira Hosny, Lea Narciso, Enaam Oudih, Victoria Sande and Majok Wutchok

Volunteers: Melissa Evans, Agni Amurbatami Manggali, Josephine Shearer and Gita Miranda Warsito

Thank you to the Centre for Culture, Ethnicity and Health; ACON (in particular Tim Chen); Western Australia AIDS Council; Communicable Disease Control Branch Government of South Australia; The Kirby Institute; Australian Research Centre in Sex, Health and Society and PEACE Multicultural Services for providing support for the project.

We would particularly like to thank the focus group and interview participants who very generously and bravely shared their stories with us.

SUGGESTED CITATION

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

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GLOSSARY

AIDS	Acquired Immune Deficiency Syndrome
CALD	Culturally and linguistically diverse
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HIVST	HIV self-testing
MSM	Men who have sex with men
NSW	New South Wales
PBS	Pharmaceutical Benefits Scheme
PrEP	Pre-exposure prophylaxis
PLHIV	People living with HIV
SA	South Australia
SEA	South East Asia
SSA	sub-Saharan Africa
TGA	Therapeutic Goods Administration
VIC	Victoria
WA	Western Australia
WHO	World Health Organization

KEY DEFINITIONS

CD4	A type of white blood cell that protects the body from infection. CD4 cells are the primary target of HIV, and CD4 cell numbers decline during HIV disease.
Epidemiology	Deals with incidence, distribution and possible control of disease.
Globalisation	Globalisation, or the increased interconnectedness and interdependence of peoples and countries, is generally understood to include two inter-related elements: the opening of international borders to increasingly fast flows of goods, services, finance, people and ideas; and the changes in institutions and policies at national and international levels that facilitate or promote such flows [1].
High HIV prevalence country	High HIV prevalence countries include those with \geq 1% estimated prevalence in at least one year of the last ten year period.
HIV self-collection testing	Self-collection (or home sampling) involves taking a mouth swab or finger prick and mailing it to a laboratory, which makes the results available either by phone, text message, or online.
HIV self-testing	HIV self-testing (also known as home-based testing) is HIV testing conducted in the home or similar environment by a community member and individuals interpret the result. It uses the same technology as HIV rapid tests.
HIV rapid testing	Rapid testing uses a pinprick of the finger (or oral fluid, depending on the test) and returns results within 10 to 20 minutes. Most rapid HIV tests detect HIV antibodies; however, some can also test for the presence of the virus itself.
Late diagnosis	Measured by a CD4 cell count of fewer than 350 cells/ μ l at diagnosis. CD4 cells are a type of white blood cell that fights infection. A normal CD4 count is from 500-1,500 cells per cubic millimetre (μ l) of blood.
Migrant	Any person who is moving or has moved across an international border or away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) the reasons for the movement; or (4) the length of the stay [2].
Mobile populations	People who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons [3].
Men who have sex with men	In this report, we use this term to describe men who are engaging in sexual contact with other men. This encompasses men who identify as gay or bisexual. We acknowledge that this classification may not be the preferred terminology for all people, however, in this study not all men self-identified as being either gay or bisexual.
Peer	In this research, a peer refers to a person born in Africa or Asia.
Peer facilitator	In this research, a peer facilitator refers to a person born in Africa or Asia, who leads the focus group discussion.
Priority population	A group identified as being vulnerable to a health condition.
South East Asia	Countries included in this region as per the Australian Bureau of Statistics Standard Classification of Countries (SACC), 2016.
sub-Saharan Africa	Countries included in this region as per the Australian Bureau of Statistics Standard Classification of Countries (SACC), 2016.



EXECUTIVE SUMMARY

A CHANGING LANDSCAPE

Over the past decade, Australia has seen an increase in Human Immunodeficiency Virus (HIV) notifications among people born in sub-Saharan Africa (SSA) and South East Asia (SEA) [4]. People living in Australia who were born in SSA and SEA have the highest rates of HIV diagnosis by region of birth and are overrepresented in late or advanced presentations of HIV infection [5].

Research indicates that migrants from SSA and SEA attend health services in Australia regularly, but only 50% have ever tested for HIV [6, 7]. General practitioners (GPs) have a vital role in diagnosing HIV infection through appropriate testing, particularly among migrants.

In addition, new testing technologies for HIV such as rapid testing, self-collection, and self-testing have recently been made available in Australia. Little is known about the acceptability of these technologies among people from SEA and SSA.

This report provides an overview of the results from the *Barriers to HIV testing among people born in sub-Saharan Africa and South East Asia* project — a qualitative research project using focus groups and in-depth interviews to explore the barriers and enablers to HIV testing among priority communities born in SSA and SEA, to better understand the factors influencing late diagnosis.

FUNDING

This project was supported by a Healthway Australian Health Promotion Association Graduate Scholarship and a grant from Gilead Sciences Pty Ltd.

METHODS

Eleven focus groups exploring barriers to HIV testing were conducted in Western Australia (n=7), South Australia (n=2), New South Wales (n=1) and Victoria (n=1). Where possible peer facilitators were used to conduct the focus groups to increase cultural security and to provide opportunities for peers to be involved in a large multi-jurisdictional research project.

Focus groups participants (n=77) had diverse experiences and backgrounds and included women, men who have sex with men, individuals on temporary visas and people who had arrived recently (less than 5 years) in Australia.

Eleven interviews were conducted with GPs in Western Australia (n=5), New South Wales (n=2), South Australia (n=1) and Victoria (n=3) exploring their experiences testing patients for HIV from SSA and SEA.

RESULTS

Across the focus groups we found that participants' understanding of HIV and readiness to test were influenced by:

- experiences in their country of birth;
- low visibility of HIV in Australia;
- perceptions of 'safety' in Australia; and
- low levels of perception of individual risk for HIV.

Most GPs reported that they often initiated HIV testing with patients, and often did so during sexual health screenings.

GP expectations about cultural and religious values held by patients presented a challenge at times - noting concern of offending, or making patients anxious or uncomfortable by offering HIV testing. Such assumptions also influenced GP perceptions of patient likelihood of being at risk for HIV, as well as their willingness to test.

RECOMMENDATIONS

Findings demonstrated a need to broaden the salience of HIV messages for other priority population groups (beyond Australian men who have sex with men). Opportunities to increase HIV testing may include GPs offering testing as part of a general health check-up. Exploring new and novel ways to increase access to testing including consideration of rapid testing or self-collection kits in community-based settings is also critical.

WHERE TO NEXT?

This report presents the findings from the project. An overview of the results, and other resources, are available for download on the WA SiREN (Sexual Health and Blood borne Virus Applied Research and Evaluation Network) website -

https://siren.org.au/project-overview-barriers-to-hiv-testing/

INTRODUCTION

Historically, HIV notifications in Australia have been predominately concentrated¹ among Australian men who have sex with men [8]. Over the past decade, Australia has seen an increase in notifications among people born in sub-Saharan Africa (SSA) and North East and South East Asia (SEA) [4]. People born in these regions have the highest rates of HIV diagnosis by region of birth and are overrepresented in late or advanced presentation of HIV infection ² [5]. Consequently, people who travel to or from countries of high HIV prevalence³ were recognised as a priority population in Australia's Seventh National HIV Strategy 2014-2017 [9].

This increase in notifications among people born in SEA and SSA living in Australia has been in part attributed to migration and mobility between countries of high HIV prevalence and Australia [4]. Migration may increase vulnerability to HIV acquisition, as access to health services and social support is different, and risk behaviour of the individual may change in the destination country [10]. Individuals from culturally and linguistically diverse (CaLD) populations living in Australia may experience difficulty accessing health services to test for HIV due to barriers including unfamiliarity with health services, language, stigma and discrimination [11-13]. There may also be frequent travel back to their country of birth or other high HIV prevalence countries. The HIV and Mobility in Australia: Road Map for Action, a discussion paper that responded to the rise of HIV notifications among migrant and mobile populations, called for further research regarding migrants' knowledge of HIV, attitudes, and behaviour in order to inform policy and programs [4].

Research on migrants' experience and risk of HIV acquisition within Australia is limited [8]. In addition, new testing technologies for HIV such as rapid testing, self-collection kits, and oral testing have recently been made available in Australia. Little is known about the acceptability of these technologies among people from SEA and SSA. Understanding the barriers to HIV testing, and identifying possible enablers may increase testing to ensure early diagnosis, better care and reduced likelihood of HIV onward transmission.

¹ A concentrated HIV epidemic refers to an HIV prevalence of less than 1% in the adult population (15-49 years), but greater than 5% in a high-risk subpopulation group.

² Measured by a CD4 cell count of fewer than 350 cells/ μ l at diagnosis. CD4 cells are a type of white blood cell that fights infection. A normal CD4 count is from 500-1,500 cells per cubic millimetre (μ l) of blood.

³ Refers to a country with an HIV prevalence below 1% in adults aged 15-49 years.

METHODS

This study aimed to gain a better understanding of barriers and enablers to HIV testing from the perspective of both migrants and GPs. The project received approval from Curtin University Human Research Ethics Committee (HREC2017-0088), ACON Research Ethics Review Committee (RERC reference number: 2017/13) and from Relationships Australia SA and was noted by the Human Research Ethics Committee of the University of New South Wales.

The study components were:

- Interviews with GPs from Western Australia (WA), New South Wales (NSW), South Australia (SA) and Victoria (VIC) who see patients born in SSA or SEA
- Focus group discussions with people born in SSA and SEA living in WA, NSW, SA, and VIC.

STEERING GROUP

The project was overseen by a group of five researchers, a policy officer and a program manager across the four sites. The steering group was established to guide the project and provide input into project methodology. One teleconference with steering group members was held (March 2017), with ongoing communication via email.

The following individuals comprised the steering group:

- Corie Gray (Curtin University)
- Gemma Crawford (Curtin University)
- Dr Roanna Lobo (Curtin University)
- Dr Rachel Thorpe (La Trobe University)
- Dr Praveena Gunaratnam (Kirby Institute)
- Lea Narciso (Communicable Disease Control Branch, Department of Health and Ageing South Australia)
- Enaam Oudih (Relationships Australia South Australia).

PROJECT ADVISORY GROUP

The project was overseen by a number of individuals in WA. The project advisory group met once (March 2017), with ongoing communication via email.

The following individuals comprised the project advisory group:

- Corie Gray (Curtin University)
- Tony Bober (Western Australia AIDS Council)
- Bernadette Masbayi (Office of Multicultural Interests Western Australia)
- Dr Indi Pattni (Multicultural Services Centre of Western Australia)
- Sue Lee (Women's Health and Family Services).
- Sue Laing and Professor Donna Mak (Sexual Health and Blood-borne Virus Program, Department of Health Western Australia)

SUPPORT AND COLLABORATION

This project received support from a number of individuals and organisations. A full list of those involved is included in the project's acknowledgements.

FOCUS GROUP AND INTERVIEW GUIDE

The focus group and interview guides were developed based on previous studies reported in the peer reviewed literature, in line with the project's objectives. The guides were refined through consultation with the project advisory group, steering group and peer facilitators involved in the project. The focus group guide was developed to be semi-structured, to encourage facilitators to explore topics of interest as they arose. The focus groups and interviews were designed to be informal and conversational in nature, providing an opportunity to understand participants' terminology and world view.

FOCUS GROUP FACILITATORS

To ensure that focus groups were conducted in a culturally appropriate manner and to capture more useful data, the decision was made that, where possible, a peer would help recruit for and conduct the focus group. A guide book was developed to assist sites to train peer facilitators. An honorarium (\$100 cash) was offered to facilitators to acknowledge the important role that they played in the success of the project.

RECRUITMENT

Peer facilitators, as well as people who work closely with the target group, developed targeted recruitment strategies. Recruitment was conducted via advertisements on social media (Facebook), e-lists for multicultural services, at clinics for men who have sex with men, and through individuals' networks.

GPs were recruited through word of mouth, advertisements in online newsletters, and social media posts. GPs who self-described as frequently working with patients from SEA and SSA were eligible to participate.

DATA COLLECTION

Eleven focus groups (n=77 total participants) were conducted to capture diverse experiences among different groups. All focus groups were audio-recorded and lasted between 45 and 90 minutes. Demographics were captured through a self-administered paper-based questionnaire. The number of participants per group ranged from 4-12. Participants were offered refreshments and a \$20 gift card to acknowledge the time taken to participate.

Eleven interviews were conducted with GPs. Phone interviews with GPs were semi-structured and lasted between 25 and 50 minutes. Demographics were captured prior to the interview via an online survey, produced in Qualtrics.

DATA ANALYSIS

Audio recordings were transcribed verbatim in English by the lead researcher and transcripts were checked against recordings for accuracy. Transcripts were read through once, then coded using NVivo software. Codes were then organised into overarching themes. Literature was read concurrently throughout data analysis to better explain and further refine themes. Themes were discussed between three members of the steering group.

FOCUS GROUP PARTICIPANTS

Focus groups were conducted over a four-month period. These involved:

- Three focus groups with men who have sex with men from South East Asia
- Three focus groups with women from South East Asia
- Three focus groups with people of mixed gender from sub-Saharan Africa
- One focus group with men from sub-Saharan Africa
- One focus group with women from sub-Saharan Africa

The decision to conduct gender-specific, or mixed gender groups, for SSA groups was determined by the facilitator. The decision to include mixed gender groups was based on the facilitator's knowledge of that community, and their perception of the group's comfort with participating in a mixed gender discussion.

South East Asian participants indicated that they were from Indonesia (n=14), China⁴ (n=7), Malaysia (n=4), Philippines (n=3), Vietnam (n=4), India⁴ (n=2), Hong Kong⁴ (n=2), Myanmar, Cambodia, Pakistan, Sri Lanka⁴, Taiwan⁴ and Thailand. Sub-Saharan African participants indicated that they were from South Sudan (n=19)⁴, Somalia (n=5), Botswana (n=2), Tanzania (n=2), Nigeria (n=2), Democratic Republic of the Congo, Djibouti, Ghana, Kenya, and Zambia.

Table 1. Socio-demographics of focus group participants by region of birth

CHARACTERISTICS NUMBER OF PARTICIPANTS				
	Sub-Saharan	South East		
	Africa (n=35)	Asia (n=42)	(n=77)	
Gender*				
Male	12	19	31 (40%)	
Female	22	23	45 (60%)	
Age (years)**				
18-24	6	5	11 (15%)	
25-29	2	22	24 (32%)	
30-34	6	7	13 (18%)	
35-39	3	4	7 (9%)	
40-44	7	2	9 (12%)	
45+	8	2	10 (14%)	
Years lived in Australia				
<1 year	6	11	17 (22%)	
1-5 years	6	15	21 (27%)	
6-10 years	3	8	11 (14%)	
>10 years	20	8	28 (36%)	
Status in Australia***				
Citizen	23	9	32 (43%)	
Permanent resident	4	6	10 (13%)	
Student visa	6	22	28 (37%)	
Other temporary visa	0	5	5 (7%)	
Education Level****				
Primary school	4	0	4 (5%)	
High school	6	1	7 (9%)	
Year 12 or equivalent	4	2	6 (8%)	
TAFE certificate/diploma	4	2	6 (8%)	
University bachelor degree or higher	15	37	52 (69%)	
Sexual orientation****			•	
Heterosexual	25	21	46 (64%)	
Homosexual	1	17	18 (25%)	
Bisexual	0	2	2	
Pansexual	0	1	1	
Other (not disclosed)	4	1	5 (7%)	

One gender missing *
Three ages missing **

Two statuses missing ***

Two levels of education missing ****
Five sexual orientation missing *****

⁴ Note: By Australia Bureau of Statistic Standard Australian Classification of Countries, Taiwan, China and Hong Kong are classified as North East Asia and Sri Lanka as Southern and Central Asia. South Sudan is classified as North Africa.

INTERVIEW PARTICIPANTS

A total of eleven interviews with GPs were conducted. These included five in WA, one in SA, two in NSW and three in Victoria. All GP participants had over ten years' experience working as a GP.

Table 2. Socio-demographics of GPs

CHARACTERISTICS	NUMBER OF PARTICIPANTS			
Gender				
Male	4			
Female	7			
Country of birth				
Australia	3			
Overseas	8			
Language spoken other than English				
No	4			
Yes	7			
Current workplace*				
Bulk-billing practice	1			
Community health centre	2			
Private practice	6			
Sexual health clinic	4			
Years practicing as a GP				
10 – 19 years	5			
20 – 29 years	2			
30 – 39 years	3			
40 or more years	1			

^{*}Able to select more than one option

Table 3. GP frequency of seeing and testing patients for HIV

CHARACTERISTICS	NUMBER OF PARTICIPANTS		
Frequency of conducting an HIV test (overall)			
Daily	3		
Weekly	6		
Monthly	2		
Frequency of seeing patients from South East Asia			
Daily	7		
Weekly	2		
Monthly	1		
Yearly	1		
Frequency of testing patients from South-East Asia	a for HIV*		
Weekly	7		
Monthly	3		
Frequency of seeing patients from sub-Saharan Af	rica		
Daily	3		
Weekly	2		
Monthly	3		
Yearly	3		
Frequency of testing patients from sub-Saharan Africa for HIV *			
Weekly	1		
Monthly	6		
Yearly	3		

One response not recorded*



FINDINGS

The barriers and motivators for people born in SSA and SEA to HIV testing, the acceptability of testing methods and opportunities to increase testing among communities are described here. Barriers and motivators for GPs in testing patients for HIV are also described, with their recommendations to increase testing.

BARRIERS TO HIV TESTING - FOCUS GROUPS

This section reports barriers and motivators to HIV testing identified in focus group discussions. The key themes and sub-themes are described below with examples from the discussions. An overall list with a description of the main themes is provided in the table below.

Focus group questions asked about 'community' perceptions and experiences. For SSA men and women and SEA women, 'community' was mostly used to describe the people from their country of birth. However, for SEA MSM, the term 'community' was often used to describe the gay community that they had connected to within Australia, which depended on sexuality rather than country of birth.

Table 4. Overview of barriers and enablers to HIV testing identified in focus groups

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THEME	OVERVIEW
Accessing health	Low levels of engagement with health services limit opportunities to test for HIV.
services	International students described low engagement with health services due to perception and understanding of eligibility.
	People from Africa described the need to be visibly unwell before they would attend health services.
Experiences	Experiences of AIDS epidemic in country of birth can create fear and reluctance to test.
from country of birth	For MSM, expectation of homophobia in relation to accessing HIV information and testing created a barrier.
Visibility of	Low visibility of HIV in the mass media limited uptake of HIV testing.
HIV	When it was seen, it was frequently negative (i.e. HIV criminal cases or media stories on migrants) contributing to HIV-related stigma.
'Othering' of risk	HIV often attributed to gay men, sex workers and people who inject drugs. People did not see themselves at risk of acquiring HIV, limiting uptake of testing.
'Safety' in Australia	Participants perceived that HIV was not an issue in Australia, due to the low prevalence of HIV in Australia in comparison to their country of birth. This limited uptake of testing and increased risk-taking behaviour.
	For MSM, participants felt okay to access gay health services after a positive experience.

ACCESSING HEALTH SERVICES

For international students, issues of cost and 'ineligibility' (not being allowed to access) often came up as barriers to accessing health services. Participants' experiences were both negative and positive – for some, the health care system was confusing, and they expressed frustration at the process of having to book appointments (particularly when they were sick), or the quality of the medical staff. Others saw the quality of the healthcare system to be better than the experiences in their country of birth.

"...they are probably too professional ... your thing (illness) is so pressing, but you still have to go through that process of making appointments, while you have to feel the pain." – Male (M), Botswana (African mixed gender group)

For many participants from SSA who had arrived some years ago (of whom many were refugees), their experiences in their country of birth shaped their willingness to access health services in Australia. Visiting the doctor was often considered a 'luxury', and many commented on the need to be obviously physically sick (where it was recognisable to others, to the point of being on their 'death-bed') to access services.

"...here for ten years and I don't have malaria or anything, I don't go to a doctor [laughter]. So this is a common thing with us, you only see the doctor when you are sick." – M, South Sudan (African male group)

A 'check-up' was often not considered important – but many expressed that they hoped the younger generation would be more willing to engage in health check-ups. Language was also described as an issue for some in the community, and concerns were raised about the confidentiality of the interpreter.

Most SEA MSM and SEA women, with the exception of international students, appeared to be well-engaged with the health care system and comfortable in their ability to access services.

ROLE OF GPS IN HIV TESTING

For many (other than MSM), GPs were seen as the 'gatekeeper' of knowledge in regards to health, and this included information about HIV. Therefore, if HIV was not discussed by the GP, it was seen as a 'non-issue' – particularly in instances where people had gone for a sexual health check-up, an overall health check-up or had had bloods taken. At the same time, participants were also concerned about being discriminated against by GPs, in that they thought by offering an HIV test, the GP was making an assumption about their behaviour. Instead, they wanted HIV testing to be offered to everyone rather than focused on specific behaviours.

"Because there is a certain judgement involved with the questions, your GP will kind of go 'Is she a slut? Is she a drug addict? How many men has she slept with?" – Female (F), Malaysia (Asian female group)

Participants discussed instances where GPs had refused to provide an HIV test, having determined that individual not to be at risk.

"....she (GP) doesn't deem me to be in the high-risk category, but it would be nice to just have the test done." – F, Malaysia (Asian female group)

EXPERIENCES FROM COUNTRY OF BIRTH

Participants' perceptions and experiences in their country of birth influenced how they understood HIV and their readiness to test for HIV. These perceptions and experiences were both enablers and barriers to access HIV testing. For example, more recent arrivals (less than two years) to Australia from Africa showed strong knowledge of HIV and expressed feeling comfortable regularly testing for HIV in their home countries. In contrast, those who had arrived more than 10 years ago, particularly from South Sudan, described poorer knowledge within their community in Australia, fear of testing for HIV and HIV-related stigma. They described their experiences of an 'AIDS epidemic', in which an individual would be isolated from a community due to fear of transmission, and later die. This fear negatively impacted on their willingness to test.

"...the fear of the unknown is better than...the benefits of testing...I'd rather not know ...the fear associated with...the perception of how people with HIV are still treated within the African community... there's this other layer of fear upon fear, and they feel like the unknown is better than... testing." – F, Africa (African mixed gender group)

Similarly, women from SEA described the conservative social and political nature of their country which impacted on their willingness to engage in HIV testing. HIV was seen as a fear-mongering tool to promote abstinence until marriage, followed by monogamous relationships. This appeared to influence perception of risk. Social exclusion as a consequence of having tested for HIV was described as a concern for some, particularly when their GP worked with family members or with other members of their community.

"...you want to have an HIV test, and people said 'Do you like having sex with people? Like with random people or what? Why do you want to do the test, why do you have to do the test?'" – F, Indonesia (Asian female group)

'COMING OUT' IN AUSTRALIA

For MSM from SEA, experiences of homophobia in social, political and healthcare settings in their country of birth resulted in a reluctance to test for HIV or to seek information about gay communities and safe sex. Concerns about confidentiality in their country of birth were raised (including sexuality, testing for HIV, and positive diagnosis). For some, an expectation of similar experiences in Australia prevented them seeking both information and testing.

"I never really checked in Indonesia... because it's better not to know...once you get HIV, there is nothing you can do. You die...people still afraid of it, and also – gay and LGB communities...you can be arrested for being you." – M, Indonesia (Asian MSM group)

Most men recounted coming to Australia with very low knowledge about safe sex and HIV. This resulted in condomless anal sex, often with multiple partners – either due to poor knowledge, or a lack of skill or confidence to negotiate condom usage. It appeared that there was a 'transitioning' period, in which they became immersed or connected to the Australian gay community. These connections became the source of information regarding HIV and safe sex and encouraged uptake of HIV testing.

"I didn't know anything about testing until last year, and my partner asked me if I'd done it before, and I said 'nah,' but he asked me whether I had unprotected sex and I was like 'uh, yeah, maybe... twice'. So we've done it together... he told me a lot about PrEP and other stuff you can use." – M, China (Asian MSM group)

While these men were in some way connected to the gay community in Australia, in all focus groups, they described other men from SEA (mainly international students) who weren't 'visibly' gay (i.e. did not identify as gay), but still engaging in sex with other men. There were concerns that these men would have very little knowledge about HIV transmission, and would be less likely to engage in safe sex and test for HIV.

VISIBILITY OF HIV IN AUSTRALIA

Most participants noted that HIV was often considered a 'taboo' topic – both in their country of birth and in Australia. For many participants, this was the first time they had been in a discussion about HIV or had even heard HIV openly discussed in Australia.

"I've been in Australia for 14 years now, and I've never seen anything on HIV." – M, South Sudan (African male group)

For some, the only things they had seen or heard about HIV while in Australia were negative — criminal cases of HIV transmission (predominantly African men) in the media, cases of PLHIV not obtaining permanent residency, PLHIV 'disappearing' or being isolated from the community, or rumours about government quarantining PLHIV. These stories (and the lack of positive stories) contributed to the belief that HIV was a taboo topic in Australia. Australia's current approach to refugees and migration appeared to be conflated with the HIV response.

"I remember one of my friends asked "so what if you find HIV positive, what do you do?"..."you get locked up, isolated areas" ...you find you're HIV positive, you get isolated, you don't stay in the community, that's what they say, you don't see your family and stuff." – M, South Sudan (African male group)

Participants also noted that they had seen very little information about HIV – either where to test or which organisation to contact for more information. While some participants demonstrated a good understanding of HIV transmission, they lacked knowledge on where to test, what testing involved and what a positive result would mean. For some, the lack of information available on HIV contributed to feelings that HIV was not an issue in Australia (described in more detail below) – or that it was an issue that wasn't being dealt with.

"Where do you test? ...if I have problems, I see a physician here, I see a dental....I haven't seen any poster of HIV. No testing centres... nobody is dealing with the HIV." – M, Tanzania (African mixed gender group)

Some participants who were more aware of the HIV response in Australia (mainly those from SSA who had lived in Australia for a number of years), commented that most HIV-related material such as pamphlets, information available online, etc. was targeted at gay men and there was a dearth of information tailored towards other communities. This resulted in difficulty accessing information that was seen as being appropriate (in terms of having information on risk factors and access to testing that was relevant to other communities) and as being culturally appropriate (mainly in that the images and language used did not reflect the community). Participants noted a need for information to be presented in a way that was relevant to their communities.

"(We need) something about us, not about them [gay man]." – F, Africa (African mixed gender group)

For MSM who were not comfortable being connected with the gay community, the association of HIV with gay and bisexual men was thought to further prevent people accessing information. In addition, most HIV material was seen as being for 'Australian gay men,' while gay men from other countries were perceived to be invisible in any promotional campaigns. Similar to the perceptions of the broader African and Asian communities, they wanted to see more material that included men who were born overseas.

"I think the international people they, they are quite lost in the message of HIV; it's more Australian people." – M, China (Asian MSM group)

Overall, most participants wanted to see and hear more about HIV – positive stories of PLHIV in Australia, information on HIV that was relevant to them (for example, consequences of testing positive for international students, practising safe sex while returning to Africa to conceive) and relevant services for support if diagnosed positive.

SAFETY IN AUSTRALIA

Living in Australia was seen by many participants as being 'safe' – with this term having different meanings for different groups. For those from SSA, Australia was often seen as a 'safe' country – there was an assumption that 'diseases' such as HIV did not exist. This was supported by the perceived low visibility of HIV in Australia. This often translated to low rates of testing, and an increase in unsafe sexual behaviours (particularly an increase in partners and low condom usage).

"...people think Australia is so safe, it is a safe place...people think it's okay, I can do anything I want even if I don't check with the doctor I am okay." – M, South Sudan (African mixed gender group)

For MSM from SEA, 'safety' was often used to describe the freedom to be gay and to regularly test for HIV. They felt Australia as a whole was more accepting of same-sex relationships, in comparison to the countries they were born in.

"[in Australia] it's okay to know about testing, it's okay to know about the gay community." – M, Asia (Asian MSM group)

For a number of men (mainly international students), there was a fear of having to return to their country of birth. Here they felt they would no longer be safe to be gay, to access testing, or if needed, access HIV treatment.

CONFIDENTIALITY AND TRUST

'Safety' was also described in relation to doctor-patient confidentiality in Australia. While some trusted that the information they disclosed and the results of their test would be safe, others were concerned that this confidentiality would be breached. Past experiences of a confidentiality breach contributed to this concern. There was concern that the government would know, that community would know, or that family would know –the result of an HIV test, the behaviour that they engaged in or who they had had sex with (particularly for SEA MSM). For these reasons, some participants recounted instances where they had not disclosed high-risk behaviour to their GP.

"...I had to hand over Medicare - would my parents be notified? Would they find out?... they say it's anonymous, but they could track me, I just signed documents, my names on paper... it tells people I'm having sex (with men)." – M, Indonesia (Asian MSM group)

'OTHERING' OF RISK PERCEPTION

Most participants (including SEA MSM) described HIV as being for 'others,' regardless of the behaviour they engaged in. This was either a perception that HIV could not happen to them (as an individual), or that it only happened to people engaging in a particular behaviour.

"...you also don't think that you are part of that AIDS, you are not one of these people...you just exclude yourself from it, you are not part of it..." – M, South Sudan (African male group)

"Like, I always thought that (HIV) was (for) someone else. It was never for me. It was someone else's problem, and it could never happen to me, because, you know, I'm invincible, and that sort of stuff (HIV) doesn't happen to me." – M, Philippines (Asian MSM group)

For those from SEA (except MSM) and SSA, HIV was often associated with 'bad' or 'sinful' behaviour or people (i.e. people who injected drugs, gay men, sex workers or people who had sex with more than one person). Looking up information on safe sex or HIV, or asking a GP for an HIV test, was, therefore, admitting to engaging in 'bad' behaviour or being a 'bad' person.

"...because its only for bad people you know like bad people like drug people and prostitutes or ... people who have free sex, I'm a good girl...I think that there is no chance I get that issue (HIV)." – F, Indonesia (Asian female group)

Likewise, those who were married, or in long-term relationships, expressed concern that by testing for HIV they were admitting to 'bad' behaviour, such as sex outside marriage. For women from SEA and SSA, there was a concern that married men were engaging in unsafe sex outside of marriage – however, the women themselves were reluctant to test for fear of being seen as the 'guilty' one (when they had not had sex outside marriage).

Some participants from SEA and SSA described people who attended church as being 'protected' or 'immune' from HIV due to their faith.

"Most of them [African community] are Christian, they have a religion at least, that can keep them away from whatever they are thinking is going to harm them. And so they really don't worry about... this complication of HIV, or any other kind of disease of that kind." – F, Africa (SSA mixed gender group).

Participants from SSA described a belief among some community members that thinking about HIV – whether hearing messages about prevention or considering testing – was to invite HIV into their life.

"If you even just think about it, you are inviting this thing (HIV) into your life... just don't think about it, it won't happen to you." – F, Africa (SSA mixed gender group).

MOTIVATORS FOR HIV TESTING

Motivators for HIV testing were often described as being in the interest of community or a partner's health for people from SSA, and often individual health for those from SEA. For those identifying as heterosexual, GP-initiated testing was often described as the reason for voluntary testing. Overall, very few people who identified as heterosexual indicated previously having a 'voluntary' HIV test. Several had been tested as part of a visa or permanent residency requirement.

For MSM, the role of peers was described as incredibly important with regards to education and reassuring confidentially of testing in Australia. Most men described learning about HIV either from a peer, or an online site specifically for MSM.

"I think for me most of the information is from [name]... I mean for me about a couple of months ago, [name] took us to test also with partner, just to see, also to see what we do and just also gain assurance." – M, Asia (SSA MSM group)

ACCEPTABILITY OF NEW HIV TESTING METHODS

Participants were asked about the acceptability of testing for HIV via GPs and sexual health clinics, rapid testing, and home-testing kits. There was a lack of knowledge about methods of HIV testing for most groups. While this was anticipated for rapid testing and home-testing, of concern was a lack of knowledge about testing for HIV via a GP, or a sexual health clinic, including among some MSM.

"I didn't even know you could go to the GP to test these things (HIV)... I'm thirty years old, and I didn't even know this – it's something so basic." – M, Indonesia (SSA MSM group)

Across all groups, there was a general consensus that having more options to test for HIV for different people and groups would only serve to increase testing. Specific positives and concerns for each method are outlined below.

HOME TESTING KITS

Home-testing raised concerns about the lack of immediate support for people who might receive a reactive result (i.e. indication of HIV antibodies in sample). In particular, it was suggested that people who believed HIV was a 'death-sentence', or feared exclusion from community, may not willingly seek a confirmatory test for HIV and be linked into care.

"...I do it myself, after testing I am positive, what do I do? What is the next step?" – F, Botswana (SSA mixed gender group)

Participants provided thoughts on overcoming barriers, including the purchase of home-testing kits (particularly oral versions) at GPs or pharmacy, where a person could receive information from a health professional on what to do if they had a reactive test, and had a place to go for support if the test was reactive.

The positive of home-testing kits was mainly described as confidentiality, including wanting to avoid the health system or Australian or country of birth government finding out they were testing for HIV. This was particularly important for MSM – several (all born in China) were already purchasing these overseas. This method was also of interest to both males and females identifying as heterosexual for the privacy it offered.

"Myself, I prefer home testing because [I am] scared of telling GP and die of embarrassment." – M, South Sudan (SSA male group)

The option to do the test orally was seen as a positive, particularly for women. There were concerns about the current cost of home-testing kits, with some MSM reporting spending upwards of \$100 per kit.

RAPID TESTING

Rapid-testing was seen as being the most time-efficient option and a useful method for improving testing frequency. This was thought to be particularly useful for testing in community-based settings, for those who were particularly anxious and who did not wish to wait for results, or for those who were concerned about having a blood test.

However, accuracy was described as the biggest concern for this method, particularly for people who were anxious about receiving a false positive result.

GENERAL PRACTITIONERS

The role of GPs was particularly important in increasing HIV testing. Above all, participants suggested that they wanted HIV testing offered to them as part of a 'general health checkup'. This avoided having to disclose behaviour, and was seen as a way to reduce HIV related stigma if HIV was seen as 'an issue for everyone'.

"Routine blood test... HIV for general overall health, you know with blood pressure, cholesterol, the diabetes, the heart disease... it's better us taking control over our own health... and then the HIV blood test becomes part of that as well." – F, Africa (SSA mixed gender group)

RECOMMENDATIONS TO INCREASE HIV TESTING - FOCUS GROUPS

Participants were asked to discuss opportunities to increase HIV testing among communities. Overall, there was a strong sense that 'something needed to be done' to address HIV:

"We don't need to hide it [HIV], we need to talk about it [HIV]." – F, Africa (SSA mixed gender group)

An overview of barriers and possible strategies to address these as discussed by participants is presented in Table 5. It is important to note that at the heart of all these recommendations was the need for community to be involved. One African woman described people from outside her community coming in to deliver education without consultation:

"They just come in with a PowerPoint... it would be good to have more employed staff from similar cultures because they would understand how to communicate the message." – F, Africa (SSA mixed gender group)

While the following are presented as opportunities to increase HIV testing, participants expressed fear that overall increased messaging about HIV testing would, in fact, lead to increased HIV related stigma and 'blame' for communities 'bringing in HIV'. This fear of blame was most noticeable among African participants, who expressed concern that HIV was already seen as an 'African disease'.





BARRIER RECOMMENDATION

Lack of awareness of HIV

"Until this thing is put out there in the open... they can't achieve what we [Africa] have achieved." – M, Botswana (SSA mixed gender group) Community or religious leaders to have positive conversations about HIV and the benefits of regularly testing for HIV (Note) some MSM folt that this would.

testing for HIV (Note: some MSM felt that this would not be possible, due to the conservative and/or religious nature of their community. There was also concerns of further stigmatising gay community members).

- Social media to be used to promote benefits of testing regularly and promote locations to receive HIV tests (using posts, infographics, short videos, etc.)
- Mass media campaigns on HIV (or STIs in general)
 encouraging the broader Australian community to
 test (Note: MSM were strongly against this. This was
 mostly due to concerns that this would further
 stigmatise the gay community.)
- GPs to encourage HIV testing in patients and to provide information
- Community forums on HIV
- Inclusion of people born overseas in HIV-related material (such as pamphlets, online information)

Patients not regularly engaging with primary healthcare

"[You go] when the symptoms are full-blown... like some physical evidence of what they are feeling." – F, Africa (African mixed gender group)

- HIV testing to be conducted at community locations
 or events.
- Community leaders to offer HIV testing to community members

Limited opportunity to test for HIV

"They don't do it... I routinely come to the clinic, and they don't say anything about HIV."

– F, Indonesia (SEA female group)

- GPs to offer HIV testing as part of a 'general health check' and when doing sexual health screening or cervical screening tests (for women)
- GPs to provide HIV testing when requested
- Increased availability of rapid testing
- Home-testing kits to be permitted for use in Australia
- PLHIV to openly share their status and stories
- PLHIV to offer peer HIV testing
- More positive reporting on HIV by the media

HIV related stigma

"I know a neighbor who works as a sex worker, people think that she uh, has AIDS... but we don't know." – M, Philippines (SEA MSM group)

Unsure of where to test

"The problem here is when you arrive is how, where do you access?" – M, Nigeria (SSA mixed gender group)

Fear of testing positive

"I'm afraid of having HIV." – F, Myanmar (SEA female group)

- More advertising of HIV testing locations or pop-up testing centres in key locations
- Information for international students on where to access testing
- Address HIV-related stigma and myths

Cost

"I'm sick and tired of being ripped off by everything here... I just don't go." – F, Indonesia (SEA female group)

- Free HIV testing to be promoted (particularly for international students)
- Discounted or free home-testing kits
- Universal access to HIV treatment if necessary⁵

BARRIERS AND MOTIVATORS FOR TESTING PATIENTS FOR HIV - INTERVIEWS

This section reports on the interviews conducted with GPs. It includes an overview of the barriers and motivators to testing patients for HIV, and an overview of the recommendations to increase testing presented by GPs.

GPs reported initiating HIV testing on most occasions, with few direct requests from patients. While several factors increased testing likelihood, others reduced GPs' willingness to test a patient from SSA and SEA for HIV. An overview of the main themes is presented in the table below.

Table 6. GP barriers and motivators to testing patients for HIV

Table 6. GP barriers and motivators to testing patients for HIV				
THEME	DESCRIPTOR			
Interest and experience in HIV testing	GPs who had a number of years of experience testing patients from these two regions reported feeling more confident than those who did not. GPs who were either involved in research or read frequently on HIV had a greater knowledge of priority groups.			
Opportunities for testing	GPs reported that a patient's request for a sexual health screen helped facilitate offering an HIV test, while they perceived that it was not as appropriate to offer testing for patients who came for other concerns (such as a cold).			
Language and interpreters	GPs experienced difficulty in securing an interpreter who was of the appropriate gender and who was confident in discussing sexual health. Interpreters who they worked with often had a good working relationship which helped facilitate testing.			
Cross-cultural communication	GPs expressed concerns about approaching people born in SSA and SEA about HIV, due to fear of offending or causing fear.			
Pre-test counselling	Spending time on counselling provided an opportunity to provide information on HIV and to address patient concerns.			



⁵ Currently, PLHIV who are not eligible for Medicare or the Pharmaceutical Benefit Scheme cannot access subsidised HIV treatment. For more information, visit http://napwha.org.au/health-treatment/hiv-treatment/how-access-hiv-care-and-treatment-australia

INTEREST AND EXPERIENCE IN HIV TESTING

GP interest and experience in HIV was reported to increase confidence in initiating HIV testing. Most participants reported an interest in either sexual health and/or HIV, or in migrant and refugee health. Additionally, all had been working as a GP for at least ten years and had initiated HIV testing numerous times. Some GPs reported being linked to research in this area, or regularly reading up on epidemiology and peer-reviewed literature, while a few described being unsure who the priority populations for HIV were in Australia.

"...some updated resources about prevalence in different communities in Australia because I don't really know that." – GP 04

Some participants suggested that other GPs who were not interested or confident in discussing sexual health may miss opportunities to screen for HIV.

"So a lot of GPs I come across who are older than me they do not want to talk about sexual health, I'm not sure about the younger cohort coming through they might be more comfortable." — GP 05

It was also perceived by participants that some GPs were not comfortable discussing sexuality.

"I think GPs do a particularly bad job... there's too much judgement layering when those individuals go to their GP, many will not disclose their sexuality and the GPs feel uncomfortable asking about it." – GP 09

OPPORTUNITIES FOR TESTING

For most GPs, a patient's disclosure of high-risk activity, a request for sexual health screening or a discussion on contraception made it easier to initiate conversations on HIV. A few GPs only offered testing in instances where a patient's likelihood of having been exposed to HIV was higher, such as only for men who had sex with other men, or those who had a recent diagnosis of an STI or hepatitis B or C. Two GPs offered HIV testing to all new patients, or when blood tests were being done. A few GPs acknowledged that although testing for HIV after travel to a high HIV prevalence country was warranted, they found it difficult to initiate this conversation. Only one GP described the risk of HIV transmission via cultural practices, such as home tattooing.

"All new patients are screened for HIV and hepatitis B, and C... Many of the patients ask me, 'Why do you want to test me for this?' I say 'Just in case you have any contact, not only sexual it can be due to blood transfusion or during sport if you touch each other with blood." — GP 10

For some GPs, timing and context were described as incredibly important in determining when to ask a patient if they would like an HIV test. Participants suggested that if a patient came in for an issue not related to sexual health, it was seen as being inappropriate to discuss HIV.

"Obviously you don't pounce on someone when they have a cough and say 'oh, by the way, what about your HIV status."" – $\sf GP 03$

GPs also described the importance of developing trust with a patient, and that time was required to build this trust.

LANGUAGE AND INTERPRETERS

Participants indicated that some patients required or preferred interpreters to discuss their health. Most GPs described challenges with this, particularly when it came to sexual health. Participants suggested it was at times difficult to secure an interpreter who was confident discussing sexual health, who was of the same gender and was not known to the patient. As a result, some GPs put off asking about sexual health and HIV until they had access to an interpreter they considered to be appropriate.

"...It's more of an issue for me because I haven't asked her the question because I haven't known how it would go down... I was anxious about how she would cope with me asking that through a male interpreter." – GP 08

Participants suggested that access to reliable and confident interpreters of the same gender facilitated cross-cultural interactions. Working with the same interpreter frequently, with whom the GP had built a good working relationship and trusted to ask questions appropriately, assisted in offering HIV testing.

"Using a phone interpreter can be hit and miss... sometimes you can tell that someone isn't very comfortable talking about sexual history of a client... Having someone that you see regularly who then understands the types of questions that you ask and why you ask them... that actually makes a big difference." – GP 06

CROSS-CULTURAL COMMUNICATION

All GPs believed that many SEA and SSA communities are conservative in regards to willingness to discuss sexual health. Because of this, some GPs described being more 'gentle' in the way they approached the topic of HIV with people from these regions compared to Australian born patients. This was often due to fear of offending patients.

"I am probably more gentle really in how I approach it...I'm a little bit more delicate I suppose of how I go about that conversation... I don't want them to think I'm making assumptions about them." – GP 08

Due to the perceived conservative nature of communities, many GPs believed that patients did not honestly report 'risk' behaviour. This made it difficult to determine who to test for HIV, and who might require further support to prevent issues down the track (such as HIV acquisition from male to male sex, or unplanned pregnancy for an unmarried female).

"Members of the group who do have high-risk behaviour... trying to get information from them can be very difficult, very, very difficult... it's a bit of an unknown problem." – GP 11

In some cases, GPs acknowledged avoiding or not prioritising conversations about sexual health and HIV, based on the assumption that they thought these groups were less likely to be engaging in at-risk behaviour.

"Depending on which country they've come from often sex before marriage in some countries is considered not a thing." – GP 03

As a way of navigating between cultures, several GPs identified using peer support staff when available. These workers guided the GP through differences in language and culture and helped them adapt their approach to the consultation and their line of questioning. This helped build a better relationship with patients and facilitated offering an HIV test.

"I often use the interpreter or the bicultural worker as not just someone who is interpreting language but who's interpreting culture and social norms as well." – GP 11

PRE-TEST COUNSELLING

GPs reported that patients often had a mix of knowledge in regards to HIV. Some knew very little about HIV or had very strong assumptions regarding which groups were exclusively affected by HIV. Others were well informed and accepting of the test, while a few requested repeated HIV tests due to anxiety of being positive. The cost of testing and impact on visa status or health insurance were often the main concerns, followed by fear of dying or experiencing HIV-related stigma from community. Most GPs described that informing patients about routes of transmission, available treatment and impact of a positive diagnosis on lifestyle and work, helped address concerns and increased willingness to test.

"Patients won't get tests with informed consent unless they feel that they have enough education about the testing they are getting and I don't think it's fair to just test... I think there is a lot of fear around HIV testing... there is a lot of stigma." – GP 02

Some GPs reported experiences where they were unable to convince a patient to test. Assumptions as to why people were unwilling to test included that the person was already diagnosed and unwilling to disclose their status, or due to anxiety and fear of testing positive.

"There is a fear that the test may come positive, if they have been at significant risk, they might think they are HIV positive, so they don't want the test." — GP 01



RECOMMENDATIONS TO INCREASE HIV UPTAKE AMONG PATIENTS - INTERVIEWS

GPs were asked what could be done to increase HIV testing among people born in sub-Saharan Africa and South East Asia. An overview of the barriers and recommendations are provided below.

Table 7. GP recommendations to increase HIV testing

R				

GPs not aware of HIV priority populations or unsure how to approach sexual health screenings

"...some updated resources about prevalence in different communities in Australia because I don't really know that." – GP 04

SEA and SSA communities are 'hard to reach' "I can only understand how hard it is to break through in that community and make them aware of these [sexual health] things." – GP07

Patients with low knowledge of HIV

"People don't understand [HIV], and the translators don't necessarily understand either... it's quite a medical consultation to try and break down some of those myths as well." – GP06

Patients not requesting HIV testing

"I think making the community aware will be easier...My barrier is that I'm not able to pick a patient and say that they should be tested... it can be missed." – GP07

Gender

"If there was a male in the room, I would not be saying anything about my genitalia but I would [to] a female doctor." – GP05

Language or cross-cultural communication

"...It's more of an issue for me because I haven't asked her the question because I haven't known how it would go down... I was anxious about how she would cope with me asking that through a male interpreter." – GP 08

Fear of offending patient

"To say that I do it for you [HIV test], maybe they get offended." – GP10

Short consultation times

"It's easier to offer them a urine test rather than taking a detailed sexual health history [for HIV]. You have limited time." – GP04

RECOMMENDATIONS

- Yearly notification rates of HIV and other STIs at national and jurisdictional level to be sent to GPs
- Increased opportunities for GPs to attend information sessions on sexual health and bloodborne viruses
- Availability of testing at community-based settings (e.g., multicultural centres, religious centres)
- Roll out HIV self-testing kits
- Widening of focus of HIV community organisations beyond Australian born gay men
- Culturally appropriate and translated resources to be available to give patients
- Interventions to increase HIV testing among communities, delivered by communities (e.g., community info sessions held by community leaders or religious leaders)
- Advertising free and confidential HIV testing centres
- Clinics to offer both male and female staff
- Receptionist to offer choice of male or female doctor to patient
- Training of interpreters to feel confident asking sexual health questions
- Increase availability of interpreters (both male and female), particularly for small language groups
- Clinic support staff pre-booking interpreters
- Availability of bicultural workers to support GP
- Research to better capture communities' understanding of health, HIV, same-sex relationships, etc. and terminology used to describe these concepts
- Offering HIV routinely (i.e., for all new patients)
- Promoting an HIV test as something everyone is offered
- Increase consultation times during some sessions to promote wider participation



STRENGTHS AND LIMITATIONS

There are some limitations to this project. For the focus groups, data collection was conducted in English, without the option for an interpreter. Given the sensitive nature of this topic, there was the possibility of social desirability bias, and differing experiences or opinions may not have been shared in the group setting. People born in Indonesia and South Sudan were over-represented, and their experiences may be different to those from other countries.

Many participants in the MSM focus groups were connected to the gay community and were frequently testing for HIV. Their levels of knowledge were generally higher than others and they had greater familiarity with services and testing procedures. This differed to the experience of a number of other participants who had only recently tested for HIV for the first time, and for those who had not yet tested—though these numbers were small overall. As such, the barriers for those who were more or less connected to community and services may have differed or may have not been sufficiently explored in this research.

Only a small number of GPs were able to be recruited. Most identified as having a special interest in HIV, and/or migrant and/or refugee health. As such, there may be additional barriers for GPs offering HIV tests to people from SSA and SEA that are not captured in this report. Again, social desirability bias may have been an issue, in that not all GPs may not have accurately described their challenges.

This project had a number of strengths. Where possible peer facilitators were used for focus groups, often with non-peer co-facilitators, who were able to help draw out unique experiences between groups and increase their own cultural competency. This project was conducted in four jurisdictions in Australia, increasing the relevancy of this project nationally. Focus groups included participants with diverse experiences – including people on temporary visas, men who have sex with men, and people across different age groups. The results have tried to identify similarities and differences between sub-groups. An additional strength of this project is that it combined both the perspectives of patients and GPs.

DISCUSSION

This project highlights significant barriers to HIV testing among people born in sub-Saharan Africa and South East Asia. It identified a number of barriers to accessing testing, both structural and sociocultural, and findings are consistent with previous research in Australia [6, 14, 15].

What this work adds to the available research is a number of recommendations to increase HIV testing, as proposed by community members and GPs. Considering this and the current literature, the following recommendations are proffered in brief with a focus on interventions to increase HIV-testing that are multi-strategic and community-led.

These recommendations are broad and may not be appropriate for all groups. It is important to recognise the heterogeneity of migrant groups and as far as is practicable segment migrant groups in order to identify and respond to their unique needs. This project identified a critical need for communities to see themselves represented in the HIV-response while avoiding putting 'blame' on specific groups. Striking a balance here will be difficult. In line with good health promotion practice, consultation and engagement with communities is necessary to ensure that the community has buy-in to forthcoming projects and a voice on issues that most affect them.

RECOMMENDATIONS FOR POLICY

Recommendation 1: HIV self-testing (HIVST) kits to be approved for use in Australia by the Therapeutic Goods Administration

Availability of HIVST may increase testing among groups who are concerned about confidentiality, are embarrassed about discussing their sexual behaviour with health professionals, or who are concerned about judgment from health professionals on behaviour [16, 17]. Currently, the only option in Australia is to purchase unregulated HIVST online, raising concerns about the quality of such tests, and the lack of health information available, such as local HIV counselling [18]. Necessary support needs to be made available through adequate funding to ensure patients who receive a reactive test are linked into appropriate care and counselling [18]. Opportunities to subsidise HIV self-testing kits, or to collect for free, should be considered by government and/or other funding bodies.

Recommendation 2: Assess benefits of increasing availability of rapid HIV testing
Rapid HIV testing provides fast results and can address some of the anxiety around waiting for a test result, or patients not returning for follow up appointments to receive results. The acceptability and feasibility of expanding rapid testing sites should be considered by state governments, including new locations. Rapid testing should be provided to populations other than gay and bisexual men in jurisdictions where this is not available [19].

Recommendation 3: Remove criminal prosecutions of the sexual transmission of HIV

For many people outside the gay community, the media is often a significant source of information on HIV

[20]. Criminalisation of HIV transmission only adds to HIV-related stigma and is inconsistent with UNAIDS policy guidelines⁶ and public health messaging. Fear of prosecution may deter people from disclosing their status to a sexual partner. Criminalisation of HIV is not believed to contribute to a reduction of onwards transmission⁵.

http://www.unaids.org/sites/default/files/media_asset/jc1601_policy_brief_criminalization_long_en.pdf

Other considerations: Universal access to HIV treatment for Medicare ineligible people living with HIV and access for Pre-exposure Prophylaxis (PrEP) for Medicare ineligible

While not directly mentioned in this research, there is a need for equal access to available treatment and prevention for people who are Medicare ineligible. The Australian Government provides subsidised antiretroviral treatment (ART) to PLHIV eligible for Medicare through the Pharmaceutical Benefit Scheme (PBS).

Temporary residents who are ineligible for Medicare must, therefore, pay the full treatment cost, source treatment from their country of birth or import generic drugs from oversea suppliers. Without access to effective HIV treatment, health outcomes for these individuals are further complicated and present the risk of onwards HIV transmission to their partners [21]. In many cases, individuals may be offered compassionate access to treatment via pharmaceutical companies. This current process is not ideal, as the goodwill of companies is subject to change. Universal access to treatment allows people to test without fear of not being able to afford treatment and subsequently either not accessing treatment, or returning to their country of birth [22, 23]. The Commonwealth Government must reform policies to ensure access to treatment for all.

Additionally, PrEP is available through the PBS for Medicare holders, effective from 1 April 2018. Medicare ineligibles must import PrEP to access it. The TGA has noted that some medications may not be approved for supply in Australia⁷. Importation of PrEP creates an additional barrier of access to HIV prevention technology for at-risk individuals.

RECOMMENDATIONS FOR PRACTICE

Recommendation 4: Increase positive conversations on HIV through community settings

Community organisations should identify appropriate methods to increase positive conversations about

HIV and regular testing among community, led and delivered by community and religious leaders. This may
be through seminars, after religious ceremonies, or through drama or story-telling. Community and
religious leaders are uniquely poised to 'break the silence' on HIV, by welcoming and accepting people
living with HIV and encouraging community members to know their status [24]. It should be noted that
there were concerns expressed by some MSM that community leaders may not be best placed to discuss
HIV testing due to their conservative and/or religious beliefs – particularly in regards to same-sex sexual
relationships.

Recommendation 5: Addressing HIV-related stigma and sharing positives stories by people living with HIV Community organisations should encourage people living with HIV from these communities to share positive living stories (possibly keeping their identity anonymous) where they feel safe to do so. Platforms should be identified for people living with HIV to share with community groups, such as through community forums, videos, social media, written stories or through drama. This involvement of PLHIV needs to be meaningful and be led by PLHIV, as outlined in the UNAIDS "Greater Involvement of people living with HIV" [25].

Recommendation 6: Advertise locations of where to test through appropriate methods

Community organisations and state governments to promote (through sources relevant to community, e.g., ethnic media, social media, online sites, etc.) locations where HIV testing can be conducted – particularly where it may be free (including for international students) and confidential. Community organisations and health services should identify, work with and promote GPs, clinics or other community-based centres where staff have undertaken cultural competency training, and are comfortable and willing to test patients for HIV.

⁷ https://www.afao.org.au/wp-content/uploads/2016/12/PrEP-Access-Options-2017.pdf

Recommendation 7: GPs to routinely offer HIV testing and be more aware of emerging priority populations People from high HIV prevalence countries, or who travel to high HIV prevalence countries, are considered priority groups for HIV testing⁷. Peak bodies and/or state governments should encourage GPs to offer HIV testing as part of a general health checkup; when a patient first joins the practice; or is requesting blood tests, rather than waiting for patient self-disclosure of 'high risk.' The ASHM HIV testing policy states that a detailed sexual behaviour and/or drug use history is not necessary for testing, and patients who request an HIV test should be tested⁸. Peak bodies, community organisations and state governments should identify opportunities to increase GPs knowledge of HIV testing and priority populations for HIV, such as through newsletters, workforce training opportunities or mailouts of national and jurisdictional epidemiology. This work can be targeted to GPs who work in locations where there is a high volume of patients from these regions.

Recommendation 8: Make HIV-testing information resources available for use by GPs

Peak bodies, community organisations and/or research centres to consolidate useful information resources on HIV, HIV transmission and prevention options, HIV testing process (including contact tracing, length of time for results, etc.), and HIV treatment options should be translated into priority languages, for GPs to deliver to patients who are unfamiliar with testing. Resources should be developed in consultation with GPs and patients, and housed online to be available for download. These resources should be available for GPs in locations where priority communities frequently visit.

Recommendation 9: Training of interpreters and bilingual workers to increase skills and comfort levels when discussing sexual health

Peak bodies and community organisations to provide workforce development training and resources for interpreters and bilingual workers to increase their skills and comfort levels when discussing sexual health and HIV. Ongoing effort should be made to ensure there are sufficient numbers of male and female interpreters, particularly for small language groups. Where appropriate, relevant services should consider employing a bilingual worker to help deliver culturally appropriate health care.

Recommendation 10: Identify opportunities to test for HIV outside sexual health clinics and general practices

'Pop up' testing in community-based settings using rapid testing, or self-collection oral samples collected by peer workers should be trialed [26]. Such initiatives could be delivered by multicultural organisations using peer workers or people living with HIV. There are also opportunities for primary health services that include HIV testing to be made available at multicultural organisations.

Recommendation 11: Ensure international students are provided relevant information on accessing health services in Australia, including sexual health services and HIV testing

Universities and community organisation to provide international students relevant information on accessing health services. This could be delivered during orientations, clear information made available on university websites, at international student social events, or using other students as 'peer educators' during the semester. Free health services for international students on campus should be advertised where available.

Recommendation 12: Ensure communities are well informed about new HIV prevention measures, such as PrEP

Community organisations to work with GPs, community health workers and community and religious leaders to ensure they are aware of new prevention methods and are able to support individuals in finding further information. This may be via forums or workshops or evidence updates. As PrEP trials continue, we expect more information will be made available to key groups. This includes those who are traveling to high HIV prevalence countries.

⁸ http://testingportal.ashm.org.au/images/HIV_Testing_Policy_Feb_2017.pdf

RECOMMENDATIONS FOR RESEARCH

Recommendation 13: Evaluate interventions and campaigns to increase HIV testing among people born in sub-Saharan Africa and South-East Asia

Interventions or campaigns such as 'pop up' testing or use of social media, should be appropriately evaluated and reported on by community and government organisations. With support from research centres, core indicators should be developed that measure more than knowledge and report on HIV-related stigma, cultural and religious barriers to testing. Evaluation should be disseminated widely, including published in the peer-reviewed literature and via open access tools such as case studies or reports and community fora.

Recommendation 14: Ensure that people born in sub-Saharan Africa and South-East Asia are accurately and appropriately represented in all HIV-related research (such as current PrEP trials)

Research centres and community organisations to identify processes to facilitate participation for these communities (e.g., peer recruiters, community involvement from the onset of research), and address barriers to participation.

Recommendation 15: Implement a national surveillance survey on HIV knowledge, testing and HIV testing barriers for priority migrant communities

In order to accurately capture critical data on often hidden populations, a national periodic survey should be developed and delivered in partnership with government, research centres and community organisations. This will assist in identifying at-risk sub-populations, and track success in addressing barriers to HIV testing.



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