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SEXUAL HEALTH

Domestic mobility and experiences of disconnection from sexual health care among gay and bisexual men in Australia: insights from a qualitative study

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ABSTRACT

Background. Previous research on mobility and HIV acquisition among gay and bisexual men (GBM) has focused on: (1) changed sexual practices in the context of travel; and (2) the association between migration and increased HIV risk. To date, little attention has been given to continuity of sexual health and HIV-prevention services in the context of relocating between different cities or regions within the same country. **Methods.** Drawing on in-depth interviews with 17 GBM recently diagnosed with HIV, we explored these men's access to sexual health care in the period prior to diagnosis. **Results.** At least five of these 17 men's accounts provided examples of becoming disconnected from sexual health care because of mobility within Australia. For some men, this disconnection from care also included loss of access to pre-exposure prophylaxis (PrEP). In all these men's accounts, reconnection with services only came about at the time of seeking the HIV test associated with their diagnosis. The fact that men who had previously been well connected to sexual health services (as indicated by early uptake of PrEP, or regular HIV/STI testing) did not easily access similar services after relocating suggest that there are other factors – such as the social and physical environment – that have an important bearing on retention in sexual health care. **Conclusions.** There is a need for more comprehensive data collection related to mobility in order to ascertain its relative importance. Regarding policy and practice, there are also opportunities for a more formalised process for interstate referral of clients of sexual health services.

Keywords: Australasia, gay and bisexual men, health care retention, HIV/AIDS, HIV testing, migrant and mobile populations, pre-exposure prophylaxis, sexual health care.

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Introduction

There have been two main strands of research on mobility and HIV acquisition among gay and bisexual men (GBM): the first has investigated the effect of travel on HIV risk;[1–6] and the second has specifically examined the association between migration and increased HIV risk.[7–12] In addition, there has been some research on internal migration and HIV risk, in particular in the US, which has focused on changes in sexual practices after moving to larger urban centres.[11,13,14] There has not, however, been any detailed exploration to date of the effect of mobility on men's access to sexual health care – including HIV testing and use of pre-exposure prophylaxis (PrEP) – which may increase vulnerability to HIV, and lead to delays in the detection of new HIV infections.

Methods

Participants in a prospective online cohort study of people living with HIV (diagnosed in 2016 or later) were invited to take part in an optional in-depth interview. This qualitative component of the study comprises 24 participants, of whom 17 had any history of

male-to-male sex. Almost all (94%) of these participants described their sexual identity as gay or bisexual, 76.5% were born in Australia, and their median age was 32 years (range 24–50 years). The interviews were conducted face-to-face or by telephone/videoconference by authors 1 (DM) and 2 (SP). Data collection occurred between January 2019 and April 2020. Interviews were audio recorded, then transcribed. Members of the research team (authors 1 and 2) coded the materials using an inductive approach,[15] as well as drawing on themes in the existing empirical literature.

Ethics approval

The UNSW Human Research Ethics Committee (HC180459) approved this study.

Results

Mobility within Australia in the period prior to acquiring HIV infection was a theme linking at least five of the accounts of the gay and bisexual-identifying men in the study. This mobility, which most often involved relocation between the major cities, was associated with discontinuity in their sexual health care. Loss of access to sexual health care meant certain loss of access to PrEP; and interestingly, loss of access to PrEP also seemed, in turn, to contribute to an extended period of disconnection from sexual health care.

Pre-exposure prophylaxis

Prior to April 2018,[16] PrEP was mostly available in Australia through demonstration studies, and the fact that these PrEP access schemes were developed at a local level presented barriers – both perceived and real – for study participants who moved between states. Angus's (aged 28 years) account provides some insight into this experience.

> I moved at the end of 2016, so I was mid-way through the [PrEP study] then. I was still on the trial for the first two months [after moving] and I would go back to [other city] a little bit, so I would replenish the script [there]. [. . .] And then I left that job and was doing something else, so wasn't going back to [other city]. I tried to get on the trial [here] and they were all full. So, I couldn't get on PrEP.

Notably, at the time of his diagnosis, approximately a year after relocating, he had still not accessed any general practitioner or sexual health provider locally. The reason for seeking this HIV test was a suspected seroconversion illness.

Like Angus, another participant, Hamish (aged 35 years), had also been accessing PrEP through a demonstration study, and his supply of PrEP ran out around the same time he moved interstate. His sexual practices – involving condomless sex in group settings in the context of injecting crystal methamphetamine – remained quite similar, however, although he tried to reduce risk by selecting partners who were HIV negative or on antiretroviral therapy.

> I had been on PrEP previously, and that was quite effective, which is why I sort of kick myself.
>
> *Why did you stop?*
>
> I'd run out and I'd moved to [current city] and [. . .] I was in a really odd sort of space in my own head, in life, and just couldn't be bothered with a lot of things. And unfortunately, that was one of them.

The regret and reproval Hamish expressed in his interview suggests he imagines it would have been possible to access PrEP if he'd established a relationship with a local service provider. His first contact with local services, however, was to seek post-exposure prophylaxis (PEP) for a needlestick injury, and testing at this time revealed established HIV infection.

Sexual health care and HIV testing

Moving states or cities can also create other risks for becoming disconnected from sexual health care. Similar to the accounts above, Dexter (aged 50 years) described relocating between two of Australia's main cities, albeit several years earlier. This move also involved a change from living in an inner-city 'gaybourhood',[17] to a more 'suburban' setting in another capital city. After relocating, his frequency of HIV and STI testing changed dramatically – from approximately once every 6 months to not testing at all for more than a decade, despite frequently engaging in condomless sex. He describes 'falling out of the habit' of testing despite occasionally visiting a general practitioner, because of discomfort around discussing sex and sexual health.

> And moving into the suburbs, not having, you know, the cute, gay doctor, and I just got out of the habit. [. . .] So, I ended up just falling out of the habit of actually requesting it to the point where I just didn't get it done anymore.

Dexter's account makes a strong connection between living in a gay enclave – as he had previously – and being habituated to regular HIV and sexual health testing. His reason for eventually testing was a suspected seroconversion illness, although he was found to have established HIV infection (with a CD4 count of 260, this was a 'late' diagnosis).

Discussion

The accounts of the men in this study suggest that even within a country like Australia, relocating from one city or state to another can present a risk of becoming disconnected from sexual health care. It is also important to note that for all of the men who experienced an interruption to their care, the time between their previous HIV test and the HIV test associated with their diagnosis was more than a year, and in at least one case, several years. Also, these men had a specific reason for seeking out this HIV test, suggesting that these diagnoses may have been further delayed had it not been for these reasons.

A theme that linked some of the accounts of men in the study was that of having previously been on PrEP. The emerging literature on reasons for discontinuing PrEP, however, has not identified mobility. Whereas some studies from the US have identified loss of access to sexual health services as contributing to PrEP discontinuation, this interruption to care has been associated with cost and time of medical visits, and loss of insurance coverage.[18–20] In addition, mobility – and its effect on access to sexual health care – have not been well explored in HIV prevention cascades,[21–24] which have tended to focus on other factors such as willingness and perceived social norms.

In Australia, community prescribing and dispensing should now reduce barriers to maintaining PrEP use for people who move between jurisdictions, compared to the period when PrEP was available primarily through state-specific studies. However, it is still necessary for men to seek out healthcare providers after they relocate, which based on the accounts of the men in this study, is something that may take some time.

Another interesting finding was that most men had previously been very well connected to sexual health services (as indicated by early uptake of PrEP, or regular HIV/STI testing). However, this history did not mean that they quickly or easily accessed similar services in a new jurisdiction after relocating. These experiences suggest that there are other factors – apart from an individual's history of service use – that have an important bearing on retention in sexual health care. One participant's account explicitly noted the role of the social and physical environment on his engagement with sexual health services. There is established international literature on these connections – including with social engagement, health-seeking behaviour, and overall wellbeing[14,25–30] – and they are now also receiving increasing attention in Australia.[31]

It is also worth noting that other mobility-related issues are also still relevant. For example, over one-third of GBM interviewed believed they acquired HIV while travelling, or living temporarily, in other countries.

Conclusion

It is unknown to what extent domestic mobility contributes to interruptions in sexual health care. There is, therefore, a need for more comprehensive data collection related to mobility, including mobility within metropolitan areas, in order to ascertain its relative importance in terms of continuity of sexual health care; for example, via existing cross-sectional surveys and cohort studies (in addition to investigating the association between mobility and HIV diagnosis). Regarding policy and practice, there are also opportunities for a more formalised process for interstate referral of clients of sexual health services (and general practice), which could be facilitated by service providers in both the departure and arrival jurisdictions, and could be promoted by local HIV and community health organisations.

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Data availability. The study dataset is available on request.

Conflicts of interest. The authors declare that they have no conflicts of interest.

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