

Experience of HIV among overseas-born men who have sex with men (MSM) and MSM from migrant backgrounds



Dr Dean Murphy

16 June 2020

Key points of consideration for the sector

- A more transnational perspective on HIV prevention and sexual health promotion is needed, including a focus on the connectedness (including travel to) countries of origin.
- More attention needs to be paid to the impact of the urban environment (i.e. neighbourhoods) on vulnerability to HIV – including, but not limited to, sexual risk.
- Interventions should focus on a ‘strengths-based’ approach, which aims to improve health by identifying and promoting existing personal, family, community and cultural resources, rather than focusing on deficits or barriers¹.
- For non-Australian-born MSM there is an opportunity to promote:
 - the availability of free, anonymous HIV (and sexual health) testing through sexual-health clinics;
 - community controlled point-of-care testing sites to overseas-born MSM (including both migrants and temporary residents), and
 - access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).
- Greater research is needed to help identify the ways in which different forms of marginalisation or exclusion intersect to increase vulnerability to HIV (e.g. language, culture, social connectedness, socio-economic class).

Background

Historically, male-to-male sexual contact has been the most common route of HIV acquisition in Australia, although this pattern has not been as strong among PLHIV born overseas (especially among people from low/middle income countries)².

Three important, and related trends, have become evident in recent years:

- 1) a decline in diagnoses among MSM^{3,4};
- 2) a decline in the proportion of diagnoses attributed to male-to-male sex⁵; and
- 3) an increase in the proportion of new MSM diagnoses among men born overseas^{i, 4, 6-8}. This divergence of epidemics in Australian and overseas-born MSM is also characterised by a difference in trends in late HIV diagnoses.⁴

ⁱ There is some variation in terminology in the literature. Studies from Australia tend to use the term, ‘overseas-born’, whereas elsewhere ‘foreign-born’ is more common. A range of other distinctions are also sometimes made, for example, between people newly arrived in destination countries, and those who have been resident for a longer period. Some studies also report on migrant populations, people excluded from Medicare coverage, which intersect the categories above. Still other research focuses on specific groups such as Asian-born (including sub-categories within this group), people from Asian backgrounds, people from Latin America, and sub-Saharan African populations, to name a few. Another category that crosscuts all the others is temporary residents, which includes people on student and work visas. It’s important to note that although there is a great deal of overlap between these categories, they are not exactly the same. Also, it is important to add that while these research studies and analyses of data act to reify, or naturalise these categories, they are not necessarily meaningful categories or identities for the individuals or groups that they describe.

HIV acquisition

Analyses of surveillance data from many countries have demonstrated that, for migrants, there is a high risk of HIV acquisition, and that this risk is higher for men who have sex with men (MSM). For example, a review of published research on HIV among migrants in a number of high-income countries (North America and Europe), post-migration HIV acquisition was 63% overall, and 72% among MSM.⁹ Socio-economic vulnerability puts migrants at additional risk of acquiring HIV, including those from countries with low HIV prevalence and/or from ethnic minorities.⁹ An analysis of HIV diagnoses in the US, found that 61% of infections among foreign-born residents were estimated to have occurred *after* arriving in the country; and that for foreign-born MSM this estimate was 76% (compared to 68% among all foreign-born men, and 50% among women).¹⁰ Another review of studies found high rates of HIV among foreign-born – especially Latin men – in North American and European countries, and the authors argue that migration and HIV risk should be understood as syndemics within ethnic minority populations.¹¹ These authors also call for more research on contextual factors for HIV risk among these men, including ethnic networks, individual post-migration transitions, gay community connections, and substance use cultures in specific destination countries and cities. There is a need to look at the impact of migration from both directions, that is, the influence of both the origin and destination countries (and the interaction between the two). It is also important to note the transnational aspects of migration. A study of MSM who migrated within Europe for example, found an association between structural stigma (in either the origin or destination country) and lack of HIV prevention.¹²

Australian HIV surveillance data, however, are not usually presented in ways that distinguish between pre-and post-migration acquisition of HIV. Assumptions about place of acquisition are made on the basis of: time in Australia; any previous HIV testing in Australia; and clinical markers at diagnosis; and self report. We do know that in Australia, migrants are more likely to receive a delayed HIV diagnosis, compared to their locally born counterparts.⁹ As noted above, this trend is becoming more evident among MSM.⁴ It is, therefore, likely that a significant proportion of these men acquired HIV before coming to Australia. Consistent with this pattern regarding late-diagnoses trends, estimates of the HIV diagnosis and care cascade for migrants who report male-to-male HIV exposure are lower (i.e. 84-83-93) compared with non-migrants reporting male-to-male HIV exposure (96-92-96).¹³ Notably, this difference between migrant and non-migrant MSM is greater than between migrants and non-migrants generally.

Redefining risk

These findings highlight the need for HIV prevention and testing among newly arrived residents. Further, targeting is complex, not least because some groups of MSM are more vulnerable to acquiring HIV despite not engaging in sexual and/or injecting behaviours that are associated with HIV transmission at higher levels than other men – in fact, risk of acquiring HIV can be greater among groups of men who report lower levels of these behaviours.

Some local studies highlight this complexity. A study of sexual-health clinic attendees found that newly arrived Asian-born MSM were more than twice as likely as other MSM to be both diagnosed with HIV, and also diagnosed specifically with newly acquired HIV infection.¹⁴ This finding is in the context of an overall decrease in incident HIV infection among MSM mentioned above and suggests a change in vulnerability to HIV infection despite lower behavioural risk (i.e. greater use of condoms and fewer sexual partners), which is also evident in other research.¹⁵ The authors suggest therefore that rather than risk behaviours, newly arrived men from Asian countries are at greater risk of HIV due to their differential (that is, less secure) access to testing, treatment, and PrEP.¹⁶ These healthcare access issues lead to delayed viral suppression in newly arrived men who acquire HIV, and consequently may also be associated with further transmissions.

Two additional observations from this study are important to note. The first is the authors' suggestion their findings raise the possibility of increasing connectedness between men newly arrived in Australia and the rising HIV epidemics among MSM in Asia, including in mainland China. The other is Medland et al.'s call for new research and programs to both identify and target the specific vulnerabilities that may place this group of men at increased risk of HIV. Some potential vulnerabilities include language, culture, gay community engagement, sources of HIV information, sexual experience, and the ability to negotiate successful risk reduction strategies.¹⁴

Findings from research among foreign-born MSM who had recently been diagnosed with HIV found that although overall there was diversity of experiences among participants, there were some trends based on the region of birth.¹⁷ Men born in Latin-American countries were more likely to: have a history of regular testing in their countries of origin; have awareness of PrEP and PEP; have more gay community attachment, and have adopted a gay sexual identity. Men born in Asian countries were less likely to have tested (and especially to test regularly) in their countries of origin, less likely to know about PrEP and PEP, and reported less sexual activity, fewer partners, and were less likely to perceive themselves at risk of HIV.

HIV prevention and testing

The introduction of HIV Pre-Exposure Prophylaxis (PrEP) (originally through implementation projects) is believed to have been a major contributor to the decline in HIV diagnoses among MSM. As an example, the PrEP study, which commenced in 2016 in New South Wales, reported a 31.5% relative risk reduction in incident HIV notifications in MSM and a 18.5% reduction in other HIV diagnoses.¹⁸ It is, therefore, important to examine factors that may facilitate PrEP use among those who may benefit, and address any barriers. Recent research has found that PrEP use among MSM is unrelated to being born in Australia versus elsewhere, (although it is related to other factors, some of which intersect with cultural background, such as sexual behaviour and sexual identity).^{15, 19} However, other research among overseas-born men has identified a number of issues related to PrEP uptake. Recent research among overseas-born men recently diagnosed with HIV found that even though these men generally considered PrEP a positive strategy, they did not necessarily consider it appropriate for them personally (because they did not see themselves as sufficiently high risk).¹⁷ Also, recent market research conducted in Australia identified a range of factors contributing to not taking PrEP among men who have sex with men from Asian and South American backgrounds, including perceived individual risk, beliefs about HIV prevalence in Australia, concerns about the impact of HIV testing on visa status, knowing how to navigate the health system, attitudes towards PrEP, cultural influences on sexuality, and cost (including for doctor's consultation for those not covered by Medicare).²⁰

Regarding access to testing, Knight et al. found that among clients at new HIV testing services, men born in Asian countries were more likely to test infrequently for HIV.²¹ They also found that attendance specifically at new community test sites (vis-à-vis a sexual-health centre) was associated with being born in Asia, and never having been previously tested for HIV. The findings suggest new testing models are important in efforts to increase HIV testing among men. Murray et al.'s survey of men from Asian backgrounds residing in Sydney and Melbourne found men who tested (for HIV and STIs) regularly were substantially more sexually active, were more likely to have multiple partners, and were more likely to engage in condomless sex.²² Those who engaged with testing initiatives were more likely to discuss HIV status with sexual partners, and to perceive greater benefits from testing benefit than did their counterparts. The men who identified as gay were most likely to have used public sexual health clinics. Other recent research among gay men from Asian backgrounds found large increases in the proportion of men who reported HIV and STI testing, in particular among men who had been living in Australia for over five years.¹⁵

Interestingly, two studies from Melbourne, and one from Adelaide, suggest more frequent testing among overseas-born men than other men, when testing is freely available.^{14, 23, 24} A study of testing patterns from the first year of operation of a community-based rapid point-of-care (POC) testing service in Melbourne found that returning for testing within 6 months of their first test was associated with being born overseas.²³ Interestingly, at this same service, when free STI testing (for those covered by Medicare, Australia's national health-insurance scheme) was introduced in 2016, this change led to an increase on the rate of return HIV testing among these clients but no change in return HIV testing among clients without Medicare coverage.²⁵ An analysis of trends in HIV testing over more than twenty years (to 2017) among MSM in South Australia found that in the context of an overall low rate of testing, being non-Caucasian, in particular having an African background, was associated with a greater odds of having had a recent HIV test.²⁴

An evaluation of another new POC testing service in Brisbane found 20% of clients were not covered by Medicare, indicating significant implications for the ongoing treatment and care of people in this situation who test positive to HIV.²⁶ These findings indicate that policy-related barriers to testing are significant, and testing among men excluded from Medicare coverage is responsive to initiatives that obviate the need for a Medicare card. What remains to be explored further is other factors that may drive testing demand, such as levels of knowledge about free and anonymous testing options (for people excluded from Medicare coverage), and concerns about privacy and potential risks to visa and residency status.

Other issues related to culture, race, gender, and country of birth

The call for more emphasis on factors such as language, culture, social connectedness, knowledge, and sexual experience and negotiation suggests the need for a more intersectional analysis of risk. This approach is based on the understanding that forms of privilege and oppression intersect with HIV and other social identities, such as race and ethnicity, nationality, gender identity, sexual orientation, sexual practices, and drug consumption.²⁷ Taylor et al. analysed how this overlap may further amplify barriers to HIV testing among foreign-born Black men in the US.²⁷ This approach has also been deployed to examine the relationship between race/ethnicity, migration, sexuality and health among men with Chinese background in Australia – which also noted the transnational nature of these men’s lives, and that experiences are constantly being changed and transformed by these forces.²⁸

Some policy-related factors (access to testing, antiretrovirals, health insurance coverage, and immigration/visa status) have already been mentioned in this paper. Other factors that relate to experiences of HIV vulnerability in the literature include societal-level factors such as attitudes towards immigrants, heteronormative gender roles, and expectations of masculinity. Although Taylor et al. focused on men from the Caribbean in the US, issues such as the masculine norms of reputation, independence and emotional control, as well as resistance to health seeking, may contribute to greater HIV risk for MSM from a range of different origins, including in Australia. Another notable issue is attitudes among health-care providers²⁹, including for example, potential unconscious and/or perceived bias among health providers towards African-American MSM, especially younger men, as demonstrated by willingness to prescribe PrEP.³⁰⁻³²

Community and cultural factors are also relevant to HIV vulnerability. Whereas some issues such as government mistrust may be more applicable to US settings, other factors such as assimilation are worth further exploration in the Australian context. Migration can lead to the loss of protective social and sexual networks, and connections to religious communities. In addition, acculturation, including the adoption of perceived social norms in a destination country, can also be associated with HIV risk^{27, 33}, and this issue may be pertinent for men newly arrived in Australia negotiating local sexual cultures. Also important to note is that men from minority backgrounds may experience social engagement with the gay community less positively than their white counterparts.^{27, 34}

Summary

There are other factors, beyond those covered in this paper, that may be equally relevant to experiences of HIV vulnerability/protectiveness and risk. These factors include social connection, location, and mobility (including domestic mobility). Although there is now attention being given to postcode of residence as an indicator of risk and prevention (for example, through data on diagnoses and PrEP use), there is an opportunity for more comprehensive approaches to the impact of the environment on gay men’s health and well-being. This includes, but is not limited to HIV risk^{35, 36}, and mobility between the neighbourhoods in which they live, socialise, and meet sexual partners.³⁷

Further work could also draw on useful conceptual tools. Intersectionality has already been mentioned. Another method is a ‘strengths-based’ approach, which aims to improve health by identifying and promoting existing personal, family, community and cultural resources, rather than focusing on deficits or barriers.¹ Finally, conceptual tools drawn from policy-analysis research, including ‘problematization’³⁸ might be useful in rethinking how issues are framed and, by implication, addressed.

References

1. Colpitts, E. and J. Gahagan, The utility of resilience as a conceptual framework for understanding and measuring LGBTQ health. *International Journal for Equity in Health*, 2016. 15(1).
2. Tilley, D.M., et al., Treatment and disease outcomes of migrants from low- and middle-income countries in the Australian HIV Observational Database cohort. *AIDS care*, 2015. 27(11): p. 1410-1417.
3. Kirby Institute, HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2018. 2018, Kirby Institute, UNSW Sydney: Sydney.
4. New South Wales Government. NSW HIV Strategy 2016 – 2020 Quarter 4 & Annual 2019 Data Report. 2020 [cited 2020 13 May]; Available from: <https://www.health.nsw.gov.au/endinghiv/Publications/q4-2019-and-annual-hiv-data-report.pdf>.
5. Gunaratnam, P., et al., HIV diagnoses in migrant populations in Australia-A changing epidemiology. *PLoS One*, 2019. 14(2): p. e0212268.
6. Department of Health & Human Services. HIV quarterly surveillance report April-June 2019. 2020 [cited 2020 13 May]; Available from: <https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/search-infectious-diseases-data/hiv-quarterly-surveillance-report-april-june-2019>.
7. Communicable Disease Control Branch. Surveillance of sexually transmitted infections and blood-borne viruses in South Australia, 2018. 2019 [cited 2020 14 May]; Available from: <file:///Users/deano/Desktop/2018+Surveillance+of+STIs+and+BBVs+in+SA+-+Epi+report+32.pdf>.
8. Gunaratnam, P., et al., HIV diagnoses in migrant populations in Australia-A changing epidemiology. *PloS one*, 2019. 14(2): p. e0212268-e0212268.
9. Alvarez-del Arco, D., et al., HIV testing and counselling for migrant populations living in high-income countries: a systematic review. *Eur J Public Health*, 2013. 23(6): p. 1039-45.
10. Wiewel, E.W., et al., Foreign-Born Persons Diagnosed with HIV: Where are They From and Where Were They Infected? *AIDS and Behavior*, 2015. 19(5): p. 890-898.
11. Lewis, N.M. and K. Wilson, HIV risk behaviours among immigrant and ethnic minority gay and bisexual men in North America and Europe: A systematic review. *Soc Sci Med*, 2017. 179: p. 115-128.
12. Pachankis, J.E., et al., Anti-LGBT and Anti-immigrant Structural Stigma: An Intersectional Analysis of Sexual Minority Men's HIV Risk When Migrating to or Within Europe. *J Acquir Immune Defic Syndr*, 2017. 76(4): p. 356-366.
13. Marukutira, T., et al., Gaps in the HIV diagnosis and care cascade for migrants in Australia, 2013-2017: A cross-sectional study. *PLoS Med*, 2020. 17(3): p. e1003044.
14. Medland, N.A., et al., Incident HIV infection has fallen rapidly in men who have sex with men in Melbourne, Australia (2013–2017) but not in the newly-arrived Asian-born. *BMC Infectious Diseases*, 2018. 18(1): p. 410.
15. Wong, T., et al., 2018 Sydney Gay Asian Men Survey: Brief report on findings. 2018, Centre for Social Research in Health, UNSW: Sydney.
16. Medland, N.A., et al., Is differential access to prevention distorting HIV epidemiology in Australia? *The Lancet HIV*, 2019. 6(8): p. e492.
17. Aung, E., Qualitative interviews with overseas-born MSM from non-English speaking countries, recently diagnosed with HIV, in CALD Gay Men's Action Group Symposium. 2019: Sydney.
18. Grulich, A.E., et al., Population-level effectiveness of rapid, targeted, high-coverage roll-out of HIV pre-exposure prophylaxis in men who have sex with men: the EPIC-NSW prospective cohort study. *Lancet HIV*, 2018. 5(11): p. e629-e637.
19. Hammoud, M.A., et al., HIV Pre-exposure Prophylaxis (PrEP) Uptake Among Gay and Bisexual Men in Australia and Factors Associated With the Nonuse of PrEP Among Eligible Men: Results From a Prospective Cohort Study. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 2019. 81(3): p. e73-e84.
20. Circa, Research into community attitudes towards Pre-Exposure Prophylaxis. 2019, Australian Federation of AIDS Organisations: Sydney.
21. Knight, V., et al., Implementation and Operational Research: Convenient HIV Testing Service Models Are Attracting Previously Untested Gay and Bisexual Men: A Cross-sectional Study. *J Acquir Immune Defic Syndr*, 2015. 69(5): p. e147-55.
22. Murray, D., et al., High levels of engagement with testing for HIV and sexually transmissible infection among gay Asian men in Sydney and Melbourne: an observational study. *Sexual Health*, 2020. 17(2): p. 121-128.

23. Ryan, K.E., et al., Characteristics of gay, bisexual and other men who have sex with men testing and retesting at Australia's first shop-front rapid point-of-care HIV testing service. *Sexual Health*, 2016. 13(6): p. 560-567.
24. Li, B., et al., Trends and predictors of recent HIV testing over 22 years among a clinic sample of men who have sex with men in South Australia. *Sexual Health*, 2017. 14(2): p. 164-169.
25. Ryan, K.E., et al., Assessment of service refinement and its impact on repeat HIV testing by client's access to Australia's universal healthcare system: a retrospective cohort study. *J Int AIDS Soc*, 2019. 22(8): p. e25353.
26. Mutch, A.J., et al., Increasing HIV testing among hard-to-reach groups: examination of RAPID, a community-based testing service in Queensland, Australia. *BMC health services research*, 2017. 17(1): p. 310-310.
27. Taylor, T.N., J. DeHovitz, and S. Hirshfield, Intersectional Stigma and Multi-Level Barriers to HIV Testing Among Foreign-Born Black Men From the Caribbean. *Front Public Health*, 2019. 7: p. 373.
28. Wong, H.T.H., Chinese diasporic gay men in Australia: intersectionality, social generations and health. 2019, PhD Thesis, UNSW. Available from: <http://unsworks.unsw.edu.au/fapi/datastream/unsworks:55262/SOURCE02?view=true>
29. Newman, C., et al., Promoting 'Equitable Access' to PrEP in Australia: Taking Account of Stakeholder Perspectives. *AIDS and Behavior*, 2019. 23(7): p. 1846-1857.
30. Calabrese, S.K., et al., A Closer Look at Racism and Heterosexism in Medical Students' Clinical Decision-Making Related to HIV Pre-Exposure Prophylaxis (PrEP): Implications for PrEP Education. *AIDS Behav*, 2018. 22(4): p. 1122-1138.
31. Quinn, K., et al., "A Gay Man and a Doctor are Just like, a Recipe for Destruction": How Racism and Homonegativity in Healthcare Settings Influence PrEP Uptake Among Young Black MSM. *AIDS Behav*, 2019. 23(7): p. 1951-1963.
32. Cahill, S., et al., Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in black compared to white gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts. *AIDS Care*, 2017. 29(11): p. 1351-1358.
33. Du, H. and X. Li, Acculturation and HIV-related sexual behaviours among international migrants: a systematic review and meta-analysis. *Health Psychology Review*, 2015. 9(1): p. 103-122.
34. Haile, R., et al., An Empirical Test of Racial/Ethnic Differences in Perceived Racism and Affiliation with the Gay Community: Implications for HIV Risk. *Journal of Social Issues*, 2014. 70(2): p. 342-359.
35. Frye, V., et al., The urban environment and sexual risk behavior among men who have sex with men. *J Urban Health*, 2006. 83(2): p. 308-24.
36. Kelly, B.C., et al., Sex and the community: the implications of neighbourhoods and social networks for sexual risk behaviours among urban gay men. *Sociol Health Illn*, 2012. 34(7): p. 1085-102.
37. Koblin, B.A., et al., Methods to Measure the Impact of Home, Social, and Sexual Neighborhoods of Urban Gay, Bisexual, and Other Men Who Have Sex with Men. *PLOS ONE*, 2013. 8(10): p. e75878.
38. Bacchi, C., *Problematizations in Health Policy: Questioning How "Problems" Are Constituted in Policies*. SAGE Open, 2016. 6(2): p. 2158244016653986.