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Editorial
Sexual Health, 2008, **5**, 313–314

Working with West African migrant communities on HIV prevention in Australia

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Australia's HIV epidemic has largely affected men who have sex with men (MSM) with 81% of the 26 836 cases diagnosed until June 2007 occurring in this group. The majority (66%) of HIV cases occur in people born in Australia, but 34% of people diagnosed with HIV in Australia between 2002 and 2006 were born overseas (Asia 10%, sub-Saharan Africa 6%, UK and Ireland 5%, Other Europe 5%, elsewhere 8%). Among those infected through heterosexual contact, 62% were born abroad. People from sub-Saharan Africa comprise an important subgroup of HIV cases diagnosed in Australia. Although the total number of sub-Saharan African-born individuals diagnosed with HIV is small (259 cases between 2002 and 2006), surveillance figures suggest African-born people are over-represented among diagnosed cases of HIV because only 1% of the Australian population was born in Africa. The estimated annual per capita rate of HIV diagnosis is 36.2 per 100 000 for Australian residents born in sub-Saharan Africa compared with only 4.4 per 100 000 in the Australian-born population; most African-born people diagnosed with HIV acquired the infection through heterosexual contact.[1–3]

Quite reasonably, the focus of Australia's HIV prevention and care efforts has been on MSM. Only limited resources have been directed towards research examining the impact of HIV on Australia's African communities. To date, published Australian research concerning HIV and African immigrants has addressed clinical issues (such as patterns of AIDS-defining illnesses), virological aspects (such as patterns of HIV subtypes), and psychosocial aspects (the experiences of African-born people living with HIV). Little has been published about the knowledge and understanding of HIV among African communities in Australia and there has been little discussion about HIV with and within the communities themselves.[4–6]

In a previous issue of *Sexual Health*, Drummond *et al.*[7] reported the results of a study that examined HIV knowledge among women who had recently migrated from West Africa to Western Australia. They found that the West African women were well informed about factors increasing the risk of HIV transmission (such as sharing an injection needle with an HIV-infected person, having more than one sexual partner, having a sexually transmitted infection) but at the same time they held several 'incorrect beliefs' about HIV transmission (such as the influence of spirits or supernatural forces, risk of transmission through touch, kissing, sneezing, sharing kitchen utensils and drinking glasses, or from toilets and swimming pools) and ways to prevent HIV (such as having sex with a virgin or washing the genitals after sex). These 'incorrect beliefs' occurred more frequently among West African women than in Australian born women (who nonetheless also held several misconceptions about HIV transmission) and were more likely to occur in West African women with less than 8 years of formal education. Attitudes towards the use of condoms were quite negative, with responses indicating an association of condoms with shame and sexual promiscuity. Interestingly, responses indicated that although the West African women were more likely to feel 'insulted,' if a male partner were to suggest the use of condoms, they were also more likely than the Australian women to feel that the male partner was being 'responsible'. The survey questions did not specify whether these were casual, short-term or long-term sexual partners.[7]

Public discussion about migration and HIV all too often focuses on the 'threat' posed by HIV-infected immigrants to the host population, yet only ~2% of HIV infections diagnosed in Australia are due to transmission from a person born in a high prevalence country to an Australian resident born in Australia or in a low prevalence country. In fact, the disproportionately high rate of HIV diagnoses among overseas-born Australians such as those born in sub-Saharan Africa suggests that more attention should be focussed on protecting members of these immigrant communities from becoming infected with HIV. Available surveillance data concerning overseas-born Australian residents diagnosed with HIV does not indicate how many were infected before first arrival in Australia, on subsequent travel abroad or within Australia, but HIV prevention strategies will probably need to be developed to reduce exposure in all of these settings.[1,8,9]

10.1071/SH08060 1448-5028/08/040313

In Israel, Soskolne and Shtarkshall created a conceptual framework for the development of HIV prevention strategies for migrant populations, based on their research with immigrants from Ethiopia and the former USSR. Rather than focusing solely on individual behaviours (trying to describe and then modify sexual risk behaviour and improve the use of HIV prevention and care services), they suggest a wider view, encompassing factors acting both at the social level and the individual level. Social factors influence individual behaviours, and need to be understood and addressed by participatory research and interventions at both the social and individual levels. This framework has been used as the basis of the UNAIDS best practice model for HIV prevention in migrant populations.[10,11]

A key principle of the framework is the active participation of migrant communities in HIV research and HIV prevention programs. Such partnerships are essential to the understanding of the specific factors affecting risk of exposure to HIV and access to diagnostic, care and support services for particular migrant communities. Even such small communities as those recently arrived from West Africa are diverse with respect to education, language, and circumstances of migration, to name a few. The approach used by Drummond *et al*. is an example of cooperation between researchers and community-based organisations, and their study contributes to the local knowledge base required for effective HIV prevention work in Australia's African communities.

Conflict of interest

None declared.

Financial support

Chris Lemoh received a scholarship from the Centre for Clinical Research Excellence in Infectious Diseases. Beverley Ann Biggs received a Public Health Research Grant from the Victorian Government's Department of Human Services. Margaret Hellard receives funding from the NHMRC for a career development fellowship and VicHealth for a senior public health research fellowship.

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Manuscript received 6 August 2008, accepted 21 August 2008